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Cover artwork:
The Artist’s Garden at Eragny by Camille Pissarro (1898)

Joint Commission MS.01.01.01: A Golden Opportunity for Physicians to “Level the Playing Field” at Intra-Hospital Hearings

By David A. Zarett and Craig D. Boom

Imagine this very realistic, and unfortunate, scenario: A physician client comes into your office one day with a certified mail letter from the only hospital where he has a medical staff appointment, advising that all of his privileges have been “summarily suspended, effective immediately.” The letter continues that this action was taken by the Departmental Director (who happens to be your client’s number one competitor), after he determined that despite a 15-year unblemished professional record, your client has suddenly become an “imminent risk of harm” to patients, having just experienced his first meaningful complication in the operating room.

As the physician’s attorney, you must explain to him that as a result of the action by the hospital—taken before he even knew there was an “investigation” on going in the first place—he is no longer able to admit patients to the hospital, a restriction that could last for months. As this is the only hospital where he has privileges, it will have the effect of practically shutting down his medical practice. Even worse, you’ll explain that: (1) he will likely be reported to the National Practitioner Data Bank, where information about the summary suspension is forever accessible by any hospital, licensing agency, professional board, or health care organization to which he applies in the future;¹ (2) he has already been, or will most likely be, reported to the Department of Health’s Office of Professional Medical Conduct (“OPMC”), which will initiate its own investigation, potentially resulting in charges of professional misconduct;² (3) the summary suspension may eventually have to be disclosed to the New York Physician Profile website, where it will be available to anyone who “Googles” his name;³ (4) the summary suspension could be relied upon by the managed care plans to remove him from their panels; (5) the summary suspension could be used by his malpractice insurance carrier to non-renew or terminate his liability coverage; and (6) even if he had been smart enough to get privileges at more than one hospital, if both are part of a larger “health system,” his privileges at the other hospital within the same system could be adversely affected as well.

To make matters even worse, you must explain to your physician client that due to the scarlet-letter effect of a “summary suspension”—which is only supposed to be implemented when a physician truly poses a real, tangible and imminent risk of harm to patients—he will most likely not get privileges at a “substitute” hospital at least until the summary suspension is removed or

resolved. Finally, you may not be able to immediately run to Court to seek an injunction to challenge the suspension, since in virtually all instances you must first exhaust the “procedural due process rights” set forth in the hospital’s medical staff bylaws and an administrative review process before the New York State Public Health Council—which could take months.⁴

Rather, your client’s only hope to right this wrong is to go forward with the intra-hospital hearing process to challenge the “summary suspension” internally, and hope to prove that the Departmental Director either jumped the gun based on faulty conclusions; or worse, is acting out another agenda having nothing to do with your client’s skills as a physician. Thus, you and your client sit down and crack open the hospital’s Medical Staff Bylaws to determine his “rights” at the hearing, and the ground rules applicable to this “due process” procedure.⁵ And this is where you will likely have to explain to your client that the procedure leading up to the imposition of the suspension and the process for challenging it could be characterized as far from fair. For example, you learn that prior to implementing the summary suspension, neither the Departmental Director nor anyone else at the hospital had an obligation to advise the physician of the investigation, get your client’s input on the matter, or have an outside independent expert review of the chart. You may also learn that at the upcoming hearing:

- The physician is presumed guilty, and it is his burden to prove by “clear and convincing” evidence that the action by the hospital was “unreasonable” or “arbitrary and capricious.”
- The physician has no rights to pre-hearing disclosure, so the hospital is not required to provide you with any information in advance, such as the medical records at issue or any exculpatory information that would prove the suspension was not warranted in the first place.
- The physician is not guaranteed an advance preview of any outside expert reports obtained by the hospital, or knowledge of what information was provided to the outside “expert” if one was obtained (oftentimes, relevant information is not received by the hospital’s outside expert, such as office records and diagnostic tests, which would have led to differing conclusions of the care rendered by the target physician).

- To your chagrin, while allowing you to “represent” your client at the hearing, some hospitals limit the lawyer’s role to attending only, but not speaking at the hearing.

So much for “due process,” your client says, as he heads home to share the news with his spouse and loved ones.⁶

While we are not questioning the legitimate value and importance of meaningful and effective peer review and quality assurance, one wonders why medical staff members throughout the state have allowed such inequities in the process to persist for years when so much is at stake. This problem persists due to a trend for medical staff members to avoid active involvement in their own bylaw process. Fortunately, the Joint Commission has recently implemented new requirements that are effectively requiring all hospitals to revamp their medical staff bylaws to implement a series of changes designed to give more power and control to the medical staff body as a whole. Specifically, in March 2010, the Joint Commission approved a revised “Medical Staff Standard” MS.01.01.01 (formerly MS.1.20), which addresses the organized medical staff’s self-governance and its accountability to the governing body.⁷ According to the Joint Commission, the new standard “contributes to patient safety and quality of care through the support of a well-functioning, positive relationship between a hospital’s medical staff and governing body.”⁸ All hospitals and critical access hospitals are expected to be in full compliance by March 31, 2011.⁹ The revised MS.01.01.01 will require significant changes to most hospitals’ medical staff bylaws, and other similar governance documents, to be made over the next few months.

While a large portion of the Joint Commission’s requirements pertain to the parliamentary aspects of medical staff bylaws, and attempts to re-balance the power sharing between the medical staff rank and file versus the few elected committees thereof (such as “Medical Board” or the “Medical Executive Committee”), the practical result of MS.01.01.01 is that all hospitals, and their lawyers and administrators, are going to be hustling to substantially revise their bylaws and make major revisions to comply with the new Joint Commission standard.

This is therefore a perfect opportunity for members of the medical staff (*i.e.*, your physician clients) to effect more than just the bare minimum changes to comply with MS.01.01.01—but also meaningful changes to the bylaws to enhance the procedural protections to a “target” physician in a peer review hearing. These modifications could include: (i) adding a “presumption of innocence” in favor of the target physician, and requiring the hospital to carry a burden of proof justifying the imposition of its disciplinary action and penalties; (ii) requiring the hospital to make reasonable information available to the

target physician in advance so that he can prepare for the hearing (such as being given prior access to the medical records and expert reviews); and (iii) requiring that the hospital produce exculpatory evidence. The modifications could also require that before a physician is summarily suspended, he be given an opportunity to “meaningfully” respond to the charges of misconduct. “Shoot first and ask questions later,” is not a responsible way to manage the professional career of medical staff members.

If the purpose of a hospital’s due process rules is to get to the truth of matter, then a fair hearing process is the only way to achieve such goals if one accepts the basic premise of an adversary system of justice. Indeed, like any system of justice, procedural fairness helps to assure the integrity of the process as a whole. The medical staff bylaw overhaul required by MS.01.01.01 presents a golden opportunity for the physicians of the organized medical staff to propose amendments to the medical staff bylaws to address these inequities. The organized medical staffs of hospitals should take this opportunity to implement changes to the bylaws to protect the rights of all its members so that fair hearings will take place.

Remember, no matter how popular, well-liked, or “in” your physician client may be with the hospital crowd today, the tables can and always do turn. Your client could find himself being the recipient of a “summary suspension” letter, which with the stroke of a pen will adversely affect the rest of his professional career. Now is the opportunity to implement changes to the rules of the road so that a hearing to challenge this potentially catastrophic disciplinary action is done in a fair, even-handed and objective fashion.

Endnotes

1. The National Practitioner Data Bank (“NPDB”) is an electronic repository of all payments made on behalf of physicians in connection with medical liability settlements or judgments, as well as adverse “peer review” actions against medical licenses, clinical privileges, and professional society memberships of physicians and other health care practitioners. The NPDB was established by Congress as part of the Health Care Quality Improvement Act of 1986 (“HCQIA”). 42 U.S.C. §§ 11101, et seq.
2. 10N.Y.C.R.R. § 405.3(e); N.Y. Pub. Health Law § 230(10)(a).
3. N.Y. Pub. Health Law § 2995-a.
4. Public Health Law § 2801-b(2) sets forth the appropriate procedural framework whereby an aggrieved physician may invoke the jurisdiction of the Public Health Council when the governing body of a hospital terminates or impairs a physician’s privileges “without stating the reasons therefor, or if the reasons stated are unrelated to standards of patient care, patient welfare, the objectives of the institution or the character or competency of the applicant.” Public Health Law § 2801-b[1]. New York courts have repeatedly dismissed actions brought by physicians who sought to have their medical staff privileges restored without first pursuing their administrative remedies before the Public Health Council. *Gelbard v. Genesee Hosp.*, 87 N.Y.2d 691, 664 N.E.2d 1240 (1996).

5. The following is a hypothetical set of procedures and guidelines that we typically see in medical staff bylaws when representing physicians in these types of matters. However, medical staff bylaws do vary from hospital to hospital.
6. The Health Care Quality Improvement Act establishes a minimum threshold for procedural due process for professionals subject to peer review by providing those involved in the peer review process with near complete immunity from claims for monetary damages arising from peer review actions, so long as these standards are met. In order to receive this immunity, only the following four safe harbor provisions set out in 42 U.S.C. § 11112(a) must be met: that the professional review action was taken (1) in a reasonable belief that the actions was in furtherance of a quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of paragraph (3).
7. Approved: Revision to Medical Staff Standard MS.01.01.01, 30(4) Perspectives, The Official Newsletter of the Joint Commission 1 (April 2010), at 1.
8. Revisions to Hospital Medical Staff Standard S.01.01.01 (formerly MS.1.20) (presentation slides), The Joint Commission, available at <http://www.jointcommission.org/NR/rdonlyres/81A0E2F3-CA04-4DC6-905B-64449A76339B/0/MS010101FINAL40810.pdf> (last visited September 27, 2010).
9. Approved: Revision to Medical Staff Standard MS.01.01.01, 30(4) Perspectives, The Official Newsletter of the Joint Commission 1 (April 2010), at 1.

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Electronic Signature Act Permits Online Registration for Organ and Tissue Donation

By Wendy J. Luftig

In July of 2010, Governor Paterson signed legislation that will amend Section 4310 of the NYS Public Health Law, permitting individuals to use an electronic signature for requesting consent to make an anatomical gift in New York State. Simply put, this law (S. 4999/ A. 10664) enables New Yorkers to sign the Department of Health "Donate Life Registry" online.

For those in the New York State organ donor and transplant community, this law signifies a welcome advance from the current cumbersome registry process. Until now, those interested in affirming their consent to organ donation had to visit the registry website, download a physical form and return it by mail to the NYS Department of Health in order for registration to be effective. Of course, New Yorkers can register in the traditional manner by declaring consent on a license or identification card renewal, but online registration dramatically streamlines the registration process.

Moreover, the Electronic Signature legislation was urgently needed. As of this writing, New York State has one of the lowest organ donor designation rates in the country. Approximately, 9,559 and an estimated 632 New Yorkers die each year while waiting. New Yorkers typi-

cally make up 10% of the national waiting list. One of the motivations for the legislation was that donation rates are consistently higher in states where registry enrollment is a straightforward and one-step process.

A consortium of groups, New York Alliance for Donation, committed to boosting the state's organ donor consent rates, worked together to promote this legislation. One member of the consortium, the New York Organ Donor Network ("NYODN"), the federally-designated organ procurement organization for the greater New York City metropolitan region, was among the groups active in campaigning for the Electronic Signature Act. According to Elaine R. Berg, President and CEO of NYODN, "it is important to educate all attorneys, particularly those practicing in the area of Trusts and Estate, about this new legislation and to encourage them to alert interested clients about this easy procedure for consenting to an anatomical gift online."

Wendy J. Luftig, a member of the NYSBA Health Law Section, serves on the Public & Professional Education Committee, reporting to the Board of the New York Organ Donor Network.