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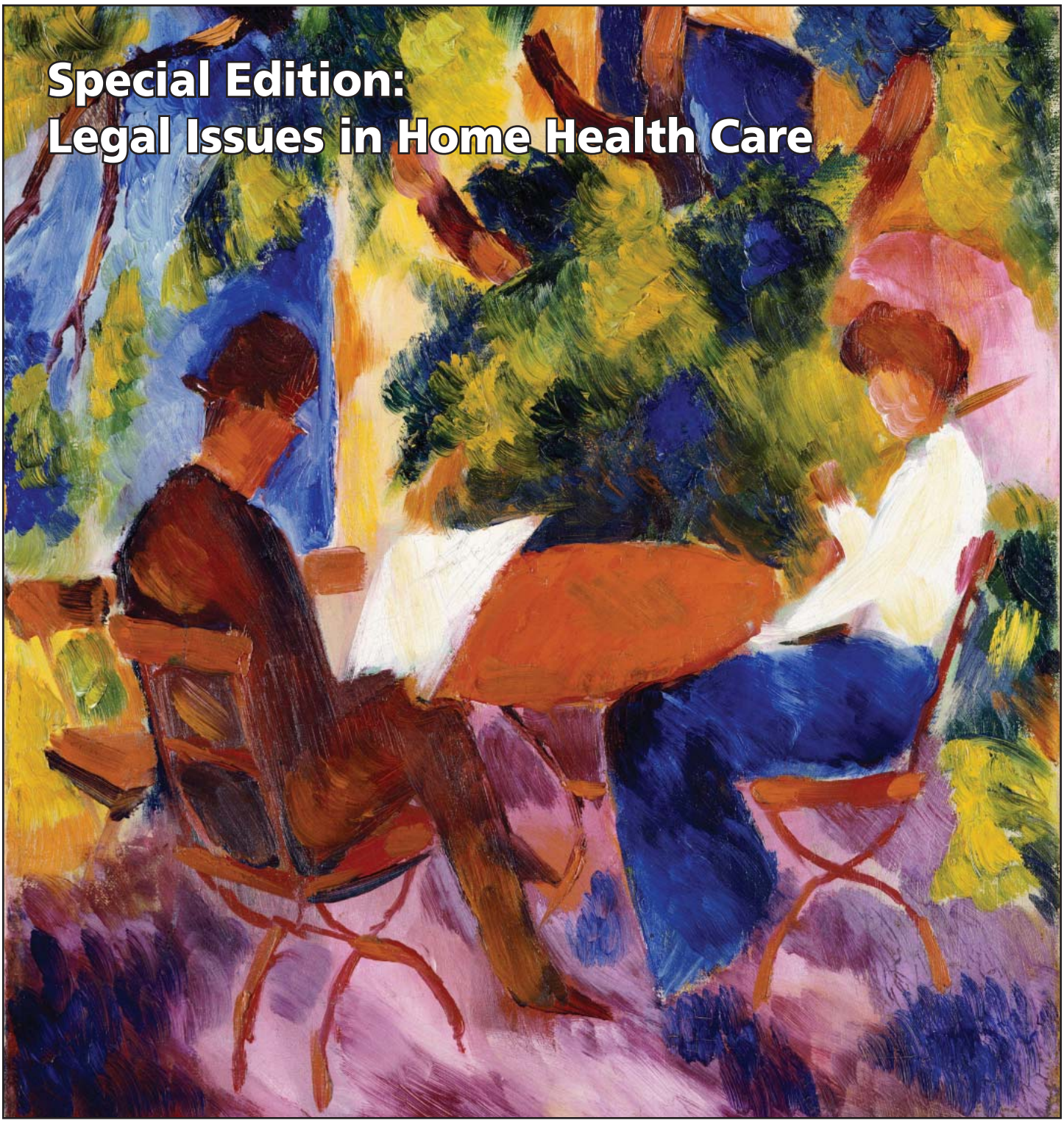
Health Law Journal

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



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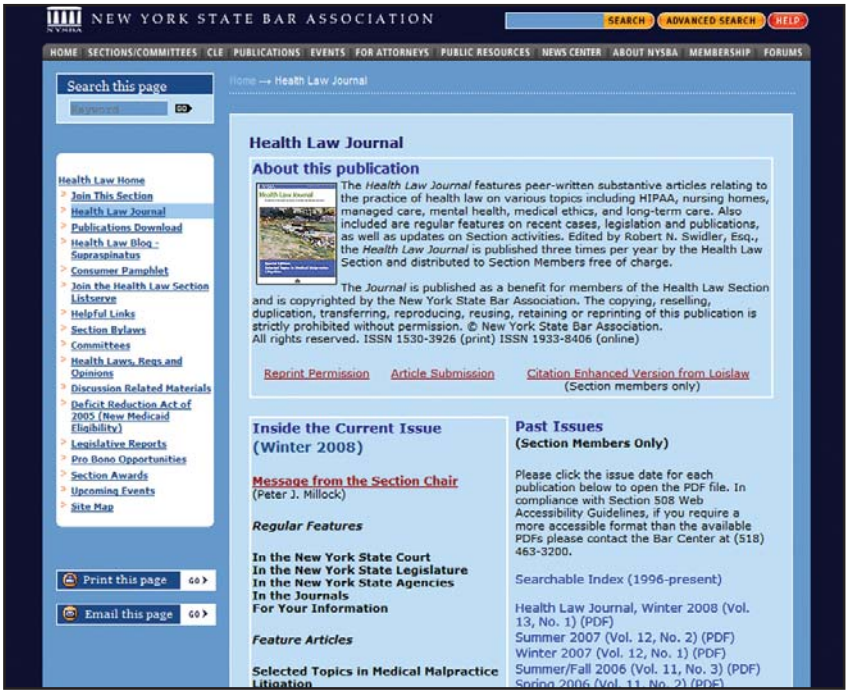

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NYSBA

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Spring 2008

Vol. 13, No. 2

THE HEALTH LAW SECTION
NEW YORK STATE BAR ASSOCIATION

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Cover artwork:
***At The Garden Table, Paar Am Gartentisch* by Auguste Macke (1887-1914), Oil on Canvas, 1914**

A Message from the Section Chair

This year brings challenges to health lawyers and our clients. The challenges take many forms.

The greatest challenges lie in the continuing dysfunction of the health care delivery system manifested in the ever escalating share of our economy devoted to health care; the huge and growing number of Americans without health insurance; the growing disparities in access to care across racial, ethnic and income lines; and the declining investment in public health programs and a host of public health problems, including obesity and poor dental health, all likely to be exacerbated by the economic recession.

In New York where most of us work, the challenges are more provincial but no less consuming: the "rightsizing" of New York's health care delivery system through the Berger Commission; the revamping of Medicaid championed by the State Health Department; the growing size and self-defined jurisdiction and authority of the Office of the Medicaid Inspector General and its sidekick, the AG's Medicaid Fraud Control Unit; the revived state effort to reform our irrational medical malpractice system and the continuing effort to enact finally a health care decision making act and similar laws which would at least put us on a par with most other states.

With the exception of a lucky few working in and around government or now and then bringing landmark litigation, there are few opportunities to grapple with these challenges as we address the discrete problems our clients bring us. In these matters, we may assess the impacts of the great challenges, but we know our clients want us to address their particular problems, not the world's.

That, of course, leads me logically to the Health Law Section of the State Bar Association. We may not solve any problems, but we sure do have fun illuminating them. If a Section member cares about an issue, and is willing to spend some time and energy on it, he or she may discuss it at one of the Section's eleven committees, organize and speak at a Section program on the subject, or write an article for our justly applauded *Health Law Journal*. As in any volunteer organization, a member with commitment will have an impact.

So if Governor Paterson or Commissioner Daines has not solicited your personal opinion about how to solve a major problem in our health care system, there's still hope. You can become, or continue to be, an active member of the Section.

So far this year, the Section has had a very well-attended program on medical malpractice reform which featured the first-ever appearance before our Section of the State Health Commissioner, and programs on long-term care and public health emergencies. We are now planning a fall program on October 18 at the Gideon Putnam in Saratoga Springs, and our next Annual Meeting in New York in January 2009. Your suggestions and participation are most welcome.

The Section has also published two issues of the *Health Law Journal*: a winter issue on medical malpractice and the current issue on home care. The new Section blog has scored more than 3,000 visits; and the Section listserve has been used almost every day to solicit input on health law questions.

On June 1, the Chair's gavel passed to Ross Lanzafame, a partner at Harter Secrest in Rochester. Ross brings a wealth of experience as a health law practitioner and active member of the Section. He has great plans for the coming year, including reinvigorating our committee structure. Best wishes, Ross, for the 2008–2009 season.

Peter J. Millock

"Editor's Note: In June 2008, Ross Lanzafame began his term as Chair of the Health Law Section. Ross' first message will appear in the next edition of the Health Law Journal*."*

In the New York State Courts

By Leonard M. Rosenberg

Medical Provider Owes No Duty to Warn Non-Patient of Risk of Contracting Illness from Patient Under Provider's Care

Herrgesell v. Genesee Hosp., 45 A.D.3d 1488, 846 N.Y.S.2d 523 (4th Dep't 2007). Plaintiff's estate administrator sued The Genesee Hospital (the "Hospital") and Dr. Patrick Connors ("Dr. Connors"), among others, seeking damages for Deborah Linzy's wrongful death from hepatitis B, which she contracted from her father. Plaintiff argued the various defendants were negligent and in violation of 10 N.Y.C.R.R. § 2.27 by failing to warn Linzy of the danger of hepatitis B and the need to take precautions from becoming infected herself. Plaintiff also argued the defendants knew or should have known Linzy was living with and caring for her father. The evidence showed that while Linzy's father was a patient of every defendant, Linzy was only a patient of Dr. Connors.

The Appellate Division held the trial court erred by dismissing the complaint against Dr. Connors, noting "[A] doctor who actually treats a patient has 'a duty of care' toward that patient" and there was an issue of fact as to when Dr. Connors might have learned Linzy was at risk of contracting hepatitis B.

The court affirmed dismissal of the complaint as to the remaining defendants. The court noted a medical provider does not owe a duty to a non-patient who contracts an illness from one of the provider's patients, even if the provider knows the non-patient is a caregiver, family member, or close friend of the patient, unless the non-patient's injury is caused by patient's treatment. In the absence of a provider-patient relationship, defendants had no duty to warn the non-patient of the dangers of contracting hepatitis B in caring for her father, or of the need to be vaccinated or use other precautions.

Finally, the court held the defendants' alleged violation of 10 N.Y.C.R.R. § 2.27 had no bearing on their right to summary judgment because that regulation does not give rise to a private right of action in favor of family members who have contracted or might contract a communicable disease from the medical provider's patient. [Ed. note: 10 N.Y.C.R.R. § 2.27 requires an attending physician to isolate a person with a highly communicable disease, and to advise other members of the person's household regarding precautions to be taken to prevent spreading the disease].

Seizure of Blood Sample and Disclosure of Blood Alcohol Test at Trial Do Not Violate Physician-Patient Privilege

People v. Elysee, 49 A.D.3d 33, 847 N.Y.S.2d 654 (2d Dep't 2007). In December 2003, Fritz Elysee ("Elysee") drove at high speed through a red light at a major Brooklyn intersection and hit a pickup truck. Police and firefighters who arrived on the scene to help Elysee testified there was a strong smell of alcohol in the car, Elysee's speech was slurred and he was belligerent and confrontational. Paramedics and emergency department personnel also testified Elysee was incoherent and smelled of alcohol.

The Police Department ("NYPD") obtained two sets of Elysee's blood samples and sent them to Dr. Elizabeth Marker ("Dr. Marker"), a toxicologist with the New York City Chief Medical Examiner's Office, for analysis. The first set ("Warrant Samples") was drawn immediately after Elysee arrived at the hospital and was seized by the NYPD in accordance with a search warrant, while the second set ("VTL Samples") was drawn about nine hours later pursuant to a court order issued under section 1194 of New York's Vehicle and Traffic Law ("VTL"). Dr. Marker testified the tests for both samples indicated Elysee was severely intoxicated at the time of the accident.

Elysee moved before trial to suppress the results of the Warrant Samples on the grounds the seizure violated the physician-patient privilege set forth in CPLR 4504. The motion court denied the motion, finding the facts in the warrant application established probable cause to obtain the warrant, and CPLR 4504 was not applicable to the vials of blood. The Appellate Division affirmed, holding neither the seizure of the Warrant Samples nor the admission of the results of the blood alcohol test performed on them violated the physician-patient privilege.

The court initially noted that, by its terms, CPLR 4504 prohibits a physician from disclosing "any *information* which he acquired in attending a patient in a professional capacity and which was necessary to enable him to act in that capacity (emphasis added)." The Appellate Division then concluded that here the plain meaning of "information" meant knowledge about the patient's medical condition, including diagnosis or treatment, or records, rather than the source of that knowledge, such as the blood vials. The court also indicated once constitutional concerns had been satisfied with respect to the taking of the sample (i.e., it was taken pursuant to a validly issued warrant), blood was similar to other property subject to seizure by warrant and therefore subject to various scientific tests.

The Appellate Division then reviewed the development of both the case law and the legislative responses to those cases, and concluded the "evolution of the relevant body of law governing the obtaining of blood

samples to be used in the prosecution of cases involving a motorist suspected or charged with driving while intoxicated or impaired evidences an intent to facilitate the State's ability to obtain this evidence." The court then distinguished those cases, such as *Dillenbeck v. Hess*, 73 N.Y.2d 278, 539 N.Y.S.2d 707 (1989), where the Court of Appeals protected the disclosure of blood alcohol tests conducted by a patient's medical provider and where the results were placed in the patient's medical record. The court argued this distinction offered the proper balance between the state's compelling interest in prosecuting drunk drivers and the three main policy objectives behind CPLR 4504, namely maximizing honest patient-physician communications so as not to deter people from obtaining medical treatment; encouraging medical providers to be candid with their patients; and maintaining complete medical records and protecting patients' reasonable privacy expectations regarding the disclosure of sensitive medical information. Furthermore, the court noted extending the privilege to cover the Warrant Samples would only "allow the driver to forestall the inevitable" because the legislature has enacted mandatory alcohol testing under VTL § 1194. Finally, the court held there was no compelling public policy objective to expand the physician-patient privilege to include a physical blood sample, as this would deprive the jury of lawfully obtained and probative evidence.

Court of Appeals Limits *Brown v. New York City Health and Hospitals Corp.* to Its Specific Facts and Holds Damages for Claims of Negligent Infliction of Emotional Distress Due to HIV Exposure Are Not Limited to the Six-Month Period Following Exposure

Ornstein v. New York City Health and Hospitals Corp., 10 N.Y.3d 1, 852 N.Y.S.2d 1 (2008). In September 2000, Plaintiff Helen Ornstein ("Ornstein"), a nurse at Bellevue Hospital in Manhattan, was stuck by a hypodermic needle that had been left in the bed of a patient infected with Acquired Immune Deficiency Syndrome ("AIDS"). Ornstein was immediately treated with anti-viral medications due to her potential exposure to the Human Immunodeficiency Virus ("HIV"). She took these medications for two months, suffering side effects, such as nausea, for several months thereafter and also promptly began an HIV antibody testing regimen. While these antibodies do not appear on the date of exposure, they can develop over time; if present, they indicate a person has contracted HIV, which may lead to AIDS or other HIV-related illnesses. Ornstein was tested every three months for a period of two years following her exposure but consistently tested negative for infection with HIV.

In May 2001, Ornstein sued New York City Health and Hospitals Corporation ("HHC"), as operator of the hospital, for negligent infliction of emotional distress. HHC then moved to dismiss that part of Ornstein's claim that sought damages for any emotional distress suffered more than six months after the needle-stick incident. In support of its argument, HHC cited *Brown v. New York City Health and Hospitals Corp.*, 225 A.D.2d 36, 648 N.Y.S.2d 880 (2d Dep't 1996) for the proposition that damages for emotional distress beyond the six-month mark are not recoverable, because a person exposed to HIV who has tested negative at that point is so unlikely to become infected it would be unreasonable, as a matter of law, for that person to continue to fear infection or claim emotional distress from that exposure.

Ornstein submitted evidence she experienced mental anguish from the incident long after the initial six-month period had passed and expected to suffer permanent post-traumatic stress disorder ("PSD"). She also testified her physician did not tell her that her fear of contracting HIV should have been allayed after six months, and she was anxious until she tested negative in June 2002, about 18 months after the incident. Ornstein stated that even after the fear of testing positive subsided, she continued to suffer PSD in the form of poor sleep and "flash backs" relating to the incident, and eventually changed her work to a position that did not require any patient contact. Furthermore, her symptoms continued even though she underwent psychiatric therapy and took anti-depressant medications. Finally, a psychiatrist testified Ornstein suffered from chronic PSD from the needle-stick incident which would require treatment for the foreseeable future.

The trial court denied HHC's motion, finding Ornstein set out a *bona fide* claim of continuing emotional distress. HHC then took an interlocutory appeal; a three-justice majority of the Appellate Division reversed and granted HHC's motion to restrict damages, while two dissenting justices would have affirmed the lower court. At trial, Ornstein was unable to offer evidence she suffered damages beyond the six-month period immediately following the needle-stick. The jury found HHC liable and awarded Ornstein $333,000 for past pain and suffering and $15,000 for past lost wages. She then sought review in the Court of Appeals, which reversed both the judgment and Appellate Division order, and remanded the case to Supreme Court for a new trial on damages.

The Appellate Division largely relied on *Brown* to limit Ornstein's right to seek damages for periods beyond the initial six months after the needle-stick. As in this case, the plaintiff in *Brown* was a nurse who was stuck by a needle used in treating an HIV-infected patient. She commenced a negligent infliction of emotional distress lawsuit seeking damages for the period between 1990, when the needle-stick incident occurred, and 2005 on the theory that, if she was free of the disease after 15 years, her risk of infection would be over. After an initial HIV test taken on the day of the incident, which would not have

shown a positive result even if she had contracted the virus that day, the plaintiff refused to take any further HIV tests. The Appellate Division, noting that HIV tests are 99% accurate and 95% of HIV-positive individuals will test positive within six months of exposure, determined that once a plaintiff tested negative for HIV six months after exposure, her fear of contracting AIDS would be unreasonable as a matter of law and it would be inequitable to allow her to circumvent this by refusing to be tested.

The Court of Appeals distinguished *Brown* by characterizing it "as a compromise fashioned to address the dilemma created by plaintiff's decision not to be tested." On the one hand, a positive test might have caused the plaintiff further emotional distress. On the other, her refusal to be tested left the defendants in the untenable position of having to defend the case while plaintiff's HIV status remained unknown, which might have led the jury to speculate the plaintiff had, in fact, contracted HIV and therefore award excessive damages. The court went on to note *Brown* should not apply to a case like this where the plaintiff has been tested at regular intervals with negative results, and was never told that her risk of testing HIV positive in the future would dramatically decrease, if not disappear, once she tested negative at the six-month point.

The court also rejected HHC's argument that damages should be curtailed in this case because of the "still-prevalent ignorance and subjective, irrational fears surrounding" AIDS, and that public policy considerations support "taking emotions out of the equation of AIDS cases at a fixed point in time so as to ensure fairness and consistency." The court stated that even assuming HHC's assertions were true, it was not persuaded emotions could be removed from the equation in cases of HIV exposure. More importantly, the court stated HHC failed to show a bright-line restriction of damages rule, an approach "unprecedented in our common law tort jurisprudence," was necessary to avoid unreasonably high verdicts in these cases.

Thus, the Court of Appeals limited *Brown* to its specific facts and held that the measure of damages for claims of negligent infliction of emotional distress for HIV exposure is not limited, as a matter of law, to the six-month period immediately following the exposure.

In Case of First Impression, Supreme Court, Queens County, Holds Plaintiff Can Assert Fraud Claim Against Unlicensed "Imposter" Dentist

Adames v. Velasquez, 2008 WL 852805 (Sup. Ct., Queens Cty. Apr. 1, 2008). In a case of first impression in New York, the court confronted the question of whether a plaintiff could bring an action against an unlicensed or "imposter" dentist for injuries sustained to his teeth on theories of fraud (CPLR 213(8)), or breach of contract (CPLR 213(2)), each of which carries a six-year statute of limitations, rather than the more common theories of negligence, which carry a three-year statute (CPLR 214(5)), or medical malpractice, which has a limitations period of two years and six months (CPLR 214-a). Jose Adames ("Adames") met Rafael Velasquez ("Velasquez"), who had allegedly falsely represented he was a dentist and, upon learning of Adames' dental problems, offered to fix Adames' teeth at a discount from the rates charged by Ketly Nino, Velasquez's wife and a licensed dentist ("Nino"). Adames agreed, and, over the course of several evenings, Velasquez filled cavities in approximately 11 of Adames' teeth. Adames then experienced dental pain; after being examined, other licensed dentists told Adames the cavities were filled improperly and he may lose his teeth as a result of Velasquez's "services." Adames then learned Velasquez was not a licensed dentist, but rather a lab technician in Nino's dental practice.

Adames then sued Velasquez, Nino, and her dental practice approximately five and one-half years after these "services" were provided. The court discerned from the complaint the plaintiff was attempting to assert two "causes of action," one for negligence, medical malpractice and fraud, and another for breach of contract and fraud. The court granted the defendants' motion to dismiss the cause of action based on negligence or medical malpractice because the statute of limitations could not be tolled and the claim was therefore time-barred. The court also granted the motion to dismiss the claim for breach of contract as against Nino and the dental practice, holding they were insufficiently stated, but denied the motion as to Velasquez on both the breach of contract and fraud claims. The court also denied the motion to dismiss the fraud claim against Nino and the practice, finding they each might be liable for Velasquez's acts on the theory of *respondeat superior*.

The court then indicated Adames had set forth all of the requirements of a fraud action by pleading (1) Velasquez made false material representations; (2) Velazquez knew they were false and made them with the intent to deceive; (3) Adames was deceived and justifiably relied on Velasquez's representations, and (4) Adames was injured as a result. The court further argued the result was necessary to protect the public from the dangers of the unlicensed practice of the professions, and noted that permitting Adames to go forward would not make an "end run" around the general rule forbidding the assertion of a fraud claim that merely restates a malpractice or negligence claim in an effort to seek greater damages. Here, the court argued, Velasquez's alleged deceptions, which are deemed to be true for purposes of a motion to dismiss, constitute a distinct act from allegedly rendering negligent dental "services."

Issues of Fact Preclude Summary Judgment Regarding Existence of Physician-Patient and Hospital-Patient Relationships in Malpractice Suit by Participant In Research Study

Sosnoff v. Jackman, 45 A.D.3d 568, 845 N.Y.S.2d 391 (2d Dep't 2007). In May 1996, plaintiff Mary Anne Sosnoff ("Sosnoff") agreed to participate in a hospital research study regarding the early detection of ovarian cancer in patients with a family history of the disease. Between 1996 and 2001, in accordance with the study's protocol, Sosnoff was examined at the hospital every six months by a variety of physicians and underwent diagnostic imaging tests such as vaginal sonograms and ultrasounds, which were interpreted by a radiologist. In February 2001, Sosnoff was diagnosed with Stage 3C uterine cancer with involvement of her ovaries and lymph system.

Sosnoff commenced a malpractice action against several defendants, including the hospital, a physician and the radiologist in connection with their failure to diagnose her uterine cancer at an earlier stage. The hospital and physician moved to dismiss the complaint. The trial court granted the hospital's motion on the grounds it had successfully shown an absence of a hospital-patient relationship, but denied it as to the physician on the grounds there were issues of fact as to whether the physician and Sosnoff had entered into a physician-patient relationship.

The Appellate Division affirmed the trial court's order as to the physician, finding issues of fact regarding the existence of a physician-patient relationship and the application of the "continuous treatment" doctrine. The court noted that discrete, intermittent diagnostic radiological interpretations are generally not considered a continuous course of treatment unless they are periodic diagnostic exams prescribed as ongoing care for an existing condition. Here, the Appellate Division found a question existed as to whether the imaging procedures provided to Sosnoff under the protocol were also prescribed to monitor her risk of developing ovarian cancer.

The Appellate Division modified the order as to the hospital, however, finding a question of fact remained as to whether Sosnoff and the hospital entered into a hospital-patient relationship. The record contained some evidence to suggest Sosnoff enrolled in the study not just as a subject or a control person, but rather as a patient who expected to receive medical treatment from hospital physicians exercising an appropriate level of professional skill such that she could rely on them to diagnose any malignancy.

Hospital Cannot Involuntarily Administer Psychotropic Medications to Minor Over Parents' Objection After Hearing to Which Parents Were Not a Party

Sombrotto v. Christiana W., 50 A.D.3d 63, 852 N.Y.S.2d 57 (1st Dep't 2008). In December 2006, Christiana W., a 14-year-old girl ("Christiana"), was admitted to Lincoln Hospital's emergency room after becoming upset and ingesting approximately 15 tabs of amoxicillin and five Motrin. She told hospital personnel that she was stressed, she had been in a physical altercation with her mother, she dropped out of school because was depressed and failing her classes and the New York City Administration for Children's Services ("ACS") had an active case file on her. Christiana further indicated she was not certain that she wanted to die but that she did intend to hurt herself.

After being medically cleared by the hospital, Christiana's mother voluntarily admitted her to Payne Whitney Manhattan ("PWM") in accordance with Section 9.13 of the Mental Hygiene Law. Christiana's mental condition appeared to improve somewhat, and the record indicates her physicians wanted to begin giving her various medications, although her parents refused to consent to this treatment. In January 2007, PWM converted her admission to an involuntary status based on the certification of two physicians that she posed a risk to herself and others. Her treating psychiatrist, Dr. David Rubin ("Dr. Rubin") asked ACS to investigate the case; the agency reviewed the matter but declined to file a medical neglect petition against Christiana's parents despite their objection to the use of medications.

Dr. Lisa Sombrotto ("Dr. Sombrotto"), on behalf of PWM, then commenced a proceeding seeking an order permitting PWM to involuntarily draw blood and administer risperidone, lithium and Depakote to Christiana. The petition was supported by two physician affirmations. Mental Hygiene Legal Services ("MHLS") opposed the petition on Christiana's behalf by arguing her parents had a fundamental right to determine the appropriate treatment for her and, if they abused that right, the proper remedy would be a neglect proceeding in Family Court. MHLS further argued neither the Mental Hygiene Law nor its implementing regulations provide for the administration of psychotropic medication to a child over the parents' objection, and the proceeding brought by the hospital is unavailable when the child is under 16 years of age and the parents refuse to consent to the treatment.

At a hearing in March 2007, the parties disagreed over whether the court had jurisdiction and whether *Rivers v. Katz*, 67 N.Y.2d 485, 504 N.Y.S.2d 74 (1986), the case pursuant to which the hearing was purportedly being held, applied to a minor Christiana's age. The court determined it possessed jurisdiction, and proceeded with the hearing. Dr. Rubin was the sole witness; Christiana's parents were present but declined to testify without counsel present.

Dr. Rubin testified Christiana's behavior had improved significantly during her hospitalization; even without medication, she was

well-behaved, polite with the staff and participated appropriately in group activities. Dr. Rubin also noted Christiana had not expressed any suicidal ideation or made any suicidal gestures, although he nevertheless felt the administration of psychotropic medication was still necessary because she felt chronically depressed and, when under stress, her mood escalated quickly.

The trial court granted PWM's petition, citing *In re Storar*, 52 N.Y.2d 363, 438 N.Y.S.2d 266 (1981), *cert. denied*, 454 U.S. 858, 102 S. Ct. 309 (1981), for the proposition that under New York law "parents may not deprive their child of life-enhancing treatment." The court also found PWM had properly presented the determination of two doctors that it was in Christiana's best interests to take the medications. Furthermore, the court denied MHLS's application for Christiana's release.

The court examined the applicable statutes, including their legislative history, and case law to determine the overarching principles of how New York law balances the right of hospitals, minor patients and parents with respect to the administration of medications over objection. The court concluded that while under New York law a parent or guardian has the right to raise his or her child as he sees fit, this right is not absolute, and a parent's or guardian's decision concerning treatment must yield to the State's interest in promoting the minor's welfare when a parent or guardian rejects treatment that is in the child's best interests and he provides no reasonable alternative treatment.

Nonetheless, the appellate court reversed, holding Christiana's parents should have been made parties to the proceeding below, and noting ACS did not file a neglect proceeding against Christiana's parents after conducting an investigation, and her parents had sought alternative treatment for her. The Appellate Division also held the lower court erred in relying on Mental Hygiene Law § 33.21(e)(2)(iii), as that section by its terms applies to minors "sixteen years of age or older," whereas Christiana was 14 years old at the time of the hearing.

The court below also erred in citing *Storar* for the proposition that parents may not deprive their child of life-saving treatment, as that case involved two incompetent, terminally ill patients with no reasonable chance of recovery. Here, the court noted there was no evidence presented that Christiana was suffering from a life-threatening condition and, in view of the medications' possible side effects and Dr. Rubin's equivocal testimony regarding whether they would provide any long-term benefit, the hearing court's reliance on *Storar* was clearly misplaced.

Court Dismisses Breach of Contract, Defamation and Tortious Interference Claims Brought by Medical Resident Against Hospital

Schaefer v. Brookdale University Hospital and Medical Center, 2008 WL 595881 (Sup. Ct., Kings Cty. Mar. 3, 2008). In July 1994, plaintiff Harold C. Schaefer, M.D. ("Schaefer") began a six-year residency program in urology ("Program") at Brookdale University Hospital and Medical Center ("Brookdale"). The first two years of the Program were spent in general surgery, while the final four years focused on the specialty of urology. Each Program year runs from July 1 to the subsequent June 30, and is covered by a separate Residency Agreement.

In July 1996, Schaefer started the urology portion of the Program; later that year, he learned he had earned a very low score on his annual in-service exam ("ISE"), a standardized exam testing knowledge of urology, and he had received poor evaluations regarding his surgical skills. For example, Dr. Hong Kim, Chairman of Brookdale's Urology Department ("Dr. Kim"), noted in May 1997 that Schaefer "did extremely poor [in his] in-service exam" and he was "poor in surgical skills." Schaefer continued to earn low scores on subsequent ISE's and receive poor evaluations of his surgical skills throughout the fourth and fifth years of the Program, The record also indicated that during this time, Schaefer had several conferences with Dr. Kim and other Program professors to discuss changing his career path to a non-surgical specialty, as they had serious doubts Schaefer would ever become sufficiently competent to provide unsupervised surgical treatment.

In January 1999, Dr. Kim and two colleagues told Schaefer he would not be promoted to his sixth and final Program year because of his poor clinical and academic performance. Dr. Sheldon Berman, Brookdale's Director of Medical Education, then told Schaefer no recourse was available to him and he was not entitled to any further due process. Schaefer resigned in March 1999 and Dr. Kim promptly accepted his resignation. In September 2003, Schaefer sued Brookdale and Dr. Kim for one claim of breach of contract, four claims of defamation, and one claim alleging tortious interference with prospective business relations, seeking an aggregate of $9 million in compensatory damages and $5 million in punitive damages. In its opinion and order of March 3, 2008, the court dismissed all of Schaefer's claims in their entirety.

The court dismissed Schaefer's breach of contract claim for lack of subject matter jurisdiction, holding the sole remedy for a hospital's alleged failure to renew a resident physician's contract is the grievance procedure set forth in Section 2801-b of the Public Health Law. It also, in *dicta*, dismissed this claim as a matter of law, finding that Schaefer's various arguments, such as being denied due process or being constructively terminated, were unavailing, and that Brookdale was, in any event, under no legal obligation to renew his contract.

The court also dismissed Schaefer's four defamation claims in-

volving letters or other written communications from Dr. Kim to various official regulatory bodies such as the Federal Credentials Verification Service ("FCVS"); the New Jersey State Board of Medical Examiners ("NJ Board") and the Residency Review Committee of Urology of the Accreditation Council of Graduate Medical Education ("ACGME Committee") regarding Schaefer's academic record and surgical skills, or other aspects of his tenure at Brookdale. The court noted Schaefer had executed a form authorizing Brookdale to release information to FCVS and extending Brookdale "absolute immunity" in connection with any such release; that each of Dr. Kim's statements were true and that truth is a complete defense to a defamation claim; and each of Dr. Kim's statements were protected by a qualified privilege to further society's interest in encouraging professionals or others under a legal duty to communicate information to communicate freely. The court also held Schaefer's conclusory allegations of malice on Dr. Kim's part were insufficient to defeat the privilege or raise a triable issue of fact.

Finally, the court held Schaefer's claim of tortious interference with business relations with a prospective employer was defective for failing to offer any proof the defendants used wrongful means or acted for the sole purpose of harming him. Rather, the allegedly defamatory communications, the same underlying Schaefer's dismissed defamation claims, were made "for the legitimate purpose of verifying [Schaefer's] competency to practice medicine so as to become licensed [in New Jersey.]"

Physician Breached Duty of Loyalty to His Hospital Employer as a Matter of Law

Scott v. Beth Israel Medical Center, 47 A.D.3d 541, 850 N.Y.S. 2d 81 (1st Dep't 2008). Dr. W. Norman Scott ("Dr. Scott"), Chairman of the Department of Orthopedics ("Department") at Beth Israel Medical Center ("BIMC"), sued BIMC for an alleged breach of his employment agreement. BIMC moved for summary judgment on two of Dr. Scott's causes of action and the Supreme Court denied this motion. BIMC appealed and the Appellate Division reversed, noting the evidence showed Dr. Scott began offering his professional services to BIMC's competitors several years before the expiration of his contract, that he also offered the services of his fellow Department physicians without their consent, and he used his position as Department Chairman to obtain confidential internal BIMC documents which he then provided to its competitors. The court then held that, as a matter of law, Dr. Scott had breached his duty of loyalty to BIMC, which therefore had good cause to terminate his employment.

Administrative Review Board Can Impose a Greater Penalty Than OPMC Hearing Committee and Revoke PA's License in Light of 10-Year History of Alcohol Abuse

Chatelain v. State Dept. of Health, 48 A.D.3d 943, 852 N.Y.S.2d 424 (3d Dep't 2008). After pleading no contest at an administrative hearing, Petitioner Rony Chatelain ("Chatelain"), a licensed physician's assistant, was found guilty of professional misconduct under Education Law § 6530(9)(a)(i). The underlying crimes consisted of two separate felony counts, occurring approximately six weeks apart, of operating a motor vehicle without a license, as well as under the influence of alcohol. A Hearing Committee for the State Board for Professional Misconduct found Chatelain guilty of professional misconduct and suspended his physician's assistant license for three years, with all but six months suspended, and placed him on probation for five years. The Bureau of Professional Medical Conduct appealed, and the Administrative Review Board for Professional Medical Conduct ("ARB") ordered Chatelain's license be revoked.

The Appellate Division affirmed the ARB's order, noting it is "well within the ARB's powers to impose a harsher penalty than that imposed by the Hearing Committee, and such penalty will not be disturbed upon review unless it is so incommensurate with the offense as to shock one's sense of fairness." The record indicated Chatelain had several other convictions for driving while under the influence, admitted to drinking alcohol in the morning before work, and he apparently did not fully cooperate with his alcohol rehabilitation program. The court therefore held the record contained ample evidence for the ARB to find that Chatelain was unfit to practice and to revoke his professional license.

The court also rejected Chatelain's claim the ARB's decision was unduly harsh or the result of racial bias because he offered no proof in support of his allegation. Finally, the court stated the fact that Chatelain received a more severe penalty than that imposed in other disciplinary proceedings was insufficient to establish bias as "each case must be judged on its own peculiar facts and circumstances."

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

In the New York State Legislature

By James W. Lytle

For those who had previously gone through life unburdened by any knowledge of New York state government, the last 1½ years must have been a rude awakening. A new reform-minded governor arrives in a landslide, a pitched battle ensues between him and both houses of the legislature, various investigations are launched relating to alleged political spying on political opponents, two special elections trim the Senate Republican majority to a single seat—and an unprecedented scandal topples the governor and ushers in a new governor, just in time to confront a multi-billion dollar budget deficit with only a few weeks before the budget deadline.

Remarkably, the always complicated, usually contentious health care budget issues were among the first to be resolved by the legislature and Governor Paterson. In general, the budget agreement reached earlier this spring rejected many of the reductions proposed initially by Governor Spitzer, but enacted, at the same time, some significant new policy initiatives aimed at reforming the state's health care system. Convinced the state needed to redirect its funds and focus toward primary care, the budget agreement contained important new initiatives to do so.

The key elements of the state's primary care legislative and fiscal policies include the following:

Ambulatory Care Reimbursement Reform

The legislature enacted the Ambulatory Patient Group (APG) Medicaid reimbursement methodology proposed in the Executive Budget, which will reimburse ambulatory care providers based on the intensity of services performed, rather than at a fixed per-visit rate. Under this methodology, which will be further described in regulations, patients are grouped based on diagnosis, intensity of services provided, and medical procedures performed. Each APG is assigned a weight reflecting the projected utilization of resources, and that weight is then multiplied by a base rate to establish the appropriate payment level for each APG. The regulations may establish more than one base rate, and may utilize bundling, packaging, and discounting mechanisms.

The APG methodology will apply to services provided in the following settings:

- General hospital outpatient department services (OPDs)
- General hospital emergency services
- Ambulatory surgery services provided either by a hospital or freestanding ambulatory surgery center
- Diagnostic and treatment center (D&TC) services

As was the case in the Executive Budget, Federally Qualified Health Centers may elect to, but will not be required to, accept reimbursement under the APG methodology.

With certain exceptions as noted below, the APG methodology would be phased in over four years, with a portion of the rate reflecting the average Medicaid payment per claim (as determined by the Commissioner of Health) for services provided by that facility in calendar year 2007 and a portion reflecting the new APG system (see Table 1, below).

Table 1

For OPDs:

Time period	Portion of rate reflecting:	
	Avg. Medicaid pmt. per claim (2007)*	APG system
Dec. 1, 2008–Dec. 31, 2009	75%	25%
Jan. 1, 2010–Dec. 31, 2010	50%	50%
Jan. 1, 2011–Dec. 31, 2011	25%	75%
after Jan. 1, 2012	0%	100%

*Excludes any payments for services covered by the facility's licensure, if any, under the mental hygiene law.

For D&TCs:

Time period	Portion of rate reflecting:	
	Avg. Medicaid pmt. per claim (2007)*	APG system
Mar. 1–Dec. 31, 2009	75%	25%
Jan. 1, 2010–Dec. 31, 2010	50%	50%
Jan. 1, 2011–Dec. 31, 2011	25%	75%
after Jan. 1, 2012	0%	100%

*Excludes any payments for services covered by the facility's licensure, if any, under the mental hygiene law.

The following services are excepted from this phase-in and will be based entirely on the APG system:

- Ambulatory surgery services payment rates would reflect the APG system after December 1, 2008, though capital costs will be computed separately.
- The operating cost component of the rates for general hospital emergency services would reflect the APG system after January 1, 2009, with no cap.

Beginning January 1, 2009, certain additional services provided by D&TCs also will be reimbursed under the APG methodology. The additional services include the following:

- services provided outside of normal operating hours
- individual psychotherapy services provided by licensed social workers to those under age 19 or those requiring such services as a result of or related to pregnancy or giving birth
- individual psychotherapy services provided by licensed social workers at D&TCs that provided, billed for and received payment for these services in CY 2007

Other Primary Care Initiatives

In addition to the ambulatory care reimbursement reform proposals described above, the Budget also contains the following additional primary care initiatives.

Prenatal Registration Project and Targeted Case Management. The Budget establishes the prenatal registration project proposed by the governor that identifies women at risk of poor birth outcomes, but makes participation by pregnant women in the program voluntary. For women who agree to participate, enrolled providers of prenatal care would collect health status data at the first visit and report it to the Department of Health, which would then share the information with managed care plans and designated providers for purposes of care management. The Commissioner of Health is authorized to establish fees to reimburse enrolled providers for collecting and transmitting this information.

Doctors Across New York. This new program was initially proposed in the Executive Budget and is designed to address physician shortages in medically underserved communities throughout New York. The final legislation tracks that in the Executive Budget, except the funding remains flat in future years, rather than increasing each year. Doctors Across New York consists of multiple initiatives to attract and keep physicians in underserved communities. The legislation leaves it to the Commissioner of Health to define "underserved communities," and state officials have indicated they will not restrict this to the federal Health Professional Service Area (HPSA) definition. Doctors Across New York is funded with Graduate Medical Education (GME) dollars, which historically have been available only to hospitals. These initiatives and their funding are described further below:

- ***Ambulatory Care Training*** provides $5 million to support clinical training of medical students and residents in free-standing ambulatory care settings, including community health centers and private practices. Two-thirds of the resources will be allocated to sponsoring entities in New York City and one-third will be allocated to sponsoring entities in the rest of the state. The funds will be distributed via Request for Proposals with preference given to sponsoring institutions which provide training in sites located in underserved rural or inner-city areas and those that include medical students in the training. The legislation provides $5 million per year through March 2011. However, state officials have expressed their desire to pursue increased funding in next year's budget and future years. (The Executive Budget proposed $5 million for 2008, $10 million for 2009, and $15 million for 2010.)
- ***Physician Loan Repayment Program*** provides $2 million for assistance to physicians who enter and remain in primary care or specialty practices in underserved communities. The funding is allocated regionally, with one-third for New York City and two-thirds for the rest of the state. The final legislation **does not** include the Assembly's proposal to broaden the program to include other health professionals. While not specified in the legislation, state officials have indicated up to 100 awards will be given annually of up to $150,000 in loan repayment over five years. The amount paid per year would grow over time to encourage tenure, and a physician who does not stay for at least two years would lose the grant (5% in year 1, 15% in year 2, 20% in year 3, 25% in year 4 and 25% in year 5). The legislation provides $2 million per year through March 2011.
- ***Physician Practice Support*** provides $5 million for assistance to physicians trained in primary or specialty tracks establishing or joining practices in underserved communities, and to hospitals and other health care providers recruiting new physicians in underserved communities. While not specified in the legislation, state officials have indicated awards of up to $100,000 will be provided over two years. The funding is allocated regionally, with one-third for New York City and two-thirds for the rest of the state.

- ***Physician Workforce Study*** provides $600,000 annually (2008–2010) to fund a study of physician workforce needs and solutions, including analyses of residency programs and projected physician workforce and community needs. The Budget fully funds this initiative at amounts recommended in the Executive Budget.
- ***Diversity in Medicine*** provides $2 million annually (2008–2010) for distributions to the Associated Medical Schools of New York to fund its diversity program, including existing and new post-baccalaureate programs for minority and economically disadvantaged students.

Nurse Family Partnership. The Budget establishes the "Nurse-Family Partnership," a Medicaid case management and nurse home-visiting program aimed at improving the health of first-time pregnant women and their children, up to the second birthday. Case management services are services that assist individuals in gaining access to needed medical, social, educational, and other services, and include the following: an assessment; development of a care plan; referral to medical, social, educational and other providers; and monitoring and other follow-up activities.

Childhood Immunizations. The Budget enacts the Executive's proposal to have the Department of Health conduct a study on the feasibility and cost-effectiveness of providing immunizations free of charge to children and adolescents up to age 19. The study will examine both financing options as well as implementation alternatives, in consultation with key stakeholders.

Future Prospects

The worsening fiscal situation, coupled with the inevitable challenge of undertaking a transition in the Executive Chamber in the midst of the legislative session, makes the prospects for other substantial health care reform, at least during the current legislative session, somewhat bleak. Nevertheless, at a time when much of the public was otherwise distracted by the scandals engulfing Albany, the fact that significant steps were taken to reshape the New York State health care system is extraordinary, at least under the circumstances, and will conceivably pave the way for even more significant health care reform in the years ahead.

James W. Lytle is a partner in the Albany office of Manatt, Phelps & Phillips, where his practice focuses on regulatory, legislative and legal issues affecting health care. **He gratefully acknowledges the assistance of his New York City-based colleagues Helen Pfister, Melinda Dutton and Kerry Griffin in the preparation of this article.**

In the New York State Agencies

By Frank Serbaroli

HEALTH DEPARTMENT

Blood Banks

Notice of adoption. The Department of Health amended Subpart 58-2 of Title 10 N.Y.C.R.R. to reflect currently accepted nomenclature and technology, update practice standards and provide needed clarification of provisions for regulation of blood banks and transfusion services. Filing Date: October 23, 2007. Effective Date: November 7, 2007. *See* N.Y. Register, November 7, 2007.

Continuing Care Retirement Communities

Notice of adoption. The Department of Health amended § 901.9 of Title 10 N.Y.C.R.R. to define the approvals required for any change in the current approved number of residential or health care units comprising the continuing care retirement community. Filing Date: November 20, 2007. Effective Date: December 5, 2007. *See* N.Y. Register, December 5, 2007.

Licensed Home Care Services Agency Regulations

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend §§ 763.12, 766.10 and 766.12 of Title 10 N.Y.C.R.R. to require licensed home care service agencies to submit annual cost reports and comply with the annual administrative and general cost requirements applied to certified home health agencies. *See* N.Y. Register, January 2, 2008.

Rate Enhancement/Pay for Performance

Notice of proposed rulemaking. The Department of Health gave notice of its intent to add § 86-2.38 to Title 10 N.Y.C.R.R. to establish a payment methodology for rate enhancements as required by Public Health Law § 2808(22). *See* N.Y. Register, January 2, 2008.

Feeding Assistants in Nursing Homes

Notice of adoption. The Department of Health amended § 415.13 and added §§ 415.2(u) and 415.26(k) to Title 10 N.Y.C.R.R. to permit the use of paid feeding assistants in nursing facilities. Filing Date: December 19, 2007. Effective Date: January 9, 2008. *See* N.Y. Register, January 9, 2008.

DRGs, SIWs, Trimpoints and the Mean LOS

Notice of emergency rulemaking. The Department of Health amended §§ 86-1.55, 86-1.62 and 86-1.63 of Title 10 N.Y.C.R.R. to update the calculation of outlier payments based on the Department of Health and Human Services ("HHS") audit findings and recommendations. Filing date: January 23, 2008. Effective date: January 23, 2008. *See* N.Y. Register, February 13, 2008.

Criminal History Record Check

Notice of emergency rulemaking. The Department of Health added Part 402 to Title 10 N.Y.C.R.R. to require nursing homes, certified home health agencies, licensed home care service agencies and long-term home health care programs to request criminal background checks of certain prospective unlicensed employees who provide direct care or supervision to patients, residents or clients of such providers. Filing date: February 19, 2008. Effective date: February 19, 2008. *See* N.Y. Register, March 5, 2008.

Physical Therapist Assistants and Occupational Therapy Assistants

Notice of emergency rulemaking. The Department of Health amended § 505.11 of Title 18 N.Y.C.R.R. to include physical therapist assistants and occupational therapy assistants as qualified professionals who can provide physical and occupational therapy, respectively, as a billable service, to Medicaid recipients. Filing Date: February 26, 2008. Effective date: February 26, 2008. *See* N.Y. Register, March 12, 2008.

Enactment of a Serialized New York State Prescription Form

Notice of emergency rulemaking. The Department of Health added Part 910 and amended Parts 80 and 85 of Title 10 N.Y.C.R.R., and amended § 505.3 and repealed §§ 528.1 and 528.2 of Title 18 N.Y.C.R.R. to enact a serialized New York state prescription form to combat and prevent prescription fraud by curtailing theft or copying of prescriptions by individuals engaged in drug diversion. Filing date: March 3, 2008. Effective date: March 3, 2008. *See* N.Y. Register, March 19, 2008.

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

Notice of emergency rulemaking. The Department of Health amended § 86-4.9 of Title 10 N.Y.C.R.R. to permit psychotherapy by certified social workers in an article 28 FQHC as a billable service under certain circumstances. Filing date: March 10, 2008. Effective date: March 10, 2008. *See* N.Y. Register, March 26, 2008.

Assisted Living Residence

Notice of adoption. The Department of Health added Part 1001 to Title 10 N.Y.C.R.R. to further the goals of the Assisted Living Reform Act by creating the regulatory framework necessary for implementation of the Act. Filing date: March 11, 2008. Effective date: March 26, 2008. *See* N.Y. Register, March 26, 2008.

Payment for Nursing Services Provided to Medically Fragile Children

Notice of emergency rulemaking. The Department of Health amended § 505.8(g) of Title 18 N.Y.C.R.R. to authorize payment of Medicaid reimbursement for private-duty nursing services at an enhanced rate when provided to medically fragile children in the community, upon submission of a certification to the Department of Health that the provider is trained and experienced in caring for medically fragile children. Filing date: March 28, 2008. Effective date: April 16, 2008. *See* N.Y. Register, April 16, 2008.

INSURANCE DEPARTMENT

Continuing Care Retirement Communities

Notice of adoption. The Department of Insurance amended Part 350 (Regulation 140) of Title 11 N.Y.C.R.R. to adopt revised standards pertaining to continuing care retirement communities authorized pursuant to Article 46 of the Public Health Law. Filing date: October 2, 2007. Effective date: October 17, 2007. *See* N.Y. Register, October 17, 2007.

Healthy New York Program

Notice of adoption. The Department of Insurance added §§ 362-2.7(d), (e) and (f) and 362-2.8 to Title 11 N.Y.C.R.R. to offer high deductible health plans in conjunction with the Healthy New York Program and to add additional benefits to the program. Filing date: October 18, 2007. Effective date: November 7, 2007. *See* N.Y. Register, November 7, 2007.

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

Notice of adoption. The Department of Insurance amended Part 52 (Regulation 62) of Title 11 N.Y.C.R.R. to require insurers, Article 43 corporations and HMOs to send notices to their policyholders, certificateholders, and members describing chapter 748 of the Laws of 2006. Filing date: February 20, 2008. Effective date: March 12, 2008. *See* N.Y. Register, March 12, 2008.

Market Stabilization Mechanisms for Individual and Small Group Market

Notice of emergency rulemaking. The Department of Insurance amended §§ 361.5 and 361.7(a), renumbered §§ 361.6-361.7 to §§ 361.7-361.8 and added new § 361.6 to Title 11 N.Y.C.R.R. to create a new market stabilization process in the individual and small group market, to share among plans substantive cost variations attributable to high-cost medical claims. Filing Date: February 22, 2008. Effective Date: February 22, 2008. *See* N.Y. Register, March 12, 2008.

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In the Journals

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- *Revealing Your Sources: The Case for Non-Anonymous Gamete Donation*, Michelle Dennison
- *A Philosophy of Privatization: Rationing Health Care Through the Medicare Modernization Act of 2003*, Eleanor Bhat Sorresso, M.D., J.D.
- *Law Students Who Learn Differently: A Narrative Case Study of Three Law Students With Attention Deficit Disorder (ADD)*, Leah M. Christensen
- *Redefining Stewardship Over Body Parts*, Elizabeth E. Appel Blue
- *Harnessing the Hired Guns: The Substantive Nature of Ohio Revised Code 2743.43 under Article IV, Section 5(B) of the Ohio Constitution*, Patrick Vrobel
- *Combating the Unfair Competitive Edge: Random Drug Testing Should Be Implemented in Standardized Testing to Deter Illicit and Unfair Use of Prescription Stimulants*, Shawn Romer
- *Regional Health Information Organizations: Lower Health Care Costs, Fewer Iatrogenic Illnesses, and Improved Care—What are We Waiting For?*, Angela Ferneding
- *Residents of County Operated Nursing Homes are Unprotected from Negligent Acts*, Katherine Knouff
- *The Deficit Reduction Act of 2005—Reducing the Number of Recipients and Applicants Eligible to Receive Medicaid Benefits: A Statutory Analysis of the Citizenship Documentation Requirements and Proposed Amendments To Ease the Burden on Individuals and States*, Christal Contini

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- *Governance and Community Benefit: Are Nonprofit Hospitals Good Candidates for Sarbanes-Oxley Type Reforms?*, Jeffrey A. Alexander, Gary J. Young, Bryan J. Weiner, Larry R. Hearld
- *Role of Budget Impact in Drug Reimbursement Decisions*, Joshua Parsons Cohen, Elly Stolk, Maartje Niezen
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- *Improving Information and Best Practices for Public Health Emergency Legal Preparedness*, Daniel O'Brien, Jr., Clifford Rees, Ernest Abbott, Elisabeth Belmont, Amy Eiden, Patrick M. Libbey, Gilberto Chavez, Mary des Vignes-Kendrick

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- *A Property Right to Medical Care*, Mark Earnest, Dayna Bowen Matthew

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- *Job Security and Income Replacement for Individuals in Quarantine: The Need for Legislation*, Mark A. Rothstein, PhD, Meghan K. Talbott
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- *Pathways Across the Valley of Death: Novel Intellectual Property Strategies for Accelerated Drug Discovery*, Arti K. Rai, Jerome H. Reichman, Paul F. Uhlir, Colin Crossman
- *Proxy Consent to Research: The Legal Landscape*, Elyn R. Saks, Laura B. Dunn, Jessica Wimer, Michael Gonzales, Scott Kim
- *Toward Solving the Health Care Crisis: The Paradoxical Case for Universal Access to High Technology*, Ani B. Satz
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- *Charity Starts in the Womb: New Research Should Allow Healthy Embryos And Federally Funded Stem Cell Research to Coexist*, Elizabeth A. Holman, 85 Wash. U. L. Rev. 161 (2007)
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- *EMTALA: Protecting Patients First by Not Deferring to the Final Regulations*, Victoria K. Perez, Fall, 4 Seton Hall Cir. Rev. 149 (2007).
- *Ethical Reflections on the Future of Technology Policy: Stem Cell Research and the Cloning Wars*, Russell Korobkin, 18 Stan. L. & Pol'y Rev 161 (2007)
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- *Getting Payment for a Clean Bill of Health: Reconciling the Health Insurance Portability and Accountability Act ("HIPAA") with the Fair Debt Collection Practices Act ("FDCPA") for Health-Care Debt Collection*, Kirsten N. Arnold, 93 Iowa L. Rev. 605 (2007)
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For Your Information

By Claudia O. Torrey

- In the Summer 2007 issue of this *Journal* (Vol. 12, No. 2; "HLJ"), this columnist focused on the dearth of geriatricians within the context of long-term care. This focus put the HLJ in the position of being approximately six to seven months ahead of both the *Washington Post* ("Post") and the Institute of Medicine ("IOM") in their observance of the same issue. In the March 11, 2008 issue of the Post, in an article examining the shortage of geriatricians (there are currently approximately 7,000 in the entire United States), it was noted that teaching hospitals produce one or two geriatricians for every nine cardiologists or orthopedic surgeons. The IOM expected to release a report[1] on March 30, 2008 that will address the future health care workforce for older Americans (age 65 and older). Potential home health care needs will be considered (another reason for having geriatricians), as well as questions examining the future health status of older Americans; utilization of health care services by older Americans; the best use of the health care workforce, including informal caregivers; health care delivery models that provide both high quality and cost efficiency; provider types for executing the potential delivery models; the education and training needed for a health care workforce that will be implementing the delivery of the high-value elderly care that is desired (sounds like a need for more geriatricians to this columnist); and, whether or not public programs, such as Medicare and Medicaid, need to be fine-tuned as a result of the obtained IOM report information.
- On March 11, 2008, Tennessee Governor Phil Bredesen proposed a plan to help reduce the state's (*TennCare*—the state Medicaid program) health care spending on nursing home/long-term care.[2] State officials estimate that the proposal could direct about half of the $1.2 billion spent on long-term care to home-based care; approximately 98% of TennCare spending on long-term care goes to nursing home facilities. The ultimate goal of the home-based care proposal is to simplify the process, under TennCare, for how the elderly and/or the disabled qualify for home-based care. If this "home-based care piece" is enacted, only time will tell concerning both the efficiency and the quality of care.
- For those who may be interested, a home care and hospice "March on Washington and Legal Symposium" was slated for April 6–8, 2008.[3] This meeting anticipated agency adaptations in financial, clinical, and administrative operations, which will be reflective of revisions in the Medicare home health prospective payment system. 2008 is being categorized as an "eventful year for home care and hospice."

Endnotes

1. Institute of Medicine—Board on Health Care Services, *Future Health Care Workforce for Older Americans* , www.nationalacademies.org.
2. http://www.kaisernetwork.org/daily_reports.
3. http://www.nahc.org/Meetings/Pol/08.

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Home Health Care in New York State: Efforts of the Office of the Medicaid Inspector General to Ensure Access and Quality and to Combat Fraud and Abuse

By Robert A. Hussar

Introduction

The provision of home health care steadily grows each year, not only in New York State but nationwide, costing the New York Medicaid program more than $4 billion in 2007 alone. Home health care is expected to become even more in demand as consumers seek to remain in their own communities as an alternative to receiving care in institutional settings.

As "patient-centered" care, home health care is a key component of New York Governor David A. Paterson's goal of "putting patients first," stressing patient autonomy, responsibility and control in the least restrictive, most familiar environment possible. Maintaining access and quality in home care while simultaneously monitoring the potential for fraud, waste and abuse as the system grows to accommodate demand is a major focus for New York's Office of the Medicaid Inspector General (OMIG). Home care providers must employ sufficient staff at all levels to serve their patient base, while simultaneously meeting the state's high standards of care and keeping timely, accurate and thorough medical records for each patient. Toward this end, OMIG is currently conducting or developing the following initiatives related to home health care:

1. CMS Third-Party Liability Home Health Care Demonstration Project

General Demonstration Project Issues

In Federal Fiscal Year (FFY) 2007, Medicaid paid more than $900 million in home health care claims in New York for beneficiaries who were eligible to receive both Medicaid and Medicare benefits, also known as "dual-eligibles."

New York is part of a five-year demonstration project sponsored by the Centers for Medicare and Medicaid (CMS), utilizing a sampling approach to determine the Medicare share of the cost of home health services claims for dual-eligible beneficiaries that were inadvertently submitted to and paid by Medicaid. OMIG is involved in conducting audits of certified home health agencies (CHHAs) as one component of this project. The process involves both a basic patient record review to confirm not only the date of service specified in the sample, but also a broader, more comprehensive review of areas that may be identified as needing further investigation.

The demonstration includes an educational component to improve the ability of all parties to make appropriate coverage determinations in the first instance, as well as an audit sample drawn from each project year's universe of dual-eligible home health claims paid by Medicaid that the state believes should have been paid by Medicare. The sample results are extrapolated to the universe of claims in determining a Medicare settlement payment for each FFY. Reconsideration appeals and arbitration procedures are included in the project to resolve cases where the states and CMS disagree on Medicare's denial of coverage. Subsequent payments are made after final determinations on disputed cases are resolved. The project covers FFY 2000 through 2007; each fiscal year is at a different stage in the determination process.

This demonstration project replaces previous third-party liability audit activities of individually gathering Medicare claims from home health agencies for every dual-eligible Medicaid claim the state has possibly paid in error. This represents an enormous savings in resources for home health agencies, as well as the regional home health intermediaries, and for the participating states.

CHHA Audits: Overview of Review Process and Areas of Concern

The OMIG's review process involves a review of patient records, including the dates of service specified in the sample, as well as the following points:

Components of a Patient Record Review

Although the patient record review focuses primarily on a specific date of service, OMIG auditors generally concentrate on the time period and circumstances surrounding that date. Comprehensive reviews generally include data identified in the patient records used in conjunction with information obtained from other sources.

The issues OMIG auditors consider when completing a patient record review include, but are not limited to, the following:

- Was the required comprehensive assessment, including the nursing assessment, completed in a timely manner relative to the service date?

- Was there a written order from a qualified practitioner signed within the specified timeframes for the care provided? Are verbal orders for Medicare patients documented and signed?
- Was the plan of care completed and signed within the specified timeframes?
- Was an aide care plan completed? Were the relevant aide activity sheets and/or time sheets available to support the service billed and signed?
- Was there continuity and consistency among the assessments, practitioners' orders, plan of care, aide care plan and aide activity/time sheets?
- Did the record indicate that the level of care and the quality of care provided be examined further?
- Did the rate codes and units of service billed to Medicaid coincide with the service rendered, including the ordered frequency/length of service and level of care?
- Were nursing supervision visits provided within the required timeframes?
- Are the signatures of practitioners, nurses, home health aides and personal care staff consistent? Do documents appear to be post-dated?

Additional information that may be obtained from the patient record for further assessment includes third-party health insurance (TPHI) data, names of caregivers, location and address of service, and names of practitioners ordering the service.

Other Review Components

- **Third-party health insurance:** TPHI coverage information furnished with our sample download is double-checked on eMEDNY, the state's claims data system, and supplemented with any new information found in the case records. Explanation of benefits (EOBs) notices are requested from the provider (even if insurance was billed) and evaluated. If no EOB is available, auditors contact the insurer to confirm eligibility, determine if the service is covered and the amount of any applicable deductible/co-insurance. For Medicare, the provider may be making decisions as to what is covered and issuing a letter (Home Health Advanced Beneficiary Notice—HHABN) to the patient. This process should also be evaluated.
- **Location of service review:** This review is directed at identifying possible other rates being paid that might cover home health care and for possible shared aide situations. Using a latitudinal/longitudinal report generated with the sample, auditors identify all patients living at the same location or address. The living situation for sample patients is then evaluated for the abovementioned issues.
- **Ordering practitioner review:** From a sample download, auditors compare ordering practitioner information (i.e., who actually signed the order) from billing records to patient record information and evaluate the results.
- **Credential review:** Auditors compile a list of caregivers identified in the patient's records and select a sample. From that sample, auditors check selected caregivers to validate whether or not they have required licenses, certifications, training, physicals and background checks (for those hired after April 2005). During the patient record review, auditors also seek to identify caregivers who are close relatives of the patient for further evaluation. Additionally, we check a sample of staff for daily/weekly duplication of time with non-sample patients and verify signatures on time sheets.
- **Contracts:** Auditors identify and evaluate all existing contracts from each provider regarding the provision of home care services for possible follow-up.
- **Adjudicated claims:** Auditors review the expenditure history for each patient in the sample for the time period surrounding the service date. This includes evaluating where the patient was on the service date (looking for day of treatment, rehabilitation, inpatient, etc.), other services billed on that date (verifying there was no duplication of service), or the next few days (i.e., "ping-pong" of one service to another), and related non-covered services being billed. Rates paid for the period of the service date are used in the "location of service" review covered above, and previous or late TPHI participation is noted. Any information that raises potential questions is investigated further.
- **Level of care/quality of care:** During the patient record review, auditors note any situations that may point to questionable level or quality of care. In such instances, relevant records should be reviewed by OMIG nursing staff after the regional office determines they should be referred. If so, it may be necessary to obtain the patient's complete medical records.

- **Call-in logs/complaint logs:** These logs are probably separate records that should be reviewed for information relevant to a sampled service that might not have been rendered, or one that was billed for more hours than were provided. Contractors may have a separate record of reported changes to the care that the patient actually received. Part of an auditor's analysis also includes examining negative billing adjustments where an adjustment was not corrected in the Medicaid billing.

A letter or home visit to selected patients or responsible relatives on a test basis may be warranted to verify the caregivers showed up for the length of time scheduled in the care plan or for the times that were actually billed.

- **Prior approvals (personal care):** If the CHHA is providing personal care services, auditors should confirm prior approvals through the county, if not otherwise available from the provider.
- **Billings after 90 days:** Recently, the OMIG added a review on sampled billings that were submitted beyond 90 days from the date of service. The provider's documentation is examined to support such late submissions.
- **Rate reclassifications:** Auditors obtain a copy of the cost report for the base year(s) used for the sampled period and the cost reports for the sampled period years. In general, the next step is to check for reclassifications into the nursing, home health aide or personal care cost centers (i.e., lines) for any potentially questionable items. More specifically, reclassifications of nurse supervision costs into the home health aide and personal care cost lines should be consistent from year to year and not include the first level of nursing supervision required by regulations if they are separately billing the reclassified field visits by nurses.

Face-to-Face Reconsideration Appeals

The OMIG continues to recover interim settlement payments won during decisions resulting from face-to-face reconsideration appeals that take place annually in Portland, Maine. These initial appeals are based on cases from samplings denied Medicare coverage under initial CMS determinations for each fiscal year.

The OMIG's office directly assists the contractor with claims detail data from the recipient claims detail reports in preparation for the face-to-face reconsideration appeals. The information is discussed by phone and/or e-mail to facilitate the medical review portion of the cases, since cases are stronger if the presentation supports all medical facts in each individual case.

There are times when the contract medical reviewer may not know if a patient had been hospitalized prior to the review dates, or, if so, what the patient's primary diagnosis was during the hospitalization. These facts can be important, since the home care beneficiary population is increasing, as is utilization, and recipients often have the need for high-intensity services.

New York State participated in the March 18–20, 2008 face-to-face reconsideration appeal meetings for the FFY 2004 in Portland. The results of those sessions are pending.

Final Arbitration Appeals

After several years of delay by CMS, the final level of appeals—the arbitration level—received the go-ahead. We are currently in the middle of the first year of these appeals.

2. Probe Audits of Demo Exclusions

Medicare Managed Care Probe Audit

In May and June 2007, the OMIG completed review and analysis of 17 targeted home health medical records from three certified home health agencies in the metropolitan New York City area.

After selecting cases based on the severity of illness, auditors reviewed medical and billing records for the potential of Medicare coverage criteria for all home health services. The target cases were dual-eligible beneficiaries enrolled in a Medicare managed care plan while receiving fee-for-service Medicaid payments. This endeavor was the first probe audit that emanated from excluded FFY 2004 cases within the TPL Demonstration Project.

Overlapping Payment Issues

The OMIG and its contractor, UMass, have initiated a probe audit into overlapping payments that CMS eliminates from the Medicaid universe of paid claims within the TPL Home Health Demonstration for each fiscal year. These payments involve Medicare episodes of coverage, which also include Medicaid payments, and represent the largest dollar amount of exclusions in each of the fiscal years.

Findings from data analysis of the Medicaid paid claims show that within the overlapping Medicare coverage, Medicaid is paying a large portion of the home health aide services, which represents the highest utilization in home care in most cases. We have completed the process of identifying the top providers for whom

CMS has eliminated overlapping payments, and who also have the highest utilization costs for the Medicaid program. The OMIG is in the process of notifying these agencies regarding on-site visits to conduct the probe audits, which have been scheduled to take place through July 2008. A decision to proceed with a probe audit starting with FFY 2004 will allow medical review of the home health care claims to determine the rationale for Medicaid payments to cases that involve a Medicare episode.

3. Home Health Agency (HHA) Claims

The OMIG is also committed to reviewing HHA claims to determine whether the claims meet the criteria outlined in 18 N.Y.C.R.R. § 505.23 and in 10 N.Y.C.R.R. Article 7, including whether the services were properly authorized and properly documented, third-party coverage was pursued, and personnel met all regulatory requirements. The OMIG analyzes beneficiaries' payment histories to identify if patients are in institutions that are reimbursed for these services in their rates.

4. Payments for Personal Care Services

The OMIG reviews Medicaid payments for personal care services claimed by selected providers to determine adherence to criteria set forth in 18 N.Y.C.R.R. § 505.14. To accomplish this goal, a sample of claims are examined to ensure the services are properly authorized, the claims are properly documented, coverage for Medicare and all other third-party insurance is pursued, and personnel meet all requirements established in regulation. Included in the pre-audit for all reviews is an analysis of the beneficiaries' payment history to ensure they are not residents of an institution that is reimbursed for these services in their rates.

5. Home Health Care in Adult Home Settings

In November 2004, the state won an appeal in a home health care disallowance brought to its attention by the Commission on Quality of Care (CQC) (*In re First to Care Home Care, Inc.*). In sum, CQC identified $420,000 in overbillings to the Medicaid program paid to CHHA providing services to residents of an adult home. The overbillings occurred because personal care services were already being funded through the adult home rate and therefore should not have been billed to Medicaid. While this particular case involved the billings of one provider, numerous home health care services, costing Medicaid tens of millions of dollars, continue to be provided and billed in adult homes. The OMIG will be reviewing those billings.

6. Physicians/Medical Directors

The OMIG is committed to ensuring that physician services in home care are appropriate and are compensated at fair market value. When conducting audits, OMIG staff will carefully consider physician documentation of the medical necessity of all services rendered.

OMIG will also look for any influences on physicians or medical directors, such as investments in or payments, gifts or considerations from other sources that could lead the doctor to refer to a particular home care provider. Such a relationship would violate anti-kickback legislation on both the federal and state levels for Medicaid providers. Although "safe harbor" provisions do exist in some instances, physicians who accept payments or other considerations in exchange for preferred referrals almost always violate anti-kickback statutes. Medical directorships will be evaluated to ensure that the services are needed, are actually provided and documented, and that compensation is at fair market value.

Conclusion

As consumers continue to demand increased health care services within the home setting, the OMIG remains committed to ensuring quality services in the least restrictive environment for Medicaid enrollees. The OMIG is dedicated to working cooperatively with providers to ensure a collaborative relationship for a common goal: to provide the highest quality care to patients while simultaneously combating fraud, waste and abuse in Medicaid.

For further information about the OMIG's efforts to reduce fraud, waste and abuse in New York's Medicaid system for home care enrollees, contact Wanda Fischer, public information officer, at 518-473-3782, or via e-mail at waf02@omig.state.ny.us. The complete 2008–09 OMIG work plan is available at www.omig.state.ny.us.

Robert A. Hussar is First Deputy Medicaid Inspector General.

Acceptance, Retention and Discharge of Patients Receiving Home Care Services—Balancing Patient Rights and Provider Obligations

By Laura Sprague

New York has seen a substantial increase in the number of home care services agencies seeking licensure through the Department of Health, a trend reflecting the relative importance of these entities in our evolving long-term care system. As states increasingly move away from institutional care to home- and community-based settings, the need for supportive services that will allow these models of care to succeed is clear. Equally as important is the ability of the consumer to rely on consistent quality care that will achieve its intended goal, permitting the recipient of services to "age in place" through changing stages of dependence and need.

The acceptance, retention, and discharge of patients is complicated by the complex statutory and regulatory framework through which home care services agencies operate, which reflect overlapping issues of payment, quality and service. Additional complications involve factors that are beyond the scope of applicable regulatory models. The population served is vulnerable and medically fragile, with social, psychological and physical needs that may change dramatically over time. Plans of care are highly individualized and evolve with the patient's needs. Coupled with the nature of the work involved and difficulties inherent in maintaining appropriate staffing in a highly stressful and relatively low-paying industry, the potential for conflict is high.

Increasingly, the Department has been faced with the issues that arise when home care services agencies seek to terminate the services provided to patients, either because the patient's needs have become too difficult for the agency to meet or because the patient or family members have engaged in behavior that is unsafe or inappropriate. This article will focus on provider obligations under these circumstances, and will outline the basic regulations that govern. In examining these issues, the following basic care scenario will be used:

> Patient AB, an 85-year-old woman, lives in the home of family members C and D. C is the daughter of patient AB, and D is patient AB's son-in-law. Patient AB has Alzheimer's disease, which is in the early stages, and is mobile although physically frail. She requires assistance with dressing, grooming, and bathing, and requires help with her mid-day meal while C and D are working. She requires assistance with travel to doctor's appointments and with errands during the day. She requires physical therapy for a hip injury and uses a cane to ambulate. She has mild dementia and wanders infrequently.

This hypothetical will form the basis for the examples to follow.

Regulatory Framework for Home Care Services Agencies—An Overview

Home care services agencies may be subdivided into two separate categories based on reimbursement eligibility. Certified home health agencies ("CHHAs") are qualified for Medicare and Medicaid reimbursement, and are consequently regulated at both the state and federal levels.[1] Traditional licensed home care services agencies ("LHCSAs") are not qualified as federal home health agencies for purposes of reimbursement through the Medicaid and Medicare programs and are regulated by the state only.[2] Both types of agencies are authorized to provide the same types of services to the patients they serve.

Patient Acceptance, Retention and Discharge by LHCSAs

Prior to accepting a patient, a LHCSA operator is required to ensure there has been a determination the patient's needs can be safely and adequately met by the agency.[3] Once the patient is accepted, a plan of care must be established and revised frequently to reflect the changing care needs of the patient.[4] The patient is entitled to receive services from the same personnel to the extent possible.[5] Prior to discharging a patient, a discharge plan must be initiated to assure a timely, safe and appropriate transition for the patient.[6] No less than 48 hours before discharge, the agency must also notify the authorized practitioner who ordered the health care services and

consult with the patient and any staff involved in coordinating the plan of care.[7] The patient has the right to be informed of services that will be provided, to participate in the planning of his or her care, to refuse care or treatment, and to be informed of the procedures for submitting patient complaints.[8]

Issues Arising Upon Discharge of Patient by LHCSA

Assume under the scenario noted above that patient AB's dementia has progressed. Due to her increasingly difficult behaviors, she has gone through several aides employed by the agency. After several weeks, the aides request reassignment. Patient AB becomes confused by the presence of aides in her room and mistakes them for burglars. On one occasion, she threw her small bedside alarm clock at an aide's head but missed. She has become increasingly frustrated and combative at times, and has muttered insults and physical threats when staff attempt to assist her with grooming and bathing. Patient AB refuses assistance when she is in a combative mood. Her physical therapist and aides have a fear that continued refusal of assistance will lead to an injury. At times, patient AB has brandished her cane at the aides. The agency does not have any additional staff who are willing to work with patient AB.

If services are being provided through a private contract with the patient or an insurance provider, services may be terminated as any other business arrangement.[9] Issues that arise tend to be limited to the failure to give notice or to implement an acceptable discharge plan pursuant to regulation, or, alternatively, the failure of the LHCSA to comply with contract provisions. Since the patient/payer does not have a specific right to service, disputes related to termination are resolved by patient complaint to the Department or private action for breach of contract. If the patient makes a complaint, the agency will be subject to investigation and/or discipline pursuant to Article 36 of the Public Health Law and applicable Department of Health regulations.[10]

Patient Acceptance, Retention and Discharge by CHHAs

The regulations governing CHHAs are far more comprehensive than those governing the traditional LHCSA model. As with LHCSAs, prior to accepting a patient, the CHHA must ensure the patient's assessed needs and its ability to meet those needs are considered.[11] However, a CHHA must make a patient assessment during the initial patient visit, which must indicate the patient's health and supportive needs (as ordered by her doctor) may be met safely and adequately at home, and which must include a consideration of whether the patient is self-directing, able to call for help, can be left alone, and/or has informal or community supports willing, able and available to provide this support for the patient.[12] The agency is not required to admit the patient if the patient meets none of the assessment criteria, if conditions are known to exist in or around the home that would threaten the safety of personnel, or if the agency has previous experience with a patient who refuses to comply—or whose family interferes with— the plan of care.[13] Further requirements for the comprehensive assessment, which must be updated at least every 60 days and more often depending on whether certain events occur, may be found in the federal regulations.[14]

A patient may be discharged by a CHHA only after consultation with the patient's doctor (the authorized practitioner who has ordered care and services for the patient), the patient, and any family members or other support involved in the plan of care.[15] The permissible grounds for discharge are as follows:

a. Therapeutic goals have been attained and the patient no longer needs services;

b. Conditions in the home imminently threaten the safety of the personnel providing services or jeopardize the agency's ability to provide care, for reasons that include but are not limited to actual or likely physical assault when there is an ability to carry it out, presence of weapons, contraband or criminal activity creating a reasonable concern for personal safety, continuing severe verbal threats when there is an ability to carry those threats out and personnel have a reasonable concern for safety, or when the agency has valid reason to believe that agency personnel will be subjected to continuing and severe verbal abuse that will jeopardize the agency's ability to secure personnel or provide care that will meet the needs of the patient;

c. Agency services have been terminated by the patient;

d. The patient, the patient's family or any other support is non-compliant or interferes with the plan of care, which has led or will lead to an immediate deterioration of the patient's condition such that home care is no longer appropriate, and interference continues despite the explanation of this likely outcome to the offender; or

e. The patient's health and safety cannot be maintained at home with the services available.[16]

A discharge plan must be initiated prior to discharge to assure a timely, safe and appropriate transition for the patient.[17]

If the CHHA seeks to terminate a Medicaid recipient's services, the patient has a right to due process protections in certain circumstances.[18] *Catanzano v. Dowling*, 847 F. Supp. 1070, 1086 (W.D.N.Y. 1994), enjoined the parties in that action from "suspending, terminating or reducing the amount of home health care services received by members of plaintiffs' class as a result of conducting a fiscal assessment or otherwise" without first providing notice, a fair hearing and continuing services ("aid-continuing") during the pendency of the hearing. The general basis for this holding was that a CHHA's actions, to the extent they affected adversely the services provided to a Medicaid recipient, were delegations of state responsibility under federal law and would therefore implicate federal fair hearing requirements.[19] The court's holding was essentially affirmed in the cases that followed, and the "Revised Catanzano Implementation Plan" ("the Plan"), was promulgated in 1996 as a regulation of the Department.[20]

Accordingly, federal and state regulations governing fair hearing requirements must be followed when a CHHA intends to discharge a patient as specified by the Plan.[21] According to the Plan, if the patient's treating physician agrees with the CHHA's decision to terminate or limit the patient's services, the patient is not entitled to due process protections. Moreover, the terms of the Plan do not address termination based on threats to the safety of CHHA personnel, as described in ground "b" supporting discharge, above. If, however, the CHHA seeks to discharge a recipient against doctor's orders because of a determination the patient has met therapeutic goals, for noncompliance, or because health and safety can no longer be maintained in the home, the patient is entitled to advance notice from the social services district, aid-continuing, and a fair hearing as described in the Plan and pursuant to federal and state requirements governing the notice and hearing process.

When the CHHA seeks to discontinue a Medicaid recipient's services for a reason covered by the Plan, the Plan requires CHHAs to consult with the patient's physician with respect to the reasons for discharge, and seek an order permitting the discharge.[22] If the physician does not agree with the CHHA's proposed termination of services, the CHHA is required to refer the patient's case to a CHHA that has agreed, after assessment, to accept that patient.[23] Alternatively, the CHHA may refer the patient's case to the social services district for a determination of whether discharge is appropriate.[24] The discharging CHHA must continue to provide services until an alternate CHHA has admitted the recipient, until further order of the social services district if the case has been referred, and in the event of an adverse decision by the social services district or after a fair hearing.[25]

Issues Arising Upon Discharge of Patient by CHHAs

Applying the requirements of the Plan to the example involving patient AB raises several issues. While the termination of services by a LHCSA that has contracted directly with the patient or an insurance provider would not necessarily have to rely on a specific basis, CHHAs must look at these issues more specifically as the right to a hearing under the Plan depends on the reason for termination. A primary issue for the CHHA would involve the sufficiency of the professed reason for termination of services in the event that discharge is challenged. For instance, if the CHHA wishes to rely on the safety of personnel in the home environment as the basis for termination of services, issues as to whether patient AB has the ability to carry out physical assault would arise. Other issues could involve whether personnel would have a "reasonable concern" for safety, and whether patient AB's conduct constitutes "severe verbal abuse." If the termination based on the safety of personnel in the home is deemed to comport with 10 N.Y.C.R.R. § 763.5(h)(2), notice and a fair hearing would ostensibly not be required and the CHHA would not have to provide aid-continuing to the patient.[26] But if challenged, the CHHA would need to be able to establish that the conduct of patient AB met the regulatory criteria for this exception to the Plan.

If the claimed basis for termination is the deterioration of the patient's physical condition so that her health and safety can no longer be maintained in the home, or alternatively, patient AB's refusal of assistance such that the CHHA has determined non-compliance will lead to the deterioration of patient AB's condition, a physician's order should be requested. Absent a physician's order, the recipient would be entitled to notice from the social services district and a fair hearing, as well as continued services pending the outcome.[27] Issues for hearing would involve whether the factual scenario meets the regulatory criteria for termination, whether the assessments prepared by the CHHA support a change in circumstances, and whether the patient may remain in the home safely.[28]

Operational Issues Relevant to Discharge

Investigation by the Department of patient complaints and hearings relating to the discharge of patients

raises issues relating to operational compliance with regulations. In arguing the facts supporting discharge, CHHAs will necessarily be required to rely on their record keeping and documentation of the issues leading to the decision to terminate services. Similarly, if the Department receives a complaint regarding patient discharge, records maintained by the agency will be reviewed for compliance with relevant operational regulations. In this regard, agencies should take particular care to comply with regulations governing patient rights, assessments/plans of care, and record keeping.[29]

For instance, patients have the right to participate in care planning and to be advised if changes to the plan of care are warranted.[30] The plan of care must be reviewed as patient conditions change and at least every 62 days by CHHAs.[31] LHCSAs must also review and revise the plan of care as frequently as needed to reflect changing care needs, and a review should be undertaken at least every six months.[32] Reviews of the plan of care should be documented, and the patient's physician should be alerted to any significant changes in the patient's condition.[33] The agency should keep records of medical orders, contacts with the patient or others relevant to the plan of care, assessments, plans of care, progress notes, observations and reports, and documentation of accidents or incidents, among other items.[34] These requirements are all relevant to issues arising at discharge, and a complete and accurate record reflecting compliance will assist home care services agencies in supporting their actions.

Issues Related to Aid-Continuing Directives

An issue that arises when a CHHA seeks to discharge a patient involves the requirement under the Plan that the CHHA continue to provide services pending the outcome of a hearing. For example, assume patient AB's family moves to a fifth-floor walk-up. Patient AB requires someone to assist with errands and doctors appointments. This requires the aide to travel up and down the stairs numerous times each day. Staff quit this position regularly, and the CHHA is having increasing difficulty providing the services needed by patient AB. AB's doctor does not want her to have to leave her home, as she has indicated her unwillingness to live in a facility, and does not wish to sign an order that AB requires a higher level of care.

If the basis for discharge is that conditions in the home have jeopardized the CHHA's ability to provide care, the fair hearing requirements would again, ostensibly, not be at issue. If, however, the basis for discharge is the inability to maintain patient AB's health and safety in the home, aid-continuing until issuance of a fair hearing decision would be required. If the CHHA is unable to locate an alternate CHHA to provide services, the discharging CHHA will be required to provide services until the issues surrounding discharge have been decided at a hearing.[35] Presuming the termination arose because of the CHHA's inability to staff the position, these same issues will affect the aid-continuing during the pendency of the fair hearing procedures.

Issues Relating to Conditions in the Home

Many times, when conditions in the home threaten the safety of personnel, those same conditions also threaten the safety of the patients. Assume, for example, that patient AB's son-in-law, D, has an alcohol and drug problem. He is verbally abusive to staff when he is impaired, which is becoming more frequent. Lately, he has become physically threatening to certain staff. Staff has become suspicious that D may be physically abusive to patient AB, as they have seen bruising that is not sufficiently explained. Patient AB is reticent when asked about the bruising.

Situations like these raise a number of issues for CHHAs and LHCSAs that are forced to deal with them. Poor social conditions in the home raise issues of whether a patient may be maintained safely at home, and whether discharge is appropriate due to concerns regarding the safety of the home care services agency's staff. If patient AB refuses to leave her home, either because she does not wish to live in an institutional setting or because she does not wish to leave her daughter, the issues may become more complex.

Documentation of "accidents and incidents" must be made in accordance with 10 N.Y.C.R.R. § 763.7(a)(8), and any conditions in the home that may affect the care of the patient should be recorded as "observations" pursuant to § 763.7(a)(7). All documented incidents and observations should be discussed with the patient's physician, as this may assist the agency in obtaining an order permitting discharge of the patient to a higher level of care. If the patient refuses to leave her home or conditions otherwise warrant it, Adult Protective Services may be contacted in accordance with Article 9-B of the Social Services Law and 18 N.Y.C.R.R. Part 457. Services that may be provided to eligible adults include arranging for guardianship and temporary short-term living arrangements.[36]

Conclusion

As the need for supportive services increases with the variety of residential options offered to our aging and disabled population, the potential for issues associated with the availability and sufficiency of services becomes greater. Home care services agencies should be extremely

careful when they accept patients, with a view towards the potential deterioration in the patient's condition and social factors surrounding the provision of care to the patient, to ensure to the greatest extent possible the agency will be able to consistently provide services as needed. Agencies should carefully document any conditions that might ultimately lead to a determination that discharge is appropriate and should ensure ample communication of those conditions to the patient's ordering physician. To the extent an agency can work with the patient's physician to reach a consensus on the best means by which to provide supportive services, including the use of community resources that may assist in resolving issues in the home, many issues relating to the retention of patients may ultimately be avoided.

Endnotes

1. *See* Public Health Law § 3602(3).
2. *See* Public Health Law § 3605(8).
3. 10 N.Y.C.R.R. § 766.3(a). The determination must be made by a registered professional nurse or individual supervised by a registered professional nurse.
4. 10 N.Y.C.R.R. § 766.3(b) and (d).
5. 10 N.Y.C.R.R. § 766.2(a)(3).
6. 10 N.Y.C.R.R. § 766.2(a)(8).
7. 10 N.Y.C.R.R. § 766.2(a)(9) and 10 N.Y.C.R.R. § 766.4(a) and (b).
8. 10 N.Y.C.R.R. § 766.1.
9. LHCSAs can obtain Medicaid and/or Medicare reimbursement under certain circumstances, such as when they have contracted with a county or a CHHA to provide services to eligible patients. This does not alter, to a large extent, the nature of the regulatory scheme applicable to the LHCSAs, as the CHHA or county acts as the point of contact for the patient. Thus, if the LHCSA has contracted with a CHHA or a county to provide services to a Medicaid/Medicare eligible patient and the LHCSA is unable or unwilling to provide services, the CHHA or county is ultimately responsible for taking reasonable and necessary steps to ensure that authorized services are provided to the patient.
10. Article 36 of the Public Health Law and 10 N.Y.C.R.R. Part 765.
11. 10 N.Y.C.R.R. § 763.5.
12. 10 N.Y.C.R.R. § 763.5(a) and (b).
13. *Id*.
14. 42 C.F.R. § 484.55.
15. 10 N.Y.C.R.R. § 763.5(h).
16. 10 N.Y.C.R.R. § 763.5(h).
17. 10 N.Y.C.R.R. § 763.5(g).
18. It should be noted Medicare recipients may also be entitled to due process protections under certain circumstances, although this article will be limited to the rights afforded to Medicaid recipients given the fact this issue has been specifically addressed in New York. Due process rights have been addressed in the Medicare context by the United States Supreme Court in *Shalala v. Grijalva*, 526 U.S. 1096 (1999), *citing American Manufacturers Mutual Insurance Company v. Sullivan*, 526 U.S. 40 (1999).
19. *See also Catanzano v. Dowling*, 60 F.3d 113 (2d Cir. 1995), which addresses more specifically the question of when a CHHA may be deemed a state actor in the Medicaid context.
20. The Plan is found at 18 N.Y.C.R.R. § 505.23(f), Appendix 1. The fiscal assessment legislation under which 18 N.Y.C.R.R. § 505.23 was promulgated expired in 1999, although the substance and status of the now-expired fiscal assessment provisions are beyond the scope of this article. The Plan remains in effect, except for the provisions addressing adverse actions based on fiscal assessments.
21. The Plan also addresses denials of and reductions in services, an issue that is beyond the purview of this article. Federal Medicaid regulations governing fair hearings are located in 42 C.F.R. §§ 431.200 *et. seq.* State regulations governing Medicaid hearings are located at 18 N.Y.C.R.R. Part 358. These regulations clarify, in greater detail, the nature and quality of the protections that must be afforded a Medicaid recipient throughout the fair hearing process.
22. 18 N.Y.C.R.R. § 505.23(f), Appendix 1, § 201.
23. *Id*.
24. *Id.* at § 201 and § 203.
25. 18 N.Y.C.R.R. § 505.23(f), Appendix 1, § 201, § 202, and § 205.
26. Although terminations based on the safety of personnel were specifically excluded from the Plan, this would not necessarily preclude a claimant from arguing that federal fair hearing requirements are implicated. Moreover, it should be noted that on a practical level, errors in whether the federal fair hearing requirements should be met lean heavily in favor of the recipient. If there is a question as to whether the grounds for termination would require a fair hearing and aid-continuing, it is likely aid-continuing will be directed pending the hearing, at which point the issues may be sorted out and decided.
27. 18 N.Y.C.R.R. § 505.23(f), Appendix 1, § 2.0.
28. 10 N.Y.C.R.R. § 763.5(h).
29. For CHHAs, these regulations are found at 10 N.Y.C.R.R. §§ 763.2, 763.6 and 763.7. For LHCSAs, these regulations are located at 10 N.Y.C.R.R. §§ 766.1, 766.3, and 766.6.
30. 10 N.Y.C.R.R. § 763.2(a)(5) and § 766.1(a)(5).
31. 10 N.Y.C.R.R. § 763.6(e).
32. 10 N.Y.C.R.R. § 766.3(d).
33. 10 N.Y.C.R.R. § 763.6(e)(1) and (2) and § 766.3(d)(1) and (2).
34. 10 N.Y.C.R.R. § 763.7 and § 766.6.
35. 18 N.Y.C.R.R. § 505.23(f), Appendix 1, § 202 and § 205.
36. 18 N.Y.C.R.R. § 457.1(d)(5) and (7).

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Operation Home Alone—Past, Present and Future

By Rachel Hold-Weiss, RPA-C, J.D.

In early 2007, Attorney General Andrew Cuomo announced the first arrests in an investigation coined "Operation Home Alone." Operation Home Alone, which is being conducted by the Medicaid Fraud Contract Unit ("MFCU") of the New York State Attorney General's office, is an ongoing investigation of New York home health care agencies.

In New York State, there are two types of home health care agencies; Licensed Home Care Service Agencies ("LHCSAs") and Certified Home Health Agencies ("CHHAs"). CHHAs must go through the Certificate of Need ("CON") process to obtain an operating certificate issued by the New York State Department of Health ("DOH"). CHHAs have Medicare and Medicaid provider agreements, service both Medicare and Medicaid beneficiaries, and bill Medicare and Medicaid, as appropriate, for services rendered. CHHAs must provide skilled nursing care, physical therapy, occupational therapy, speech language pathology, home health aides and homemaker services. They may also provide medical social services.[1] At least one of the qualifying services must be provided by employees of the CHHA; any additional services may be provided via contracted arrangements.[2]

Many New York CHHAs choose to contract with LHCSAs for home health aides to provide the home health aide services to CHHA patients. The contracts usually specify the LHCSAs are responsible for ensuring, among other things, that the home health aides are properly certified, they meet criteria for legal employment, have been properly vaccinated and tested for tuberculosis, and continue to meet educational requirements throughout the course of employment.

Home health aides receive their certification after attending a program licensed by DOH or the State Education Department.[3] The home health aide training program includes a minimum of 75 hours of training, 16 of those hours must be supervised practical training by a registered nurse.[4] To obtain certification, the home health aide must also pass an English written test.

DOH has published a valuable guide which provides information about the training programs and certification of home health aides. The guide, entitled "Home Health Aide Scope of Tasks: Guide to Home Health Aide Training and Competency Evaluation and Matrix, Permissible and Non-permissible Activities Home Health Aide (HHA) Services," is available at: http://www.health.state.ny.us/professionals/home_care/curriculum/docs/home_health_aide_scope_of_tasks.pdf.

During the course of Operation Home Alone thus far, charges have been lodged against home health aides, home health aide training schools, nurses, owners and operators of home care agencies, home care companies and patients. Aides have been charged with obtaining false certifications, lying about the hours they worked, and billing for home health aide services provided to family members. The aides billed for time they claimed was spent with patients but actually was not, sometimes splitting the payments with the patients. In addition, some home health aides billed more than one agency for services purportedly rendered to multiple patients during the same time period.

The owners of home health aide training schools were charged with providing certificates for a fee without providing any training to the home health aides. Some nurses were charged with submitting bills to multiple CHHAs for services rendered to a number of patients at the same time. Other nurses were charged with billing for services that were supposedly rendered, however, the nurses each billed for services provided at the same time to the same patient.

Patients have also been charged for splitting fees with the home health aides when the aides received payment for hours billed, but the services were never actually provided to the patients.[5]

While the Operation Home Alone investigation began in the New York City region, recently, on April 17, 2008, the New York State Attorney General's Office revealed that it had issued 27 subpoenas to CHHAs in three regions: Buffalo, Rochester and Syracuse. The subpoenas seek information pertaining to home health aides, including home health aide personal information, the names of the LHCSAs that provided the aides, and proof of the home health aide credentials. Additionally, the Attorney General's Office obtained convictions against one registered nurse, one licensed practical nurse and one recruiter. The nurses were convicted for billing for services not rendered and the recruiter was convicted for, among other things, selling falsified personal care aide (PCA) certificates.[6]

On April 30, 2008, the Attorney General's Office released its New York State Medicaid Fraud Control Unit

2007 Annual Report to the Secretary of the United States Department of Health and Human Services.[7] The report indicates that more than $41 million of the total $112.5 million in restitution to Medicaid during 2007 came from home health cases.[8]

Until very recently, providers did not have a method by which to determine whether the school that had provided the home health aide certificate was an approved school by either DOH or the Department of Education. That changed in April 2008 with the publication of the list of approved home health aide training schools.[9]

CHHA and LHCSA providers still do not have any method to determine whether a home health aide is validly certified. Many providers have requested a home health aide registry, in order to enable them to determine quickly whether a home health aide has the proper certification. Attorney General Cuomo has called for legislation requiring DOH develop and maintain a home health aide registry which would include the following:

- The name, address, gender and date of birth of certified home health aides
- Name and date of state-approved training and competency evaluations programs successfully completed
- A copy of the training certificate issued
- The aide's employment history in home care and health care.[10]

During the past year, MFCU has investigated CHHAs and LHCSAs, their owners and high managerial employees, recruiters, nurses, home health aides and patients. As evidenced by the recent subpoenas issued to the upstate region CHHAs, Operation Home Alone is ongoing and will continue into the foreseeable future.

Endnotes

1. 42 C.F.R. §§ 484.30 *et seq.*
2. 42 C.F.R. § 484.14.
3. A list of approved home health training programs as of 4/08/2008 is *available at* http://www/health.state.ny.us/professionals/home_care/curriculum/docs/home_health_aid_training_programs.pdf.
4. 42 C.F.R. § 484.36.
5. Press releases regarding Operation Home Alone can be found on the New York State Attorney General's website at: http://www.oag.state.ny.us/press/2007/aug/aug22a_07.html; http://www.oag.state.ny.us/press/2007/aug/aug27a_07.html; http://www.oag.state.ny.us/press/2007/sep/sep25a_07.html; http://www.oag.state.ny.us/press/2007/oct/oct25a_07.html; and http://www.oag.state.ny.us/press/2008/may/may1a_08.html.
6. The press release regarding the subpoenas issued to the upstate NY home health agencies can be found at http://www.oag.state.ny.us/press/2008/apr/apr17b_08.html.
7. The full report can be found at http://www.oag.state.ny.us/press/2008/apr/mfcu2007annualreportfinal043008_2.pdf.
8. *Id*. at 9.
9. *See* note 3, *supra*.
10. http://www.oag.state.ny.us/press/2007/sep/sep25a_07.html.

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Discharge Planning Issues in Hospitals: Steering to Preferred Certified Home Health Agencies and the Risks of Providing Free Discharge Planning Services to Hospitals

By Connie A. Raffa, LL.M, J.D.

Freestanding Certified Home Health Agencies (CHHA) often complain hospitals are steering patients because the hospitals discharge most patients to the hospital's own home health agency. The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services has identified as a risk area tampering with a patient's freedom of choice by hospital discharge planners steering patients to certain home health agencies, DME suppliers or long-term care and rehabilitation providers. See *Compliance Program Guidance for Hospitals*, 63 Fed. Reg. 35, 8987, 8990 (2/23/98). In 1997, Congress addressed this issue by amending the statutory definition of a hospital and amending its conditions of participation (COPs) to require that patients who need post-hospital services be given a list of providers located in the patient's geographic area to choose from. 42 U.S.C. § 1395a(a), Social Security Act (SSA) § 1802(a) entitled *Free Choice by Patient Guaranteed* is the basis for the Balanced Budget Act (BBA) '97 amendments. The Centers for Medicare and Medicaid Services (CMS) has answered many questions involving these requirements in Frequently Asked Questions, most of which are summarized below. *See also CMS Program Memorandum Transmittal A-02-106* (10/25/02).

BBA'97 Amendments Impacting Discharge Planning

The definition of a hospital and discharge planning at 42 U.S.C. § 1395x(e),(ee), SSA § 1861(e),(ee), was amended to strengthen the discharge planning (D/C) process by requiring hospitals to follow standards detailed in its COPs at 42 C.F.R. § 482.43. Hospitals must identify patients who will need post-hospital extended care, CHHA or hospice services at an early stage in their hospital stay. This requirement applies to all patients in Medicare and Medicaid participating hospitals, regardless of whether the patient is covered by Medicare, Medicaid, managed care, private insurance or private pay. The hospital must evaluate patients they have identified will need post-hospital services, and also patients for whom an evaluation is requested by the patient, their representative or physician. The evaluation must be performed by a registered professional nurse, social worker, or other qualified personnel on an ongoing basis and in a timely manner to avoid delay in discharge, and ensure post-hospital care is in place. The D/C evaluation must be included in the patient's medical record, and its results discussed with the patient or his or her representative. The hospital must discharge the patient with necessary medical information to the appropriate provider chosen by the patient or his representative.

Patient Choice Requirements

The patient choice requirements are the hospital must provide a list of CHHAs or post-hospital extended care services to the patient or his or her representative. The list should only be provided to patients who need these services as indicated in the patient's discharge plan. This list should be given to the patient or representative at least once prior to discharge. The hospital must list providers who request to be listed, if those providers are certified to participate in the Medicare program. Except for skilled nursing facilities (SNFs), the providers must make a request to the hospital to be listed, and they must be located in the geographic area where the patient resides.

Although regulation 42 C.F.R. § 482.43 discusses services provided by CHHAs and SNFs, the statute includes hospices. Therefore, a hospice which meets the requirements and requests to be listed on the post-hospital service list may be included. The discharge planner is expected to assist the patient with choices for other post-hospital services. Therefore, if a hospice or DME company or other post-hospital service that is not a CHHA or a SNF contacts the hospital to be included on the list, such a request made to the hospital may be honored. The list does not have to indicate the services provided by the provider. While the hospital should identify Medicare-certified providers, there is no requirement the hospital identify accreditations.

SNFs are not required to contact the hospital to be on the list. The CMS recommends SNFs can be identified from CMS's website at the Nursing Home Compare link, or by calling 1-800-MEDICARE (800-633-4227). The SNFs must be in the geographic area requested by the patient, which is not restricted to the geographic area where the patient lives. SNFs that are listed should be kept on the list regardless of whether they have available beds.

The hospital must not specify or otherwise limit the providers who are listed. As part of the D/C planning process, the hospital must inform the patient or representative or family *"of their freedom to choose among participating*

Medicare providers of post hospital care services and must, when possible, respect patient and family preferences when they are expressed." See 42 C.F.R. § 482.43(c)(7). Although the hospital discharge planner is not required to document the attempts to implement patient choice by placing a patient in a CHHA or SNF requested by the patient, it is recommended such documentation be kept in the patient record. Hospitals are required to document in the patient's medical record that a list of CHHAs or SNFs was presented to the patient or representative. The hospital is not required to duplicate the list in the patient's medical record. The hospital has flexibility to determine how to document in the medical record that the list was presented.

The hospital must disclose a financial interest in any of the listed providers. A disclosable financial interest is the same definition that is used in the provider enrollment process at 42 C.F.R. § 420.201(3). Financial interests include a direct or indirect ownership of 5% or more, or an interest of 5% or more in any mortgage, deed of trust, note, or other obligation that equals 5% or more of the property or assets of the disclosing entity. The method of disclosure is up to the hospital since there are no specific requirements. The hospital could highlight or identify those entities by another method, or maintain a separate list.

Should the list be given to patients who are enrolled in Managed Care Organizations (MCO)? Most definitely, members of an MCO should receive a list which identifies available and accessible providers in the network, as well as other providers, because the patient has the right to choose a provider outside the network. However, it is recommended, but not required, that the list contain a statement to remind the member there may be financial liability if services are obtained from a provider outside their network. The hospital should contact the MCOs its patients use and request a list of their in-network providers.

Hospitals can create the list of CHHAs and SNFs from the CMS website by including a list of CHHAs in the patient's geographic area where the patient resides, taken from the Home Health Compare link. For post-hospital extended care services, a list of SNFs in the geographic area requested by the patient can be printed from the Nursing Home Compare link. In the alternative, the hospital can choose to develop its own list.

If the hospital chooses to create its own list of CHHAs and SNFs, it must comply with the patient choice requirements discussed above. The hospital cannot recommend or endorse the quality of care of any CHHA or SNF. The list must be legible and current. It is recommended the list be updated at least annually. CHHAs must request to be on the list, and must be geographically available. SNFs do not have to request to be on the list. SNFs that are in the geographic area requested by the patient should be included. This is not restricted to where the patient lives. If the hospital has a financial interest in a CHHA or SNF on the list, it must be disclosed on the list. A licensed home health agency that is not certified to participate in Medicare may be placed on the list if it makes the request. Hospitals may have one list combining the different types of providers or separate lists. The list does not have to arrange the providers in alphabetical order. There is no requirement specifying how the hospital should update its list; hospitals have the flexibility to determine their own processes. However, use of the CMS website is recommended. Hospitals are not required to have lists for different geographic areas, or for each patient. For example, a hospital could distribute a list of SNFs located in selected geographic areas, or the entire state. Patients cannot be directed to the CMS website in lieu of giving them a list.

Enforcement Against Steering

Complaints about not providing a list to a patient who requires post-hospital services, or a hospital's steering a patient to a specific CHHA or SNF, should be filed with the state survey agency, the New York State Department of Health (DOH). Theoretically, the DOH could determine the hospital is not in compliance with its COP. Sanctions could include a mandated Plan of Correction, or possible termination from participating in the Medicare program. However, before filing such a complaint, the hospital should be contacted by the complaining CHHA or SNF. This communication should occur at a President or CEO level, or health care counsel level. The purpose of the contact should be to explain the requirements concerning patient choice, the non-compliance, possible sanctions, and suggestions to remedy the situation before any government contacts are made. In addition to health care law violations, there may be antitrust issues, as well as unfair competition by hospitals who engage in steering.

Kickback Risks of Providing Free Discharge Planning Services

Another risk area identified in the *OIG Compliance Program Guidelines for Home Health Agencies* is incentives to actual or potential referral sources, such as hospitals, that may violate the anti-kickback laws. *See* 63 Fed. Reg. 152, 42410, 42414 (8/7/98). Sometimes this occurs when a CHHA intake coordinator crosses the line and performs discharge planning services for the hospital. Examples include rounding with hospital staff or reviewing medical records for the purpose of identifying patients who need home health services before the patient has been referred to the CHHA. The hospital COPs require the hospital provide D/C planning services, and the hospital is reimbursed for those services by Medicare and Medicaid. Therefore, if a CHHA provides the D/C planning services for free to the hospital, the free service is a kickback for the referral of the

patient to the CHHA. The *OIG Special Fraud Alert on Home Health Fraud* issued in June 1995 discussed the paying or receiving of kickbacks in exchange for Medicare and Medicaid referrals to include *"providing hospitals with discharge planners, home care coordinators, or home care liaisons in order to induce referrals."*

The Provider Reimbursement Manual (PRM) §§ 2113–2113.5 defines in detail the difference between home health intake coordination activities and discharge planning type activities. A CHHA can claim home health intake coordination activities on their Medicare cost report. After a patient's physician determines that home health services are medically necessary as documented in the patient's medical record and there is a referral to a CHHA chosen by the patient or his or her representative, the CHHA's nurse or social worker commences intake coordination activities. Intake activities include explaining CHHA's policies to the patient and family; developing the home health plan of care prior to D/C; assessing the patient for home health services such as nursing, therapies, home health aide services, medical supplies, DME and medications; and making the appropriate arrangements to ease the patient's transition from the hospital to the patient's home. These intake activities take place while the patient is still in the hospital, but only after the patient has been referred to the CHHA. Intake activities must be medically necessary, and not duplicative of services already performed by the hospital and for which the hospital is reimbursed, such as D/C planning activities. Intake coordinators are prohibited from reviewing medical records, visiting the patient and family, or participating in hospital rounds to determine the level of care needed by the patient once discharged. If the decision to refer the patient for post-hospital care has not been made, and the patient has not been referred to a CHHA, SNF or hospice, the activities needed to reach that decision are included as part of the hospital's D/C planning activities.

Solutions Found in Safe Harbor

The anti-kickback law is a broad prohibition precluding an offer, solicitation, payment or receipt of anything of value, direct or indirect, overt or covert, in cash or in kind, that is intended to induce referral of patients for items or services reimbursed by all federal programs, including Medicare, Medicaid, and programs covering veterans' benefits. Remuneration is anything of value including money, rebates and free services. Both the offeror and recipient of a kickback violate the law. A kickback can exist if one purpose of the payment is to induce referrals, regardless of the legitimate reason for the payment. Offering or receiving a kickback is a felony punishable by imprisonment, fine, automatic exclusion, and civil money penalties. *See* 42 U.S.C. § 1320a-7b(b)(2); SSA § 1128(b)(2).

However, there are "safe harbors" that describe different types of business relationships. If you follow the requirements of the safe harbor, there is no criminal or civil sanction. Failure to meet the requirements of a safe harbor is not automatically a kickback arrangement. The facts of the business relationship must be evaluated to determine intent. There are 26 business relationships for which there are safe harbors, including contracting for personal services. If state law permits, a hospital could contract with a CHHA to purchase discharge planning services. The contract and its implementation must comply with the safe harbor for contracting for personal services. Those safe-harbor requirements are: the contract must be in writing, signed by both parties, for a period of a year or more, and describe the discharge planning services to be provided. If the services are not provided on a full-time basis, the contract must describe the schedule or interval when the contracted services will be provided. Payment must be set in advance, be fair market value (FMV), and have no link to the volume of referrals from the hospital. The contract must not promote a violation of federal law, and it must have a reasonable business purpose. *See* 42 C.F.R. § 1001.952(d). FMV generally means the price paid in an arm's-length transaction, and does not take into account the volume or value of any referrals or business paid by Medicare, Medicaid or other government-funded programs.

In addition to the potential kickback issue, the CHHA would have to obtain prior approval from its Medicare contractor, formerly called a fiscal intermediary, for a method to allocate the salary and fringe benefits of its nurses or social workers who will be performing the D/C planning services for the hospital, as well as providing services for the CHHA.

Conclusion

Both the steering and the kickback issue invite government scrutiny and sanctions. Relationships between hospitals and CHHAs, SNFs and hospices should be periodically examined by the provider's compliance officer with health care counsel to ensure that what is occurring in real life is consistent with the many requirements.

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The Role of Home Health Care Services in Assisted Living

By Susan V. Kayser

Elderly residents of New York are increasingly seeking assisted living services as they age and require supportive services. Many elderly individuals find they require assistance with personal care needs, such as bathing, dressing and grooming. Living at home may not be an option because of the demands of preparing meals and home upkeep. For those who do not require around-the-clock skilled nursing care, assisted living can be the ideal solution—providing meals, housekeeping services, support with personal care, monitoring of health status, and social and recreational opportunities.

However, there may be circumstances when an assisted living resident requires additional services not provided by the facility. For instance, an individual who has had back surgery may be recuperating at "home," the assisted living facility where he or she resides. Skilled nursing care is not required on a continual basis, but the dressing on the incision must be changed and the individual's physician has prescribed a course of physical therapy during the recovery period. While the assisted living facility can provide the usual personal-care services, the facility is not licensed to provide the higher-acuity services. In such a situation, a viable alternative is for the individual (not the facility) to engage a home care agency to provide the services. By contracting with the home care agency, the individual is able to receive the required level of services at the facility. In more routine circumstances, an assisted living resident may require ongoing, long-term assistance with certain needs such as insulin injections and nebulizer treatments that cannot be provided by facility staff. In such circumstances, the resident may contract with a home health agency to provide the services.

Where home care services are rendered to assisted living facility residents, there is the potential for violation of certain laws if the parties are not vigilant. This article will discuss the various models of assisted living in New York State, the laws that can be implicated when home care services are provided to assisted living residents, and how to avoid violating the laws.

Models of Assisted Living in New York

Adult Care Facilities ("ACFs")

Adult homes and enriched housing programs are types of adult care facilities, licensed and inspected by the New York State Department of Health.[1] They provide room and board, housekeeping, supervision, case management, activities, and personal care (such as assistance with personal hygiene, dressing, and feeding and nutritional support).[2] ACFs are for people who are unable to live completely independently.[3] However, ACFs have some significant limitations: they are not intended for persons who are in need of continual nursing or medical care. Unlike nursing homes, they are not staffed with nurses, a medical director or other doctors, or specialists for therapies.

Regulations governing ACFs mandate an operator may not accept or retain a resident who is in need of continual medical or nursing care, has a medical condition which is unstable and requires continual skilled observation of symptoms and reactions or skilled recording of such skilled observations; is chronically bedfast, chairfast and unable to transfer, or chronically requires the assistance of another to transfer, chronically requires assistance of another person to walk, or climb or descend stairs (unless on a ground floor); has chronic unmanaged incontinence; or is dependent on certain types of medical equipment.[4]

A resident requiring health services in the ACF that are in addition to those services an ACF is authorized to provide must arrange for such services by contracting with an appropriate provider. As noted above, required services are frequently provided by a home care agency, either a Medicare-certified home health agency ("CHHA") or a licensed home care services agency ("LHCSA").

Assisted Living Residences ("ALRs")

An "Assisted Living Residence" as defined in the Assisted Living Reform Act passed in 2004 must be licensed as an adult care facility (either adult home or enriched housing program) and must also be licensed as an "Assisted Living Residence" ("ALR").[5] The term "assisted living" or any derivation thereof cannot be used in marketing or advertising or any other facility materials unless the facility is licensed as an ALR.[6] ALRs must comply with existing rules for ACFs[7] and new regulations for ALRs.[8]

Certain special certifications are available to ALRs. Enhanced Assisted Living Residence ("EALR") certification allows residents to "age in place" (in accordance with their residency agreement with the facility) beyond ACF retention standards for ambulation, transfer, medical equipment, and unmanaged incontinence.[9] Special Needs

Assisted Living Residence ("SNALR") certification allows the facility to serve individuals with "special needs" such as dementia or cognitive impairments.[10] The facility must submit to the Department of Health a special needs plan that demonstrates how the special needs of such residents will be safely and appropriately met.

As is the case with ACF residents, ALR residents who require health services beyond those that can be provided by the facility also must arrange for the services by contracting individually with an appropriate service provider.

Assisted Living Programs ("ALPs")

ALPs are a combination of adult home (or enriched housing program) services and home care services to provide residential supportive services to individuals who would otherwise require nursing facility placement. In order to be licensed as an ALP, both an ACF license and a LHCSA license are required.[11]

Residents who are appropriate for ALP admission have the following characteristics:

- they have no suitable home in which to live or home care services cannot be safely provided in home;
- they need more supervision than can be provided economically through home care but nursing home services are not a necessity; and
- they have little complex medical need.[12]

To be eligible for ALP admission, the resident must:

- require more care than an ACF provides;
- be medically eligible for nursing home placement;
- otherwise require placement in a nursing home due to factors which may include, but need not be limited to, lack of a home or home environment in which to live and receive services safely; and
- be able to be appropriately cared for in an ALP.[13]

A resident's payment options for ALP services are either private pay or, if the individual is income-qualified, SSI for residential services and Medicaid for health care services. A Medicaid capitated per diem payment is made to the ALP for health services provided to residents by the LHCSA component of the ALP. In return for the payment received from Medicaid, an ALP is obligated to provide a resident with the following services:

- personal care services which are reimbursable under Medicaid;
- home health aide services;
- personal emergency response services;
- nursing services;
- physical therapy;
- occupational therapy;
- speech therapy;
- medical supplies and equipment not requiring prior authorization; and
- adult day health care in a program approved by the Commissioner of Health.[14]

The ALP program is the only type of assisted living service in New York where a Medicaid funding stream is available to a resident. Only a limited number of ALP slots have been allocated by the Department of Health and ALP licensure is strictly controlled.

Legal Pitfalls in Home Care/Assisted Living Relationships

Frequent involvement of home care agencies in services to assisted living facility residents may give rise to areas of legal danger for both home care agencies and assisted living facilities. The laws that impact on the role of home care in assisted living are discussed below.

Anti-kickback Laws

Home care agency/assisted living facility relationships may be particularly vulnerable to violations of the health care fraud and abuse laws. For instance, a home care agency may offer free or reduced-cost services or items to an assisted living facility as a mechanism for generating referrals from the facility. This is likely to constitute a violation of the federal anti-kickback statute.[15] This statute prohibits the knowing and willful offer, solicitation, payment or receipt of any remuneration in any form, directly or indirectly, to induce referrals of any item or service for which payment may be made under a federal health care program such as Medicare or Medicaid. The law is written in very broad terms and is interpreted liberally by the government. A violation of the statute is punishable by a prison term of up to five years and a maximum fine of $25,000.[16] Both parties to a prohibited arrangement are candidates for prosecution. The Balanced Budget Act of 1997 added a civil monetary penalty that can result in a $50,000 fine for each act and treble damages.[17] Despite the breadth of the anti-kickback statute, federal "safe-harbor" regulations set forth criteria that, if met, insulate certain specific types of arrangements from a finding of a violation of the law.[18]

New York has its own anti-kickback law which closely follows the language of the federal law, but applies only to items and services reimbursed by Medicaid.[19] New York's law incorporates by reference the safe-harbor regulations that apply to the federal anti-kickback law.[20]

An assisted living facility can be very attractive to an agency providing home care services because of the ready access to a group of elderly people likely to need the agency's services. While giving incentives to a referral source is an accepted practice in settings outside of the health care industry, the federal and New York State anti-kickback laws restrict this tool for business generation among health care providers where the items or services are ultimately paid for by Medicare, Medicaid or any other federally funded health care program. In assisted living settings, programs that provide Medicaid-reimbursable services are directly impacted. But even those programs whose residents are strictly private pay must exercise caution because the anti-kickback statute implicates both the party that gives remuneration intended to induce referrals and the party that accepts the remuneration. Both parties to a prohibited arrangement are candidates for prosecution if the items or services involved are reimbursed by a federal health care program. If a home care agency has an arrangement with an assisted living facility, care should be taken to ensure no anti-kickback law violations exist and, if possible, the arrangement meets "safe-harbor" criteria set forth in federal regulations.

Lease Arrangements and the Anti-kickback Laws

Frequently, a home care agency occupies space on the premises of an assisted living facility and does business out of that space. If an incentive for referrals is built into a lease arrangement, e.g., the rental paid by the home care agency to the facility is in excess of fair market value, the enforcement authorities may scrutinize the arrangement to determine whether the excess amount was intended as a payment to the facility to induce it to refer residents to the home care agency in violation of the kickback prohibition. However, if the arrangement meets the following "safe-harbor" regulatory requirements for leases, the arrangement will be protected:

1. The lease agreement is set out in writing and signed by the parties.
2. The lease covers all of the premises leased between the parties for the term of the lease and specifies the premises covered by the lease.
3. If the lease is intended to provide the lessee with access to the premises for periodic intervals of time, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule for such intervals, their precise length, and the exact rent for such intervals.
4. The term of the lease is for not less than one year.
5. The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid or other federal health care programs.
6. The aggregate space rented does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental. "[T]he term *fair market value* means the value of the rental property for general commercial purposes, but shall not be adjusted to reflect the additional value that one party (either the prospective lessee or lessor) would attribute to the property as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare, Medicaid and all other Federal health care programs."[21]

Where a home care agency occupies space in an assisted living facility but does not pay any rental amount, using the space free of charge, the arrangement could not trigger government concerns if the agency is in a position to make referrals to the facility. The free rent could be viewed as remuneration from the facility given to the agency in return for referrals to the facility. Caution must be taken to analyze such a situation for potential kickback law violations.

Duplicate Payment for Services

Duplicate Medicaid payment for services in ACF and ALP settings is getting attention from the Department of Health and New York's new Office of Medicaid Inspector General. Both are focused on provider audits to determine if payments for the same services are being made to both an assisted living facility and a home care agency.

A Department of Health audit in such a case was challenged by the home care agency provider being audited. In *In re First to Care Home Care, Inc.*,[22] the Department determined the home care agency, a non-profit CHHA, received overpayments in the amount of $420,017 because the agency billed the Medicaid program for home health aide services to residents of an ACF located in Brooklyn that either duplicated or supplanted personal-

care services that were required to be provided by the ACF. The Department took the position the ACF was required by law to provide the services and payment the ACF received from its residents covered the cost of the services. The agency contended the services it provided were not being provided by the ACF, as the aides were providing "total assistance" with personal care to the residents and not simply "some assistance," as these terms are defined in 18 N.Y.C.R.R. § 505.14(a)(2). After an administrative law judge found for the Department in an appeal made by the agency, the agency brought an Article 78 proceeding in the Appellate Division, First Department, to challenge the ALJ's determination. The Appellate Division upheld the administrative determination, stating the ACF was statutorily obligated to provide the housekeeping and personal-care services the agency provided and billed for, and the ALJ's determination the agency provided "some assistance" with personal care needs, and not "total assistance," was supported by the record in the administrative proceeding.[23]

Audits of a similar nature are likely to follow, if the OMIG's Work Plan for 2008/2009[24] is any indication. The Work Plan, specifically referencing the *First to Care Home Care, Inc.* decision, states the OMIG will review billings of home care agencies for services to ACF residents.[25] The Work Plan notes "tens of millions of dollars" of home health services are being provided in ACFs and billed to the Medicaid program.[26] The OMIG also states in its Work Plan it will review payments to home care agencies for personal-care services to determine whether the criteria set forth at 18 N.Y.C.R.R. § 505.14 have been met.[27] This audit initiative could very well include services home care agencies provide to ACF residents.

The OMIG's 2008/2009 Work Plan also highlights its intention to review Medicaid payments for services provided to ALP residents to determine if claims were improperly reimbursed for items included in the ALP's per diem rate.[28] As noted above, the ALP Medicaid rate includes payment for a variety of services, as set forth at 10 N.Y.C.R.R. § 494.5(b). Services that are covered by the per diem rate but for which a home care agency bills are likely to result in overpayment determinations.

Conclusion

The combination of assisted living and home care services is likely to continue to develop as a means of providing the elderly with the community-based supportive services they require as they age. Care must be taken to ensure the relationships between home care agencies and assisted living providers do not overstep legal boundaries.

Endnotes

1. *See generally* Social Services Law Article 7, §§ 460 and 461.
2. 18 N.Y.C.R.R. §§ 487.2, 488.2, 487.7, 488.7.
3. 18 N.Y.C.R.R. § 485.2(a).
4. 18 N.Y.C.R.R. §§ 487.4, 488.4.
5. Public Health Law § 4650.
6. *Id.*
7. 18 N.Y.C.R.R. Parts 485, 486, 487, and 488.
8. 10 N.Y.C.R.R. Part 1001.
9. Public Health Law § 4651.
10. Public Health Law § 4655.
11. Social Services Law § 461-l.
12. 18 N.Y.C.R.R. § 494.4.
13. 18 N.Y.C.R.R. § 494.4.
14. 10 N.Y.C.R.R. § 494.5(b).
15. 42 U.S.C. § 1320a-7b(b).
16. *Id.*
17. 42 U.S.C. § 1320a-7a(b).
18. 42 C.F.R. § 1001.952.
19. Social Services Law § 366-d.
20. Social Services Law § 366-d(2)(d).
21. 42 C.F.R. § 100.952(b).
22. *In re First to Care Home Care, Inc*., New York State Department of Health Administrative Decision by Hon. Stephen L. Fry, November 5, 2004.
23. *First to Care Home Care, Inc. v. Novello*, 825 N.Y.S.2d 198 (N.Y. App. Div. 2006)
24. Office of the Medicaid Inspector General's Work Plan for 2008/2009, *available at* http://www.omig.state.ny.us/data/images/stories//omig_workplan2008_2009v2.pdf.
25. *Id.* at 6.
26. *Id.* at 6.
27. *Id.* at 6.
28. *Id.* at 3.

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Non-Hospital Order Not To Resuscitate

By Michele Petruzzelli

Many terminally ill patients desire to spend the remaining part of their lives at home. With help from home care services agencies, family members, and friends, this is becoming an increasingly feasible option. Residents of a residential health care facility and patients in a general hospital may have orders written in their chart they do not want resuscitative measures (CPR) undertaken if they suffer a cardiac and/or respiratory arrest. To provide parity to patients who reside at home, New York state law provides for the issuance of a "nonhospital order not to resuscitate (DNR)." A patient's physician writes a nonhospital DNR order on a specific Department form. The original of the form must be kept at home with the patient and must be honored by emergency medical services (EMS) personnel.[1]

The conundrum here, however, which happens more often than it should, is that family members or caregivers of a patient with a nonhospital DNR order will call 911 when the patient's breathing and heart rate begin to slow down. While it seems to be almost an instinctive action, it has the possibility of causing havoc at the end of the patient's life.

It is important for health care attorneys with home care services agencies as clients to understand what will happen in certain scenarios:

1. The patient does not have a nonhospital DNR order. When the patient begins showing signs of decreased breathing or heart rate, the family calls 911. When EMS personnel arrive at the home, they will ask whether the patient has a nonhospital DNR order. If the family says the patient does not, the EMS personnel will begin CPR and transport the patient to the nearest emergency room. This is absolutely appropriate.

2. The family members call 911, even though the patient has a nonhospital DNR order. When EMS personnel ask to see the order, the family cannot provide it. EMS personnel must begin CPR and transport the patient to the nearest emergency room. If EMS personnel don't actually see the nonhospital DNR order, they cannot simply depend on the word of the family members. To solve this problem, the nonhospital DNR order should be readily available in a place where all family members know the location.[2]

3. The family members call 911. They tell the EMS personnel the patient does not have a nonhospital DNR order. One of them identifies him or herself as the patient's health care agent and refuses DNR on the patient's behalf. EMS personnel must begin CPR and transport the patient to the nearest emergency room. Even if presented with a copy of the health care proxy form, EMS personnel cannot determine whether the health care proxy form is legally adequate and/or whether the health care agent is legally authorized to act.

4. This is the worst-case scenario. Even though they know the patient has a nonhospital DNR order, the family members call 911. When the EMS personnel arrive, the family shows them the nonhospital DNR order. At this point, EMS personnel can do nothing. They cannot begin CPR and they cannot transport the body.[3] EMS personnel will contact their medical control physician regarding the facts the patient has suffered a cardiac and pulmonary arrest and relate any other pertinent clinical findings, including that the patient had a nonhospital DNR.[4]

This is where the quandary begins, since what happens next depends on local protocols and custom. EMS personnel cannot transport a dead body.[5] A hospital emergency room cannot admit a dead body.[6] EMS personnel cannot stay in the home indefinitely. Local or regional protocol usually requires EMS personnel to phone the local police department. A police officer is usually sent to the home to secure the body. At that point, EMS personnel will leave the home. Neither the police nor the family can transport the body.[7]

Depending on the city, county or town and local and regional protocols, the coroner, medical examiner, funeral director or undertaker will come to the home to transport the body. Before removing the body from the home, the funeral director or undertaker must perform certain tests to determine whether life is extinct.[8]

Depending on a wide-range of circumstances, the ability of the coroner, medical examiner, funeral director or undertaker to come to the home varies tremendously. They may be able to come very quickly or it may take them several hours or more. This situation need not happen.

Attorneys have valuable advice to offer their home care services agency clients, some legal and some practical:

1. If the patient does not want CPR started should he or she suffer a cardiac or respiratory arrest while residing at home, the patient should ask their physician to write a non-hospital DNR order. The order must be written on a specific Department form,[9] to which all caregivers must have access. The patient or a family member must take possession of the original form.
2. The physician should review the order at least every 90 days. Failure of the physician to do so, however, does not invalidate the order.
3. Educate home care services staff members, and ensure that they understand, the impending signs of death so they can educate family members to the extent appropriate. More importantly, when the signs begin to appear, staff members can explain what is happening to the family members.
4. If the patient has a nonhospital DNR order and his or her breathing and heart rate are slowing down, DO NOT CALL 911.
5. Instead of calling 911, the family should call the home care services agency, which should then follow its own protocols regarding impending death or death of a patient.
6. Urge the patient and family members to make pre-arrangements with a funeral home. If such pre-arrangements are made, it is much more likely the funeral director or undertaker will come to the home as quickly as they can.
7. Educate and re-educate staff members, patients and family members regarding all pertinent issues.
8. Never allow the patient or family members to feel abandoned, especially as death is drawing closer.

A person's death is always painful, even when it is expected. A death at home which leaves family members with the person's body is likely very traumatic and undignified to the deceased. Compassionate preparation, care and prevention of these issues will be remembered and appreciated by the family members.

Endnotes

1. Public Health Law (PHL) § 2977.
2. Although this may sound strange, the nonhospital DNR order could be secured to the refrigerator with a magnet or could be put in the freezer in a freezer-safe bag. This is the first place many EMS personnel look.
3. There are three statutory exceptions: (1) if the EMS personnel believe in good faith the consent to the nonhospital DNR order has been revoked; (2) if the family members demand CPR be started and the patient be taken to the nearest emergency room and a confrontation is likely; or (3) the hospital emergency medical services physician directs otherwise. If any one of the exceptions exists, the EMS personnel should initiate CPR and transport the person to the nearest emergency room. PHL § 2977 (10)(a)(i) and (ii) and (b); Title 10 (Health) of the Official Compilation of the Codes, Rules and Regulations of the State of New York (10 N.Y.C.R.R.) § 800.15(c)(1) and (2).
4. *See* PHL § 3001(15).
5. 10 N.Y.C.R.R. § 77.7(b)(1).
6. *See* 10 N.Y.C.R.R. § 405.9(b).
7. *See* 10 N.Y.C.R.R. § 77.7(b)(1).
8. PHL § 3440; 10 N.Y.C.R.R. § 77.9.
9. DOH-3474 (4/95)

Strange Questions for the Home Health Agency Attorney

By Robert N. Swidler

Health care attorneys who represent a mix of providers will find their home health agency (HHA) clients generate some of the oddest, most challenging patient care-related questions. The change in the locus of care from an institutional setting, which is more or less under the control of the provider, to a patient's home has far-reaching implications. Home health nurses and aides witness conduct and circumstances that institutional or office staff would be unlikely to see. And home health staff are more apt to be drawn into personal and business relationships that rarely ensnare hospital or physician office staff.

To be sure, experienced home health care agency administrators and care staff are familiar with that setting, and rarely need to seek legal counsel's help. But when they do, their questions can be quite strange.

This article provides a few examples of the strange questions that may be posed by home health agency administrators or staff to the HHA's counsel, and guidance in addressing those questions.

It is assumed for this article the client is a Medicare-participating "home health agency" under the Centers for Medicare and Medicaid Services (CMS) regulations subject to the conditions of participation in 42 C.F.R. Part 484—Home Health Services, and also a "certified home health agency" (CHHA) as defined by NYS Public Health Law § 3602.3 subject to the minimum standards in 10 N.Y.C.R.R. Part 763.

Having noted that, few of these questions can be answered by reference to regulatory standards.

1. The Love Affair

Q ***We just learned one of the home health aides has become romantically involved with the patient's adult son, who lives with the patient. They are seeing each other after work. In fact, we heard she plans to move into the patient's home. Can we let her do that? Do we have to transfer the aide from caring for this patient, or more drastically, terminate her employment?***

A Nothing in the CMS or DOH home care regulations directly prohibit a home health aide from entering into a romantic or sexual relationship with a patient's family member—or for that matter, even with the patient. Moreover, nothing in those sources expressly prohibit an aide from moving into the patient's home. So the HHA is not compelled by regulation to terminate the aide's care of the patient or the aide's employment.

If the caregiver were a licensed professional like a registered nurse or physical therapist, professional conduct principles might be implicated—especially if the relationship were with the patient.[1] If so, the HHA would also face exposure since CMS regulations provide "the HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA."[2] But the home health aide, while a "paraprofessional," is not a licensed professional subject to Education Department sanctions for unprofessional conduct.

Nonetheless, it would be legally and ethically perilous to permit an aide to care for a patient while romantically involved with a family member, and even worse for the aide to move into the home.

For one thing, it would become difficult to reliably distinguish the aide's reimbursable care-giving time from non-reimbursable personal time. That same blurring of work time and personal time creates exposure to the HHA for labor law violations. Also, if the aide moved into the home, the payor (including a governmental payor) could take the position the care constitutes non-reimburseable family care-giving. The situation therefore invites either actual fraud, abuse or noncompliance, accusations of fraud, abuse or noncompliance, or at least payment disputes.

Even more problematic, the aide's emotional involvement with the family would jeopardize her care-giving objectivity, and compromise her loyalty to her employer. Thus it might lead her to provide a level of care, or extra services, that another objective aide would not provide. The personal relationship could also lead the aide to expect or demand gifts or favors that another aide would not seek. Indeed, the relationship would likely inhibit a patient from asserting complaints or grievances relating to the aide's conduct or care.

Finally, if the patient were ever harmed as a result of negligent care by the aide, one can easily envision the plaintiff's attorney highlighting the aide's personal relationship with a family member, and contending the HHA violated some standard of care by permitting the aide to continue to serve the patient. Whether the argument is logical or not, it provides the opportunity for a salacious presentation that could harm the HHA's defense.

For these and other reasons, the HHA should not allow the aide to continue to serve the patient. It would also be helpful for the HHA to have a policy that states that an aide cannot continue to serve a patient if he or she is romantically involved with a family member. The HHA, with a clear statement in the employee code of conduct or handbook prohibiting such conduct, will be on firmer ground when responding to this situation and less likely to face a complaint by the employee to a regulatory agency, or a lawsuit.

The HHA should also provide materials upon admission to patients and the family members who live with them that explain the need to preserve boundaries in the relationship. Such materials may not prevent a romantic relationship, but it should reduce the risk of a complaint by the patient in the event the HHA feels compelled to transfer the patient's care to another aide.

Finally, the HHA needs to consider whether it is sufficient to terminate the aide's care of the patient, or whether it should terminate the aide's employment. Obviously the terms of employment policies and collective bargaining agreements might bear on this decision and on the process that must be afforded in implementing it. But all other things being equal, it appears to this author that the reassignment of the aide from the care of the patient is an appropriate response to a romantic relationship with a family member.

2. The Drug-Dealing Son

***Q** Our home health aide told us she has seen the patient's adult son dealing drugs in an adjacent room on more than one occasion. Are we required, or even permitted to report this illegal activity to the police? What if the patient is pleading with us not to do so? Also, now the aide is reluctant to return to the home—especially if we report the illegal activity. Can we stop providing services as a result of this?*

A Neither the aide, nor the RN supervising the aide, nor the HHA have a legal obligation to report this criminal conduct to the police. While agencies, RNs or aides are required to report certain offenses, such as child abuse[3] and in some cases health care fraud,[4] they have no general responsibility to act as police informants.

As to whether the HHA or aide are *permitted* to report the conduct to a law-enforcement HHA, it is clear they can do so. To be sure, the HHA and aide are obligated under HIPAA[5] and DOH regulations[6] to maintain the confidentiality of patient health information. But their knowledge of drug-dealing by the son is not patient health information by any reasonable construction of those requirements.[7]

Interestingly, HIPAA specifically authorizes a covered entity to disclose to law enforcement personnel protected health information that the entity "believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the covered entity."[8] That exception would not be available here since the conduct is not occurring on the premises of the covered entity. While the policy rationale for the exception seems applicable to this case, it is likely the drafters of the exception gave little consideration to criminal conduct in the home care setting. In any event, there is no need to rely upon the exception in this case; again, the information about the son's drug dealing is not protected health information (unlike, for example, illegal drug use by a patient, which would be protected health information).

Accordingly, the home health agency is free to exercise its own judgment regarding whether to report the conduct or not. A key factor that weighs in favor of reporting is that drug dealing on the premises has a high potential to attract violence, and therefore endangers both the aide and the patient. If reporting were apt to stop that conduct, it would be an attractive option. Simple civic virtue also weighs in favor of reporting this offense.

But the countervailing considerations are obvious and significant: Reporting could itself expose the aide, or possibly the patient, to retaliatory violence. Moreover, if the patient knew and tolerated her son's activity, or was complicit in the activity, reporting would likely destroy the therapeutic relationship.

Another option is to notify the patient, or perhaps the son directly, that unless the activity ceases, the HHA will withdraw from the case. Significantly, DOH regulations strictly limit the ability of a home health agency to discharge a patient.[9] Indeed, home health agencies are far more constrained in this regard than are other health care providers, such as physicians and hospitals. But this situation does seem to fall solidly within one of the permissible bases for discharge: DOH regulation 10 N.Y.C.R.R. § 763.5(h) provides that discharge is appropriate, among other instances, when "(2) conditions in the home imminently threaten the safety of the personnel providing services or jeopardize the HHA's ability to provide care as described in [§ 763.5(b)(2)(ii) and (iii)]." The referenced clauses then provides an HHA is not required to admit a patient (and therefore can discharge a patient):

> (ii) when conditions are known to exist in or around the home that would imminently threaten the safety of personnel, including but not limited to . . . (b) presence of weapons, criminal activity or contraband material which creates in personnel

a reasonable concern for personal safety.

So in this case the HHA would have a clear legal basis to discharge the patient if the activity persists. But should it do so? Taking that step would penalize, and maybe even jeopardize, the innocent patient for the transgressions of her son. While this raises more of an ethical question than a legal one, it is suggested here the HHA cannot ask its aides to risk their lives to serve the HHA's patients. The discharge could be made with a referral to adult protective services, which may be in a better position to address the broader circumstances in this home.

There is no simple or one-size-fits-all answer to the case of the drug-dealing son, and the specific facts of the case can be very important. Evidence of a teenager selling one marijuana cigarette to a friend warrants a different response than evidence of routine transactions involving large amounts of cocaine and larger sums of cash. Certainly evidence of violent criminal conduct by a family member, such as rape or murder, would drive a decision to call the police.

3. The Accusation of Theft

Q*A patient phoned us to complain she is missing valuable jewelry. She suspects our aide stole it. The aide has worked for us a long time and we think she is honest and trustworthy. We interviewed her and she denied taking anything and seemed quite credible. We think either the patient misplaced the jewelry, or someone else stole it. What are our further obligations, if any?*

Unfortunately, most home health agencies are familiar with accusations of theft and experienced in responding to them. Such accusations are common, in part because thefts by home health agency staff do occur. But they are common also because the home care patient population includes elderly and infirm persons who may be forgetful, who may misplace items, and who may be suspicious of strangers in their homes. Determining the truth when confronted with one party's accusation and another's denial is exceedingly difficult in any setting, including this one.

It should be noted at the outset that home health agencies are required to take steps to prevent thefts by aides. Aide training programs must include components on respect for patient property.[10] Also, home health agencies are required to conduct criminal history background checks on home health aides and other caregiving staff,[11] in addition to the usual interviews, reference checks and Medicare/Medicaid exclusion checking. Finally, agencies will typically offer staff guidance on ways to reduce the risk of accusations of theft.[12]

When an accusation occurs, it must be regarded from a regulatory standpoint as a patient complaint or grievance. Agencies are required to develop and implement a patient complaint procedure, which must include documenting the receipt, investigation and resolution of complaints, reviewing and responding to complaints, describing the investigation and findings and decisions, and providing an appeals process.[13] The patient must also be informed of his or her right to complain about "lack of respect for property" to the DOH Office of Health System Management.[14] And as discussed further below, the patient should also be informed of the right to report the alleged theft to the police.

So in this instance the HHA must follow that procedure by, among other things, investigating the allegation of theft. Ordinarily such investigation would include an interview with the patient, with the aide, and with any other relevant witnesses.

If the HHA finds evidence that the aide committed the theft, several issues arise. First, the HHA needs to decide what to do about the aide. While the HHA is under no regulatory obligation to terminate the aide's employment, it would probably seek to do so, absent unusual extenuating or mitigating circumstances. Such an employee is a threat to patients and ultimately to the HHA. Any such termination would have to be pursued in accordance with the process prescribed by the employment handbook or collective bargaining agreement.

Second, the HHA needs to consider what reporting obligations it has, if any. Currently, home health agencies have no obligation to report thefts or incidents to any state agency. A bill introduced in the NYS Assembly by Health Chair Dick Gottfriend would require incident reporting by home care services agencies, but the list of reportable incidents would not include theft.[15]

However, the HHA could, and probably should, report its evidence of a crime to the police. Alternatively, or additionally, it could encourage the patient to report the crime to the police. This is different from the case described previously where an aide witnessed criminal conduct by a patient's son: In this instance the HHA placed the aide in the patient's home, and should assume some responsibility for remedying the problem by making the report.

Which raises the last issue—compensating the patient. Here again, there is no regulatory obligation to compensate the patient. The question of civil legal liability is a closer one: The HHA is unlikely to have vicarious liability for the employee's theft under the doctrine of *respondeat superior*. As the Court of Appeals explained,

> The doctrine of respondeat superior renders an employer vicariously liable for torts committed by an employee acting within the scope of the employment. Pursuant to this doctrine, the employer may be liable when the employee acts negligently or intentionally, so long as the tortious conduct is generally foreseeable and a natural incident of the employment (citation omitted). If, however, an employee for purposes of his own departs from the line of his duty so that for the time being his acts constitute an abandonment of his service, the master is not liable.

RJC Realty v. Republic Ins. Co., 2 N.Y.3d 158 (2004), *citing Judith M. v. Sisters of Charity Hosp.*, 93 N.Y.2d 932 (1999). However, a plaintiff's lawyer could try to circumvent that barrier by asserting a claim based on negligent hiring, training or supervision. In any event, the HHA may feel an ethical obligation, or at least public-relations interest, in compensating the patient.

In any event, in the hypothetical above, the HHA firmly concluded the aide is not a thief. In that instance, the HHA has no obligation to, and should not, terminate the aide, report the theft to the police or any other HHA, or compensate the patient. It might, however, still encourage the patient to report the matter to the police. That way the police will conduct their own professional investigation, which will hopefully confirm the HHA's findings and put the matter to rest. It may also be a precondition to the patient's ability to file an insurance claim on the missing items.

4. Smoking in Bed

Q ***The aide is telling us she sees evidence the patient smokes in bed when the aide is not there: cigarette butts on the floor, even burn holes in his bedspread. It's clear the patient has fallen asleep while smoking several times. The aide has counseled the patient not to do this but he persists. The patient lives in an apartment building and the aide is quite fearful the patient will cause a fire, and so are we. What can we do?***

A Agencies and home health aides understand they cannot be overly judgmental; that often they must turn a blind eye to patient lifestyles, conduct and choices that are disturbing to them. But this conduct is beyond the pale: It poses a significant danger to the lives of many people.

Once again, regulations provide no directly applicable mandates, standards or guidance. Even so, the HHA would be well advised to become more aggressive in stopping this conduct, primarily to protect its patient and the other building tenants, but also to protect itself: If the building were to burn down with loss of life, and it appeared the HHA, while aware of the danger, limited itself to counseling the patient, the legal, financial, public relations and emotional consequences could be terrible.

Initially it could insist the patient enter into a Patient Conduct Contract obligating the patient not to smoke in bed. The ability of agencies to compel patients to enter into such contracts, and the right of an HHA to discharge a patient based on breach of such contract, is a complex topic beyond the scope of this article. But the fact is such contracts often resolve HHA-patient tensions by clarifying and formalizing mutual expectations clearly.

The HHA might also assist the patient in installing technological safeguards to reduce the risk, e.g., smoke detectors, safer cigarettes, fire-resistant bedspreads and floor coverings, and so on.

But if the patient's dangerous conduct continues, the HHA could and should notify the fire department and/or police. While HIPAA obligates the HHA to protect the confidentiality of patient health information, this does not appear to be patient health information (although that conclusion is subject to debate). In any event, HIPAA allows a covered entity to make a disclosure the entity regards "is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public."[16] A disclosure to the fire department in this situation would fit that exception.

5. Sexual Harassment

Q ***The patient, a 60-year-old man with capacity, tends to make lewd comments to aides, expose himself inappropriately, and ask for sexual activity. More than one aide has refused to return due to this conduct. We warned the patient, but his conduct continues. Any advice?***

A Initially, the home health agency should try to resolve this case the way it was advised to resolve the last case: by insisting that the patient enter into a Patient Conduct Contract. The contract should define the problematic conduct, prohibit the patient from engaging in it, and provide for discharge in the event of the patient's breach of the contract. It should also include basic procedural protections for the patient, such as the right to notice of an alleged breach, and the opportunity to respond and, if appropriate, correct the breach before being discharged.

The Patient Conduct Contract should be viewed not as a way to provide legal support for an eventual discharge, but as a way to try to improve conduct to avert a discharge. Indeed, if the repugnant conduct persists, it is

not clear the HHA can rely solely on the breach of contract as its basis for discharge; it may still need to identify an independent regulatory basis for the discharge.

That may not be easy. The regulation, 10 N.Y.C.R.R. § 763.5(b), permits an HHA to discharge a patient in these circumstances (and others not relevant here):

> (ii) when conditions are known to exist in or around the home that would imminently threaten the safety of personnel, including but not limited to:
>
> (a) actual or likely physical assault which the individual threatening such assault has the ability to carry out
>
> (b) presence of weapons, criminal activity or contraband material which creates in personnel a reasonable concern for personal safety; or
>
> (c) continuing severe verbal threats which the individual making the threats has the ability to carry out and which create in personnel a reasonable concern for personal safety;
>
> (iii) when the HHA has valid reason to believe that HHA personnel will be subjected to continuing and severe verbal abuse which will jeopardize the HHA's ability to secure sufficient personnel resources or to provide care that meets the needs of the patient; . . .

An argument could be made that sexual harassment satisfies one or more of these standards. Notably, the introductory clause makes it clear a discharge is permitted in cases "including but not limited to" the ones described. Moreover such harassment may constitute the "criminal activity" referred to in (ii)(b). Still, there is no clear unequivocal clause that allows an HHA to discharge a patient for sexually harassing aides. There ought to be one.

In any event, the HHA and aide should recognize their caregiver relationship with the patient does not preclude them from making a criminal complaint, or filing a civil lawsuit, against the patient. Of course, that would be quite drastic and would destroy the therapeutic relationship; but it may suffice for the HHA and aide to simply warn the patient that they intend to take such step unless his abuse stops. In the case described here, they probably should do so.

Indeed, the HHA faces legal liability under Title VII of the Civil Rights Act of 1964 if it knowingly allows its employees to be exposed to sexual harassment, even by non-employees like customers—or patients. Such conduct might give rise to a "hostile-work-environment"-type claim under EEOC guidelines on sexual harassment.[17] As a result, the HHA may find itself in one of the many "damned-if -you-do-damned-if-you don't" situations in health care: The HHA could face liability if it discharges the patient (for violating the discharge regulations) and could face liability if it sends aides into a hostile work environment.

Amplifying the problem for the HHA, a lawyer for the patient might contend the patient's propensity to sexually harass aides is an uncontrollable mental disorder and a "disability" within the meaning of the Americans with Disability Act, and discharging the patient on account of that disability would constitute discrimination in public accommodations on the basis of disability in violation of Title III of the ADA.[18] The HHA's counsel should not find it too difficult to defeat that legally weak claim, but HHA counsel also should not be too surprised to encounter it: The author has encountered that argument by lawyers to counter steps to discharge patients for similarly offensive conduct.

With no easy answer at hand, the HHA needs to do what it can to control this patient's conduct. One effective, albeit expensive solution, would be to send a security guard, or simply an escort, along with the aide. Another interesting idea is to seek the patient's agreement to videotape the provision of care, which might inhibit the offensive conduct.

6. The Bigoted Patient

***Q** A new patient, an 80-year-old woman, insists we assign her only white aides, and says she will refuse care by any non-white aide. We could accommodate her, but we think it would be wrong to agree to do so, and we question whether we are even allowed to accommodate her. Are we?*

A This is easy to answer from a legal standpoint: The home health agency needs to just say "No." The HHA is prohibited by federal[19] and state[20] law from discriminating on the basis of race in the terms and conditions of employment. That prohibition encompasses race discrimination in the assignment of aides to patients. It is paramount to any right the patient may have in decisions about his or her care.

In fact, the Federal Equal Employment Opportunity Commission (EEOC), in revised guidelines on race discrimination issued in 2006, described a similar case as an example of prohibited race discrimination:

> **EXAMPLE 6—YIELDING TO CUSTOMERS' RACIAL PREFERENCES**
> The employer is a home care agency that hires out aides to provide personal, in-home assistance to elderly, disabled, and ill persons. It has a mostly White clientele. Many of its clients have expressed a desire for White home care aides. Gladys, an African American aide at another agency, applies for a job opening with the employer because it pays more than her current job. She is well qualified and has received excellent performance reviews in her current position. The employer wants to hire Gladys but ultimately decides not to because it believes its clientele would not be comfortable with an African American aide. The employer has violated Title VII because customer preference is not a defense to race discrimination.[21]

Although the example posits a discriminatory impact on a specific employee, the EEOC or Human Rights Division, given evidence of overt race discrimination in the assignment of aides, would not find it difficult to find such a link.

Accordingly, the home health agency that accedes this patient's request would face liability in a civil rights lawsuit by the reassigned or unassigned aides, as well as regulatory sanctions from the EEOC and New York State Division of Human Rights.

Accordingly, the HHA needs to decline the request, even if it has the staff to accommodate the request, and even if the patient refuses admission for that reason.

A closer question, though outside the scope of the case described, is whether the HHA could accommodate a request by this patient for a female aide, or honor her rejection of a male aide. The civil rights laws cited above also prohibit discrimination on the basis of sex. However, the laws also include the exception for "bona fide occupational qualifications" (BFOQ). As Title VII states:

> Notwithstanding any other provision of this subchapter . . . it shall not be an unlawful practice for an employer to hire and employ employees . . . on the basis of his religion, sex or national origin in those certain instances where religion, sex or national origin is a bona fide occupational qualification reasonably necessary to the normal operation of that particular business or enterprise.[22]

The question of whether discrimination based on sex is permissible as a BFOQ in employment that involves intimate contact between employees and others, like hospitals, bathrooms and prisons, is the subject of several court decisions.[23] Courts have tended to look at whether the discrimination is necessary to reduce the danger of physical and sexual assault, the invasion of privacy or assault to modesty, and the frustration of rehabilitative goals.[24]

For now, until the evolving law settles and points to a different result, it would seem this home health agency could honor a reasonable request by this patient for a female aide based on the BFOQ exception, with low risk of civil or regulatory liability.

7. Elder Neglect

***Q** Patient, a dual Medicare/Medicaid client, is largely confined to her bed, and lives with an adult daughter who is clearly dysfunctional herself. There is almost no food in the house, and the place is never cleaned and is itself a health hazard. We sought the daughter's help with some basic but critical tasks, but she is uncooperative. At what point is the daughter's conduct considered "elder abuse" and are we required to report it, and to whom?*

A Elder abuse and neglect is widely recognized as a serious problem both nationally and in this state. However, few New York state laws or regulations address it specifically. In fact, there is no specific definition of "elder abuse" in New York law; instead it is encompassed by the more general definitions of abuse in N.Y. Social Services Law § 473, which relates to the adult protective services operated by local social services districts.

Section 473 separately defines "physical abuse," "sexual abuse," "emotional abuse," "active neglect," "passive neglect," "self-neglect," and financial exploitation." The categories relevant to address this question, "active neglect," and "passive neglect," are defined as follows:

> (d) "Active neglect" means willful failure by the caregiver to fulfill the caretaking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment, willful deprivation of food, water, heat, clean clothing and bedding, eyeglasses or dentures, or health related services.

(e) "Passive neglect" means non-willful failure of a caregiver to fulfill caretaking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment or denial of food or health related services because of inadequate caregiver knowledge, infirmity, or disputing the value of prescribed services.

It is not clear in this case whether the daughter is a "caregiver," and therefore responsible for the active or passive neglect of her mother. That would be a key issue if the question was the daughter's criminal or civil liability. But from the HHA's standpoint, it is not necessary to resolve the daughter's caregiver status for it to answer the question about its reporting obligation.

The HHA does not have an obligation to make a report of third-party "elder abuse" to any agency. Unlike many other states, New York does not have a law that mandates professionals or other caregivers to report elder abuse in the community, akin to the child abuse reporting law.[25] This state's main foray into mandating elder abuse reporting is to require certain persons to report the abuse or neglect of residential care facility residents.[26]

But while HHAs and aides are not legally required to report abuse or neglect of elderly patients, they certainly can do so, and should do so when warranted. Specifically, a report should be made to the Adult Protective Services office of the local social services district if the HHA or aide identifies an "endangered adult," a category that would include an adult who may be the subject of abuse or neglect. Persons making such reports are protected from liability for doing so.[27]

Another operational challenge with legal implications in this case is developing a lawful package of services for this patient. Medicaid will cover housekeeping and laundry services and home-delivered meals for people who require such support services based on a medical need. However Medicaid, in reviewing the care plan, will expect family members to provide support to the extent of their ability. This appears to be a case in which the daughter has proven herself unable to much provide much support, but it may be a challenge to convince Medicaid she is truly unable, and not just unwilling. Moreover, it may prove even more difficult to find a way to provide such home health care assistance to the client, without taking on the housekeeping, laundry, home-delivered meals, and other tasks for the daughter as well—which would raise Medicaid fraud and abuse concerns.

8. The Off-Hours Errands

Q ***We learned the patient is paying our home health aide some money "on the side" to run private errands for the patient after hours: e.g., to buy lottery tickets, cash checks, pick up a visiting relative at the bus station. Are there any legal concerns about her doing that?***

A No law or regulation precludes the HHA from permitting its staff to "moonlight;" i.e., to take on assignments from the patient after hours. But it is a practice fraught with risk for the patient, the employee and the HHA, and it should be prohibited or discouraged by HHA as a matter of employment policy.

The concerns here are similar to those raised by the romantic relationship in the first example: It creates these risks, among others:

- The aide could easily drift into providing such private errands, or discussing or engaging in follow-up activities relating to such errands, during a reimbursable home health aide visit. If so, the HHA could be led to submit improper bills Medicare, Medicaid or other payors, exposing it to charges of fraud or abuse.
- Conversely, the Labor Department and/or Tax Department could regard the aide's after-hours work for the same patient as overtime, subjecting the HHA to liability for overtime pay, withholding, and regulatory violations.
- If the aide or patient were injured, or their property harmed, in the course of such activity, the HHA would be exposed to uninsured claims against it.

Probably the greatest concern is that permitting such activity invites either the aide or the patient to pressure the other party to enter into such private arrangements. A clear prohibition at the start will head off the potential for exploitation.[28]

Conclusion

This article offers only a few examples of the unique problems that can arise when health care is delivered in the patient's home. Home health care agencies and caregivers face challenges, and reap rewards, that differ greatly from those faced by their colleagues in hospitals, nursing homes and doctors offices. Legal counsel to home health care agencies do as well.

Endnotes

1. *See* 8 N.Y.C.R.R. Part 29—Rules of the Board of Regents: Unprofessional Conduct.

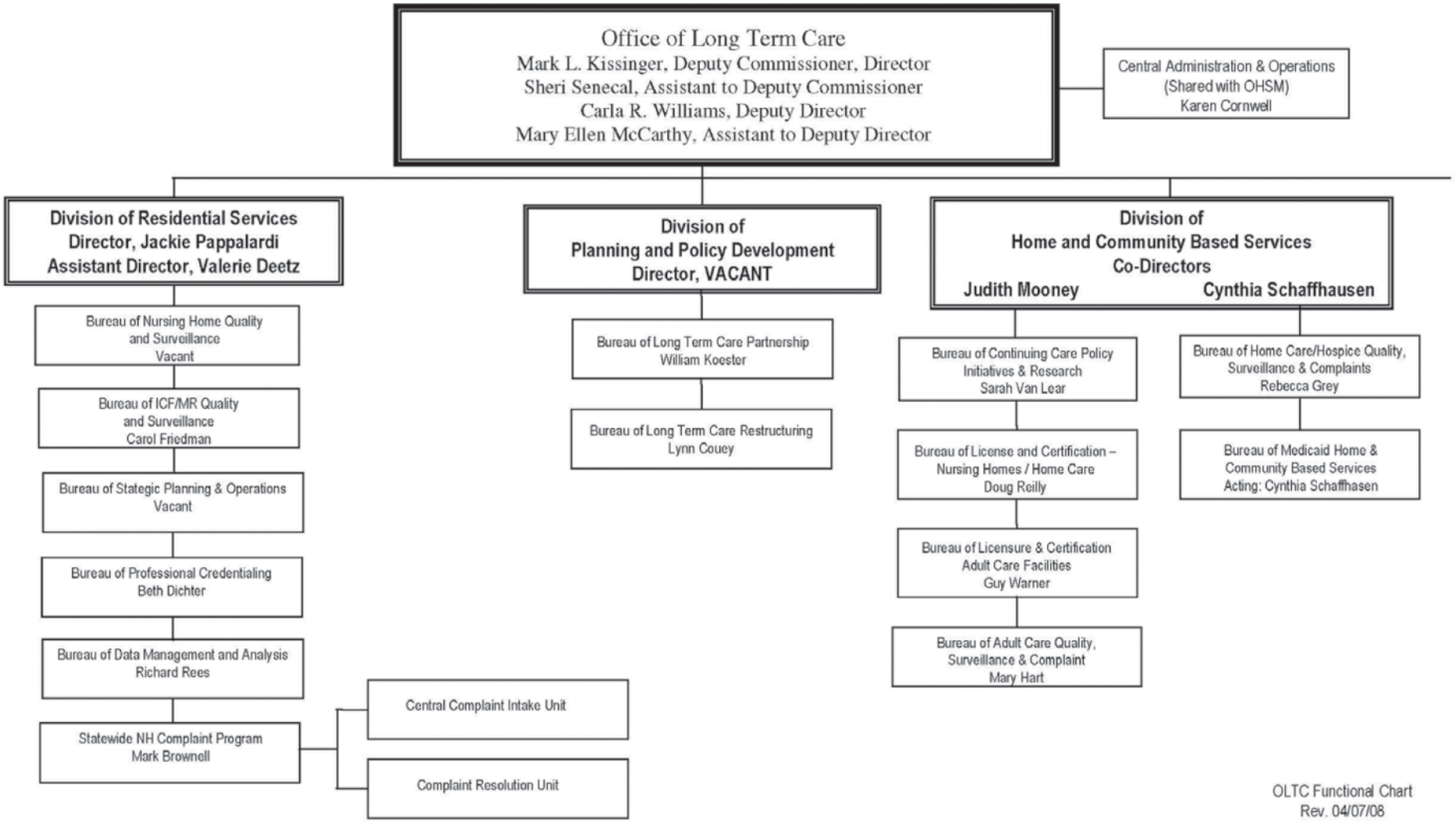
2. 42 C.F.R. § 484.12(c).
3. N.Y. Social Services Law § 413 (persons and officials required to report cases of suspected child abuse or maltreatment).
4. 42 U.S.C. § 1320a-7b(a)(2) (provider's duty to disclose improper payments).
5. 45 C.F.R. § 164.501.
6. 10 N.Y.C.R.R. § 763.2(a)(10).
7. *See* 45 C.F.R. § 164.501 (definition of "health information").
8. 45 C.F.R. § 164.512(f)(5).
9. 10 N.Y.C.R.R. § 763.5.
10. *See* 42 C.F.R. § 484.36(a)(viii).
11. *See* 10 N.Y.C.R.R. 400.23, which for CHHAs is referred to in 10 N.Y.C.R.R. 763.13(b) .
12. For example, the Eddy Home Care "Professional Code of Conduct of Home Health Aides" (hereinafter "Eddy HHA Code") states "When the Home Health Aide prepares to care for a patient and finds money or jewelry in the patient's clothing or area, the patient will be told: 'I wanted to make sure you knew this because our HHA wants to protect employees from any accusations relating to theft.'"
13. 10 N.Y.C.R.R. § 763.11(a)(8).
14. 10 N.Y.C.R.R. § 763.11(a)(7).
15. Assembly Bill 3792-A (2008) (A. Gottfried)
16. 45 C.F.R. § 164.512(j)(1)(A).
17. *See* 29 C.F.R. § 1604.11.
18. 45 C.F.R. Part 84. http://www.hhs.gov/ocr/discrimdisab.html.
19. *E.g.,* Title VII of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000e *et seq*.
20. N.Y. Executive Law § 296 (part of NY Executive Law Article 15—Human Rights Law).
21. EEOC Compliance Manual Section 15, *available at* http://www.eeoc.gov/policy/docs/race-color.html.
22. 42 U.S.C. § 2000e-2(e).
23. *E.g., Slivka v. Camden-Clark Mem. Hosp.*, 594 S.E.2d 616 (S. Ct., W.Va. 2004) (remanding for reconsideration of whether a hospital's policy of selecting only female nurses for the obstetrics unit is legal as BFOQ)
24. *See generally*, S. McGowan, The Bona Fide Body: Title VII's Last Bastion of Intentional Sex Discrimination, *Columbia Journal of Gender and Law*, Vol. 12, 2003.
25. N.Y. Social Services Law § 413 (persons and officials required to report cases of suspected child abuse or maltreatment).
26. N.Y. Public Health Law § 2803-d.
27. N.Y. Social Services Law § 473-b.
28. *See* Eddy HHA Code ("Home Health Aides may not work privately for a patient while an Eddy Home Care employee") .

Robert N. Swidler is General Counsel to Northeast Health, a Troy-based health care system that includes general hospitals, rehabilitation hospitals, nursing homes, home health care agencies, primary care centers, assisted living programs, senior residences, and other facilities and services.

The author would like to thank Michelle Mazzacco for her guidance and insights regarding the cases discussed in this article. Ms. Mazzacco is Vice President/ Director, Eddy Visiting Nurse Association, a certified home health care agency and long-term home health care agency affiliated with Northeast Health.

The NYS Department of Health Office of Long Term Care: An Organizational Chart

April 2008



NEWS flash

What's Happening in the Section

New Section Chair—Ross Lanzafame

Ross Lanzafame began his term as Chair of the Health Law Section in June. Ross is a partner in Harter, Secrest & Emery, and practices out of the firm's main office in Rochester. He counsels long-term and acute health care providers, with a focus on reimbursement issues and regulatory compliance.

Ross received his B.S. from Cornell University and his law degree from SUNY Buffalo. He also holds a Masters from Cornell in Hospital and Health Services Administration, and for four years Ross managed the neonatal intensive care unit and all surgical units of a large Rochester hospital.

Ross has been active in the Health Law Section for many years in a variety of capacities, and has served on the Executive Committee since 2002.

Other New Officers

At the Annual Meeting, the Section elected the following new officers, with terms commencing in June:

- **Chair-Elect**: Edward S. Kornreich, Proskauer Rose, LLP
- **Vice-Chair:** Ari J. Markenson, Cypress Healthcare Management
- **Secretary:** Francis J. Serbaroli, Cadwalader, Wickersham and Taft LLP
- **Treasurer**: Marcia B. Smith, Iseman, Cunningham, Reister & Hyde

Recent Events

- **Getting Ready in New York: Public Health Emergency Legal Preparedness.** This professional education program considered the legal aspects of possible public health emergencies in New York, such as pandemic flu, SARS or a terrorist attack using biological weapons. The program, which was held in Yonkers on May 15, was organized by Margaret Davino of Kaufman, Borgheest & Ryan, LLP.
- **Long-Term Care 2008.** This program was recently held in three locations—New York City, Albany and Rochester. It covered such topics as the impact of the Berger Commission on Long-Term Care, Medicaid initiatives in long term care, current models for care at home-licensed agencies, certified agencies and long-term home health care, consumer perspectives, long-term care restructuring affecting assisted living, needs analysis in nursing home beds, fraud and abuse. The program co-chairs were Raul A. Tabora, Jr., Esq., Ruffo, Tabora, Mainello & McKay, PC, Albany; Jerome T. Levy, Esq. of Duane Morris, LLP, New York City; Anna D. Colello, Esq., New York State Department of Health, Albany and Mary E. Ross, Esq., Harter Secrest & Emery, LLP, Rochester.
- **Health Information Technology (teleconference)** Friday, June 13, 2008. This teleconference seminar covered:
  - challenges of the hybrid paper-electronic medical record in long term care
  - legal issues with the use of electronic medical records
  - current technologies.

The faculty were: Anna D. Colello, Esq. , NYS Department of Health; Dr. Patricia Hale, NYS Department of Health; Jonathan Karmel, Esq., NYS Department of Health and Bridget Gallagher, Senior Vice President of Community Services Division, The Jewish Home Lifecare.

Program attendees received 2.0 MCLE credits.

Upcoming Program—Save the Date

- **Fall Retreat.** The fall retreat will take place on October 18 and will be held at the Gideon Putnam Hotel in Saratoga Springs. The program, "Anatomy of an Internal Investigation," is being organized by Ross Lanzafame, and by Anne Maltz of Herrick, Feinstein. It will address, among other questions: How to handle an internal investigation? How do you protect attorney client privilege? How is an investigation conducted? When do you seek outside expertise? How do you know when you are in over your head? What do you do with the results?

Upcoming Journal Edition

The Summer/Fall Edition of the *Health Law Journal* will focus on the implementation of the recommendations of the Commission on Healthcare Facilities in the Twenty-first Century (the Berger Commission). Martin Bienstock, Special Counsel, NYS Department of Health, will be Special Editor. Persons interested in contributing articles on that topic should contact Mr. Beinstock at mxb30@health.state.ny.us.

Notable Committee Activities

- **New Special Committee on Conforming the NYS Practitioner Self-Referral Law with the Federal Physician Self-Referral Law.** At its last Executive Committee meeting, the Section Chair asked Marcia Smith of Iseman Cunningham, Reister and Hyde, LLP to form and lead an ad hoc committee to develop proposals to conform New York's practitioner self-referral law with the federal physician self-referral law. Smith has since convened the committee, which is making progress in developing a recommendation.
- **Public Health Emergency Preparedness.** The Public Health Committee held a well-attended meeting on May 15 on public health emergency preparedness, and the need to adopt a model law. The meetings were chaired by Margaret J. Davino of Kaufman, Borgeest & Ryan. Margie is chair of the committee.

Recent Supraspinatus Blurb Topics

- St. Vincent's Claims Hardship in Expansion
- Prescription Drug charges impact efficiency and equity: a collection of international perspectives
- HIPAA in Research-Institute of Medicine (IOM) project underway, others
- NYSTEM: nearly $109 million for new RFA's issued, meeting May 13, 2008: draft strategic plan
- Two Percent of NY Physicians on Monitoring List
- Criminal HIPAA Charges—Coming Wave?
- More Woe for Ingenix and Its Clients (Updated)
- MFCU Doubles Recoveries in '07
- Stark II, Phase III, Rev. 2
- Another HIPAA Criminal Indictment
- How do we know? Reported Trials of China, RCTs, the CONSORT Statement
- New "Tag Cloud" Site Feature
- A Trial in South Africa compares effectiveness of a primary care system on nurse-led ART
- WSJ Profiles CBO Director Peter Orszag's Role in Health Care Debate
- Another Security Breach, And Some Musings About Authentication (Updated)
- Supraspinatus, the Health Law Section's blog, is found at http://nysbar.com/blogs/healthlaw.

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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