

## SPECIAL REPORT: THE STATE OF SENIORS' HOUSING ON LONG ISLAND

By Wayne L. Kaplan



Wayne L. Kaplan

The seniors' housing industry on Long Island is starting to level out. Active Adult Communities (also known as independent living communities) for people "55 and over" are proliferating as baby boomers start to hit retirement and empty nesters no longer want the chores and obligations that come with their older houses. Most of these communities offer fitness, recreational and social amenities. They usually have single-family detached homes, garden apartments and/or town-homes and a low-maintenance lifestyle.

Only a few assisted living communities have been built in the last few years on Long Island as the oversaturation of newly built facilities from the 1990's has dissipated. In New York, licensed assisted living facilities are regulated by DOH as either adult homes or enriched housing programs. Notwithstanding recent unbalanced press about the industry, the new residences being built are state-of-the-art and are charging market rates, and many of the more mature, middle-market facilities are upgrading in order to compete. Unfortunately, many of the older adult homes that cater to lower income seniors are closing or the properties are being sold for alternative uses due to a lack of adequate government reimbursement.

N.Y. State has not increased its share of the inadequate Level II SSI rate (\$28 a day) since 1988 and it denies Medicaid personal care services and reimbursement to assisted living residents while it approves those services for individuals in other community-based housing, such as private apartments, federally funded senior citizen housing and OMRDD (Office of Mental Retardation and Developmental Disabilities) community residences. The State's regulations have not been significantly revised in almost 20 years, are outdated and no longer reflect the needs and characteristics

### *From the Editor's Corner*

It is our goal to keep you abreast of current issues in the health-care arena. We have included a variety of topics in this issue, from seniors' housing to regulations governing foreign physicians. We encourage you to e-mail us with your questions so we can devote future articles to the issues you deem critical in our field. I hope to hear from you at [smaliszewski@rmfpc.com](mailto:smaliszewski@rmfpc.com).

— Sandra Maliszewski

of the population living in these facilities today. Because of the different types of seniors' housing in existence today, and to create greater uniformity in the industry and the flexibility to account for a diverse resident population, the industry's trade association (The Empire State Association of Adult Homes & Assisted Living Facilities) is urging the State Legislature to amend the existing statutes to: (1) account for the emergence of assisted living and the concept of allowing people to grow more dependent in place; (2) vary the level of regulation and oversight based on the level of care and services needed by the residents; and (3) provide for additional consumer information and disclosure to better educate consumers about the different housing models in existence for elderly and disabled people.

The CCRC (Continuing Care Retirement Community) or Life Care industry on Long Island may finally be adding to its two existing communities. The site of a proposed 8.9-acre, 400-unit CCRC in Port Washington overlooking Hempstead Harbor (the failed Marriott-managed project) was recently sold for \$22 million (\$2.47 million per acre) and the new owners plan to begin development once necessary state permits are obtained, tax-exempt financing is lined up and 70% of the units are pre-sold. Unlike equity model "55 and over" communities and assisted living rentals, CCRCs charge substantial refundable entrance fees and ongoing monthly maintenance fees. They offer a long-term care insurance contract that provides for housing, services and healthcare, usually on one campus. CCRCs deliver a continuum of care throughout the lifetime of its elderly residents usually by combining all three levels of care – independent living, assisted living and nursing home care.

Wayne L. Kaplan is a partner and chair of the Seniors' Housing Group and practices in the Health Law, Corporate Law and Real Estate Departments. He can be reached at 516-663-6553 or [wkaplan@rmfpc.com](mailto:wkaplan@rmfpc.com).

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#### INSIDE UPDATE

Have You Committed Professional Misconduct...Lately?.....	2
Foreign Physicians: J-1 Visa Waivers Pose Risks.....	2
Medical Directorships: Not An Empty Title.....	3

EXCELLENCE. PERIOD.

## HAVE YOU COMMITTED PROFESSIONAL MISCONDUCT...LATELY?

By Gregory J. Naclerio



Gregory J. Naclerio

The Office of Professional Medical Conduct (OPMC) is the body which has authority to sanction physicians who commit professional misconduct. These sanctions range from the non-public Administrative Warning and public Censure and Reprimand to Suspension of License (actual or suspended) and the "professional death penalty" of Revocation. Moreover, all public sanctions are prominently displayed on the OPMC website for family, patients and your current managed care carriers to view. You can be sure your carrier will check the website often and terminate your participation in its plan if your name appears.

**In order to avoid an OPMC appearance, let's test your knowledge on what constitutes professional misconduct in everyday life.**

1. "Dr. Yankee," says Nurse Mets, "I'm having back spasms, can you write me a script for Vicodin?" As you rush out the door you write out a script.

**...Have You Committed Professional Misconduct?**

2. You receive an offer from the manager of We C. Thru-U MRI: "We do great MRIs and for every patient you send to us you will get 200 credits. Send 100 patients and your 20,000 credits will get you a cruise for two to Bermuda."

**...Have You Committed Professional Misconduct?**

3. You are in all the managed care plans but you're getting older and do not want to work so hard. You hire JR, who was in the top of his class and in the process of taking his Boards. He now sees the bulk of the office's patients, but since it will be at least six months before JR is enrolled in the managed care plans, you tell your office manager to bill all the services provided by JR under your billing name and number.

**...Have You Committed Professional Misconduct?**

see page 4 for answers

Gregory J. Naclerio is a partner and chair of the firm's Health Law Regulatory Department, co-chair of the White Collar Crime & Investigations Group and a member of the Corporate Governance Practice Group. He can be reached at 516-663-6633 or gnaclerio@rmfp.com.

## FOREIGN PHYSICIANS: J-1 VISA WAIVERS POSE RISKS

By Nili S. Yolin



Nili S. Yolin

Although participants in the "J" exchange visitor program (as provided in the Immigration and Nationality Act) vary from academics to international visitors coming for travel purposes, the J-1 visa is the most commonly used non-immigrant visa category for international medical graduates – and it is also a potential source of many problems for foreign physicians attempting to permanently relocate to the U.S.

While the J-1 visa is easy to obtain – and therefore enticing to international graduates seeking to participate in a U.S. medical residency program – once it has been issued, the foreign physician is subject to a two-year home-residence requirement before he/she may become eligible to apply for an immigrant (green card or permanent residence) or temporary worker visa. In order to avoid the onerous home-residence requirement, these physicians have the option of obtaining a J-1 waiver (J-1 Physician). Sponsors of J-1 Physicians in need of waivers include, among others, the

Department of Health and Human Services, local State Departments of Health and the Appalachian Region Commission (ARC). Because J-1 Physicians seeking sponsorship typically have counsel and their proposed employer actively involved in obtaining the J-1 waiver on his/her behalf, it is critical that J-1 Physicians inquire about and understand what is involved in obtaining and maintaining their J-1 waiver.

Generally, J-1 Physicians are aware that their program requires a 2 or 3 year employment commitment to work in a health professional shortage area (HPSA), but many do not know – or disregard – the ARC requirement that their employment agreement contain a liquidated damages clause, which is often executed as an addendum to the primary employment contract. This provision requires the J-1 Physician to pay \$250,000 in liquidated damages if he/she fails to fulfill the three-year commitment to remain with his/her employer. Pursuant to the ARC waiver, the J-1 Physician will only be excused from the employment contract if the J-1 Physician becomes a full time employee at an alternative HPSA within the ARC.

Although many sponsors similarly include a liquidated damages clause in the employment contract, unique to the ARC's is the requirement that the J-1 Physician remain in ARC's jurisdiction. In other words, employment at another health care facility located in

# MEDICAL DIRECTORSHIPS: NOT AN EMPTY TITLE

By Andrew T. Garbarino



Andrew T. Garbarino

As physicians gain experience and notoriety, it is common for health care facilities to offer positions of authority, including medical directorships. While the title of medical director denotes a degree of respect and acumen in the medical field, physicians who fail to meet the legal obligations attendant to their position may be subjected to disciplinary action.

When a medical directorship is offered, a facility should explicitly notify the physician of the obligations the medical director must meet. Unfortunately, not all facilities inform their medical directors of their duties. Recent publications indicate that medical directors are woefully uninformed as to their expected responsibilities.

## OBLIGATIONS OF A MEDICAL DIRECTOR IN NEW YORK

The position of medical director is not simply an empty title; the medical director serves administrative and supervisory functions essential to the operation of a facility. Medical directors also serve as compliance officers, ensuring a medical staff's adherence to various statutory and regulatory obligations.

A host of federal and state statutes and regulations determine the duties of medical directors in New York. A hospital's governing body is required to appoint a medical director. Duties include management of clinical treatment plans, oversight of medical staff accountability and supervision of patient care in general, as well as supervision of the medical staff. Other duties, however, such as ensuring patient's rights, review of privileges issues and the organizational development and conduct of the medical staff, are apparently not as obvious to many medical directors. Physicians considering a medical director appointment should be sure to familiarize themselves with the legal requirements of the position.

In 2003 the Office of Inspector General published a survey of a number of medical directors of nursing homes and found that while some functions expected of medical directors seem to be uniformly understood, "much of what medical directors are expected to do by the nursing homes begins to vary markedly" as non-administrative duties are considered. Differences of opinion in this area concern patient services and resident rights. The Code of Federal Regulations makes nursing home medical directors responsible for "the implementation of resident care policies" and "coordination of medical care services by the facility."

It is unlikely that these issues are restricted to medical directors of nursing homes. As there is no centralized body of law governing medical directors in New York, it is difficult for a medical director to know when to act. While New York State's Rules and Regulations generally define the duties of medical directors, various statutes and regulations govern specific facilities or situations. For example, the Social Security Law determines when a medical director must commence civil commitment proceedings; the Correction Law determines special duties germane to correctional facilities and the Public Health Law contains special rules on the resuscitation of patients.

The Office of Professional Medical Conduct (OPMC) has, on several occasions, initiated investigations based on allegations that a medical director had failed in meeting all of his/her duties. Many of these subjected to the OPMC process were unaware that they had not met all of their obligations.

Physicians must review all potential medical directorships and comprehensively determine *all* of the responsibilities associated with the position. While many medical societies offer guidelines for medical directors and most facilities will detail responsibilities with a contract, the physician is ultimately responsible for knowing what is expected and required.

Andrew T. Garbarino is an associate in the firm's Health Law Department and White Collar Crime & Investigations Group. He can be reached at 516-663-6653 or [agarbarino@rmfp.com](mailto:agarbarino@rmfp.com).

## FOREIGN PHYSICIANS: J-1 VISA WAIVERS POSE RISKS *continued from page 2*

a HPSA is not enough – the J-1 Physician must relocate within the Appalachian Region, which includes the entire state of West Virginia as well as parts of New York, Alabama, Georgia, Kentucky, Maryland, Mississippi, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee and Virginia.

While the ARC seems broad enough to allay the fears of a J-1 Physician who is thinking of moving to another part of the country, when a spouse finds a new job in Texas, a mother is sick in California, or the grandchildren live in Florida, relocation will not be possible unless the J-1 Physician is prepared to pay \$250,000 in damages. Ultimately, J-1 Physicians work very hard at advancing their careers while simultaneously seek to qualify for U.S. immigration. Accordingly, counsel for J-1 Physicians applying for an ARC

waiver are strongly advised to develop a comprehensive strategy for their J-1 Physician clients that takes into account key issues such as the geographic location of the HPSA and the J-1 Physician's interest in clinical activity. Full disclosure of the risks involved in obtaining an ARC waiver is essential for the J-1 Physician to make informed decisions about the enormous amount of work he/she will be undertaking as well as the commitment involved, including three full years in a HPSA within the ARC region.

Nili S. Yolin is an associate in the firm's Health Law Department, Seniors' Housing and White Collar Crime & Investigations Groups. She can be reached at 516-663-6616 or [nyolin@rmfp.com](mailto:nyolin@rmfp.com).

## HAVE YOU COMMITTED PROFESSIONAL MISCONDUCT...LATELY?

*continued from page 2*

### ANSWERS:

1. A physician can only write a prescription for a patient. If you argue Nurse Mets is your patient: where is her chart, which reflects her "evaluation and treatment"? If she is not your patient, why are you prescribing medication for her? Either way you lose. You have committed Professional Misconduct.
2. While you may believe the MRI office has the best equipment and the best radiologists, you cannot accept "a fee or other consideration" from a third party for the referral of a patient. While this activity constitutes professional misconduct if the patients involved are covered by Medicare or Medicaid, you have also just committed a federal felony...a violation of the Federal Anti-Kickback Statute.
3. I know, I know. It's the managed care company's fault! If they processed JR's application in a timely fashion this would not have happened. You can grumble all you want, but you just committed Professional Misconduct. You committed fraud against the insurance company. Fraud is defined as: 1) a false statement; 2) relied upon by another; 3) to the other person's detriment. The false statement you made was that you did all the work, when in truth and in fact, JR did it.



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### RUSKIN MOSCOU FALTISCHEK, P.C.

East Tower, 15th Floor  
190 EAB Plaza  
Uniondale, New York 11556-0190  
(516) 663-6600  
www.rmfp.com

#### *Health Law: Transactional, Regulatory Healthcare Professionals and Seniors' Housing*

Leora F. Ardizzone  
Alexander G. Bateman, Jr.  
Andrew T. Garbarino  
Wayne L. Kaplan  
Ellen F. Kessler  
Sandra Maliszewski  
Gregory J. Naclerio  
Melvyn B. Ruskin  
Jay B. Silverman  
Keshia B. Thompson  
Nilli S. Yolin

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