Healthcare

by Terri K. Benton*

I. INTRODUCTION

This Article offers a review of recent healthcare law developments in the United States Court of Appeals for the Eleventh Circuit. The cases discussed below span topics from disclosure of protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA),[1] arbitration agreements and their interplay in wrongful death suits, and the reduction of medical care provided through the Georgia Pediatric Program (GAPP).[2]

II. DISCLOSURE OF PROTECTED HEATH INFORMATION UNDER HIPAA

In *Opis Management Resources, LLC v. Secretary Florida Agency for Health Care Administration*,[3] the United States Court of Appeals for the Eleventh Circuit focused on whether Florida Statutes § 400.145,[4] which allowed a nursing home to release medical records of a deceased resident to certain specified individuals, was preempted by HIPAA.[5] As general practice, the nursing homes in Florida "received requests from spouses and attorneys-in-fact for the medical records of deceased nursing home residents."[6] The nursing homes denied these requests because the parties did not meet the requirements of a personal representative under HIPAA.[7] "Consequently, the requesting parties filed complaints with

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* General Counsel for The Reunion Group, LLC, Macon, Georgia. Albany State University (B.A., 2009); Mercer University, Walter F. George School of Law (J.D., 2012). Member, Mercer Law Review (2010-2012). Member, State Bar of Georgia.

1. Pub. L. No. 104-191, 110 Stat. 1936.
2. *See infra* note 57.
3. 713 F.3d 1291 (2013).
4. Fla. Stat. Ann. § 400.145 (West 2012 & Supp. 2014), *invalidated by* Opis Mgmt. Res. LLC v. Sec'y Fla. Agency for Health Care Admin., 713 F.3d 1291 (2013).
5. *Opis Mgmt. Res. LLC*, 713 F.3d at 1293.
6. *Id.*
7. *Id.*

the U.S. Department of Health and Human Services Office for Civil Rights, which concluded the [nursing homes'] actions were consistent with HIPAA."[8] However, the defendant-appellant, Florida Agency for Health Care Administration (the Agency), issued citations to the nursing homes for violating Florida law by refusing to grant the requests of the spouses or attorneys-in-facts of the deceased residents.[9] The Agency interpreted § 400.145 to mean that a spouse qualifies as a personal representative under HIPAA, and so a deceased resident's medical records may be disclosed to the resident's spouse.[10]

Due to the conflicting interpretations of the same statute, the nursing homes filed a complaint in the United States District Court for the Northern District of Florida seeking a declaratory judgment that § 400.145 is preempted by HIPAA. After reviewing the parties' motions for summary judgment, the district court decided that HIPAA preempted § 400.145 because the statute afforded nursing home residents less protection than required by HIPAA.[11]

The Agency appealed to the United States Court of Appeals for the Eleventh Circuit.[12] The court of appeals reviewed the district court's grant of the nursing homes' motion for summary judgment under de novo review, viewing all the evidence and drawing all reasonable inferences in light most favorable to the nursing homes.[13] On appeal, the Agency argued that the district court erred in granting the nursing homes' motion for summary judgment because § 400.145 does not impede the goals and purposes of HIPAA. Further, § 400.145 fulfills a vital requirement of HIPAA by defining the category of personal representatives that may receive a deceased individual's protected health information.[14]

In its analysis of the Agency's position, the court of appeals reviewed the preemption doctrine and stated that when state law conflicts with federal law, the federal law controls.[15] Moreover, in HIPAA, there is an expressed preemption clause that further expresses Congress's intent for HIPAA to preempt state law.[16] Congress drafted HIPAA to protect the confidentiality of patients' health information, and Congress

8. *Id.*
9. *Id.*
10. *Id.*
11. *Id.* at 1293-94.
12. *Id.*
13. *Id.* at 1294.
14. *Id.*
15. *Id.*
16. *Id.*

specifically outlined the disclosures permitted under HIPAA.[17] In regards to deceased individuals, "[i]f under applicable law an executor, administrator, or other person has authority to act on behalf of a deceased individual or of the individual's estate, a [nursing home] must treat such person as a personal representative under [HIPAA], with respect to protected health information relevant to such personal representation."[18] Further,

> a [nursing home] may disclose to a family member, or [other relatives, close personal friends of the individual, or any other persons identified by the individual] who were involved in the individual's care or payment for health care prior to the individual's death, protected health information of the individual that is relevant to such person's involvement, unless doing so is inconsistent with any prior expressed preference of the individual that is known to the [nursing home].[19]

The main point of the Agency's argument against preemption was that any person who has authority to act on behalf of the deceased person should be treated as a personal representative.[20] However, "the plain language of § 400.145 does not empower or require an individual to act on behalf of a deceased" person.[21] Thus, the statute permits disclosures to individuals without regard to whether the individuals have authority to act on the deceased resident's behalf.[22] The court of appeals "agree[d] with the district court that § 400.145 frustrates the federal objective of limiting disclosures of protected health information, and that the statute is thus preempted by the more stringent privacy protections of HIPAA and the Privacy Rule."[23]

In further analysis of the Agency's arguments the court of appeals stated that the Agency's argument, that section 164.510(b)(5)[24] of volume 45 of the Code of Federal Regulations (C.F.R.) saves Florida Statutes § 400.145, faces the same problem as discussed above.[25] "While § 164.510(b)(5) authorizes [nursing homes] to release a deceased individual's protected health information to family members or other individuals, the regulation does not open a broad new avenue of access

17. *Id.*
18. *Id.* at 1295 (quoting 45 C.F.R. § 164.502(g)(4) (2013)).
19. *Id.* (second alteration in original) (quoting 45 C.F.R. § 164.510(b)(5) (Supp. 2013)).
20. *Id.* at 1296.
21. *Id.*
22. *Id.*
23. *Id.*
24. 45 C.F.R. § 164.510(b)(5) (Supp. 2013).
25. *Opis Mgmt. Res. LLC*, 713 F.3d at 1296.

to protected health information, as the [Agency] contends."[26] Instead, 45 C.F.R. § 164.510(b)(5) permits nursing homes to release protected health information in only certain circumstances.[27] First, the request for protected health information must be submitted by those involved in a deceased resident's health care and those who paid for a deceased resident's health care.[28] Then, a nursing home may only disclose information that is relevant to such person's involvement.[29] Florida Statutes § 400.145 does not address the impact of HIPAA and is not carefully tailored to permit only those individuals who have a HIPAA-compliant authorization to receive the protected health information of the deceased residents.[30] Therefore, § 400.145 is preempted by HIPAA, and the court of appeals affirmed the district court's grant of summary judgment.[31]

III. ARBITRATION AGREEMENTS AND WRONGFUL DEATH SUITS

Next, in *Hogsett v. Parkwood Nursing & Rehabilitation Center, Inc.*,[32] the United States District Court for the Northern District of Georgia decided whether an arbitration agreement was binding when a nursing home resident's daughter signed the agreement without any legal authority to do so.[33] In review of the relevant facts, a mother had the lower part of her leg amputated and was admitted to a nursing and rehabilitation center to recover. The daughter of the prospective resident completed the intake paperwork for her mother, including an arbitration agreement. The mother did not sign any of the intake paperwork, was not present at the time her daughter completed the intake paperwork, and had not given her daughter the authority to complete the intake paperwork. Further, both the daughter and Parkwood Nursing & Rehabilitation Center, Inc. (Parkwood) agreed that the daughter did not have any legal status that would authorize the daughter to complete the paperwork on behalf of her mother.[34]

Following the mother's admittance to Parkwood, the staff did not adhere to the plan of care for the mother, and her amputation became severely infected. As a result, the mother's condition quickly deteriorat-

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26. *Id.*
27. *Id.*
28. *Id.*
29. *Id.*
30. *Id.* at 1297.
31. *Id.* at 1298.
32. 2013 U.S. Dist. LEXIS 30016 (N.D. Ga. 2013).
33. *Id.* at *28.
34. *Id.* at *2-3, *5-6.

ed, and she died fifteen days after being admitted to Parkwood. The resident's husband and daughter brought claims against Parkwood in their individual capacities, and the daughter brought claims against Parkwood in her capacity as the representative of her mother's estate. The claims on behalf of the estate were dismissed.[35]

In response to the daughter's and husband's claims, Parkwood filed a motion to dismiss the plaintiffs' claims and to compel arbitration on the said claims "based on the arbitration agreement signed by [the daughter]."[36] In deciding whether to grant Parkwood's motion to dismiss, the district court analyzed whether the arbitration agreement was binding on the estate, despite the estate's claims being dismissed, because "if the decedent . . . agreed to arbitrate any claims against defendants, then presumably her survivors on a wrongful death claim would be bound by that agreement as a wrongful death claim would be derivative of the medical malpractice claim that the decedent could have made."[37]

While analyzing the arbitration agreement, the court stated that the agreement required consent by the parties to the agreement.[38] Both parties agreed the daughter signed the agreement when her mother was admitted to Parkwood. However, the plaintiffs argued that the daughter did not have the authority to bind her mother to the arbitration agreement because the daughter did not have power of attorney over her mother. Further, the daughter stated that her mother did not give her permission to sign the arbitration agreement on her mother's behalf. Parkwood did not offer any evidence that the mother was incapable of making decisions for herself at the time the mother was admitted to Parkwood. Parkwood argued that despite the absence of expressed authority, the daughter had implied authority to sign the arbitration agreement as her mother did not protest her daughter signing the agreement or her admittance to Parkwood.[39]

In order for implied authority to exist, the mother must have given some indication that she agreed to be represented by her daughter.[40] Under the present set of circumstances, the district court held that the mother never made any statements that would lead Parkwood to believe that her daughter had any authority to sign the arbitration agree-

35. *Id.* at *6-7.
36. *Id.* at *7.
37. *Id.* at *10.
38. *Id.* at *12.
39. *Id.* at *13-14.
40. *Id.* at *16.

ment.[41] Moreover, Parkwood could not have inferred that the daughter had any sort of implied authority based on the circumstances.[42] Even if the mother knew that her daughter signed the admissions documents prior to her arrival to Parkwood, the mother could not have known that an arbitration agreement was included in the admissions documents and could not have assented to her daughter's signature of that agreement.[43]

In regards to mental or physical incompetence, if a patient is incompetent, "an adult child, among others, may consent for treatment for her parent."[44] However, Parkwood did not provide any evidence that the mother was mentally or physically incompetent to sign the admissions documents, including the arbitration agreement.[45] Furthermore, Georgia case law states that unless a patient's representative has a general power of attorney over the patient, the representative cannot bind the patient to an arbitration agreement signed prior to the patient's admittance to a nursing facility.[46] Parkwood failed to address the Georgia case law that was in direct opposition to its position that the daughter had implied authority over her mother.[47] Thus, because there was no binding arbitration agreement, the husband's wrongful death claim was not subject to the agreement.[48]

Analysis of whether the daughter's individual claims were barred by the arbitration agreement was more difficult to decide because there was no precedent on that issue.[49] Equitable principles fail to support a daughter not being bound by an arbitration agreement that she signed.[50] However, the agreement was never between the daughter and Parkwood, but between the mother and Parkwood.[51] The district court side-stepped the issue of whether the daughter was bound by the arbitration agreement by noting that the daughter was not the proper party to bring a wrongful death claim.[52] The mother's husband had

41. *Id.* at *17.
42. *Id.* at *18-19.
43. *Id.* at *18.
44. *Id.* at *20.
45. *Id.*
46. *Id.* at *23 (citing Life Care Ctrs. of Am. v. Smith, 298 Ga. App. 739, 743, 681 S.E.2d 182, 186 (2009); Ashburn Health Care Ctr., Inc. v. Poole, 286 Ga. App. 24, 27, 648 S.E.2d 430, 433 (2007)).
47. *Id.* at *26.
48. *Id.*
49. *See id.* at *28.
50. *Id.*
51. *Id.*
52. *See id.* at *29.

standing to bring a wrongful death claim, and he was not bound by the arbitration agreement.[53] Therefore, Parkwood's motions to dismiss or compel arbitration was denied, and the plaintiffs were ordered "to file an amended complaint setting out their existing claims."[54]

Following both *Opis Management Resources, LLC* and *Hogsett*, the implication for plaintiffs is that an agreement executed by someone without the legal authority to act on behalf of a deceased patient may be rendered void.[55] Thus, a plaintiff may be able to recover damages even after the plantiff knowingly signed an agreement waiving any right to said damages.[56] For defendants, *Opis Management Resources, LLC* is a reminder that nursing or rehabilitation facilities must ensure that any person executing an agreement on behalf of a patient has the proper legal authority to act on behalf of that patient.[57] By failing to verify that an individual who is executing a document or requesting protected health information has the legal authority to do so, nursing or rehabilitation facilities leave themselves open to unnecessary liability.

IV. THE REDUCTION OF MEDICAL CARE PROVIDED THROUGH THE GEORGIA PEDIATRIC PROGRAM

In *Hunter v. Cook*,[58] another case in the United States District Court of the Northern District of Georgia, the court decided whether Georgia's Department of Community Health (DCH) was permitted to reduce the number of hours of care that a doctor recommends for a child to receive through the GAPP.[59] "Under the Medicaid Act, Georgia is required to provide certain categories of care to eligible children, including early and periodic screening, [and] diagnostic and treatment services [EPSDT]."[60] This mandate is carried out by the DCH through GAPP.[61] Through GAPP, the child receives private-duty nursing services from either "a registered nurse or nurse practitioner under the direction of the [child's]

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53. *Id.* at *26, *30.

54. *Id.* at *31-32.

55. *See Opis Mgmt. Res. LLC*, 713 F.3d at 1297; *Hogsett*, 2013 U.S. Dist. LEXIS 30016, at *22.

56. *Hogsett*, 2013 U.S. Dist. LEXIS 30016, at *26-27.

57. *Opis Mgmt. Res. LLC*, 713 F.3d at 1296.

58. Hunter ex rel. Lynah v. Cook, 2013 U.S. Dist. LEXIS 72110, at *1-2 (N.D. Ga. 2013).

59. *Id.* As part of the Georgia Medicaid system, the Georgia Pediatrict Program (GAPP) provides services for medically fragile children as an alternative to institutionalization. *See* FACT SHEET: THE GEORGIA PEDIATRIC PROGRAM (GAPP), dch.georgia.gov/sites/dch.georgia.gov/files/gapp_fy14_final.pdf (last visited Apr. 12, 2014).

60. 2013 U.S. Dist. LEXIS 72110, at *1-2; *see also* O.C.G.A. § 42-2-142 (2013).

61. *Id.*

physician at either the [child's] home, a hospital, or a skilled nursing facility."[62]

The plaintiffs filed a complaint alleging that they did not receive sufficient hours of private-duty nursing services because the defendant did not approve "their requests for private duty nursing services based on physician recommendations."[63] The plaintiffs later amended their complaint to include "claims for violations of the Medicaid Act and its EPSDT provisions, violations of Title II of the Americans with Disabilities Act [ADA], and violations of the Fifth and Fourteenth Amendments."[64] The defendant moved for a "partial summary judgment arguing that all of the Plaintiffs' claims should be dismissed with the exception of those claims related to the number of skilled nursing hours which are medically necessary for the Plaintiffs to correct or ameliorate their medical conditions."[65]

The defendant based its motion for summary judgment on several grounds.[66] The defendant argued

> that (1) the Plaintiffs have not identified the services they have been deprived of under the Georgia Medicaid Program; (2) the Plaintiffs have not demonstrated that the Defendant fails to inform them of the scope of services available under the EPSDT; (3) the Plaintiffs have not shown that the Defendant denies or reduces services based on a Plaintiff's specific illness or condition; (4) the Plaintiffs have not shown that the Defendant applies the wrong standard to requests for nursing services; (5) the Plaintiffs have not shown that the Defendant violated the law by reducing services based on a Plaintiff's relative stability; (6) the Plaintiffs have not shown they have been denied medically necessary services; (7) the Plaintiffs have not shown that the Defendant denies private duty skilled nursing services on the basis of cost; and (8) the Plaintiffs have not shown that they have been denied transport with a nurse to doctor appointments.[67]

Further, the defendant argued that it had not violated the plaintiffs' rights under the Fifth Amendment, Fourteenth Amendment, or ADA.[68] In its analysis of the plaintiffs' claims under the Medicaid Act, the district court examined whether: (1) the defendant provided all medically necessary services; (2) the defendant informed the plaintiffs of the scope

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62. *Id.* at *2.
63. *Id.* at *2-3.
64. *Id.* at *3; *see also* U.S. CONST. art. V; U.S. CONST. art. XIV; 42 U.S.C. § 1396 (2012); 42 U.S.C. § 12131 (2012).
65. 2013 U.S. Dist. LEXIS 72110, at *4.
66. *Id.* at *5.
67. *Id.* at *5-6 (footnote omitted).
68. *Id.* at *6-7.

of services available under EPSDT; (3) the defendant denied or reduced services based on the plaintiffs' illnesses or conditions; (4) the defendant applied the proper standard to requests for nursing services; (5) the defendant denied services because the plaintiffs' condition had not deteriorated enough; (6) the plaintiffs were provided with medically necessary services; (7) the defendant denied services based on cost; and (8) the defendant provided for a nurse to travel to doctor appointments.[69]

First, the plaintiffs did not allege in their complaint that they were deprived of medically necessary services, case management services, personal care services, and incontinence supplies.[70] Therefore, the defendant's partial motion for summary judgment was granted with an exception for the plaintiffs' claim that they were not receiving the medically necessary number of private-duty nursing hours from the defendant, which was deemed a question for a factfinder.[71]

Second, the plaintiffs did not provide evidence or case law supporting their contention that confusion with the DCH website is a violation of the requirement to inform EPSDT participants.[72] Thus, the defendant's motion for summary judgment was granted on this ground.[73]

Third, the plaintiff did not establish that the defendant reduced or denied services based on specific illnesses or conditions.[74] Therefore, the defendant's motion for summary judgment was granted on that ground.[75]

Fourth, the plaintiffs did not set forth any evidence to support their allegation that the defendant did not adhere to the medically necessary standard as required by the Medicaid Act when evaluating requests for private-duty nursing.[76] However, there was a question of fact regarding whether the defendant followed the medically necessary standard when deciding to limit the plaintiffs' private-duty nursing service hours.[77]

Fifth, plaintiffs' claims "based on whether the Defendant [reduced] services based on the relative stability of a patient's conditions" were unfound and, therefore, were dismissed.[78] However, a question of fact

69. *Id.* at *7-9, *11-16.
70. *Id.* at *7.
71. *Id.* at *7-8.
72. *Id.* at *9.
73. *Id.*
74. *Id.* at *10-11.
75. *Id.* at *11.
76. *Id.* at *11-12.
77. *Id.* at *12.
78. *Id.* at *13.

existed "with respect to whether the Defendant . . . provid[ed] the plaintiffs with the medically necessary level of private duty nursing services."[79]

Sixth, the court stated that "the fact that the hours of private duty nursing services provided by the Defendant" may decrease from the number of hours recommended by the physician does not mean that the defendant "has not provided all medically necessary treatment."[80] Thus, there is a question of fact with respect to the number of hours that are medically necessary for the plaintiffs' care.[81]

Seventh, the plaintiffs failed to provide evidence that the defendant denied services based on cost.[82] Thus, the defendant's motion for summary judgment was granted on this point.[83]

Eighth, the defendant's motion for summary judgment was granted on the issue of providing a nurse to travel to doctor appointments because the plaintiffs failed to produce evidence showing that the defendant denied such requests.[84]

Next, the plaintiffs argued that the threat of institutionalization is cognizable under the ADA.[85] The court stated that "[b]ecause there is a question of fact . . . whether the reductions in private duty nursing hours were in accordance with the . . . medically necessary treatment, there is an issue of fact to whether the plaintiffs face a threat of premature institutionalization."[86] Thus, summary judgment was denied on this issue.[87]

Finally, in regard to the plaintiffs' claims under the Fifth and Fourteenth Amendments, the plaintiffs did not provide evidence that the boilerplate language in the denial of coverage letters indicated arbitrary and capricious decision-making.[88] Therefore, the defendant's motion for summary judgment was granted with respect to the plaintiffs' Fifth and Fourteenth Amendment claims.[89] As there remain issues left to be decided at the district court level in *Cook*,[90] its implications are not yet known. However, entities providing medical services under the GAPP

79. *Id.*
80. *Id.* at *14.
81. *Id.*
82. *Id.* at *16.
83. *Id.*
84. *Id.* at *16-17.
85. *Id.* at *17.
86. *Id.* at *20.
87. *Id.*
88. *Id.* at *20-21.
89. *Id.* at *22.
90. *Id.* at *1.

should ensure that any reduction in medical services is based on verifiable evidence that the services are not needed. By having an articulable reason for reducing medical services, entities providing medical services under the GAPP would have an argument against liability alleged by those who received a reduction in medical services.

V. CONCLUSION

The Eleventh Circuit did not have many noteworthy cases during 2013. The main points discussed in these cases were that the administrative portion of nursing or rehabilitation facilities and entities providing medical services under the GAPP must ensure that the legal status of individuals is known prior to releasing protected information and allowing individuals to execute documents on a patient's behalf. Further, medical services offered under the GAPP should not be reduced unless there is a verifiable, articulable reason for reducing such services.

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