

IN THE WEST VIRGINIA SUPREME COURT OF APPEALS  
NO. 14-0965

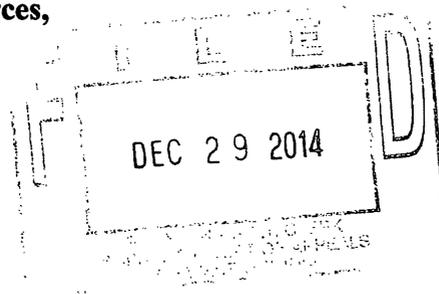
West Virginia Department of Health and Human Resources,  
Bureau for Behavioral Health and Health Facilities,  
Defendants Below,

*Petitioners*

v.

E.H., et al.,  
Plaintiffs Below,

*Respondents.*



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PETITIONER'S BRIEF

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## INTRODUCTION

This case is about whether the West Virginia Department of Health and Human Resources's state-run psychiatric hospitals must provide Legal Aid of West Virginia, an outside entity advocating on behalf of individual patients, carte blanche access to all confidential psychiatric records—*without requiring Legal Aid to obtain patient consent before viewing the records*. See App. 286, 322, 335 (Orders of August 18 & Aug. 27, 2014).

The lower court's order mandating such blanket disclosure is in error because both the federal Constitution and the federal Health Insurance Portability and Accountability Act (HIPAA) require state hospitals to protect patients' privacy by disclosing psychiatric records to an outside third party only *after* the patient consents. If upheld, the lower court's order will result in widespread privacy violations throughout the state psychiatric hospital system.

## ASSIGNMENTS OF ERROR

Two sources of federal law limit the state disclosure of psychiatric records. *First*, under the Fourteenth Amendment, states must satisfy constitutional scrutiny before disclosing any "personal matters." *Whalen v. Roe*, 429 U.S. 589, 599–600 & n.23 (1977). *Second*, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related rules, states may not disclose any individually identifiable "health information" unless the individual consents or an exemption applies, in which case HIPAA permits the minimum disclosure necessary. Pub. L. No. 104-191, §§ 1176–77, 110 Stat. 1936 (codified at 14 USC §§ 1320d-5, 1320d-6 (2010)); 45 C.F.R. §§ 160.103, 164.502.

In violation of this federal law, the lower court ordered the State's psychiatric hospitals to give Legal Aid of West Virginia (an outside entity advocating on behalf of individual patients) carte blanche access to *all* confidential patient records—*without requiring patient consent first*.

App. 335 (Order of Aug. 27, 2014). The assignments of error are:

(1) The lower court's blanket disclosure order violates the Fourteenth Amendment because releasing all psychiatric records to a private entity without patient consent fails any level of constitutional scrutiny.

(2) The lower court's order violates HIPAA because HIPAA requires patient consent before disclosure, provides no exemption for independent Legal Aid patient advocates, and even under its exemptions, permits only the minimum disclosure necessary.

(3) The lower court's factual findings that the hospitals (a) forbade all advocates' access to patients and records and (b) forbade patients from consenting to the disclosure of their records were both clearly erroneous because undisputed evidence showed that the advocates (a) can talk to patients and staff and (b) can also, with signed patient consent (*or* patient's guardian consent), access confidential information orally or in records.

(4) Because the lower court's order was final in nature and effect, the lower court incorrectly refused to certify its order as an appealable final judgment under Rule 54(b).

### STATEMENT OF THE CASE<sup>1</sup>

#### **I. The Department of Health and Human Resources funded an external group of independent advocates to raise grievances on behalf of individual patients at state psychiatric hospitals.**

Over the last three decades, under changing legal and budgetary conditions, the Legislature and public hospitals have worked to protect psychiatric patients in many ways—both on their own initiative and in response to orders in this case.

The Department funds *outside* advocates from Legal Aid of West Virginia to raise

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<sup>1</sup> Also pending in this case are two appeals concerning the lower court's power to order the Department of Health and Human Resources to restructure hospital staff pay according to a court-selected plan. *See* No. 14-0664, No. 14-0845 (raising separation of powers challenges to the lower court's remedial plan). This appeal raises distinct merits issues.

grievances on behalf of individual psychiatric patients to create an “*external* advocate system.” App. 357 (Order of Feb. 20, 1990). Under state regulations, “[t]here shall be persons designated as client (or patient or resident) advocates who are *independent* of the facility management in every behavioral health facility.” W. Va. Code R. § 64-59-20.1 (emphasis added). Each patient has the right to file a grievance. W. Va. Code R. § 64-59-20.2. The advocates exist to perform several functions independently of the hospitals and on behalf of the patients; specifically, they “assist *clients* in registering and filing grievances, acknowledge grievances, conduct investigations of grievances, notify the administrator of results of grievance investigations, assure that abuse/neglect grievances have been reported to Adult Protective Services, educate staff regarding client rights and maintain accurate documentation of all grievances and investigations.” W. Va. Code R. § 64-59-20.2.16.b (emphasis added); *cf.* App. 357 (Order of Feb. 20, 1990) (One-page order to establish an “*external* advocate system” and “contract with an entity *outside* State government” for patient advocates) (emphasis added) (no appeal taken).

An independent advocate therefore may inspect all “pertinent records” held by a hospital when a patient asks the advocate to investigate and bring a grievance on the patient’s behalf. W. Va. Code R. § 64-59-20.2.9. State regulations do not require prior *written* consent from patients, although they do require the independent and external advocates to be acting *on behalf of* a patient, which presumes oral or otherwise-communicated prior consent. W. Va. Code R. § 64-59-11.5.1.d (“No written consent is necessary for employees of the department, comprehensive behavioral health centers serving the client, or advocates under contract with the department.”). State law also says that “[p]rocedures and investigations conducted under this rule shall be conducted with due regard for the confidentiality, rights and dignity of all parties.” W. Va. Code R. 64-59-20.2.15.

Among other means, the Department of Health and Human Resources funds outside patient advocates annually through an arm's-length grant agreement with Legal Aid, a private entity that independently acts on behalf of individual patients. *See* App. 7 (2014 Grant Agreement). This agreement reflects Legal Aid's independent role. Under the grant agreement, the advocates are not the state psychiatric hospitals' employees, not under the hospitals' control, and do not provide services to or for the hospitals. *Id.*; *id.* at 12.01 ("The relationship of the Grantee to the Department will be that of an independent grantee and no principal-agent relationship or employer-employee relationship is contemplated or created by the parties to this Grant Agreement.").<sup>2</sup> Under the grant, Legal Aid "provide[s] *external* advocacy services to *West Virginians* who face challenges brought about by behavioral health disorders." App. 7 (Grant Agreement at 1–2 & Exh. A) (emphasis added). In this capacity, they must "[p]rovide advocacy, [i]nvestigate complaints, train patients, disseminate surveys to their clients, document their findings, and conduct two "audits." App. 27. Other advocacy groups also serve as patient advocates, as well as private attorneys retained by individual patients. App. 27; 267–68.

Upon entry to the hospitals in 1991, advocates have been given access and space to facilitate their work. They were provided access to patients' physical records, which led, in time, to electronic access to patient records. App. 76. This access was provided before the enactment of the Health Insurance Portability and Accountability Act (HIPAA) in 1996 and the HIPAA Privacy Rule in 2002. *Id.* Both William R. Sharpe, Jr. and Mildred Mitchell-Bateman Hospitals have also provided outside advocates office space since 1991. App. 38, 76.

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<sup>2</sup> *See also* W. Va. Code R. § 64-59-11.5.1.d (distinguishing between employees and advocates); App. 269 (Transcript of August 1, 2014, hearing, pp. 174-75 ("You would agree with me that DHHR does not control your work? They don't have the right to tell you what to do when you do your job." "That's correct.") (Advocate Sharoon Reed)); App. 270 ("DHHR isn't your boss or giving you instructions on how to do your job?" "No." "And as a matter of fact, quite often in the grievance process you are adverse to DHHR?" "That's possible.").

Later, without auditing or reviewing the advocates' practices or state regulations, the Department added boilerplate language to the advocates' standard-form grant agreements citing HIPAA. App. 337, 339. In a number of ways, this new grant language placed upon the advocates the duty to ensure that Legal Aid's access to confidential psychiatric records follows federal law, which generally means obtaining patient consent before viewing a patient's file in order to raise grievances on the patient's behalf.

*First*, the agreement required the advocates to identify and comply with all applicable laws. App. 10 ("The Grantee is responsible for obtaining" information about applicable federal and state laws and regulations and "possible sources for obtaining the information is attached as Exhibit C."); App. 21 ("The Grantee shall comply with all applicable State and Federal laws and regulations in the performance of this Grant Agreement.").

*Second*, the agreement listed a myriad of laws that *may be* applicable, including HIPAA. App. 21 ("Strict standards of confidentiality of records and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) shall be maintained in accordance with State and Federal laws."); App. 10 (listing as "possible" laws "Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 110 Stat. 1936 (1996) (HIPAA) and regulations promulgated thereunder (HIPAA Regulations)."); App. 47 (charging Legal Aid with the duty to "not use or disclose the [information] in a manner in violation of existing law and specifically not in violation of laws relating to confidentiality of [health information], including but not limited to, the Privacy and Security Rules.").

Because the agreement was a stock form used for many state grants, many of the laws the agreement cited as potentially binding were merely boilerplate clauses obviously inapplicable to the advocates because the Legal Aid advocates are not federal grantees. App. 44, 45, 47.

*Compare* App. 34 (providing a blank for federal funds and then only listing *state* funds as the grant’s source), *with id.* 19 (noting as potentially applicable federal Executive Order 12549, “Debarment and Suspension” for federal grantees; the Environmental Tobacco Smoke/Pro Children Act of 1994, the Drug-Free Workplace Act of 1988, federal lobbying certifications, federal civil rights and education laws, and the federal Program Fraud Civil Remedies Act); App. 35 (listing other requirements for federal grantees, such as “the Federal Funding Accountability and Transparency Act of 2006 and the American Recovery and Reinvestment Act of 2009, as may be applicable” ); App. 39 (federal grant audit requirements); App. 40 (federal grant reporting requirements).

*Third*, the grant included a boilerplate addendum citing the HIPAA exception for business associates. App. 47. This section permitted access to patient records only “if such use or disclosure of the [information] would not violate the Privacy or Security Rules or applicable state law if done by Agency or violate the minimum necessary and related Privacy and Security policies and procedures of the Agency.” App. 48. It incorporated HIPAA into the agreement “by and between Bureau for Behavioral Health and Health Facilities Office of Programs and Policies the (‘Agency’), and LEGAL AID OF WEST VIRGINIA INC a Business Associate (‘Associate’).” App. 47; App. 323. It states that “Business Associate shall have the meaning given to such term in 45 CFR § 160.103” and purports that “[t]he Associate performs certain services on behalf of or for the Agency pursuant to the underlying Agreement that requires the exchange of information including protected health information.” App. 47. Legal Aid then “agree[d] to document disclosures of the [protected health information] and information related to such disclosures as would be required for Agency to respond to a request by an individual for an accounting of disclosures of [protected health information] in accordance with 45 CFR §§

164.528 and 164.316.” App. 49. This section did not actually identify any services that Legal Aid—which is supposed to advocate *independently* on behalf of *patients*—would provide on behalf of or to or for the *hospitals*.

**II. The state psychiatric hospitals discovered that outside Legal Aid advocates were accessing all confidential psychiatric patient records without first obtaining patients’ consent or having a reason related to a grievance.**

Earlier this year, as part of the state psychiatric hospitals’ continuing efforts to monitor their own compliance with federal constitutional and statutory requirements, the hospitals internally reviewed their patient privacy protections. App. 76. Under the Fourteenth Amendment, the State must satisfy constitutional scrutiny before disclosing any “personal matters.” *Whalen v. Roe*, 429 U.S. 589, 599–600 & n.23 (1977). And, under the Health Insurance Portability and Accountability Act (HIPAA) and related rules, the hospitals may not disclose any “health information” unless the patient consents or an exemption applies, in which case HIPAA permits only the minimum disclosure necessary. 42 U.S.C. § 1320d-6; 45 C.F.R. §§ 160.103, 164.502. The regulations that enforce HIPAA also require the hospitals to document each time patient information is accessed. 45 C.F.R. §§ 164.528, 164.316.

Unfortunately, the hospitals’ internal review concluded that the Legal Aid advocates did not follow these federal privacy standards. In particular, it was discovered that the Legal Aid advocates had network access to all patient records and were accessing the information without signed consents—and, in some cases, *without a reason related to a grievance*. App. 76, 88–96; *id.* 186–87, 193, 210–12, 235, 238, 269 (Transcript of August 1, 2014, hearing p. 90–91, 97, 114–16, 140, 143, 174 (stating how advocates had been caught “fishing” in files for reasons unrelated to grievances or audits)); App. 258–59, 269 (Transcript of August 1, 2014, hearing, pp. 163–64, 174 (admitting that advocates regularly looked at patient files without a reason related to a grievance as well as before talking with them the first time and obtaining consent to view files)

(Advocate Sharon Reed)). Nor were HIPAA-required accounting procedures in place. App. 544.

If, as the hospitals believed, the advocates' access violates HIPAA, the hospitals had to cut off access immediately or they could face civil and criminal penalties and damages. 42 U.S.C. § 1320d-5 (civil penalties for covered entities); 42 U.S.C. § 1320d-6 (criminal penalties for covered entities). Although the hospitals do not concede that a State may be held liable for HIPAA violations, the statute provides that HIPAA violations can bring civil penalties of \$100 to \$50,000 per violation. 45 C.F.R. § 160.404(b)(2). Stricter penalties of \$10,000–\$50,000 apply to *each* violation attributable to willful neglect. *Id.* Deliberate violators face prison sentences of up to ten years. 42 U.S.C. § 1320d-6; *see generally* Jonathan P. Tomes, *Individual criminal liability for HIPAA violations: who is potentially liable? Or should we say, who isn't?*, 9 J. Health Care Compliance 5 (2007). And, while there is no direct federal cause of action to vindicate HIPAA violations, some courts have held that a HIPAA violation may establish an element of a patient's state tort claim for unauthorized disclosure. *E.g., Acosta v. Byrum*, 638 S.E.2d 246, 250–51 (N.C. Ct. App. 2006).

### **III. The state psychiatric hospitals required the independent advocates to obtain patients' consent before accessing psychiatric records in the future.**

In order to rectify this situation and protect its patients' privacy, the hospitals took immediate remedial action. They revoked the advocates' network access to all patient records and instead informed the advocates that they would only provide access to records when the patient (or the patient's guardian) first consented to disclosure in a signed writing. App. 76; App. 337; App. 181, 195, 197, 210–11 (Transcript of August 1, 2014, hearing p. 85, 99, 101, 114–15). The hospitals then provided the advocates a form to use that met the authorization standards of HIPAA. *See* App. 78–79; 45 C.F.R. § 164.508(c)(1). This transition in policy and

procedure from carte blanc access to the requirement to obtain signed authorizations to view patient records was virtually instantaneous, because every other individual, advocacy group, or entity wishing to view patient records is required to obtain authorizations.

The hospitals explained that while they respected the role of advocates as outside entities who initiate adversary-style grievance proceedings on behalf of patients, the hospitals must protect their patients' rights to privacy until the patient consented to Legal Aid acting on the patient's behalf. *See* App. 77. The Hospitals and the Legal Aid advocates then "had several communications discussing the new process." *Id.* The hospitals also noted that "[t]hese requirements . . . have been complied with by every advocacy group other than [Legal Aid] that serves as patient advocates for Sharpe and Bateman hospitals." App. 79; *id.* 196, 269–70 (Transcript of August 1, 2014, hearing p. 100, 174–75).

The plaintiffs (a group of patients who are not advocates) responded by seeking a court order requiring the hospitals to turn over to the Legal Aid advocates *all* psychiatric records and never again require patient consent before allowing the advocates live network access. App. 6.

Legal Aid did not appear as a party in these proceedings, but another advocacy group, West Virginia Advocates, filed a brief requesting the court "to direct the [hospitals] to stop using HIPAA and [any other laws] to violate its patients' rights" and "to allow Legal Aid of West Virginia to access its patient records without written authorization." App. 72–73.

In response, the hospitals explained that the U.S. Constitution and HIPAA mandated the hospitals' actions. Under "the Constitution of the United States," the hospitals explained, patients' informational "privacy is protected from government intrusion." App. 76–77, 85–86. The plaintiffs did not have any response to the applicability of the federal constitutional precedents in their oral arguments or in their written filings. The hospitals also explained that

the Legal Aid advocates do not fall under any exemption to HIPAA's requirement to obtain patient consent before viewing records. App. 77–85 (citing 45 C.F.R. § 164.502(a)). The hospitals stated that the Legal Aid advocates *first*, “are not exempted from following HIPAA by Legislative Rule,” *second*, do not fall under HIPAA's exemption for business associates, and *third*, cannot be exempted under state law because HIPAA preempts state law and prior hospital policies. App. 80.

**IV. The lower court ordered the state psychiatric hospitals to provide the independent advocates full access to psychiatric records without each patient's consent—but the court refused to certify its ruling as a partial final judgment.**

The lower court entirely misunderstood this situation, believing that the hospitals had forbidden *any* access to patients in person or to their records, and that the hospitals would only allow guardians and surrogates, not patients, to consent to disclosure. App. 322–24, 326 (Aug. 27, 2014 Order at ¶¶ 2–3, 9, 16). The undisputed testimony at the evidentiary hearing showed otherwise. The Legal Aid advocates were able talk to patients and staff at any time—and with signed patient consent (*or* patient's guardian consent) the advocates could *also* access confidential information orally or in records from staff. App. 177 (Transcript of August 1, 2014, hearing, pp. 83).

Reasoning from these incorrect factual premises, the court sided with the plaintiffs on the law. It ruled that HIPAA exempted the Legal Aid advocates from consent requirements because the Legal Aid is a business associate, a public health authority, an entity providing health oversight activities, an entity involved in health care operations, and an entity conducting abuse and neglect investigations. 45 C.F.R. §§ 160.203(c), 164.501, 164.512; Order of August 18, 2014. It also held that *state law* required disclosure without consent. Neither the lower court nor the plaintiffs addressed the hospitals' constitutional precedents on a patient's right to privacy.

The lower court then ordered the state psychiatric hospitals to disclose all records to

Legal Aid advocates without first obtaining patient consent. App. 321. Specifically, the circuit court held that the state psychiatric hospitals “shall” provide the advocates with “access to patients and patient units immediately and without limitation”; the state psychiatric hospitals “shall” provide the advocates with “access to patient records immediately and without limitation except when patients request limitations on the disclosure of their individual, identifiable health information”; and the state psychiatric hospitals “shall not limit patient advocate conversations or discussions with [the state psychiatric hospitals’] staff.” *Id.* The court further directed that “[a]ccess shall include all medical records of all patients committed to the Hospitals.” *Id.*

The hospitals promptly moved the circuit court to stay this order and to enter an express order of partial final judgment to provide for expeditious appellate review. *See* W. Va. R. Civ. P. 54(b); App. 301. As the hospitals stated, there is “no just reason to delay” designating this part of the case as final. *Id.* at 302. The circuit court resolved all merits liability, reduced its order to writing, and ordered immediate action. *Id.* No party objected to the stay request or moved for reconsideration.

Shortly after the hospitals moved for a stay, however, the circuit court *sua sponte* amended its merits order, correcting factual errors, changing the foundation of its legal reasoning, and simultaneously denying as moot a stay of its original order and an express entry of finality. App. 335 (Amended Order of August 27, 2014); *id.* 351 (Order Denying Stay of August 27, 2014). The main change was the removal of the court’s incorrect holding that the Legal Aid advocates were “created and organized by federal law.” App. 315, 317 (Order of Aug. 18 at ¶¶ 35, 48); App. 343, 345–46. The Court did not change its ultimate legal conclusions or the relief ordered, and the hospitals moved again to stay the amended order and declare it final. App. 329.

On August 29, 2014, the court denied the state psychiatric hospitals' request to stay the amended order and declare it final. App. 359 (Order of Aug. 29, 2014). The court's denial rested largely on its merits order. *Id.* 361–62. The circuit court also opined that this Court would *never* have jurisdiction to review the circuit court's decisions even if its orders were designated final. *Id.* 363 (stating that because the creation of the advocates program stemmed from a 1990 unappealed order, the state psychiatric hospitals could not appeal the court's later decisions "reinforce[ing]" this order and ruling that the subsequent blanket disclosure of confidential patient records was legal).

The hospitals meanwhile sought a stay from this Court while preparing to comply with the lower court's ruling. It promptly reported the lower court's order to the State Privacy Office and began to research and draft procedures that would give the Legal Aid advocates access to records in a way that complied with HIPAA's security standards and requirements that hospitals be able to provide an accounting of all disclosures. App. 541, 544 (Respondent's Opposition to Petitioners' Motion to Enforce and For Sanctions at 2, 5 (citing 45 C.F.R. § 164.528)).

Dissatisfied with this response, the respondents moved one week after the amended order to hold the hospitals in contempt for failing to immediately restore unrestricted access. App. 540–543 (Respondent's Opposition to Petitioners' Motion to Enforce and For Sanctions at 1–4). The hospitals finalized their new procedures, as promised, two days after the contempt motion was filed and was prepared to grant the Legal Aid advocates full network access. *Id.* 550–552. The hospitals continued to object to the lower court's ruling, though they argued that contempt sanctions were unnecessary and moot in light of the new procedures. *Id.* 546. The Court nevertheless proceeded to hold a hearing, during which the Department promised to submit an order addressing any remaining plaintiff issues with compliance under the amended order while

reserving the right to appeal. App. 668–677 (Transcript of Sept. 17, 2014 at 115–24).

**V. This Court stayed the circuit court’s order so that state hospitals now provide external advocates access to psychiatric records only after patients consent.**

This Court then stayed the lower court’s disclosure order pending this appeal. App. 680 (No. 14-0867, Order of Sept. 17, 2014). Under this Court’s stay, advocates currently are permitted to access confidential psychiatric records only after obtaining written consent from the patient or the patient’s guardian.

**SUMMARY OF ARGUMENT**

The Fourteenth Amendment’s right to informational privacy and the Health Insurance Portability and Accountability Act (HIPAA) forbid state psychiatric hospitals from providing an outside entity carte blanche access to psychiatric records without first obtaining patient consent. No rule or law grants Legal Aid advocates the right to unfettered access to patient records. Instead, under the Constitution and HIPAA, patients have the right to refuse to share their private psychiatric records.

Nor does Legal Aid fall under any HIPAA exemption. Legal Aid performs independent, private advocacy duties *on behalf of, to, and for patients*—and not *on behalf of the hospitals*. The advocates’ job is to act on each patient’s behalf with their consent or audit the hospital as a whole through de-identified data and non-confidential records. 45 C.F.R. § 164.514(a). For that reason, Legal Aid does not fall under HIPAA’s exemptions for business associates acting on behalf of the hospitals, or under HIPAA’s exemptions for a public health authority, an entity providing health oversight activities, an entity involved in health care operations, and an entity conducting abuse and neglect investigations

This Court may also reach the merits of this appeal at the present time, just as it has reviewed past circuit court orders in this case. *First*, the dispositive ruling on appeal is a final

judgment and immediately appealable. A formal entry of judgment is unnecessary because the August 27 order's nature and effect makes it appealable, not a formalistic label that the circuit court later may or may not add. *Second*, at a minimum, this court has jurisdiction to review the lower court's refusal to certify this dispositive order as a partial final judgment. If reversed, full appellate jurisdiction would exist under Rule 54(b). *Third*, in the alternative, this Court may review the order under the collateral order doctrine. Finally, no prior order in this case precludes review and the Department has not waived its right to appeal.

### STATEMENT REGARDING ORAL ARGUMENT AND DECISION

The Department requests oral argument pursuant to Rule of Appellate Procedure 20 because this petition raises important questions of first impression under federal law about the indiscriminate governmental disclosure of personal psychiatric records.

### STANDARD OF REVIEW

This Court reviews questions of law de novo and factual findings for clear error. Syl. Pt. 2, *Walker v. W. Va. Ethics Comm'n*, 201 W. Va. 108, 110, 492 S.E.2d 167, 169 (1997).

### ARGUMENT

#### **I. The Fourteenth Amendment's right to informational privacy forbids the indiscriminate disclosure of state psychiatric records.**

A. Federal courts have long recognized that the Fourteenth Amendment protects individuals' right to "[p]rivacy of personal matters" as an interest in and of itself, including an "individual interest in avoiding disclosure of personal matters." *Whalen v. Roe*, 429 U.S. 589, 599 (1977); *Griswold v. Connecticut*, 381 U.S. 479, 483 (1965). Nearly every federal court of appeals has found an individual right to informational privacy against government disclosure,<sup>3</sup>

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<sup>3</sup> See *Borucki v. Ryan*, 827 F.2d 836, 839 (1st Cir. 1987); *Statharos v. New York City Taxi & Limousine Comm'n*, 198 F.3d 317, 322 (2d Cir. 1999); *Fraternal Order of Police, Lodge 5 v. City of Philadelphia*, 812 F.2d 105, 109 (3d Cir. 1987); *Walls v. City of Petersburg*, 895 F.2d

and the U.S. Supreme Court has twice assumed the existence of such a right, *see Nat'l Aeronautics & Space Admin. v. Nelson*, 562 U.S. 134, \_\_\_, 131 S. Ct. 746, 751 (2011) (“We assume . . . that the Constitution protects a privacy right of the sort mentioned in *Whalen* and *Nixon*”); *Nixon v. Adm'r of Gen. Servs.*, 433 U.S. 425, 457–460 (1977) (noting that “[o]ne element of privacy has been characterized as ‘the individual interest in avoiding disclosure of personal matters’ which may constitute ‘constitutionally protected privacy rights in matters of personal life.’”).

This right provides protection for “information about the state of one’s health.” *Doe v. City of New York*, 15 F.3d 264, 267 (2d Cir. 1994); *see also Tucson Woman's Clinic*, 379 F.3d at 551; *Norman-Bloodsaw v. Lawrence Berkeley Lab.*, 135 F.3d 1260, 1269 (9th Cir. 1998); *United States v. Westinghouse Elec. Corp.*, 638 F.2d 570, 577 (3d Cir. 1980); *Deniusp*, 209 F.3d at 956; *Alexander v. Peffer*, 993 F.2d 1348, 1351 (8th Cir. 1993); *Fraternal Order of Police, Lodge 5*, 812 F.2d at 113; *United States v. Westinghouse Elec. Corp.*, 638 F.2d 570, 577 (3d Cir. 1980).<sup>4</sup> As one federal appeals court has explained, the “right to confidentiality to personal medical information recognizes there are few matters that are quite so personal as the status of

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188, 192 (4th Cir. 1990); *Plante v. Gonzalez*, 575 F.2d 1119, 1132 (5th Cir. 1978); *Lambert v. Hartman*, 517 F.3d 433, 440 (6th Cir. 2008); *Denius v. Dunlap*, 209 F.3d 944, 955 (7th Cir. 2000); *Eagle v. Morgan*, 88 F.3d 620, 625 (8th Cir. 1996); *Tucson Woman's Clinic v. Eden*, 379 F.3d 531, 551 (9th Cir. 2004); *Mangels v. Pena*, 789 F.2d 836, 839 (10th Cir. 1986); *Hester v. City of Milledgeville*, 777 F.2d 1492, 1497 (11th Cir. 1985); *Alpha Med. Clinic v. Anderson*, 128 P.3d 364, 376 (Kan. 2006) (federal constitution); *cf. American Fed'n of Gov't Emps. v. HUD*, 118 F.3d 786, 793 (D.C. Cir. 1997) (“AFGE”) (assuming without deciding that the Fourteenth Amendment encompasses a right to informational privacy).

<sup>4</sup> In accord with this line of federal cases, this Court has long held under state law that “a substantial and potentially serious invasion of privacy” occurs through disclosure of “sensitive information related to prior injuries to various body parts” or through disclosure of “information related to psychiatric diagnoses and treatment.” *Robinson v. Merritt*, 180 W. Va. 26, 30–31, 375 S.E.2d 204, 208–09 (1988). In such cases, an “individual may well object to dissemination of that information without his knowledge and approval for reasons of professional and personal dignity.” *Id.* at 31, 375 S.E.2d at 209.

one's health, and few matters the dissemination of which one would prefer to maintain greater control over." *City of New York*, 15 F.3d at 267.

Whenever this right to privacy is implicated, courts apply a fact-sensitive analysis balancing the nature of the privacy intrusion, "the context in which [the governmental disclosures] arise," the "reasonable[ness]" of the governmental actions, including any safeguards against disclosure outside the government, and the strength of "the Government's interests." *Nat'l Aeronautics & Space Admin.*, 131 S. Ct. at 757, 759. Under this balancing test, the key factor allowing the government to collect private information in the first place often is the individual's right to consent before further disclosure is made to entities outside the government. *Nat'l Aeronautics & Space Admin.*, 131 S. Ct. at 761–62; *Nixon*, 433 U.S. at 458–60; *Whalen*, 429 U.S. at 600–01. Where there is a realistic probability of public disclosure of private matters, the Court has been far more concerned than if the information were merely held by the government. *Nixon*, 433 U.S. at 458–60. As the Supreme Court has held, safeguards against disclosure to third parties "evidence a proper concern for individual privacy" and "give forceful recognition to" the individual "interest in maintaining the confidentiality of sensitive information," without which it could be unconstitutional to collect the personal information in the first place. *Nat'l Aeronautics & Space Admin.*, 131 S. Ct. at 762 (quotation marks omitted).

The court below erred by failing even to address the applicability of these constitutional privacy protections for health information, let alone balance the advocates' interests in blanket disclosure against the patients' rights to individual privacy. At a minimum, serious constitutional questions exist when state hospitals provide an outside entity carte blanche access to patient records without prior patient consent.

B. Here, the individual interest in privacy is at its apex. The hospitals' psychiatric

patients, many of whom are committed to the government's care without their consent, receive treatment for some of the most severe psychiatric and medical conditions possible. The hospitals hold the patients' records in confidence so that patients are willing to cooperate and share their most intimate details. Abandoning the confidentiality that induced this trust would irreparably harm the patients and hospitals' relationship: "Effective psychotherapy ... depends upon an atmosphere of trust and confidence in which the patient is willing to make frank and complete disclosure of facts, emotions, memories, and fears." *Jaffee v. Redmond*, 518 U.S. 1, 10, (1996). "[T]he mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment." *Id.* That is why federal courts recognize a privilege against disclosure of confidential communications between a psychotherapist or licensed social worker and a patient. *Id.*; see also *Taylor v. United States*, 222 F.2d 398, 401 (D.C.Cir. 1955); *Hawaii Psychiatric Soc'y v. Ariyoshi*, 481 F.Supp. 1028, 1052 (D.Hawai'i 1979); *Lora v. Bd. of Educ.*, 74 F.R.D. 565, 571 (E.D.N.Y.1977).

Disclosing to an outside entity all patients' psychiatric and medical records without the patient's consent could not constitute a broader or more objectionable violation of individual privacy. "Public disclosure of highly personal and confidential information," like psychiatric and medical records, always "result[s] in a harm that is both substantial and irreversible." *Hirschfeld v. Stone*, 193 F.R.D. 175, 187 (S.D.N.Y. 2000). "Clearly, an individual's choice to inform others that she has" been committed to a state psychiatric hospital, or that she has a 'serious medical condition'" or psychiatric disorder, "is one that she should normally be allowed to make for herself." *City of New York*, 15 F.3d at 267. Often, when a psychiatric patient makes such a disclosure, she "exposes herself not to understanding or compassion but to discrimination and intolerance, further necessitating the extension of the right to confidentiality over such

information.” *Id.*

C. The government’s interest in disclosure is also at its lowest here. No legitimate interest exists in violating hospital patients’ constitutional privacy so indiscriminately. Instead, the government has an interest in protecting patients’ privacy, in respecting their right to consent, and if required to make a disclosure, in ensuring that any disclosures are the minimum necessary.

The government does have an interest in ensuring that patients have access to independent advocates, but that does not require granting Legal Aid advocates unrestricted and unconditional access to all patient files. After all, if the Legal Aid advocate’s role is to serve as a non-governmental advocate who acts on behalf of individual patients, each Legal Aid advocate can investigate grievances on behalf of patients who consent to share their records. And Legal Aid can audit hospital care as a whole by examining de-identified records. After all, the Legal Aid advocates exist to enhance patient autonomy and rights. One patient right is the right to agree or not agree to an advocate’s services, as the patient chooses. Some patients will wish to exercise their right to advocacy services provided by Legal Aid or other personal representatives; other patients may choose another right: “the right to be let alone.” *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).

**II. HIPAA precludes disclosing patient psychiatric information absent patient consent or a specific exemption, and even then, only permits the minimum disclosure necessary.**

**A. HIPAA protects confidential information from widespread state disclosure.**

HIPAA requires hospitals to obtain patient consent before disclosing any “individually identifiable health information,” unless an exemption applies, in which case HIPAA permits only the minimum disclosure necessary. 45 C.F.R. §§ 160.103, 164.502. Through HIPAA, Congress recognized “the importance of protecting the privacy of health information,” *S.C. Med. Ass’n v. Thompson*, 327 F.3d 346, 348 (4th Cir. 2003), and sought to “address concerns about the

confidentiality of patients' individually identifiable health information," *OPIS Mgmt. Res., LLC v. Sec'y, Fla. Agency for Health Care Admin.*, 713 F.3d 1291, 1294–95 (11th Cir. 2013). HIPAA thus ushered in a "strong federal policy in favor of protecting the privacy of patient medical records." *Law v. Zuckerman*, 307 F.Supp. 2d 705, 711 (D. Md. 2004).

Federal regulations known as the Privacy Rule spell out HIPAA's substantive mandates to protect individuals' rights to individually identifiable health information, establish procedures for exercising privacy rights, and regulate the use and disclosure of personal health information. HIPAA Privacy Rule, Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. Part 160 & Part 164, subpart A & E; *S.C. Med. Ass'n*, 327 F.3d at 349; see *Citizens for Health v. Leavitt*, 428 F.3d 167, 172–74 (3d Cir. 2005) (setting forth the Privacy Rule's history and requirements). "The Privacy Rule provides a national standard for who may access [personal health information] and establishes a federal floor of safeguards to protect the confidentiality of medical information." Heather Fesko, *Privacy and Security Compliance for Health Care Providers and Other Covered Entities*, Aspatore, 2008 WL 5689108, at \*1 (2008). It requires health care providers to follow several administrative requirements, including the development of physical and technical privacy safeguards and employee training." *Id.* at \*3–\*4; *Florida ex rel. Atty. Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1335 (11th Cir. 2011) (citing 45 C.F.R. §§ 164.308, 164.310, 164.312) (rev'd in part on other grounds in *Nat'l Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566, 2593–2600 (2012)); see 45 C.F.R. § 164.530.

Most important, the Privacy Rule establishes that "[a] covered entity or business associate may not use or disclose protected health information," that is, any individually identifiable health information created or transmitted by a covered entity, except in certain

circumstances or with valid authorization. 45 C.F.R. §§ 164.502(a), 164.508(a)(1). The Rule defines health information as all “information related to past, present, or future physical or mental health condition of an individual, the provision of health care to an individual, or . . . payment for . . . health care . . . .” 42 U.S.C. § 1320d; 45 C.F.R. § 160.103.

Pertinent here, HIPAA encompasses state psychiatric hospitals in its definition of a “covered entity” subject to HIPAA. *See* 45 C.F.R. § 160.103. A covered entity under HIPAA includes any “health care provider” transmitting health information. 45 C.F.R. § 160.103. And HIPAA defines a “health care provider” as any “person or organization who furnishes, bills, or is paid for health care in the normal course of business.” 45 C.F.R. § 160.103. Because the state psychiatric hospitals furnish health care and retain records, they are covered entities subject to HIPAA.

**B. The lower court erred when it held that the advocates fall under the business associate exemption to HIPAA.**

Under HIPAA, a covered entity may share certain necessary information with its “business associates,” who are then subject to HIPAA’s requirements to protect shared health information, but who then are not required to obtain patient consent before viewing records. *See* Health Information Technology for Economic & Clinical Health Act (HITECH), Pub.L. No. 111–5, §§ 13401, 13404, 123 Stat. 115, 260, 264 (2009) ) (codified at 42 U.S.C. §§ 17931, 17935); 45 C.F.R.164.502(e), 164.504(e), 164.532(d) & (e). A “business associate” is defined as a person who:

(i) *On behalf of* such covered entity... but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data

analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or

(ii) Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in § 164.501 of this subchapter), management, administrative, accreditation, or financial services *to or for* such covered entity . . . .

45 C.F.R. § 160.103 (emphasis added). Covered entities must enter into written contracts with their business associates and limit the business associates' conduct. *Id.* §§ 164.502(e)(2), 164.504(e); *cf.* 42 U.S.C. § 17931 (applying security provisions and penalties to business associates). Business associates are thus entities that provide services *on behalf of* the hospitals, like a hospitals' lawyer or accountant.

In fact, HHS has repeatedly stated that even if the external entity seeking access to records is funded by the covered entity, that alone is not enough to make the external entity a business associate, if the outside entity is not acting on behalf of or to or for the covered entity. For example, "an external researcher is not a business associate of a covered entity by virtue of its research activities, even if the covered entity has hired the researcher to perform the research." 78 Fed. Reg. 5566-01, 55775 (Jan. 25, 2013). "Similarly, an external or independent Institutional Review Board is not a business associate of a covered entity by virtue of its performing research review, approval, and continuing oversight functions." *Id.*

**1. The advocates are not business associates because they are arm's-length grant recipients assisting patients in adversarial proceedings: they do not provide services *on behalf of* the hospitals.**

Legal Aid advocates are not exempt from HIPAA as business associates. 45 C.F.R. § 160.103. They are not business associates of the hospitals because the advocates do not provide

services *on behalf of* the hospitals. They do *not* help administer the hospitals on the hospitals' behalf or manage the hospitals on the Department's behalf or provide attorneys to act on behalf of or for the hospitals in court. Legal Aid, by court order, instead receives grants from the Department to independently provide services to the patients and in that role serves an adversarial function against the hospitals. App. 269–70 (Transcript of August 1, 2014, hearing, pp. 174–75). Indeed, advocates' total independence is their reason for existence. Under the grant, Legal Aid will “provide external advocacy services to *West Virginians* who face challenges brought about by behavioral health disorders.” App. 7–8, 24. *In this capacity*, they must “[p]rovide advocacy, [i]nvestigate complaints, disseminate surveys to their clients, document their work, and conduct two “audits” summarizing their work for individual patients. *Id.*

The lower court wrongly held that Legal Aid “is a ‘business associate’ as set forth in its contract with Respondents and as defined by HIPAA because it ‘creates, receives, maintains, or transmits protected health information for a function or activity regulated by [HIPAA],’ namely for quality assurance, patient safety, and other health care operations as defined.” App. 343–44 (Aug. 27, 2014 Order at ¶¶ 4, 39 (citing 45 C.F.R. §§ 160.103, 164.501)).<sup>5</sup> This ignores the requirement that the business associates must act *on behalf of the hospitals*, or provide services to or for the hospitals, which Legal Aid does not do.

The lower court also relied incorrectly on Legal Aid's auditing role. Legal Aid's role is

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<sup>5</sup> The advocates also do not fall under the “patient safety organizations” prong of this exception, which defines “patient safety organization” as “a private or public entity or component thereof that is listed by the Secretary [of the Department of Health and Human Services] pursuant to section 299b-24(d).” 42 U.S.C. § 299b-21, *et seq.* No evidence shows that the advocates obtained federal certification, meet the standards for certification, or that their work product otherwise observes the heightened confidentiality protections that patient safety organization must follow. *Id.*

to serve as patient advocates documenting their work, not act as free-ranging auditors. To the extent their job is to “monitor and ensure overall compliance with civil rights at the hospitals and review systemic violations of rights,” App. 335–48 (Aug. 27, 2014 Order at ¶¶ 2–3, 5, 31–32, 36, 42, 47–49, 52, 59, 62), that role stems entirely from their advocacy for individual, consenting patients who wish to file a grievance against the hospital. That is what the grant agreement contemplates when it charges the advocates with auditing and reporting the overall observations in their work. Thus, when asked if the Department had contracted for advocates “to ensure Title 64 compliance sort of across the board in the hospitals, to investigate that?” the Commissioner of the Bureau of Health and Health Facilities Victoria Jones testified only “I agree that *when an individual seeks their assistance*, that yes, they have that obligation. See App 176 (Transcript of August 1, 2014, hearing, pp. 80 (emphasis added)). And, when asked the same question, as well as about audits, the Department’s Privacy Officer, Lindsey McIntosh agreed with the Commissioner and replied, “that’s not my understanding.” App. 227–28.

The lower court also did not identify any state law or court order in which it had required the Legal Aid advocates to pursue systemic violations, let alone pursue them in a context apart from advocacy for individual, consenting patients. See App. 348 (Aug. 27, 2014 Order at n. 67). The court monitor report does and cannot provide for this sweeping mandate. App. 739 (A Report of Legal Aid Advocacy at William R. Sharpe Hospital & Formal Recommendations of the court Monitor, (Mar. 1, 2011) (formally recommending performance improvements for deficient Legal Aid management and advocates, but not formally charging any advocates with any substantive responsibilities, such as pursuing systemic violations in the absence of individual client representation)).

The grant agreement contemplates that advocates *advocate* on behalf of specific patients

on particular issues, and in the course of doing so, to note the aggregate effect of such issues on hospital policies in an auditing function. When asked if an advocate “may have unfettered access,” the Department’s Privacy Officer, Lindsey McIntosh replied, “I do not believe that is sufficient. . . . Because they’re in, they’re in our hospitals to, to handle grievances. [Although] the patient can authorize the advocate to view what the advocate wants to view.” App. 223. Advocates can investigate systemic violations through individual patient’s authorization for particular cases as well as hospital-wide through *de-identified* and non-confidential material. 45 C.F.R. § 164.514(a). The lower court therefore was mistaken when it said that overall compliance, divorced from client-authorized representations, *was the advocates’ job*. App. 335–49 (Aug. 27, 2014 Order at ¶¶ 2–3, 5, 10, 20, 24, 31–32, 36, 42, 47–49, 52, 59, 62).

**2. The advocates’ grant agreement does not transform the advocates into business associates under HIPAA.**

The lower court also wrongly deferred the resolution of this statutory question to the grant agreement’s boilerplate terminology, since Exhibit L of the Grant Agreement states that Legal Aid is the Department’s business associate. But the agreement itself further states, “Business Associate shall have the meaning given to such term in 45 C.F.R. § 160.103” and the grant does not attempt to otherwise justify or explain how the work duties of the advocates fall under the business associate exception. App. 47 (Grant Agreement Exh. L). Nor is it clear how it could: Legal Aid’s *work* never will be providing services on behalf of the hospitals or to or for the hospitals. *Id.* The agreement also states that its purpose is only to provide disclosure to the extent allowable under HIPAA and the privacy rule and in accord with the Department’s policies, not to evade those provisions. So under the grant’s plain terms, whether or not the Legal Aid advocates are a business associate is ultimately defined by statute and current hospital policy, not by the grant’s labels.

Moreover, such an agreement cannot supplant HIPAA's exemption for only bona fide business associates who provide services on behalf of the hospitals. The hospitals have no power to make someone a business associate just by labeling them as such when the so-called associate's defined responsibilities do not otherwise comport with the exception HIPAA provides for bona fide business associates. If that were the case, covered entities would have an easy route out of the need to obtain client consent before sharing whatever information they want. A doctor could simply enter a contract with any person who wants the information and call that person a business associate—whether or not the person actually provides services on behalf of or to or for the covered entity and whether or not they serve the roles in which federal law deems it appropriate to share information before first obtaining client consent.

Deference to a parties' term is particularly inappropriate here, where it would be based on a boilerplate grant agreement. As one leading treatise has noted, entities covered under HIPAA will frequently use boilerplate designations even where they do not apply: because “[s]ometimes it may be difficult to accurately determine the entity’s status as a business associate and due to the government enforcement efforts parties may enter into a business associate agreement when the service is not, in fact, a business associate.” Paul J. Routh, *Welfare Benefits Guide: Health Plans and Other Employer Sponsored Benefits* § 3:17 (2014). But, as this treatise notes, boilerplate language like the grant agreement does not displace the need to see if the so-called business associate in the agreement is actually a business associate as HIPAA considers it. “[A] business associate, as defined by statute, is a service provider that performs certain functions for a covered entity. The fact that the parties entered into a business associate agreement does not, in itself, turn the entity into a business associate.” *Id.* Such an agreement only in itself ensures that under state law, the “associate” is “contractually obligated to comply with the terms of the

contract,” whether or not HIPAA applies. When a grant calls a *non-business* associate a business associate, as the grant agreement does for the advocates, therefore, “the nonbusiness associate would *not* be statutorily subject to the HIPAA requirements and penalties.” *Id.* (emphasis added).

That is the circumstance here. Historically, boilerplate business associate addendums were attached to all grant agreements, even where they do not apply, for fear of omitting to create an agreement where HIPAA requires one (similar prudence is also why the grant agreement also includes a laundry list of other federal laws do not apply to the advocates). *See supra* at 5–6. Indeed, the Department admitted that it has made this mistake in its grants for years to avoid flouting HIPAA’s stern mandate to have an agreement in place with any business associate. *See id.* It does the same thing for a laundry list of other federal laws.

**C. State law and privacy policies cannot preempt HIPAA or provide a HIPAA exemption**

The lower court held that, even if HIPAA prohibits the access the Legal Aid advocates desire, state laws preempt HIPAA. App. 343 (Order of Aug. 27, 2014 at ¶ 36) (“This Court is of the opinion that the advocates are entitled to access the Hospitals, patients, and patient records whether or not the laws of this State contradict HIPAA.”).

That has matters exactly backwards. As explained below, state law is entirely consistent with HIPAA. But if there is a conflict, as plaintiffs contend, it is state law that must give way. “In drafting HIPAA, Congress included an express preemption provision.” *OPIS Mgmt. Res.*, 713 F.3d at 1294 (citing 42 U.S.C. § 1320d–7). HIPAA’s preemption clause provides that the statute “shall supersede any contrary provision of State law,” unless state law is more stringent or if one of several other exceptions exists. 42 U.S.C. § 1320d-7; 45 C.F.R. §§ 160.202, 45 C.F.R. § 160.203 (listing exceptions to preemption). If no exception applies, “State laws are contrary to

HIPAA if: (1) it would be impossible for the health care provider to comply simultaneously with HIPAA and the state directive; or (2) the state provision stands as an obstacle to the accomplishment of the full objectives of HIPAA.” *Wade v. Vabnick-Wener*, 922 F. Supp. 2d 679, 686 (W.D. Tenn. 2010) (citing 45 C.F.R. § 160.202(1), (2)).

**1. Properly understood, state law and HIPAA are not contrary and both preclude indiscriminate disclosure of psychiatric records**

As a threshold matter, HIPAA and state laws are not inconsistent. None of the various alleged state laws proffered by the respondents or the lower court require unrestricted access to all patient files at the hospitals. Thus, none is contrary to the requirements of HIPAA described above.

a. State law only permits access to “pertinent records.” Section 64-59-20.2.9 of the Code of State Rules states, “[a]s part of the investigative process the advocate shall have access to all staff members, *pertinent records* and documents and shall interview witnesses and take statements as appropriate.” Consent forms provide the mechanism for determining what is “pertinent” under this rule. The Legal Aid advocates’ role in the hospitals is to investigate grievances, which means that any information not furthering a specific grievance is not “pertinent” and, therefore, not to be disclosed under state law as well as federal law. Unfettered access to patient records does not limit the advocates to pertinent records, but instead gives them access to whatever records the advocate wants to view, regardless of whether it is to investigate a grievance or not. Neither do these regulations empower the advocates to act other than on a patient’s behalf, such that they have a statutory role directly requiring *per se* access to all patient records. In accordance with state and federal law, the hospitals therefore grant advocates access to *pertinent* patient records, so long as they submit a validly executed release from the patient or guardian and it is related to a grievance, or so long as the information is not personally

identifiable.

Section 64-59-11.5.1.d of the state regulations is not to the contrary. That rule states, in part, “No written consent is necessary for employees of the department, comprehensive behavioral health centers serving the client, or advocates under contract with the department.” However, Legal Aid is not under contract with the Department; they are in the hospitals under a Grant Agreement. App. 7. Grant agreements are distinctly different from state contracts, as a grant agreement deals solely with how money is to be exchanged and does not deal with the legal obligations of the parties. The advocates are not hospitals’ contractors and, therefore, are not exempt from the requirement to submit a written consent to view medical records. W. Va. Code St. R. §§ 64-59-11.5.1.d, 64-59-11.3.

Finally, W.Va. Code St. R. § 64-59-20 is also not inconsistent with the limited access required by HIPAA. The lower court concluded that the state rule effectively prohibits a consent form, because the unwillingness of some patients to sign a consent form hinders the Legal Aid advocates from performing their duties under the rule. App. 348 (Aug. 27 Order at ¶ 62). But nothing in that state rule trumps a patient’s right to refuse consent. It is a patient’s right to tell an advocate that they cannot have access to their private medical records. The hospitals, as well as the advocates themselves, are under the obligation to protect patients’ rights. W. Va. Code R. 64-59-20.2.15.

**b.** In addition to state rules, the plaintiffs have argued that the Department is violating state law by flouting its own policies. App. 4–5. It is not. The plaintiffs first assert that the Department’s “Authorization or Consent to Use or Disclose Protected Health Information Policy” gives them the right to patient health information without patient consent because it states, protected health information “also may be disclosed without an authorization

when required by law, or when permitted to assist law enforcement or other public purposes.”

*Id.* But advocates’ access to patient records is not required by law. The state law does not provide an exception for advocates from the HIPAA law. Petitioners are also not serving a public purpose by filing grievances on behalf of private citizens.

The plaintiffs also argue that the Department is not following its “General Policy – Use and Disclosure of Protected Health Information” policy in denying the Legal Aid advocates access. The Department, in its “General Policy – Use and Disclosure of Protected Health Information” policy states, “Workers *may* use and disclose protected health information, without the written consent or authorization of the person to who the information pertains, as follows... workers *may* disclose [protected health information]... to business associates, under the terms of a business associate contract... for any purpose for which [the Department] itself may use the information.” App. 60 (emphasis added). This policy says the Department “*may* disclose” protected health information to business associates: nothing *requires* the Department to do so.

The problem with this argument is that plaintiffs do not work for the Department or on its behalf. A disclosure to an advocate is made pursuant to a grievance, which is in the purview of advocates to investigate, not the hospitals. As such, Legal Aid is not in a business associate relationship or receiving information for a “purpose for which [the Department] itself may use the information” as the Department does not investigate grievances.

c. Lastly, the lower court treated its own orders as state laws that require full access to psychiatric records. Even assuming that the court’s orders carry such force, there is no order that issues such a far-reaching requirement. *See* App. 348 (Aug. 27, 2014 Order at n. 67). The court’s own terse 1990 order to establish an “*external* advocate system” and “contract with an entity *outside* State government” to provide patient advocates cannot be read to encompass

anything so broad. App. 357 (Order of Feb. 20, 1990). And, contrary to the lower court's assumption, no court monitor report does or can provide for this sweeping mandate. App. 739 (A Report of Legal Aid Advocacy at William R. Sharpe Hospital & Formal Recommendations of the Court Monitor, (Mar. 1, 2011)).

**2. State law, under the lower court's interpretation, would be contrary to or frustrate HIPAA and thus would be preempted**

Nevertheless, to the extent that state law permits disclosure to Legal Aid advocates without written consent, HIPAA preempts those state rules. HIPAA presumptively "supersede[s] any contrary provision of State law," 42 U.S.C. 1320d-7, unless the state law is more stringent than HIPAA, which it is not here under the lower court's interpretation. 45 C.F.R. § 160.202; 45 C.F.R. § 160.203 (listing exceptions to preemption). HIPAA requires patient consent; state law would not. HIPAA and the state law also would also be directly contrary to each other: it would be impossible for the hospitals to both require consent before disclosure and not require consent before disclosure. The state law would then "stand[] as an obstacle the accomplishment of the full objectives of HIPAA," thwarting the strong federal policy in favor of patient consent before disclosures are made. *Wade*, 922 F. Supp. 2d at 686 (citing 45 C.F.R. § 160.202(1), (2)).

The only way that state law would not be preempted is if HIPAA provides an exemption to its own preemption provision. The lower court erroneously relied on several such exemptions.

**a. The advocates are not a public health authority exempt from HIPAA because state law does not vest Legal Aid advocates with any public health power.**

One HIPAA exception to preemption is when the "State law, including State procedures established under such law, as applicable, provides for the reporting of disease or injury, child abuse, birth, or death, or for the conduct of *public* health surveillance, investigation, or

intervention.” 45 C.F.R. § 160.203(c) (emphasis added). “The . . . purpose of the public health exception is to facilitate government activities that protect large numbers of people from epidemics, environmental hazards, and the like, or that advance public health by accumulating valuable statistical information.” *Miguel M. v. Barron*, 950 N.E.2d 107, 111 (N.Y. 2011). After all, “requiring consent prior to release of health information to a public health official who is attempting to track the source of an outbreak or epidemic could endanger thousands of lives.” 65 Fed. Reg. 82462-01, 82566 (Dec. 28, 2000).

This public health exception does not apply to actions involving only individual mental health patients. “To disclose private information about particular people, for the purpose of preventing [harm to] themselves or others, effects a very substantial invasion of privacy without the sort of generalized public benefit that would come from, for example, tracing the course of an infectious disease.” *Miguel M.*, 950 N.E.2d at 111. New York’s highest court has thus held that “disclosure of a mentally ill person’s hospital records” in proceedings about that person’s welfare only presents a “counterintuitive” “sense” of the word “public health”—a sense that “was not within the scope of the public health exception.” *Id.* at 110–11 (holding that a mental health patient’s records could not be disclosed to or by a person bringing an action for treatment for the patient).

Moreover, this exemption contemplates uniquely governmental functions. HIPAA defines a public health authority as “an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency . . . or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.”

45 C.F.R. § 164.501. “Examples of a public health authority include State and local health departments, the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, and the Occupational Safety and Health Administration (OSHA).” HHS, Public Health, <http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/publichealth/>. In fact, HHS considered, but rejected, “amending the regulation to permit covered entities to disclose protected health information to private organizations for public health reasons.” 65 Fed. Reg. at 82624. “Broadening the exemption could provide a loophole for private data collections for inappropriate purposes or uses under a ‘public health’ mask.” *Id.* at 82568–69.

Here, Legal Aid is *not* a public health authority because its advocates are *not* charged by state law with conducting *public* health surveillance, investigation, or intervention, nor have they received an “official mandate” in law to do so. The lower court held that Legal Aid is a public health authority because “the advocates are created and organized by state law and authorized by Court order to monitor and investigate the Hospitals in order to ensure quality care and prevent injury to the patients.” App. 294 (Aug. 18 Order at ¶¶ 34–35). But this holding over-generalizes the advocates’ role. Legal Aid is a private, non-governmental entity, not legislatively-chartered public agency, and the advocates are charged under state law as advocates only to act for *individual* patients who consent to representation in individual proceedings about that patient’s welfare. *See supra* at 2–7, 27–30.

The advocates’ auditing function does not make them into public health authorities under state law. To begin, state *law* does not provide for any audits. They are only mentioned in the grant agreement, which is not law. In addition, the audits are not a “public” health purpose, because they focus on individual compliance through non-compliance in individual psychiatric cases and hospitals. As discussed above, the grant agreement charges Legal Aid with providing

services to individual “West Virginians” and conducting audits in that *individual* role. *Supra* at 2–7, 27–30. Consistent with the agreement, the lower courts’ prior orders in this case directed the hospitals to create an advocates program to act on behalf of *individual* patients; the court never charged the advocates with *public* health activities or required them to investigate, survey, and intervene on behalf of the whole population of patients *at large* in the state, wholly apart from individual grievances and patient consent. *See infra* \_\_\_.

Indeed, if Legal Aid could act as a governmental authority, free from any obligations to act for individual patients or obtain client consent, there would be serious separation of powers concerns. Under the state constitution, “[t]he executive department shall consist of a governor, secretary of state, auditor, treasurer, commissioner of agriculture and attorney general.” W. Va. Const. art. VII, § 1. And Article V, Section 1 prohibits any other department of state government from exercising executive powers. W. Va. Const. art. V, § 1. Neither the Legislature nor the courts nor the Department can delegate the Executive Branch’s powers to a private entity lacking any public control or electoral oversight. *See Ass’n of Am. R.R. v. U.S. Dep’t of Transp.*, 721 F.3d 666, 670 (D.C. Cir. 2013) cert. granted 134 S. Ct. 2865 (2014).

**b. The advocates do not perform HIPAA-exempt health oversight activities because no state law vests Legal Aid with public oversight authority.**

HIPAA similarly provides that “covered entities are permitted to disclose protected health information to oversight agencies that act to provide oversight of federal programs and the health care system.” 65 Fed. Reg. at 82476. Specifically, “[a] covered entity may disclose protected health information to a health oversight agency for oversight activities *authorized by law*, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of: (i) The health care system . . . or (iv) Entities subject to

civil rights laws for which health information is necessary for determining compliance.” 45 C.F.R. § 164.512(d). These oversight agencies are not performing services for or on behalf of the covered entities and so are not business associates of the covered entities. 65 Fed. Reg. at 82476.

“The definition of health oversight agency does not include private organizations” with no powers imbued through law. 65 Fed. Reg. at 82492. HIPAA instead defines a health oversight agency as a public-empowered entity, that is, “an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory,” “or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee” healthcare or civil rights enforcement. 45 C.F.R. § 164.501. For example, “health oversight agencies that conduct oversight activities relating to the health care system” include “state insurance commissions, state health professional licensure agencies, Offices of Inspectors General of federal agencies, the Department of Justice, state Medicaid fraud control units, Defense Criminal Investigative Services, the Pension and Welfare Benefit Administration, the HHS Office for Civil Rights, and the FDA.” 65 Fed. Reg. at 82492, 82592. And the only examples HHS provided of an entity that conducts civil rights enforcement are the U.S. Department of Justice, the HHS Office for Civil Rights, and the U.S. Equal Employment Opportunity Commission. *Id.*

The lower court erred in holding that Legal Aid “is acting under” this kind of “contract and grant of authority from [the Department]” because Legal Aid “is authorized by Title 64 to investigate and ensure compliance with the patient civil rights.” App. 345–46 (Aug. 27 Order at ¶¶ 48–49). For much the same reasons as why Legal Aid is not a public health authority,

however, Legal Aid is also not a health oversight agency. Legal Aid is not created and organized by state law: it is a private entity. No state *law* vested Legal Aid with a *public* health oversight role, only an *individual* advocate role. Neither did any state law or prior court order empower Legal Aid to audit hospitals. And, even with a limited auditing power provided under a grant agreement, they have no civil rights “enforcement power” on par with the U.S. Department of Justice or the U.S. Equal Employment Opportunity Commission.

If anything, Legal Aid’s role is analogous to attorneys representing persons with a private cause of action under civil rights laws. But HHS did not say all such private attorneys or plaintiffs are enforcement agencies tantamount to health oversight agencies. In fact, “[i]n developing and clarifying the definition of health oversight,” HHS sought “to achieve a balance in accounting for the full range of activities that public agencies may undertake to perform their health oversight functions while establishing clear and appropriate boundaries on the definition so that it does not become a catch-all category that public and private agencies could use to justify any request for information.” 65 Fed. Reg. at 82611.

**c. The advocates do not perform HIPAA-exempt health care operations because Legal Aid does not perform the hospitals’ own health care operations.**

Next, the lower court relied on the exemption under which a “covered entity may use or disclose protected health information for *its own* treatment, payment, or health care operations.” 45 C.F.R. § 164.506(c)(1) (emphasis added). “[H]ealth care operations are the listed activities *undertaken by the covered entity* that maintains the protected health information.” 65 Fed. Reg. at 82490 (emphasis added). They include “[c]onducting quality assessment and improvement activities,” “patient safety activities (as defined in 42 CFR 3.20 [for certified organizations and providers]),” and “relation functions that do not include treatment.” 45 C.F.R. § 164.501. In turn, “[p]atient safety activities means [certain listed] activities carried out by or on behalf of a

[certified patient safety organization] or a [health care] provider.” 42 C.F.R. § 3.20. Covered operations also include “[c]onducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs,” as well as “[b]usiness management and general administrative activities of the entity, including, . . . [r]esolution of internal grievances.” 45 C.F.R. § 164.501.

Using or disclosing information for a covered entity’s “resolution of internal grievances” can include “disclosure to an employee and/or employee representative,” but it does not include disclosure to outside patient advocates. In some cases, “the employee needs protected health information to demonstrate that the *employer’s* allegations of improper conduct are untrue.” *Id.* (emphasis added). Disclosure of patient records thus may need to occur in employment cases, if hospitals have no other way to *resolve* a hospital’s allegations underlying an employee grievance. But this exception does not apply in the same way to “disputes” a *patient* brings against a hospital about “the quality of care and similar matters.” 65 Fed. Reg. at 82491. Instead, when a *patient* brings a grievance, the hospital’s role is to *resolve* the grievance; the hospital does not *bring* the grievance for the patient as part of its *own* operations.

In applying this exception, the lower court again mistook the role of Legal Aid as an independent entity. Specifically, it held that “[t]he advocacy and auditing services provided in accordance with legislative rule and the law of this case are part of the covered health care operations of” the hospitals. App. 346 (Aug. 27 Order at ¶¶ 50–52). Recognizing that “these activities are contracted out to [Legal Aid], rather than conducted by Respondents’ employees,” the court described Legal Aid’s activities as “in furtherance of the Hospitals’ health care operations.” *Id.*

But this ignores Legal Aid’s independent operations on behalf of patients, not hospitals.

Services “in furtherance of” a covered entity’s health care operations do not fall under HIPAA’s healthcare operations exemption. The exemption instead allows disclosure or use by a covered entity only “for *its own* treatment, payment, or health care operations.” 45 C.F.R. § 164.506(c)(1) (emphasis added). Thus, for example, a hospital can access records under the exemption to resolve grievances, but it cannot do so to bring grievances. Bringing grievances—as Legal Aid does—is not a covered entity’s operation, but rather an activity external to the hospital and outside the scope of the exemption. It is also an activity on behalf of patients, who, as HHS contemplates, can consent to any disclosures necessary. A hospital may likewise access records for its own *internal* audits, but *external* audits like Legal Aid’s would not constitute the hospital’s *own* operations.

**d. HIPAA’s exception for abuse and neglect investigations does not apply because state law does not mandate disclosure, Legal Aid is not a governmental authority, and the exception does not extend to all patients at all hospitals.**

HIPAA also provides for disclosure in certain situations when it is “required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.” 45 C.F.R. § 164.512(a). In particular, “a covered entity may disclose protected health information about an individual *whom the covered entity* reasonably believes to be a victim of abuse, neglect, or domestic violence to *a government authority*, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.” *Id.* § 164.512(c) (emphasis added). This exception thus has two initial components: *first*, the hospitals must reasonably believe a patients is an abuse or neglect victim; and *second*, the disclosure must be to a *government authority*, such as a social service or protective services agency.

Disclosure under this exception still depends upon the nature of the state law. If the state law *mandates* disclosure to a government authority in these circumstances, HIPAA imposes no

further obstacles. *Id.* But if state law merely *authorizes* disclosure, HIPAA still forbids disclosure unless “[h]e covered entity, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the individual or other potential victims” or, for a patient incapable of providing consent, “a law enforcement or other public official authorized to receive the report” certifies the disclosure is necessary. *Id.*

The lower court held that under this provision, disclosure of patients’ confidential records is “required by law” because under HIPAA such records “may be disclosed for an abuse and neglect investigation if the individual is unable to agree because of incapacity and waiting for authorization would materially and adversely impact the investigation.” App. 347 (Aug. 27 Order at ¶ 54). The court believed that “[t]his provision applies to the abuse and neglect investigations undertaken by [Legal Aid] when a patient has been declared legally incompetent and the signature of a legal guardian would otherwise be required.” *Id.*

But giving Legal Aid unfettered access to all patient records meets none of this exemption’s criteria. *First*, this exception only applies if state law mandates access to confidential information without a patient or patient’s guardian consent—and, as earlier \ section II.C.1 shows, no state law, policy, or court order directs the hospitals to provide such access to Legal Aid. *Second*, this exemption only applies to disclosure to a *to a government authority*, such as a social service or protective services agency—not a private independent entity like Legal Aid. *Third*, this exemption only applies to cases where the hospitals reasonably believe abuse or neglect occurred—which Legal Aid did not even attempt to prove (nor could they prove) is the case for all patients and all records in perpetuity. *Fourth*, even if state law permitted this disclosure, which it does not, this exception is further contingent on a hospital’s or law enforcement’s certification of need.

**e. HIPAA’s exemption for court orders enforcing disclosures mandated under state law does not apply because no state law mandates wholesale disclosure.**

Finally, HIPAA provides an exception for certain disclosures made in court proceedings under court order. This exception applies when disclosure is “required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.” 45 C.F.R. § 164.512(a). “[R]equired by law’ means a mandate contained in law that compels a covered entity to make a use or disclosure of protected health information and that is *enforceable in a court of law.*” 65 Fed. Reg at 82497 (emphasis added). And, under paragraph (e) of this section, disclosure may also only be made by a covered entity “in the course of any judicial or administrative proceeding” and “[i]n response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order.” *Id.* § 164.512(e)(1).

The lower court held that under this part of HIPAA, “disclosure may be made in response to an express authorization by court order” and that disclosure is “required by West Virginia law and by the law of this case to enable the advocates to assist Respondents in ensuring that patients’ rights are not being violated.” App. 347 (Aug. 27 Order at ¶¶ 55–56 (citing 45 C.F.R. § 164.512(e)(1)(i) & W. Va. Code St. R. §§ 64-59-11.5.1.d; 64-59-20)). This holding is mistaken for several reasons. *First*, as shown above, no state law mandates disclosure of all patient records. Instead, state law permits release of “pertinent” records after an individual patient consents to a Legal Aid advocate working on his or her behalf. *Second*, this exception only applies to disclosures made “in the course of any judicial or administrative proceeding,” *not* to disclosures made to advocates on a daily basis outside the context of an ongoing proceeding. *Third*, the lower court’s holding presumes that judges can “expressly authorize disclosure” at any time, giving a court per se power to declare HIPAA inapplicable. But the rule is not sweeping.

It requires a court to identify a separate “mandate contained in law” “that *is enforceable in a court of law.*” 65 Fed. Reg at 82497 (emphasis added). This limited exception, for disclosures in judicial and administrative proceedings, “do[es] not supersede other provisions of [HIPAA] that otherwise permit or restrict uses or disclosures of protected health information.” 45 C.F.R. § 164.512(c)(2). That is because it does “*not* permit disclosures merely authorized by other laws,” or for that matter, disclosures merely authorized by court orders, “that do not fit within the other public policy purposes recognized by [HIPAA].” 65 Fed. Reg.at 82671 (emphasis added).

**D. In any event, indiscriminate disclosure of state psychiatric records violates HIPAA’s “minimum necessary” standard.**

Furthermore, even if HIPAA allowed the hospitals to share information with advocates without patient consent, the advocates still would be able only to access the minimum information necessary for their work. C.F.R. § 164.50245 C.F.R. § 164.502(b, 164.514(d). Under HIPAA, when an exemption applies, the covered entity may disclose the health information to the exempted entity without prior patient consent—but still “a covered entity . . . must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.” C.F.R. § 164.502(b)(1)45 C.F.R. § 164.502(b)(1). The grant agreement incorporates this restriction on any disclosure to the advocates. App. 47 (Grant Agreement at Exh. L).

Completely unfettered access by Legal Aid to all patient medical records does not comply with the minimum necessary standard. The advocates do not need to access all patient records to bring a grievance requested by an individual patient. Nor is full records access necessary to identify individuals who may have grievances, given that patients can contact the advocates directly and the advocates themselves can reach out to patients themselves directly to inquire about whether patients may have any grievances.

The only way the hospitals can comply with HIPAA's minimum necessary standard is to provide Legal Aid advocates with only the records they need for an individual grievance based on an appropriately filled out consent that indicates what patient information is needed and that disclosure is necessary because the individual patient has requested an investigation into these matters. Without such a form, the hospitals are not making "reasonable efforts" to ensure that they or the advocates are complying with the minimum necessary standard and that no more is disclosed than is necessary to investigate an individual's grievance.

The lower court's order suggests that the Legal Aid advocates audit every client file in the abstract without acting on behalf of individual patients. App. 344 (Order of Aug. 27, 2014 at ¶ 42). But in reality the advocates' job is to ensure compliance through a practical, case-by-case investigation as requested by individuals seeking representation on their behalf into issues that affect the individual patient but that can also be common to many patients in certain system-wide situations. Their audits are merely a summary of this individual patient work. The lower court also ignores that patients have the right to affirmatively decline to provide access, in which case the advocates cannot access their information under any HIPAA exemption, and that de-identified records can be used for any audits. The Legal Aid advocates' actual role does not require access to all records and thus all records are not the minimum necessary for their job, even if a HIPAA exemption applied to the advocates and allowed for the minimum necessary disclosure.

**III. Two of the lower court's factual findings are clearly erroneous statements of the hospitals' consent requirements.**

The lower court's order also found several facts about the hospitals that were clearly erroneous. It found *first*, that the hospitals had forbidden *any* access to patients in person or to their records, and *second*, that the hospitals would only allow guardians and surrogates, not

patients to consent to disclosure. App. 335–37, 348 (Aug. 27, 2014 Order at ¶¶ 2–3, 9, 61).

Neither of these facts are true, let alone supported by the evidentiary hearing. As a result, to the extent they are factual findings they should be reversed, and to the extent they entail legal conclusions, they should receive no deference. Syl. Pt. 1, in part, *State ex rel. Cooper v. Caperton*, 196 W.Va. 208, 210, 470 S.E.2d 162, 164 (1996) (“Generally, findings of fact are reviewed for clear error and conclusions of law are reviewed *de novo*. However, ostensible findings of fact, which entail the application of law or constitute legal judgments which transcend ordinary factual determinations, must be reviewed *de novo*.”).

*First*, the record shows that under the hospitals’ new, HIPAA-compliant policy, the hospitals allowed advocates to talk to patients and staff generally *and* the hospitals disclosed all records and confidential information upon patient consent. App. 179 (Transcript of August 1, 2014, hearing, pp. 83 (“the patient has to make a request, and then the patient or their legal guardian has to sign a form with very specific limitations to it.”) (plaintiffs’ counsel)); *id.* (“[W]e’re not restricting access to the patients at all. What—we have restricted access to the records without a medical authorization. And in terms of physical access, what we are doing is restricting physical access to areas where the records can be physically”) (hospitals’ counsel); *id.* 180–82 (“The directive that I gave was to ensure that advocates had complete access to the patients” and “not prevent them from having access to the patients, just from having access to medical records, files, documents that they may not have had a release for,” for which areas the advocates just “need someone with them.”) (Hospitals’ Commissioner); *id.* 183, 194–95, 197–98 (“They may have access to the patients, but they do not have access without authorization to review charts, medical records, anything that would fall within the HIPAA regulatory requirements.”); *id.* 184 (describing conference rooms where patient-advocate meetings may

occur without hospital escorts); *id.* 189 (denying that patients can only meet with advocates “upon specific request by the patient”); *id.* 190 (testifying that advocates may walk from room to room unaccompanied, so long as they do not examine confidential records over which they do not have the individual patients’ consent); *id.* at 198–99 (“So if an individual says “I want an advocate to be able to review my entire medical records,” they can still have that access? “As long as it abides by all the rules and regulations. . . . we are not trying to stand in the way of an advocate performing their duties or an advocate having access to our patients. . . . [i]f a patient says ‘I want my advocate to have unfettered access,’ we will abide by that.”); *id.* 214–16 (“Why are you denying them free access to talk to the patients?” “We’re not. And this might be something that may be a little bit of a misunderstanding.”) (DHHR Privacy Officer Lindsey McIntosh); *id.* at 222–23 (“[I]t is up to the patient to decide if there’s access permitted. That’s why we’re requiring the” consent forms.); *see also* App. 282 (DHHR Proposed Order at ¶ 8 (“DHHR/BHMF has specifically agreed and stipulated that advocates shall continue to have access to patients on a twenty-four hour per day seven day per week basis, and that the advocates will be given unrestricted access to all areas of the facilities which do not include confidential medical records and information.”)).

The only advocate to testify *agreed* that this was the factual situation on the ground. App. 255–56 (Transcript of August 1, 2014, hearing, pp. 160–61 (“[W]hat this does by a lack of medical records, it ties up staff because they’re having to get the medical records. We have to have witnesses on all of these releases that we sign, so it ties up staff *to get the releases.*”) (emphasis added) (Advocate Sharon Reed)); *id.* 256 (noting that when advocates and patients wished to speak, they were able “to call them out to meet with us or call them out to go up to the office to meet with us. . . . The CEO told us that staff weren’t allowed to talk to us unless we had

the releases signed. He actually told us that patients weren't allowed to talk to us unless we had releases signed. But the Nurse Manager says, '*You can talk to patients. Of course you can.*'") (emphasis added); *id.* 257, 259 (confirming she was told how the releases work to get access to files); *id.* at 268–69 (confirming that the patient should have the right to consent to access). The advocate's testimony as a whole also showed that she was able to talk to staff, but needed consent to inquire into about confidential matters, and that staff would only disclose the minimum confidential information necessary. *Id.* 256, 263–64 (“[T]hey didn't know if they could let us know. More than that, staff are afraid to divulge any more information than they need to.”). No other testimony on this issue was submitted.

It is therefore clear beyond any doubt that without authorization the advocates can approach and talk to whoever they want among patients and staff—and then with signed consent they can *also* access confidential information in conversation or in records. The lower court thus was wrong to find that the hospitals never permit “access to records,” never allow the advocates “to talk or meet with patients [unless] the patient specifically requests a meeting with an advocate,” that the hospitals “will not permit the advocates to speak with patients without first obtaining a signed release from the patient regarding the specific grievance,” and that the hospitals “no longer permit Hospital staff to talk to the advocates without signed releases specific to each conversation or interaction.” App. 338–41 (Aug. 27, 2014 Order at ¶¶ 11–12, 13, 18, 20, 22, 24).

*Second*, the hospitals allowed patients, as well as guardians and surrogates, to consent to disclosure. App. 179 (Transcript of August 1, 2014, hearing, pp. 83 (“the patient has to make a request, and then the patient or their legal guardian has to sign a form with very specific limitations to it.”) (plaintiffs’ counsel)); App. 199 (Transcript of August 1, 2014, hearing, pp.

103 (“The patient’s authorization is sufficient?” “Yes.” “No one else? They don’t have to have a guardian or—” “Well, if a, if a patient has a guardian, then that, that guardian would be the one. I mean, that’s the one who is making decisions for that patient And so that guardian, is my assumption, would be the one that would give access or, or not.”)). No other evidence on this issue is in the record. The lower court was therefore wrong to state that the hospitals would not be satisfied with patient consent and would also “require the signature of the health care surrogate and medical power of attorney on each authorization.” App. 337–38, 348 (Aug. 27, 2014 Order at ¶¶ 9, 61).

**IV. This court may hear this appeal just as it has resolved this case’s past appeals.**

**A. The order on appeal is a final judgment.**

**1. The lower court’s dispositive ruling “approximates a final order in its nature and effect.”**

An order is final and appealable when it “resolves the litigation as to a claim or a party.” *Durm v. Heck’s, Inc.*, 184 W. Va. 562, 566, 401 S.E.2d 908, 912 (1991). Where an order “completely disposes of any issues of liability,” the order is appealable so long as “this Court can determine from the order that the trial court’s ruling approximates a final order in its nature and effect.” *Id.* at Syl. Pt. 2; Syl. pt. 2, Syl. Pt. 2, *Sipp v. Yeager*, 194 W. Va. 66, 67, 459 S.E.2d 343, 344 (1995) (same). That is the case here for the lower court’s August 27, 2014 ruling.

The August 27, 2014 dispositive order “approximates a final order in its nature and effect.” Because the lower court asserts continuing jurisdiction, this case’s pleadings and progress differ from the usual civil case, in which a complaint raises claims, a final judgment disposes of all claims, an appeal may proceed from a final judgment, and then the case is over. Instead, in this case, whenever the plaintiffs desire court action on a new issue, instead of filing a new complaint satisfying full pleading requirements, they file a “request for resolution” or

motion for relief identifying new legal claims under the same docket number, the court next issues an order resolving any disputed issues in the request for resolution, and then the court provides for appropriate action by the parties while retaining continuing jurisdiction. Order Appointing Court Monitor, *E.H. v. Matin*, 81-MISC-585 (July 30, 2009).

The dispositive order is then directly appealable. *E.g.*, Memorandum Decision, No. 35505, slip op. at \*1 (W. Va. Apr. 1, 2011) (hearing the Department’s direct appeal of an “August 7, 2009 order of the Circuit Court of Kanawha County that enforced two previous consent orders of which DHHR was a party”). The August 27, 2014 order fits this established process. It resolves the plaintiffs’ claims and it orders the hospitals to implement a remedy: blanket disclosure of all records.<sup>6</sup>

The August 27, 2014 order is therefore an appealable final judgment or partial final judgment on the claims it resolves. The lower court does not intend to revisit this order or any other order on this subject: nor can it, given this Court’s subsequent stay. Nor did the August 27 order include any language indicating that the court would take future evidence on whether federal law required full access, and it would not have made sense to provide for future hearings here, because the court already resolved liability and held federal law inapplicable, which in turn prompted the court to order the specific remedy of disclosure. And so, when the lower court enters a final order like this one, disposing of both liability and setting a remedy, both the plaintiffs and the hospitals should be able to appeal, just as they would be able to appeal any

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<sup>6</sup> Plaintiffs would be wrong to suggest, as they have in the past, that instead of appealing the hospitals should seek a writ of prohibition. A writ is only appropriate when no appellate review is available, and, as prior appeals in this case show, appellate jurisdiction exists here. *Cf. State ex rel. McGraw v. King*, 229 W.Va. 365, 371, 729 S.E.2d 200, 206 (2012) (“This Court looks with disfavor upon the use of the extraordinary writ process to address problems which should have been handled by an appeal.”). Should this Court depart from precedent and hold that no appellate jurisdiction in fact exists, a writ would become ripe.

other final determination of liability or remedy.

Being able to appeal dispositive orders like this one makes particular sense here because, in a case like this, no other final judgment may be entered. The lower court has not yet entered any omnibus final judgment encompassing similar dispositive orders from the past several years, and in light of its continuing jurisdiction, the lower court appears unlikely to ever enter such an omnibus express entry of final judgment as to all issues and past requests for resolution. That is because even when all existing requests have been resolved, this case will remain open for further requests for resolution. And so, as a practical matter, each order deciding each request for resolution operates as a final judgment as to the claims raised in the request.

In contrast, interlocutory orders in this case are not appealable as a final judgment and are appealable only under an exception to the final-judgment rule. Examples of such interlocutory orders include, for example: an order finding a legal claim to be stated and ordering the parties to present evidence and arguments at a hearing or an order excluding or admitting evidence at a hearing under the rules of evidence. *Vaughan v. Greater Huntington Park & Recreation Dist.*, 223 W. Va. 583, 588, 678 S.E.2d 316, 321 (2009) (holding that an order resolving a motion in limine concerning the admissibility of testimony is “not a final judgment because it obviously is not dispositive of the entire suit, it does not conclude proceedings on a claim raised in the suit, nor does it release a party from all or part of the suit”); *Gooch v. W. Va. Dep’t of Pub. Safety*, 195 W. Va. 357, 363, 465 S.E.2d 628, 634 (1995) (holding that a court’s decision to proceed to trial and issue a “denial of summary judgment is interlocutory and not appealable unless it falls within one of the exceptions”).

Another type of interlocutory decision is when, prior to a conclusive determination of liability and deficiency, the court retains jurisdiction so that it may in the future reach liability.

That was the case in *Adkins v. Capehart*. 202 W. Va. 460, 463–64, 504 S.E.2d 923, 926–27 (1998) (*per curiam* non-precedential decision).

It is irrelevant that other requests for resolution on other issues remain pending. Because of the nature of continuing jurisdiction, many requests often are filed in the circuit court at overlapping times. That happens because when the court is resolving one request for resolution, the plaintiffs remain free to file new requests for resolution on other unrelated issues— unlike private litigants, who are limited in their ability to amend a complaint and add new claims. A final order disposing of one request for resolution is not affected by what the court ultimately orders in other, unrelated requests for resolution. Indeed, if the mere existence of new requests for resolution could destroy the finality of the court’s orders on other requests for resolution, no order—no matter how final and how immediately it must be implemented—would ever be appealable and manifest injustice would result for both sides. Each dispositive order is at a minimum a *partial* final judgment as to the issues raised in that request for resolution, which is immediately appealable providing there is no just reason for delay.

And, at the very least, if the existence of other requests for resolution means that an individual dispositive order is *not* a final judgment as to *all* claims and issues pending in the case, each dispositive order is still at a minimum a *partial* final judgment as to the issues raised in that request for resolution. And, under the rules, a partial final judgment is immediately appealable providing there is no just reason for delay.

**B. The lower court need not have certified its order as a partial final judgment.**

The fact that the lower court did not *call* its order a final judgment, denominated as such under Rule 54(b), is moreover of no moment. When a judgment is final in its *nature* and *effect*, the party is not required to ask that it be *labeled* so. It is already final.

As this Court has explained, “[t]he liberalization of our practice to allow more issues and

parties to be joined in one action and to expand the privilege of intervention by those not originally parties has increased the danger of hardship and denial of justice through delay if each issue must await the determination of all issues as to all parties before a final judgment can be had.” *Durm*, 184 W. Va. at 565, 401 S.E.2d at 911 (quotation and citation omitted). Rule 54(b) therefore must “strike a balance between the undesirability of more than one appeal in a single action and the need for making review available in multiple-party or multiple-claim situations *at a time that best serves the needs of the litigants.*” *Id.* at 566, 401 S.E.2d at 912 (emphasis added) (quotation and citation omitted). And, under this “practical interpretation” and “spirit of Rule 54(b),” this Court can review “dispositive” motions even without the lower court’s certification language. *State ex rel. McGraw v. Scott Runyan Pontiac-Buick, Inc.*, 194 W. Va. 770, 775, 461 S.E.2d 516, 521 (1995).

Consequently, in this Court, “[t]he key to determining if an order is final is *not* whether the language from Rule 54(b) of the West Virginia Rules of Civil Procedure is included in the order, but is *whether the order approximates a final order in its nature and effect.*” Syl. Pt. 1, in part, *id.* at 773, 461 S.E.2d at 519 (emphasis added). This Court therefore does *not* “require an ‘express determination that there is not just reason for delay and . . . an express direction for the entry of judgment.’” *Sipp*, 194 W. Va. at 71, 459 S.E.2d at 348 (quoting *Durm*, 184 W. Va. at 566, 401 S.E.2d at 911). “[T]he absence of” such language, this Court emphasized, “will *not* render the order interlocutory and bar appeal provided that this Court can determine from the order that the trial court’s ruling *approximates* a final order in its nature and effect.” Syl. Pt. 2, in part, *Durm*, 184 W. Va. at 563, 401 S.E.2d at 909 (emphasis added).<sup>7</sup>

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<sup>7</sup> Furthermore, when an order resolves liability, even if other claims and parties remain in the case, such an order “certainly is final in its ‘nature and effect’” and “*must* be viewed as a final order subject to appeal,” regardless of the lower court’s inclusion or exclusion of language from

The lower court order is appealable here under this standard: the August 27, 2014 order disposes of all claims raised in the plaintiff's filing and conclusively rules on the applicability of federal law, the parties' liability, and the necessary remedy. It operates as (or at the very least "approximates") a final order "in nature and effect." It ordered the state psychiatric hospitals to disclose all records to Legal Aid advocates without requiring patient consent. App. 349 (Order of August 27, 2014 at 15). Specifically, the circuit court held, the state psychiatric hospitals "shall" provide the advocates with "access to patients and patient units immediately and without limitation"; the state psychiatric hospitals "shall" provide the advocates with "access to patient records immediately and without limitation except when patients request limitations on the disclosure of their individual, identifiable health information"; and the state psychiatric hospitals "shall not limit patient advocate conversations or discussions with [the state psychiatric hospitals'] staff." *Id.* The court further directed that "[a]ccess shall include all medical records of all patients committed to the Hospitals." *Id.* This order is final in nature and effect and so this Court therefore has jurisdiction to review it.

**C. This Court has jurisdiction to review the lower court's refusal to certify its dispositive order as a partial final judgment—which if reversed, would provide clear appellate jurisdiction to review the underlying dispositive order.**

At a minimum, this court has jurisdiction to review and reverse the lower court's denial of a certification of the August 27, 2014 order as a partial final judgment—which would provide an uncontested basis for jurisdiction to review the order. Here, the hospitals asked the lower

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Rule 54(b). *Durm*, 184 W. Va. at 567, 401 S.E.2d at 913 (quoting *Taylor v. Miller*, 162 W. Va. 265, 268–69, 249 S.E.2d 191, 194 (1978); *Turner ex rel. Turner v. Turner*, 223 W. Va. 106, 112, 672 S.E.2d 242, 248 (2008) (holding that even without certification language, a court "finding had the nature and effect of ending the litigation between the appellants and City Hospital with regard to City Hospital's reimbursement/subrogation claim" and "is properly appealable to this Court"); *Province v. Province*, 196 W. Va. 473, 480, 473 S.E.2d 894, 901 (1996) (reviewing a partial final order even though other proceedings continued in lower courts and the lower court did not certify the order's finality).

court to certify its August 27, 2014 order as a partial final judgment. App. 329–30 (DHHR/BHMF Motion for Stay and Entry of Partial Final Judgment as to the August 27, 2014, Patient Confidentiality Order at 1–2). The denial of such a certification is immediately appealable, and if reversed, provides for full review.

This Court has long held that under Rule 54(b), a circuit court’s determinations, if made, “are not conclusive.” *Province*, 196 W. Va. at 478, 473 S.E.2d at 899. Instead, this Court will “review” the lower court’s “determinations to see if they fit within the scope of the rule,” that is, if the lower court properly characterized its order as a partial final judgment or not. *Id.* As to the lower court’s determination as to whether it “has disposed entirely of one or more claims,” review is virtually *de novo*, but some deference extends to the lower court’s evaluation of whether there is “any just reason for delay.” *Id.* at 479, 473 S.E.2d at 900.

Here, the lower court clearly erred when it decided that both of Rule 54(b)’s requirements were unmet. *First*, the August 27, 2014 order “dispose[s] entirely of one or more claims.” This case thus presents a clean “bifurcation of distinct issues.” *See Province*, 196 W. Va. at 480, 473 S.E.2d at 901. No issues overlap between this order and other requests for resolution pending in the lower court, as shown by the lower court’s order to provide full network access despite other requests remaining pending on other issues. And, as shown above, the order is final: there are no further matters to be held before the lower court regarding the advocates’ legal ability to access confidential information, and the lower court ordered that access be implemented right away. Nor could this issue be re-opened, given this Court’s stay. *Second*, there is “no just reason to delay” designating this part of the case as final. The hospitals were ordered to provide access immediately. All issues of liability or the choice of a proper remedy are over: the lower court was only monitoring the case on this issue for compliance with its final order before this Court

issued a stay. Reviewing this order now thus would not affect any other proceedings, nor need *those* proceedings conclude to permit a full review of *this* order.

If anything, waiting to review this order would be unjust. Indeed, delaying this appeal would only require a stay to be in place until all other issues are resolved, thus delaying the resolution of this issue for years, which is not in the interest of plaintiffs or the hospitals. And, if a lower court can force the hospitals to follow orders that are final in their nature and effect, while nevertheless labeling its orders as “not final,” the circuit court could strip the hospitals of any meaningful right to appeal.

**D. The collateral order doctrine provides an alternate basis for review**

In the alternative, to the extent this Court concludes that the August 27, 2014 order is not final, the order would then be appealable as a collateral order. The “collateral order” doctrine, first established in *Cohen v. Beneficial Industrial Loan Corp.*, 337 U.S. 541 (1949), permits appeal of an interlocutory order when three factors are met: “it (1) conclusively determines the disputed controversy, (2) resolves an important issue completely separate from the merits of the action, and (3) is effectively unreviewable on appeal from a final judgment.” *Credit Acceptance Corp v. Front*, 231 W. Va. 518, 523, 745 S.E.2d 556, 561 (quoting *Durm*, 184 W.Va. at 566 n. 2, 401 S.E.2d at 912 n. 2).

*Cohen*’s requirements are met here. *First*, the lower court’s order “conclusively determines the disputed controversy” because it rules on each disputed issue. The order is not tentative, informal or incomplete. Rejecting the hospitals’ arguments on the merits, the order required the state psychiatric hospitals to disclose all records to Legal Aid advocates without requiring patient consent. App. 349 (Order of August 27, 2014 at 15). The court therefore fully resolved both the merits and the remedy. This “disposes of the factual and legal issues” such that “there would be no likelihood of further appeal” on these same questions. *C & O Motors, Inc. v.*

*W. Va. Paving, Inc.*, 223 W. Va. 469, 474, 677 S.E.2d 905, 910 (2009) (quoting *Apex Fountain Sales, Inc. v. Kleinfeld*, 27 F.3d 931, 936 (3d Cir. 1994)). And, because the lower court has no intention of revisiting these orders, nor can it, with this Court's stay order, the lower court's decision "conclusively determines" these issues. *Second*, this order "resolves an important issue completely separate from the merits of the action." To the extent this Court concludes that the orders are not a full or partial final judgment, this prong is almost by definition satisfied. If the order is non-final, in whole or in part, then presumably some other, larger merits issue exists to which this order is separate and collateral.

*Third*, without this Court's interlocutory review, this order "is effectively unreviewable on appeal from a final judgment." If the August 27 order is non-final, in whole or in part, that presumes that a future final judgment at some point will come, and that the lower court will not exercise continuing jurisdiction in perpetuity. But, as a practical matter, by the time this future final judgment is entered, there is no way to unscramble these eggs. The order requires immediate disclosure of all patient psychiatric records. The order acts as a final decision on what the hospitals must do: turn over the records. Requiring the hospitals to wait to raise this question until after the lower court has ruled on many other unrelated issues will deny the hospitals' patients the right to have their personal psychiatric information kept confidential.

Finally, because of the exceptional gravity of the constitutional, federal, and privacy problems at issue, even if this Court doubts jurisdiction, it should still review this order. In important cases this Court may act even when jurisdiction is questionable. *See McGraw v. Am. Tobacco Co.*, 224 W. Va. 211, 223, 681 S.E.2d 96, 108 (2009) ("[I]n extraordinary circumstances, this Court has addressed issues not properly before it."); *State ex rel. Foster v. Luff*, 164 W. Va. 413, 419, 264 S.E.2d 477, 481 (1980) (noting that even though a collateral

issue was not properly before the court, the Court nevertheless “accepted this issue under our original jurisdiction powers . . . to resolve a substantial issue of considerable importance”).

**E. No prior orders in this case preclude appellate review of these orders.**

Despite this case’s long history, this Court has neither ruled upon the orders below nor held that the hospitals may not ask this Court to decide whether the lower court’s blanket disclosure order violates federal law. *E.g., State ex rel. Matin v. Bloom*, 223 W. Va. 379 674 S.E.2d 240 (2009) (not addressing these issues). There is also no previous lower-court order that resolves the question of consent or the degree of access for advocates.

That the hospitals declined to appeal the 1990 order to create an advocates program does not waive the hospitals’ ability to object to or appeal from a future order purporting to enforce the order to create an advocates program but in reality expanding the order or other orders beyond its original issues. Indeed, if that were the case, it would deprive the hospitals of due process and patients of their federal rights.

**F. No issues were waived because the hospitals noted their objections in the circuit court.**

Once a party presents its objections and the court rejects them, there is no further need for the party to continue to present its objections in order to preserve them for appeal. W. Va. R. Civ. P. 46 (“Formal exceptions to rulings or orders of the court are unnecessary; but for all purposes for which an exception has heretofore been necessary it is sufficient that a party, at the time the ruling or order of the court is made or sought, makes known to the court the action which the party desires the court to take or the party’s objection to the action of the court and the grounds therefor; and, if a party has no opportunity to object to a ruling or order at the time it is made, the absence of an objection does not thereafter prejudice the party.”).

Here, the hospitals thus never waived their objections and instead preserved them for

appeal. The hospitals noted their objections on the record orally and in writing and repeatedly argued that the court should allow them to require patient consent for records access. The hospitals then objected to the plaintiffs' request at each subsequent hearing and in each filed pleading, and even *faced contempt hearings*. See *supra* 8–13. The lower court's merits order then noted these submitted memoranda, which made sense, because instead of having live legal argument on this issue at the evidentiary hearing, the court instead directed the parties to submit written proposed orders in addition to these memoranda. App. 275–76 (Aug. 1, 2014 Transcript at 180–181); *id.* 335 (Order of Aug. 27 at 1).

The hospitals' subsequent, court-ordered, and short-lived procedures to provide network access likewise does not mean the hospitals acquiesced to the court-ordered plan. Instead, in contempt and facing sanctions, and before this Court issued a stay, the hospitals merely complied with the lower court's order, over its objections. As the hospitals noted in their pleading apprising the court of the new network access, while they would provide the access to avoid contempt, the hospitals still objected to the court's order to follow and submit such a plan. App. 540, 543.

A party does not waive its objections to a court's order when it complies with an order—over its noted objections—merely to avoid contempt. W. Va. R. Civ. P. 46. Nor can compliance with an order issued over a party's previously-stated objections waive the opportunity to appeal. Indeed, it is difficult to imagine what more the hospitals could do to object to the lower court's ruling if their raft of objections, *plus facing contempt*, is not enough.

## CONCLUSION

The lower court should be reversed.

Respectfully submitted,

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Dated: December 29, 2014

## CERTIFICATE OF SERVICE

I, Julie Marie Blake and counsel for Defendant-Petitioner, verify that on December 29, 2014, I served a copy of the *Petitioner's Brief and Appendix* upon all parties as indicated below by mail:

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