

Session 203

Managed Health Care Litigation

Jay D. Mitchell
Litigation Counsel
Columbia/HCA Healthcare Corporation

Michael J. O'Leary
Associate Managing Director and Regional Counsel
Kroll Associates

Robert T. Adams
Partner
McGuire, Woods, Battle & Boothe, LLP

Philip H. Stern
Senior Managing Director and Counsel
DSFX, LLC

LITIGATION RELATED TO ACCESS AND QUALITY OF MANAGED CARE

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McGUIRE, WOODS, BATTLE & BOOTHE_{LLP}

Robert T. Adams

Bethany G. Lukitsch

Scott A. Simmons

One James Center, 901 E. Cary Street

Richmond, Virginia 23219-4030

Telephone: (804) 775-1000

Fax: (804) 775-1061

LITIGATION RELATED TO ACCESS AND QUALITY OF MANAGED CARE

- **Control & Liability**

- **Managed Care** → **Control** over health care delivery → **Ethical Responsibility** for access and quality → **Legal Duty** → **Liability**

BACKGROUND

- "Managed Care" here refers to the use of various administrative procedures and health care delivery systems to limit the consumption of health care, ideally to a level of medical necessity.

I. Types and Operation of HMOs

A. Types of HMOs

1. Staff Model

In the Staff Model, the HMO directly employs staff physicians and compensates them on a salary basis, often with bonuses or other financial incentives based on the HMO's performance. The physicians are employees of the HMO.

2. Group Model

In a Group Model HMO, the HMO contracts with a group of physicians, rather than individual physicians. The medical group is usually a multi-specialty group practice. The group generally devotes all or most of its time to providing care to HMO members at the group's clinic and facilities for a fixed monthly fee per covered individual. The fixed per-member monthly fee is referred to as a "capitation rate".

3. IPA Model

In an IPA Model HMO, the HMO contracts with an independent practice association ("IPA") which is ordinarily a partnership or corporation comprised of various independent practicing physicians. The association, in turn, contracts directly with each of the independent physicians. The physicians usually work out of their own offices or facilities, use their own equipment, and keep their own records. The physicians are free to and usually do maintain their own private practices outside the HMO. Thus, the primary difference between the IPA and Group Models is that the physicians in the IPA model do not work primarily or exclusively for the HMO. The HMO usually pays the IPA a specified capitation amount and the IPA, in turn, pays the participating

physicians on a fee-per-service or other basis. The IPA Model is the fastest-growing HMO model in the United States.

4. There are often variations of these basic types of HMOs that may have characteristics of one or more.

B. Methods to Control Expenses Utilized by HMOs

1. "Gatekeepers" -- prior approval of:
 - a. Outside Treatment (with exceptions for emergencies).
 - b. Specialist Treatment -- usually whether inside or outside the HMO.
 - c. Hospital Admissions.
2. Utilization Review ("UR") -- note that UR may be employed by any type of third party payer. Note also that the UR function may be handled by the payer itself or by a separate firm under contract.
 - a. Prospective -- all "gatekeeping" functions can be seen as a form of prospective UR.
 - b. Concurrent.
 - c. Retrospective.
3. Financial Rewards or Incentives to Physicians or Groups Who Practice "Effectively and Economically"
 - a. Bonuses to physicians if cost of outside medical services is below a certain level.
 - b. HMO may withhold a certain percentage of physicians' fees and allocate such fees to a contingency risk pool. If costs remain within budget, participating physicians share the surplus funds in the risk pool.
4. Disincentives to Those Who Do Not Practice "Effectively and Economically"
 - a. Loss of a percentage of risk pool funds.
 - b. Increased scrutiny of practice.
 - c. Termination from HMO.

C. Preferred Provider Organizations ("PPOs")

1. Definition -- health care delivery model in which physicians, hospitals, and/or other providers of health care contract to administer their services on a predetermined fee-per-service basis to a defined group of patients.¹
2. Characteristics of Most PPOs
 - a. Core panel of participating physicians.
 - b. Strict utilization management procedures.
 - c. Disincentives for patient to utilize non-PPO physician or hospital.
3. Participating Physicians -- usually reimbursed on fee-per-service basis at a negotiated or discounted rate.
 - a. PPO physicians usually maintain their own private practices.
 - b. PPO physicians may participate in more than one PPO.
 - c. PPO physicians generally are independent contractors who maintain more independence in their medical practice than HMO participants. Because the level of physician control is generally less, less quality-oriented liability (*i.e.*, malpractice liability) is present at the organizational level.
4. Medical Decisions
 - a. Hospital admission is usually subject to utilization controls -- typically non-emergency admissions must be approved in advance and the lengths of stays are closely monitored.
 - b. UR may work similarly as with HMOs. In theory, then, similar access-oriented liability issues may be presented, depending on the system of UR. However, the financial incentives presented by cost containment measures are not as great to the PPO physician, who is usually compensated on a negotiated fee-for-service basis. Indeed, some commentators have pointed out that PPO physicians have an incentive to provide more services to patients to make up for the losses of income due to the discounts given by the physicians to the PPO. On the other hand, "provider profiling" by insurers is on the upswing and insurers are facing increasing demands by large employers to terminate physicians from their PPO networks based on "inappropriate" utilization.

ACCESS ISSUES

Litigation Related to Utilization Review and Improper Financial Incentives

I. Wickline v. California² (1986). First case dealing directly with liability of third-party payers for UR decisions.

A. Facts. Patient Wickline sued the state of California's Medi-Cal medical assistance program. She had been hospitalized, following the required Medi-Cal authorization for a ten day hospital stay, for peripheral vascular surgery. Following the original surgery, circulatory complications in her right leg developed. Second surgery to remove a blood clot in the right leg was performed. Following this, patient underwent a lumbar sympathectomy to relieve spasms and pain and prevent further clotting. Treating physician then submitted a complete and accurate form to Medi-Cal requesting an additional eight days beyond the original discharge date. Reviewing physician employed by Medi-Cal authorized only four additional days. Treating physician discharged Wickline after four days. Testimony was that he acted within standards of practice of the medical community. Treating physician did not seek to appeal Medi-Cal's authorization of only four additional days. Complications developed after discharge and patient's leg had to be amputated. Treating physician testified to a reasonable medical certainty that had patient remained in the hospital for the eight additional days she would not have lost her leg.

B. Court's Analysis.

1. The court framed the case as follows:

Principally, this matter concerns itself with the legal responsibility that a third party payer, in this case, the State of California, has for harm caused to a patient when a cost containment program is applied in a manner which is alleged to have affected the implementation of the treating physician's medical judgment.³

2. The court analyzed the UR mechanism at issue as being prospective review. The court noted that:

[t]he stakes, the risks at issue, are much higher when a prospective cost containment review process is utilized than when a retrospective review process is used.

A mistaken conclusion about medical necessity following retrospective review will result in the wrongful withholding of payment. An erroneous decision in a prospective review process, on the other hand, in practical consequences, results in the withholding of necessary care,

potentially leading to a patient's permanent disability or death.⁴

3. Court's Holding. The court ruled that Medi-Cal was not liable because the physician made the ultimate decision to discharge the patient and, in any event, that decision was not negligent when made. Moreover, the treating physician did not pursue the available appeal of Medi-Cal's decision.
4. Significance. The true significance of the case lies in the court's major caveat to its ruling. The court stated that in the proper case a third party payer could be held legally responsible for injuries resulting from the deprivation of needed care:

Third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.⁵

5. The court concluded that:

[w]hile we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment.

II. Wilson v. Blue Cross of Southern California⁶ (1990). Greatly increased liability exposure of managed care entities in theory. Eviscerated Wickline's reasoning that the UR entity is not liable because the treating physician is ultimately responsible for medical decisions.

- A. Facts. On March 1, 1983, Howard Wilson, Jr. was admitted to College Hospital in Los Angeles suffering from major depression, drug dependency, and anorexia. His treating physician, Dr. Taff, determined that Wilson needed three to four weeks of in-patient care at the hospital. Defendant Western Medical Review provided concurrent UR services for hospitalized Blue Cross patients. On March 11, 1983, Western Medical informed Dr. Taff that further hospitalization was not justified nor approved. Wilson's policy provided coverage had the treatment been approved; he had not reached his policy limits. Dr. Taff felt the patient needed further in-patient treatment. Nevertheless, he informed Wilson and his family members that his further stay was not approved. Dr. Taff told Wilson's aunt to "come and get him." Wilson left the hospital. His family later testified that they did not have the financial means to pay for continued hospitalization. On March 31, 1983, the decedent committed suicide. Dr. Taff testified that there was a "reasonable medical probability" that Wilson would not have committed suicide if

his hospital stay had not been terminated. Wilson's family sued the Blue Cross plans involved, Western Medical and its physician employee Dr. Wasserman and others, but did not sue Dr. Taff.

- B. Court's Analysis. The court ruled that the lower court erred in not holding a trial on the plaintiff's claims. The court rejected the defendants' arguments that Wickline provided as a matter of law that exclusive responsibility for a discharge decision rests with the treating physician.
1. The court limited Wickline to its facts: the discharge decision in Wickline was in accord with the usual standards of medical practice and the decision there to withhold funding was made pursuant to statutory authority permitting Medi-Cal to review requests for hospitalization.
 2. Substantial Factor Test. The Wilson court declared that the rule for private insurers and their UR agents was whether the alleged negligent conduct was a "substantial factor" in bringing about the harm, here the patient's death. In other words, the treating physician's negligence, if any, in discharging a patient does not absolve the managed care entity whose decision or policy was also a "substantial factor" in causing the ultimate harm.
 3. Contract Issue. One of Wilson's claims was for "tortious breach of an insurance contract." There was some question as to whether Wilson's Alabama Blue Cross policy, which was being administered in Los Angeles by the Blue Cross plan in Southern California, even authorized concurrent UR. This issue appears to have greatly influenced the court's decision. Note, however, that making a contract-based claim can backfire for plaintiffs if it results in the entire case being removed to federal court under the Employee Retirement Income Security Act of 1974 ("ERISA"). See below for a discussion of the (sometime anomalous) impact of ERISA.
 4. Availability of Appeal Issue. The court rejected Western Medical's argument that Wickline stood for the fact that the treating physician must avail himself of available avenues of appeal for the UR company to share any blame. The court reiterated that whether the insurance policy even provided for concurrent review was an issue and noted that even if Dr. Taff should have followed an "informal" policy permitting reconsideration, this did not answer the question of "whether such a reconsideration request would have been granted."⁷
 5. Public Policy Issue. The court also rejected Western Medical's argument that public policy considerations supported the use of UR and justified some degree of legal protection for UR decisions. The court noted that there was no clear public policy, or statutory authority such as existed in Wickline, that would provide for the protection of the UR decision made in Wilson.

III. Lessons of Wickline and Wilson.

A. Conflict between provider's independent medical judgment and third-party payer's UR mechanisms.

1. Degree of Control. The degree of control or intervention is critical. The legal issue is known as "causation." Utilizing the language of Wilson, it is unlikely that a UR mechanism will be deemed a "substantial factor" in bringing about harm if there is no demonstrable effect on a provider's treatment of the patient. Conversely, to be effective, UR mechanisms must have some impact on treatment decisions. It is important to note, however, that UR mechanisms may have clearly demonstrable aggregate effects while a specific effect in any individual case is difficult to show. Litigation, unlike effective health care policy generally, is almost always concerned with specific cases.

In general:

- a. Prospective and Concurrent UR Versus Retrospective UR. Prospective and concurrent review are more intrusive (and arguably more effective in eliminating unnecessary treatment) than retrospective review. The lawsuit in cases involving prospective and concurrent review will usually be, in essence, a tort action based on physical harm to the patient because of foregone treatment. The lawsuit over retrospective review will generally be a contract action to recover the costs of the treatment.
- b. Duty Not to "Corrupt" Medical Judgment. Both courts recognize that cost containment mechanisms such as UR can have a "corrupting" effect on independent medical judgment, notwithstanding any beneficial effects in reducing unnecessary costs and treatment. There is a duty on the part of managed care entities not to corrupt medical judgment through the use of cost containment mechanisms.
- c. Effects of Payment Decisions on Treatment Decisions. Wilson recognizes more so than Wickline that refusal to approve payment in advance realistically means that treatment may not occur, despite a provider's judgment that the treatment is necessary. Especially now that insurers themselves are sensitive to cost-shifting, it should no longer be tenable for those wrongfully refusing to pay to point to a theoretical freedom on the part of providers to provide expensive care without the prospect of payment. Wilson stands for the proposition that a provider's wrongdoing, if any, in permitting medical judgment to be overborne by a bad UR decision is no reason to hold the UR entity blameless.

- d. Availability of Provider Appeal. The availability of clear and meaningful provider appeal of UR decisions is important. Following the reasoning of Wickline, where the treating physician was sued in addition to the third-party payer, physicians and other providers can protect themselves to some degree by pursuing available appeals. Following the reasoning of Wilson, however, simply making some form of appeal available does not necessarily shield the UR entity from liability. On the other hand, Wilson can be read to suggest that the UR entity may not be liable if it can prove an appeal would have been granted (presumably based on previously unavailable clinical information) and the harm thus prevented. In any case, both Wickline and Wilson stand for the proposition that an appeal mechanism should be available and operate in a nonarbitrary manner.
 2. Basis for UR. The law for over a hundred years, and the basic default rule still, is that the treating physician determines medical necessity and the treating physician and his or her patient together make significant medical decisions. Wickline and Wilson remind that any kind of UR should be clearly based on contract (*i.e.*, an insurance policy), statute, or administrative regulation.
- B. Negligence Requirement. As a matter of legal theory, negligence and causation are both required for liability. A bad result is not enough. [As to whether this is true when a jury is involved, no guarantee is offered here.]
1. The major difference in the outcome of the two cases may simply be that the evidence in Wickline was that the discharge decision on the part of the treating physician was within the standard of accepted medical practice when made. The discharge itself was thus not negligent. Under these circumstances, it is difficult to hold the UR entity responsible for harm alleged to result from the patient's discharge.
 2. Dr. Taff, the treating physician in Wilson (who, interestingly, was not a defendant) opined that at the time of discharge Wilson needed further hospitalization. The evidence before the court thus indicated that the discharge was below the applicable standard of care.
- IV. Litigation Directly Attacking Allegedly Improper Financial Motives. Although cost containment measures are clearly at issue in Wickline and Wilson, the plaintiffs did not directly attack the UR mechanisms at issue on the basis that they were inherently defective because they put dollars before patient care. The following cases illustrate that such a frontal attack on managed care is somewhat risky, and more recently governed under the confines of ERISA. Courts, aware of the public policy implications of this theory, appear reluctant to permit claims that managed care is inherently improper to go forward.

A. Swede v. CIGNA Healthplan of Delaware⁸ (1989). Patient Sweede sued Dr. Neef and the CIGNA HMO -- an IPA model HMO -- for failure to timely refer her to a surgeon when it was discovered she had a lump in her breast. Sweede alleged that the delay was influenced by financial motives. The court rejected Sweede's claim for punitive damages based on allegedly improper financial motivation.

1. Financial Incentive Structure. The court described the incentive structure of the HMO, a fairly typical arrangement, as follows:

Under the terms of the agreement between the IPA and the participating physicians, primary care physicians are paid a monthly capitation fee for each CIGNA plan member under their care. This payment is received regardless of whether the patient visits the physician during the month. Twenty percent of each monthly capitation payment paid to primary care physicians is withheld and allocated to a Performance Risk Pool ("Risk Pool"). In addition, twenty percent of each fee for service payment made to member specialists for referral services to patients referred by primary care physicians is withheld and allocated to the Risk Pool. At the end of a twelve month period actual costs of the Institutional Services and Professional and Ancillary Services are compared to the budgets for those items to which a monthly allowance has been allocated. Whether or not the physicians receive a return of the twenty percent withhold from the Risk Pool depends upon whether the budgets are in a deficit or surplus at the end of the twelve months. It appears that the IPA decides as to the actual distribution of funds. Whether the budgets are in a deficit or surplus depends upon how many referrals and hospitalizations are made in total by all participating physicians. The number of referrals made by any individual physician does not determine whether that physician will receive a refund of his withholds. It is possible, however, that an individual physician's withholds could be increased above twenty percent if it were determined that he or she was making too many referrals.⁹

2. Key Facts as to Treatment. Dr. Neef was Sweede's primary care physician and "gatekeeper." Sweede saw her gynecologist, Dr. Duque, for her annual gynecological exam on July 22, 1986. Dr. Duque found a lump in Sweede's right breast and urged her to see a surgeon immediately. Sweede had to get Dr. Neef's referral, however, and on July 23, he examined her, found a lump in her other breast, and sent her for a mammogram. The mammogram report in early August indicated no radiographic evidence of malignancy. Sweede continued to see Dr. Neef for other problems. On March 26, 1987, she saw Dr. Duque for another gynecological check-up, and mentioned she had never seen a surgeon. Dr. Duque told her to see a

surgeon immediately. Dr. Neef examined her and referred her to a surgeon on April 3, 1987. By May 4, 1987, a Stage III-B cancer -- inoperable and incurable -- was diagnosed in the right breast. Sweede's case against Dr. Neef and the HMO was essentially a claim that Dr. Neef should have referred her to a surgeon on July 23, 1986, instead of only sending her for a mammogram.

3. Court's Analysis. The court noted that out of 278 CIGNA patient visits in 1986, Dr. Neef made 83 referrals, including three for Sweede. The court noted that "plaintiff has offered no evidence that Dr. Neef has failed to make other necessary referrals" and there was "absolutely no evidence to indicate that Dr. Neef was ever advised that he was making too many referrals."¹⁰ The court concluded that any connection between the facts concerning Sweede's treatment and the HMO's financial arrangements was simply too tenuous:

Based on this record, I find that any connection between the CIGNA capitation/withhold policy and Dr. Neef's decision regarding the referral of plaintiff is too remote to be of significant probative value. The facts, taken together, do not support submitting the question of punitive damages to the jury.¹¹

- B. McClellan v. HMO of Pennsylvania¹² (1992). The patient's family sued their decedent's primary care D.O. and the IPA-style HMO for failure to submit a removed mole for testing. The patient allegedly told the doctor that the mole had markedly changed in size and color. The patient died from malignant melanoma. In a case primarily involving the HMO's liability for the malpractice of participating physicians and the negligent selection and retention of participating physicians, both of which aspects are discussed below, the plaintiff also added a claim based on the financial incentives inherent in HMOs. The court, aware of the social policy implications of such a claim, refused to address the financial incentive theory and, instead, deferred to the legislative branch:

[The plaintiffs] include in their complaint an allegation that the agreements between [the HMO] and their "primary care physicians" are themselves tortious since it is "against the 'primary care physicians' personal or pecuniary interest to give proper medical advice and make appropriate referral." This allegation suggests as issues whether the essential elements of the HMO system violate public policy, and whether the HMO system itself contributed to the asserted malpractice in this case. It is settled beyond peradventure, however, that the judicial branch is precluded by constitutional mandate from addressing the ethical, moral, or social implications of a health care program which indirectly provides a diminished compensation for a provider who deems further medical attention necessary or desirable. The fundamental prerogative and duty of considering and establishing

social policy, including, of course, the regulation of health care providers, is vested solely in the legislature.¹³

- C. Bush v. Dake¹⁴ (1989). The plaintiff in this Michigan case asserted that the defendant HMO's financial incentive arrangements led to an untimely diagnosis of cervical cancer. Plaintiff had suffered from vaginal bleeding. She alleged that her primary care physician and a specialist did not perform a Pap smear, nor did her primary care physician give her a second referral to the specialist when her symptoms persisted. Three months later she was diagnosed with the cancer. The HMO at issue was apparently a group model HMO. The group was paid on a capitation/risk pool arrangement. The plaintiff asserted that the arrangement gave the physicians an incentive for not rendering necessary services, not referring to specialists, or admitting to hospitals, and, critically, that the HMO's financial arrangements caused her injury. The trial court, although noting that the legislature had approved of HMO utilization management and cost containment and that the capitation arrangement did not violate public policy, held that the plaintiff's complaint at least stated a viable cause of action.¹⁵ However, the case was settled prior to trial, and no opinion was published.
- D. Compare Shea v. Esensten¹⁶ (1997). Plaintiff in this action, the decedent's wife, brought a wrongful death suit in Minnesota state court alleging that the defendant HMO's fraudulent nondisclosure and misrepresentation regarding the HMO's financial incentive programs limited her husband's ability to make an informed decision regarding his health care.
1. Relevant facts: Decedent, Mr. Shea, had a family history of heart disease and displayed symptoms of chest pain, shortness of breath, muscle tingling and dizziness. In order for a visit to a cardiologist to be covered under Mr. Shea's health plan, he needed a referral from his primary care physician (PCP). Mr. Shea's PCP repeatedly stated that referral to a cardiologist was unnecessary. Unknown to Mr. Shea, the PCPs under his HMO were rewarded for not making covered referrals to specialists and were docked a portion of their fees if too many referrals were made. Plaintiff contended that had her husband known that his PCP received a financial incentive for not performing referrals, he would have sought treatment from a cardiologist on his own dollar.
 2. Removal: Medica, the HMO, removed this case to federal court claiming that plaintiff's tort claims were preempted under ERISA. Plaintiff filed a motion to remand which was denied by the district court. Plaintiff then amended her complaint to allege that the HMO breached its fiduciary duty by not disclosing its financial incentive plan with participating PCPs. The district court dismissed plaintiff's claims stating that under ERISA, an HMO was not required to disclose its doctor compensation arrangements. The Eighth Circuit affirmed the District Court's decision regarding removal stating as follows: "Mrs. Shea maintains Medica wrongfully failed to disclose a major limitation on her husband's health care benefits. Along these lines, we have held that claims of misconduct against the

administrator of an employer's health care plan fall comfortably within ERISA's broad preemption provision."

3. Breach of Fiduciary Duty: The Eight Circuit disagreed however with the District Court's holding, and found that an HMO has a fiduciary duty to disclose its financial relationship with its doctors.

From a patient's point of view, a financial incentive scheme put in place to influence a treating doctor's referral practices when the patient needs specialized care is certainly a material piece of information. This kind of patient necessarily relies on the doctor's advice about treatment options, and the patient must know whether the advice is influenced by self-serving financial considerations created by the health insurance provider. . . . [Accordingly], [w]hen an HMO's financial incentives discourage a treating doctor from providing essential health care referrals for conditions covered under the plan benefit structure, the incentives must be disclosed and the failure to do so is a breach of ERISA's fiduciary duties.¹⁷

- E. Neade v. Portes (1999)¹⁸: Plaintiff in this Illinois state court was allowed to plead a cause of action against a physician, her husband's PCP, who failed to disclose his financial relationship with the contracting HMO. Anthony Neade, the plaintiff's deceased husband, sought treatment for chest pain and shortness of breath, two symptoms of coronary artery disease. Mr. Neade's physician refused to authorize Mr. Neade's admission for an angiogram to rule out coronary artery disease and instead relied on a thallium stress test. Plaintiff claims that had she known about the PCP's financial relationship with the HMO, she would have questioned the refusal of the test and her husband would have sought a second opinion. The physician's contract with Mr. Neade's HMO included a "Medical Incentive Fund" which was utilized when physicians sent their patients for various tests, such as the angiogram at issue, and referrals to specialists. Any monies left in the Fund at the end of the year contract period were split 60-40 between the physician defendants and the HMO. Relying in part on the Eight Circuit's decision in Shea, the Illinois Court of Appeals held that plaintiff had sufficiently stated a cause of action against the physician for breach of fiduciary duty in not disclosing the financial relationship with the HMO.

QUALITY ISSUES

Introduction

As regards the quality of managed care, courts have generally reasoned by analogy from cases that extended liability to hospitals for negligent care by physicians. As with the hospital cases, courts closely scrutinize the degree of control that the managed care entity exerts over the

provider. In making this determination, the actual employment relationship between the provider and the managed care entity -- *i.e.*, independent contractor versus employee -- is important. Courts also examine closely, however, the manner in which the managed care entity represents or "holds out" its relationship with providers and the quality of care it provides. On this point, courts are cognizant of patients' reasonable expectations.

Up until recently, many HMO's have been able to avoid liability for medical negligence under the protection of ERISA. However, recent cases coming out of federal district and appellate courts point to the erosion of ERISA's hold. In courts where claims against HMOs have been allowed to proceed, a distinction is made between claims challenging the "quality of medical care" and those dealing with denial of benefits (*i.e.* "access" related claims).

Direct Corporate Liability

- I. Litigation Related to Negligent Credentialing and Supervision. It has become practically universally recognized since the landmark 1965 case of Darling v. Charleston Community Hospital¹⁹ that hospitals owe a duty to their patients to properly credential and supervise physicians with staff privileges. This duty has been found applicable to HMOs.
 - A. Harrell v. Total Health Care, Inc.²⁰ (1989). Total Health Care essentially accepted all fully-licensed physicians with staff privileges at a hospital who applied. The Missouri appellate court in this case found that this non-staff model HMO had a duty similar to that imposed upon hospitals to adequately investigate the competence and reputation of its contracted physicians:

The corporate negligence doctrine, however, is not a theory limited to claims against hospitals. . . . The principal difference between the hospital-patient relationship in medical malpractice cases and the relationship between plaintiff and Total Health Care in the present case is that the hospital is intimately involved in the provision of patient care whereas Total Health Care has no participation at all in the rendition of the health services. Indeed, the liability of a hospital may well continue beyond the initial step of admitting physicians to staff privileges and involve a monitoring of performance within the institution. The duty of care to protect patients from foreseeable risk of harm, however, finds a common ground in both situations.

A subscriber to Total Health Care, or to any other prepaid medical services plan, expects and assumes that the plan will cover the expenses of medical care. In order to realize the benefit of the Total Health Care plan, the subscriber must, under the plan terms, accept treatment by physicians Total Health Care has approved. Although Total Health Care argues otherwise, the evidence shows that a subscriber does not have unlimited choice of a specialist physician. In order to be assured that payment of the charges will be made by Total Health Care, the subscriber must go to the physician to whom he is referred by his primary care physician and

the specialist must have contracted with Total Health Care. The fact that the subscriber may select some other doctor and pay for the services outside the Total Health Care coverage is irrelevant.

In this arrangement where Total Health Care collects a premium for the expense of medical care and limits the choice by the subscriber to physicians acceptable to Total Health Care, there is an unreasonable risk of harm to subscribers if the physicians listed by Total Health Care include doctors who are unqualified or incompetent. The presence of that risk gives rise to a common law duty owed by Total Health Care to conduct a reasonable investigation of physicians to ascertain their reputation in the medical community for competence.²¹

B. Another Illustrative Case -- McClellan v. HMO of Pennsylvania²² (1992). The court in McClellan, the basic facts of which are described above, concluded that IPA model HMOs "have a non-delegable duty to select and retain only competent primary care physicians."²³

1. Hospital Analogy. The court noted that hospitals in Pennsylvania had four duties requiring reasonable care under a "corporate negligence" doctrine: (1) the maintenance of safe and adequate facilities and equipment; (2) the selection and retention of only competent physicians; (3) the supervision of the practice of medicine within its walls; and (4) the formulation, adoption and enforcement of adequate rules and policies to ensure quality patient care.²⁴ However, the court also noted that "While HMO PA could be viewed as having 'assumed the role of a comprehensive health center', only two of the four duties defined by the [case law as to hospitals] could be imposed upon a modified IPA model HMO since such an HMO has no facilities or equipment and thus cannot 'oversee . . . patient care [within its walls].'"²⁵ The court therefore deferred a full extension of the theory of hospital corporate negligence to IPA model HMOs.

2. Restatement of Torts (Second) ' 323 Theory. The court instead based its decision on the Restatement of Torts. Section 323 provides:

One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if (a) his failure to exercise such care increased the risk of harm, or (b) the harm is suffered because of the other's reliance upon the undertaking.

Based on this, the court held:

It thus follows that a complaint, if it is to state a cause of action under Section 323 against an IPA model HMO, must contain factual allegations sufficient to establish the legal requirement that the HMO has undertaken

- (1) To render services to the plaintiff subscriber,
- (2) which the HMO should recognize as necessary for the protection of its subscriber,
- (3) that the HMO failed to exercise reasonable care in selecting, retaining, and/or evaluating the plaintiff's primary care physician, and
- (4) that as a result of the HMO's failure to use such reasonable care, the risk of harm to the subscriber was increased.²⁶

C. Negligent Supervision - Shannon v. McNulty²⁷. Plaintiffs in Shannon claimed that their HMO, HealthAmerica, was vicariously liable and corporately liable for the premature delivery and resulting death of their son. The Court, after examining plaintiffs' claims under the four duties imposed by the corporate negligence doctrine (set forth in McClellan above), found that there existed enough evidence to allow a claim to go forward under the third duty -- "A duty to oversee all persons who practice medicine within its walls."

1. Relevant Facts: Mrs. Shannon's membership card instructed her that in the event of an emergency or a need for medical advice, she should contact either her treating physician or the HMO's emergency phone line which was staffed by registered nurses. During her pregnancy, Mrs. Shannon saw her treating physician every month, but also on occasion sought advice from the emergency hotline. About half way through her pregnancy, Mrs. Shannon began to experience severe abdominal pain. Her physician examined her after her first complaints, prescribed bed rest and attributed her pain to a fibroid uterus. Her symptoms continued and worsened in the next few days. She again called her physician's office seeking advice and additional treatment. Her treating physician stated that he did not need to see her again and that she was not having premature labor. Frustrated with her physician, Mrs. Shannon called the HMO's hotline seeking advice. She relayed on three separate occasions her symptoms and her fears regarding pre-term labor. The hotline referred her to her physician on two occasions and to a hospital for a back exam on the third. Plaintiff proceeded to the hospital and on the same night gave birth to an extremely premature baby who died shortly after birth.

2. The Court's Holding: The Court found that the HMO had a duty to supervise the care being given by its hotline:

Likewise, we recognize the central role played by HMOs in the total health care of its subscribers. A great deal of today's healthcare is channeled through HMOs with the subscribers being given little or no say so in the stewardship of their care. Specifically, while these providers do not practice medicine, they do involve themselves daily in decisions affecting their subscriber's medical care. . . . While all of these efforts are for the laudatory purpose of containing health care costs, when decisions are made to limit a subscriber's access to treatment, that decision must pass medical reasonableness. . . .

Where the HMO is providing health care services rather than merely providing money to pay for services their conduct should be subject to scrutiny. We see no reason why the duties applicable to hospitals should not be applicable to an HMO when that HMO is performing the same or similar functions as a hospital. When a benefits provider, be it an insurer or a managed care organization, interjects itself into the rendering of medical decisions affecting a subscriber's care it must do so in a reasonable manner. Here, HealthAmerica provided a phone service for emergent care staffed by nurses. Hence, it was under a duty to oversee that the dispensing of advice by those nurses would be performed in a medically reasonable manner. Accordingly, we now make explicit that which was implicit in McClellan and find that HMOs may, under the right circumstances, be held corporately liable for a breach of any of the Thompson duties which causes harm to its subscribers.²⁸

D. Conclusions as to Negligent Credentialing and Supervision.

1. All HMO models likely have a duty to reasonably investigate the qualifications and competence of the physicians providing services to their members.
2. "Any willing provider" laws -- on the increase in many states -- may conflict with, or lessen to some degree, the imposition of this duty.
3. By extension of the hospital cases, staff model HMOs likely have a legal duty to monitor and supervise the quality of care and the maintenance of the equipment at HMO facilities.

4. It stands to reason that HMOs may be legally vulnerable at both extremes: having an open-door "mail-in" credentialing process as in Total Health Care makes the entity liable, but logic and the reasoning of the cases also suggests that maintaining a highly restrictive panel places a greater duty on the HMO or PPO to ensure the quality of the available physicians.

Vicarious Liability for Malpractice

All of the causes of action that have been discussed thus far are based, in theory, on the HMO's or other managed care entity's own culpability as a negligent actor. A distinction can be drawn, for what it is worth, between these theories and the managed care entity's vicarious (or indirect) liability for the malpractice of the providers it employs or contracts with. The key issue remains the same, however: Did the HMO have a sufficient level of control over the provider's day-to-day activities, or "hold itself out" to patients that it did?

I. Respondeat Superior and Ostensible Agency.

- A. Respondeat Superior. A Staff model HMO's physicians are employees; the doctrine of respondeat superior makes the "master" (employer) liable for the actionable wrongs of its "servants" (employees). Illustrative cases:
 1. Gugino v. Harvard Community Plan²⁹ (1980). In Dalkon Shield case, Massachusetts Supreme Court holds that cause of action for vicarious liability exists against HMO which employed allegedly negligent doctor and nurse. Liability against HMO must rest on "factual basis for inferring that the [HMO] had power of control or direction over the conduct in question."³⁰
 2. Sloan v. Metropolitan Health Council of Indianapolis³¹ (1987). An Indiana appellate court reversed the trial court's ruling that an HMO cannot be liable for malpractice because allowing the claim represented acknowledgement of the "corporate practice of medicine."
 - a. Corporate Practice of Medicine. The court quite properly rejected the "corporate practice of medicine" defense, (although such a defense has occasionally been successful in other jurisdictions, such as Ohio³² and Texas³³):

"It is, however, a non sequitur to conclude that because a hospital cannot practice medicine or psychiatry, it cannot be liable for the actions of its employed agents and servants who may be so licensed. Similar logic would dictate that a city cannot be liable for the negligence of its employees in driving automobiles since the city cannot hold a driver's license or that a corporation cannot be liable

for the misactions of its house counsel since it could not [sic] hold a license to practice law.

. . . However, we find no logical basis for denying liability under proper circumstances on the ground that the professional must exercise a professional judgment that the principal may not properly control."³⁴

b. Factors Supporting Liability. The court identified the following facts as supporting a finding of vicarious liability:

- 1) Employer-Employee relationship;
- 2) HMO provides medical office and maintains records for each member;
- 3) Complaints made to HMO, not physicians;
- 4) HMO does billing;
- 5) Physicians on salary and cannot engage in outside employment without HMO consent;
- 6) Medical Director's judgment controls if there is a dispute;
- 7) Physician agrees to participate in quality review by outside entities chosen by HMO and the HMO's "Medical Audit Committee."

B. Ostensible Agency. With non-staff model HMOs growing most rapidly, courts have borrowed the doctrine of ostensible (sometimes called "apparent") agency from the hospital context. Because the IPA or Group model HMO is not the provider's employer, rather the provider is usually an independent contractor, this doctrine is based on indicia of control -- "holding out" the provider as one's employee -- as well as actual control. Cases often turn on the specific facts involved. Illustrative cases:

1. No Liability -- Chase v. Independent Practice Association³⁵ (1991). Plaintiff sued the IPA which contracted with the HMO at issue based on allegedly negligent prenatal care. She claimed that one of the physicians who provided her care failed to conduct certain tests, resulting in her child being born with cerebral palsy and retardation. Plaintiff claimed that she did not choose her physicians and claimed only that "she was not made aware that the doctors providing her prenatal care were not employees of [the HMO]."³⁶ The court found that the IPA could not be held liable because "as matter of law, . . . IPA did not control, or retain the right to control, the professional activities of [the doctor] and [the HMO]."³⁷ The court noted that the IPA was more of a broker between the HMO and the

physician community, although it checked the credentials of agencies with which it contracted.

a. Actual Control. Important factors identified by the court, which were not found to exist on the part of the IPA in the case:

- 1) Right to hire and fire;
- 2) Setting of salaries;
- 3) Setting of work schedules;
- 4) Other terms of employment;
- 5) Who controlled medical decisions (most important factor).

b. Ostensible Agency. The court rejected ostensible agency because the plaintiff did not allege that IPA "held out" the physicians as employees or agents. She had no basis to rely on a lack of representations -- her lack of awareness was not the same as some affirmative act on the part of the IPA. Note, however, that such a showing is a fairly low hurdle for most plaintiffs when suing the HMO as opposed to an IPA.

2. Ostensible Agency Upheld -- Jones v. Chicago HMO Ltd.³⁸ (1998). An Illinois court upheld the viability of an ostensible agency theory in this IPA HMO case. The plaintiff's mother alleged that her child's physician was negligent for failing to schedule an immediate appointment for her three month old infant after hearing that her child was warm, irritable and constipated -- symptoms later indicative of meningitis.

a. Theory Under Illinois Law. The court described the theory under Illinois law:

Questions of fact arise in an apparent agency case:
Was the agent authorized to act for the principle?
Did the injured patient have notice of the lack of the agent's authority?

The word "apparent" is the key to the inquiry. "Apparent authority in an agent is the authority which the principal knowingly permits the agent to assume or the authority which the principal holds out the agent as possessing."

Apparent authority elements have little to do with actual control of the physician's conduct. Rather, "It is the authority which a reasonable prudent person [the patient], exercising diligence and discretion, in view of the principal's [the HMO's]

conduct, would naturally suppose the agent to possess.”

The inquiry focuses, then, on the principal's words and conduct made known to the patient. Appearances count. It does not matter that the doctor was in fact an independent contractor. It could matter very much when the patient is informed on a consent form that the treating doctor is an independent contractor.³⁹

b. Factors Supporting Finding of Ostensible Agency. The court described the following factors as supporting its finding of ostensible agency:

- 1) The HMO's aggressive marketing campaign;
- 2) The HMO's literature present in her physician's office;
- 3) Plaintiff's "assignment" of her physician by the HMO;
- 4) The HMO's handbook which referenced her physician as a "Chicago HMO personal doctor" and "a Chicago HMO primary care physician;" and
- 5) No indication written or otherwise that her physician was an independent contractor.⁴⁰

The Federal Court's Erosion of ERISA's Protection for HMOs.

Prior to recent months, the federal ERISA statute broadly preempted any state law claims that "relate to" a covered employee health benefit plan⁴¹ or that seek to "recover [plan] benefits due . . . under the terms of [the] plan, to enforce . . . rights under the plan, or to clarify . . . rights as to future benefits under the terms of the plan."⁴² The health plans offered by almost all private employers are covered; those offered by state and local governmental groups and certain religious organizations are not. ERISA preemption is usually not desirable for the plaintiffs in the types of cases this outline reviews -- jury trials and punitive damages are generally not available and certain types of wrongs may be completely without a remedy under ERISA (while the state law counterpart is "preempted" and unavailable). The recent trend in case law suggests that courts are now less willing to allow managed care organizations escape liability under ERISA's umbrella. District Courts in Arizona, California, Connecticut, Florida, Illinois, Maryland, Missouri, New Mexico, New York, New Jersey, Ohio, Oklahoma, Pennsylvania, South Carolina, Texas and Virginia, have allowed state law claims of medical malpractice against HMOs to proceed free from ERISA's grasp. These cases below are illustrative of the courts' analysis.

- I. Quality of Care v. Quantity - Dukes v. U.S. Healthcare (1995). The Third Circuit in Dukes made a distinction between claims alleging a lack of quantity in services and claims which attack the quality of benefits received by a plan participant. The Dukes court, narrowing the scope of ERISA, held that state law claims, such as medical malpractice, regarding the quality of care received by a plan participant were not preempted by ERISA.
 - A. Relevant Facts. Two cases were consolidated on appeal. Plaintiff in the first action alleged medical malpractice against various physicians and her husband's HMO, under an ostensible agency theory, for the delayed screening and testing of her husband's blood. The Viscontis, plaintiffs in the second case, brought actions against their HMO under an ostensible agency theory, as well as for direct corporate negligence resulting from negligent supervision and selection of its employees. Mrs. Visconti's symptoms of preeclampsia were allegedly ignored by her physician and ultimately resulted in the stillborn birth of their child.
 - B. Quality of Care v. Quantity. The Third Circuit reversed the District Court's holding that plaintiffs' state law claims fell within the scope of § 502(a)(1)(B) of ERISA and were, therefore, completely preempted.⁴³ In doing so, the Third Circuit made a distinction between claims regarding the quality of care and claims regarding access to care.

Nothing in the complaints indicates that the plaintiffs are complaining about their ERISA welfare plans' failure to provide benefits due under the plan. Dukes does not allege, for example, that the Germantown Hospital refused to perform blood studies on Darryl because the ERISA plan refused to *357 pay for those studies. Similarly, the Viscontis do not contend that Serena's death was due to their welfare plan's refusal to pay for or otherwise provide for medical services. Instead of claiming that the welfare plans in any way withheld some

quantum of plan benefits due, the plaintiffs in both cases complain about the low quality of the medical treatment that they actually received and argue that the U.S. Healthcare HMO should be held liable under agency and negligence principles.

Quality control of benefits, such as the health care benefits provided here, is a field traditionally occupied by state regulation and we interpret the silence of congress as reflecting an intent that it remain such.

II. Other Illustrative Cases - Ironically plaintiffs' claims are less likely to be preempted by ERISA when the HMO or other managed care entity is being held vicariously liable for the malpractice of associated providers. To the extent that the plaintiff attempts to directly tie the defendant HMO into the case based on the HMO's own negligence or breach, especially if the claim is based in any way on the written documents governing the health plan, the action becomes in danger of being preempted.

A. McDonald v. Damian (1999).⁴⁴ Defendants sought to remove plaintiff's claims arising out of defendants failure to properly diagnose her back lesion as malignant, claiming that her allegations arose under federal ERISA law. The court examined the removal issue under the guidelines set forth in Dukes. The court noted that the Third Circuit found that "§ 502(a)(1)(B) preempts only state law claims that allege a lack of quantity in services provided that membership in an ERISA plan entitles the participant to have such services."⁴⁵ State law claims that merely attack the quality of the benefits participants received are not preempted.

Under such an analysis, this Pennsylvania district court found that plaintiff's claims were not preempted:

Like the plaintiffs in Dukes, the McDonalds allege the care Anne Marie received by her physicians was inadequate and negligent and the managed care defendants should be liable under agency and negligence principles. Anne Marie is asserting that she received a benefit under the plan --- i.e. her physician's care, and that this benefit was inadequate to treat her condition. . . . In the instant case, . . . the McDonalds are attempting to hold the defendants liable for conduct of the physicians that treated Anne Marie because of its failure to ensure that complete and proper care was given to her, its failure to oversee and supervise her primary care physicians and its failure to control referrals to other specialists.⁴⁶

B. Herrera v. Lovelace Health Systems (1999)⁴⁷. This New Mexico District Court held that plaintiff's claims for vicarious liability, corporate negligence, negligence per se and intentional infliction of emotional distress arising out of an allegedly improperly performed vasectomy, were not preempted by ERISA. In so holding, the court again drew a distinction between access issues and quality of care issues.

As in [Dukes and Lupo v. Human Affairs Int'l, Inc.], [i]n the present case, Defendants are accused of being responsible for the design and delivery of

[medical services] which injured the Plaintiff. Who paid for the procedure is inconsequential. The issues in the case address solely the quality of medical services provided by Defendant's physician. It has nothing to do with the administration of the HMO plan nor the approval or withholding of benefits under the plan. "Rather this is a case in which beyond the simple need to refer to the Plan, the Plan is irrelevant to the dispute." Thus, the claims raised by Plaintiff may not be properly recharacterized as "to recover benefits due" or "to enforce . . . rights under the terms of the plan." Accordingly, the claims are not completely preempted and removal was improvident.⁴⁸

1. John L. Smith, III, & Lawrence L. Lemond, *Preferred Provider Plans Break New Legal Ground*, LEGAL TIMES, Nov. 21, 1983, at 27, Column 1.
2. 239 Cal. Rptr. 810 (Cal. Ct. App. 1986).
3. Id. at 811.
4. Id. at 811-12.
5. Id. at 819.
6. 271 Cal Rptr. 876 (Cal. Ct. App. 1990).
7. Id. at 674.
8. 1989 WL 12608 (Del. Super. Ct. 1989).
9. Id. at *1-*2.
10. Id. at *5.
11. Id.
12. 604 A.2d 1053 (Pa. Super. Ct.), *appeal denied*, 616 A.2d 985 (1992).
13. Id. at 1056 n.6.
14. No. 86-25767-NM, slip op. (Mich. Cir. Ct., Saginaw Cty., 1989) (dismissed without published opinion).
15. Id. at 4.
16. 107 F.3d 625 (8th Cir. 1997).
17. 107 F.3d at 628-629
18. 710 N.E.2d 418 (Ill. App. 1999)

19. 211 N.E.2d 253 (Ill. 1965), *cert. denied*, 383 U.S. 946 (1966).
20. 1989 WL 153066 (Mo. Ct. App. 1989), *transferred and aff'd on other grounds*, 781 S.W.2d 58 (Mo. 1989).
21. Id. at *4-*5.
22. 604 A.2d 1053, *appeal denied*, 616 A.2d 985 (1992). See *supra* note 24 and accompanying text for a discussion of the improper financial motivation claim.
23. Id. at 1059.
24. Id. at 1058-59.
25. Id. at 1059.
26. Id. at 1059.
27. 718 A.2d 828 (Pa. Super. 1998).
28. 718 A.2d at 835-36
29. 403 N.E.2d 1166 (Mass. 1980).
30. Id. at 1168.
31. 516 N.E.2d 1104 (Ind. Ct. App. 1987).
32. Propst v. Health Maintenance Plan, 582 N.E.2d 1142, 1143 (Ohio Ct. App. 1990) (*per curiam*) ("Since the corporate defendants do not practice medicine, they may not be held liable under a complaint which sounds in medical malpractice.").
33. Williams v. Good Health Plus, Inc., 743 S.W.2d 373 (Tex. Ct. App. 1987).
34. Sloan, 516 N.E.2d at 1108-09 (quoting Mathes v. Ireland, 419 N.E.2d 782 (Ind. Ct. App. 1981)).
35. 583 N.E.2d 251 (Mass. Ct. App. 1991).
36. Id. at 252.
37. Id. at 253.
38. 703 N.E.2d 502 (Ill.App.Ct. 1998)
39. 703 N.E.2d at 510
40. 703 N.E.2d at 510-11

41. ERISA § 502(a)(1)(3), 29 U.S.C. 1132(a)(1)(B)
42. ERISA _ 514(a), 29 U.S.C. _ 1144(a).
43. ERISA § 502(a)(1)(B) provides that claims “to recover benefits due. . .under the terms of [the] plan, to enforce. . .rights under the terms of the plan, or to clarify. . .rights to future benefits under the terms of the plan” are completely preempted by ERISA.
44. 1999 WL 500133 (E.D. Pa. 1999)
45. 1999 WL 500133 at *2
46. Id. at *4.
47. 35 F.Supp.2d 1327 (D.N.M. 1999)
48. Id. at 1332.

ACCA PRESENTATION OVERVIEW
Observations Related to Managed Care Contracting and Litigation

Jay D. Mitchell, Esq.

Parties negotiating managed care arrangements have a wide variety of issues upon which to focus. In many instances, specific rates and operating terms are negotiated and articulated thoroughly, while secondary issues may not be covered with the same degree of particularity. Described herein are observations regarding managed care agreements; they describe issues that should be considered at the initiation of the contractual relationship rather than in litigation.

"Silent PPO" Disputes

A great deal of attention has recently been focused on the issue of discount sharing relative to managed care contracts, a term commonly referred to as "silent PPO discounts". Generally, situations occur where a party attempts to benefit from a negotiated discount in a contract between payor and provider by sharing information relative to the contract discount with third parties who may or may not be entitled to the benefit of the original payor-provider contract terms. The creation of the silent PPO issue arises most often in agreements whose terms are vague and ambiguous, thus leaving the possibility of multiple interpretations. In a silent PPO situation, an insurer may have no direct contract with the hospital giving it discount rights, and the patient is not enrolled directly in the payor plan through which the discount is taken. While the motivation to access the discounts is different depending on the party represented, plain language limiting third-party access

and the ability of the parties to share discount information is the best protection against confusing interpretations ultimately resulting in costly litigation.

In HCA Health Services of Georgia v. Employees Health Ins. Co., 22 F.Supp.2d 1390 (N.D. Ga. 1998), the Court ruled in favor of a provider in its claim against a PPO alleging unauthorized discounts. The provider sought payment from the payor under federal ERISA provisions, which allow the provider/assignees to recover benefits from a patient/assignor's insurance company subsequent to a potentially improper rejection of coverage. Prior to treatment, the patient had assigned benefits to the specific provider, and when the payor received the invoice, it attempted to access a "leased PPO network" which had the effect of reducing the provider's invoice by applying the network discount. Specifically, the payor had no contract with the provider giving it any discount rights, and the specific patient was not enrolled in the PPO network through which the discount was sought. (The patient was enrolled in another network which the insurer had marketed to the patient's employers and which had a relationship with the provider.) The provider challenged the discount, asserting that the patient plan could not be interpreted to encompass other shared arrangements or similar discounts accessed through other vendors.

The Court ultimately held that fees could be discounted only through the policy's specific provisions, and also found that the attempt to indirectly access another shared arrangement was arbitrary and capricious, and thus violated ERISA. (The case is currently on appeal to the 11th Circuit.) This holding illustrates the importance of reviewing

agreements to determine whether actions taken by a payor or provider would be supported by the agreed terms of the contract. If any discount sharing is contemplated, it should be specifically disclosed and limited as appropriate.

Assignability Clauses and State Licensure Issues

Typically, managed care contracts will address the propriety and mechanisms for assignment of the agreement. The terms should clearly describe the rights of the parties relative to the application of assignability, the method of notifying affected parties, and the specific form of consent (if required). Notwithstanding careful drafting of this language, non-assignability clauses may not be upheld where applicable law dictates that corporate mergers technically operate as an automatic transfer of certain rights under the agreements.

Assignment in violation of a non-assignability clause, which can constitute a transfer of a significant interest, may or may not be considered a breach of the non-assignability provisions of the agreement based on the applicable law of the jurisdiction. Moreover, even where a transfer or merger may allow a corporate entity to obtain rights under agreements from a predecessor entity, any such assignment via merger may be void if it materially increases the burden of risk of the obligor. In other words, if the assignment of a contractual right materially changes the duty of the obligor, and its burden of risk is materially increased or its value is materially reduced, such assignment would likely be void.

Following the theme of the effects of a merger on an existing contractual agreement, many states require that specific types of insurance licenses be obtained and maintained

by the payor entity. In some circumstances, a change in a corporate entity's status through merger or other transaction may materially affect the status of the license. Where the merger of two corporate entities may in fact extinguish the existence of the former entity by operation of law, such extinguishment may result in the loss of a valid license. Hence, a payor with a valid license issued by a state department of insurance may lose the valid license if the payor's legal status has changed via a transaction with another entity. Although the successor entity may have the required licenses to operate in the specific state, the former entity may be deemed to have lost its license, and thus its ability to participate in the managed care contract under applicable state law.

Recently, in HCA Health Services of Tennessee, Inc., et al. v. CIGNA Healthcare of Tennessee, Inc., 20th Judicial District of Tennessee, Chancery Court, Case No. 99-1405-I (1999), plaintiff Health Services asserted that because Healthsource (a party to the original managed care contracts with Health Services) merged with and into another entity (CIGNA), Healthsource ceased to exist and thus was required to surrender its applicable license to the insurance regulatory agency in Tennessee. Because one of the grounds for termination of the original agreements was the loss of a required insurance license, Health Services gave notice of termination. The Court held that the Healthsource license did not transfer to CIGNA as a result of the merger between itself and CIGNA, and that Health Services did not consent to assignment of the agreements by Healthsource to CIGNA. Thus, the contracts were validly terminated.

This case (which is on appeal) illustrates the importance not only of articulating the

ability to assign the managed care contract, but also the potential effects of ownership changes on state licensure and other regulatory requirements, those changes potentially having an effect on the validity of the contract. Arguably, even more severe claims could be asserted as a result of a payor operating with an insurance license which has expired, been surrendered, or terminated as a result of a change in the regulated party's ownership status.

Dispute Resolution Clauses

In negotiating managed care contracts, significant attention should be paid to dispute resolution provisions. A well articulated, step-by-step process can avoid set-offs and refusals that delay the payment process and ultimately may cause coverage confusion at the patient level. Recently, the industry has explored the implementation of a multi-tiered dispute resolution process. An initial step is the implementation of a process whereby each party agrees to exchange dispute requests and supporting documentation within defined periods, and such dispute requests must be timely addressed between the parties.

If the parties cannot resolve the dispute, a third party mediator (previously agreed to and named in the contract) is contacted, and the dispute is submitted thereto. Both parties may agree that payment be made in accordance with the third party mediator's determination, or either party can request arbitration if it is not satisfied with the mediator's determination.

It is recommended that arbitration be conducted in accordance with the American Health Lawyers Association rules in an attempt to obtain arbitrators who are knowledgeable in the managed care area of law. There are obviously different dispute resolution processes

which can be invoked, and each process should be specifically tailored to the goal of the parties to the agreement. In any event, a process that provides dispute resolution within expedited time periods hopefully causes minimal delay in payment, and, more importantly, no disruption in patient care.

RICO Claims Involving HMO Business Practices

In the recently decided case of Humana, Inc. vs. Forsyth, 119 S.Ct. 710 (1999), the U.S. Supreme Court held that the McCarran-Ferguson Act did not preclude federal RICO act against an HMO. The plaintiffs in the Humana case were a class of Humana insureds, and the allegations involved Humana's alleged scheme in obtaining discounts for hospital services which were never disclosed nor ultimately passed on to them. (The plaintiffs had responsibility for a co-payment for all charges exceeding the specified deductible.) In response, defendant Humana Health Insurance of Nevada, Inc. asserted that the plaintiff's claims were precluded by the McCarran-Ferguson Act, which generally precludes the use of federal laws that supersede state insurance laws. Prior to this Supreme Court decision, the Circuits were generally split on the application of the Act. The Supreme Court held that because the federal law did not directly conflict with state insurance regulation, and the application of the federal law would not frustrate any state policy, the McCarran-Ferguson Act did not preclude application of federal law. Thus, the Supreme Court found no direct conflict between RICO and Nevada state insurance law.

This case obviously has ramifications relating to significant strengthening of claims which can be used by insureds against payor organizations. It is expected that federal

RICO claims will become common in managed care class action litigation.

Fraud and Abuse Litigation in Managed Care

**By
Michael J. O'Leary
Associate Managing Director
And Regional Counsel
Kroll Associates**

Fraud and Abuse Litigation in Managed Care

I. 1999 HHS-OIG Work Plan

In its work plan for fiscal year 1999, the Department of Health and Human Service's Office of the Inspector General targeted for scrutiny a number of concerns applicable to managed health care plans. These areas identify activities likely to be a focus of government investigative efforts directed toward managed care entities for a number of years to come. Specifically, the work plan called for analysis of the following practices:

- A. General and Administrative Costs - a review was planned to determine whether costs associated with enrollment, marketing, membership, directors' salaries and fees, executive and staff administrative salaries, and organizational and other costs were being properly allocated.
- B. Institutional Status - HHS-OIG planned a review of whether managed care plans are properly classifying beneficiaries as institutionalized, which results in higher capitation payments.
- C. ESRD Beneficiaries - the work plan notes previous OIG efforts identifying problems with payments for beneficiaries with end stage renal disease. The review will analyze payments for beneficiaries who no longer appropriately qualify under such status.
- D. Medicare Payments for Medicaid-Eligible Beneficiaries Living in Medicaid Nursing Facilities - enhanced payment rates are provided to beneficiaries with this status even though Medicaid reimbursed nursing facilities provide most of the care. The review planned to examine the reasonableness of this approach.
- E. Physician Incentive Plans - the work plan was to scrutinize such contracts and also look at whether they are properly disclosed to beneficiaries.
- F. Duplicate Billings - the review will determine whether there was inappropriate duplication,

during calendar years 1995 through 1997, of managed care and fee for service billings.

- G. Investment Income Earned by Risk-Based HMOs - HHS-OIG will review whether HMOs should be held accountable for such income earned on Medicare funds.
- H. National Marketing Guidelines - reacting to complaints about regional differences in approvals, and particularly the treatment of large plans in different regions, the OIG planned to review whether national guidelines should be established with regard to recruitment practices.
- I. Health Plan Data - the review was to assess the quality of data submitted to HCFA by plans regarding encounters and how this data was subsequently utilized by HCFA. The government also planned to analyze how managed care plans are held accountable for poor quality performance.
- J. Additional Benefits - this review was to examine whether beneficiaries understand what additional benefits a provider extends and how they affect a decision to enter a particular plan.
- K. Access to Emergency Services - a review to look at whether existing federal protections in this area are adequate and scrutinize plan rules and hospital policies in this area.
- L. Services Provided After Disenrolling - this review planned to examine services that are paid by Medicare on a fee-for-service basis to beneficiaries who disenroll from a risk-based managed care organization. Will be used to assess whether the MCO was providing all necessary services.
- M. Medicaid Managed Care - the work plan also specifically called for reviews of managed care activities in the context of the Medicaid program. These reviews were to examine the states' use of contractors to monitor quality of care; the impact of managed care on the delivery of mental health services to Medicaid recipients; and the efforts

of the states to fight fraud and abuse in their respective Medicaid managed care plans.

The entire text of the HHS-OIG 1999 Work Plan, including the portion on managed care, can be accessed at <http://www.hhs.gov/progorg/oig>.

II. Legal Framework

There are numerous federal statutes and regulations which are potentially applicable in the context of health care fraud and abuse issues. The following is a non-exhaustive listing of codifications that may have direct applicability in the context of managed care. A substantial number of these provisions were newly enacted as a part of the Health Insurance Portability and Accountability Act of 1996.

A. Criminal Statutes

- 18 U.S.C. 287 - prohibits the submission of false or fraudulent claims to any government agency.
- 18 U.S.C. 641 - outlaws the theft, embezzlement or conversion of federal property, including money.
- 18 U.S.C. 664 - prohibits theft, embezzlement or conversion of funds and assets of any employee benefits plans.
- 18 U.S.C. 666 - makes it unlawful for any agent of a entity which receives at least \$10,000 in federal funds to embezzle, steal, or obtain by fraud funds of such entity having a value of \$5,000 or more. Also prohibits soliciting, demanding or agreeing to accept anything of value in connection with business of the entity.
- 18 U.S.C. 669 - specifically outlaws any thefts or embezzlements relating to health care programs and/or matters.
- 18 U.S.C. 1001 - prohibits the use of false statements or documents in connection with any matters within the jurisdiction of a federal agency.

- 18 U.S.C. 1035 - prohibits false statement or representations "in connection with the delivery of or payment for health care benefits, items or services".
- 18 U.S.C. 1341 - prohibits the devising of a scheme to defraud and the use of the mails to further such a scheme to defraud.
- 18 U.S.C. 1343 - similarly prohibits use of the interstate wires (telephone, facsimile, wire funds transfers, etc.) to further a scheme to defraud.
- 18 U.S.C. 1347 - tailored after mail and wire fraud statutes, specifically prohibits a scheme to defraud health care programs (which includes privately funded programs as well as government programs).
- 18 U.S.C. 1505 - outlaws various activities constituting obstruction of proceedings before federal departments, agencies and/or committees.
- 18 U.S.C. 1505 - specifically outlaws activities constituting an obstruction of a criminal investigation.
- 18 U.S.C. 1516 - prohibits efforts to influence, obstruct or impede a federal auditor in the performance of his official duties.
- 42 U.S.C. 1320a-7b - generally prohibits kickback arrangements involving providers but recent legislation has made this a very murky area with managed care safe harbors set forth in 42 C.F.R. Part 1001 and the Risk Sharing Exception set forth in 42 U.S.C. 1320(b)(3).

B. Civil Enforcement

- 31 U.S.C. 3729 - While at first blush the False Claims Act does not appear to be an appropriate vehicle to address fraud involving managed care arrangements, as opposed to more traditional fee for service arrangements, a closer look at the statute reveals substantial applicability even in

the managed care context. Specifically, the statute prohibits knowingly:

1. presenting a false or fraudulent claim for payment or approval to the government;
2. using a false record or statement to get a false or fraudulent claim paid or approved;
3. using a false record or statement to avoid or decrease an obligation to the government; and
4. conspiring to defraud the government by getting a false or fraudulent claim allowed or paid.

The statute's intent requirement can be particularly troublesome as it includes not only acts done with actual knowledge, but also actions taken in **deliberate ignorance** or **reckless disregard** of the truth or falsity of relevant information.

C. Administrative Penalties - 42 U.S.C. Section 1395mm(i)(6) et seq.; 42 U.S.C. Sections 1396b(m)(5) et seq.; 42 C.F.R. Sections 417, 434, 1003.103, establish the following penalties:

- Denial of medically necessary items or services penalized up to \$25,000 for each violation.
- The practice of charging subscribers impermissible fees can be fined up to \$25,000 for each instance plus twice amount of overcharging.
- Wrongful expulsion or refusal to enroll eligible individuals can be fined up to \$25,000 per instance.
- Engaging in favorable selection by denying eligible individuals whose history shows they may need substantial future services can be fined \$100,000 per determination.
- Misrepresenting or falsifying information provided to the government can result in penalties of \$100,000 per determination.

- Failing to make prompt payment on claims of persons providing services and supplies can result in \$25,000 penalties.
- Contracting with excluded persons or entities can be fined \$25,000 per determination.

D. Exclusion Authority

- Mandatory Exclusion - 42 U.S.C. 1920a mandates the exclusion of any providers convicted of health care fraud program offenses.
- Permissive Exclusion - 42 U.S.C. 1920b grants the Secretary the authority to pursue exclusion in any situation in which the provider was convicted of another offense.

III. Risk Areas and Historical Enforcement Efforts

Prosecution and false claims activity in the fee for service environment continues to dwarf such activities in the managed care context. To date, most fraud and abuse enforcement efforts in the context of managed care have involved Medicaid programs in those states, including Maryland, Tennessee and New York, that had incorporated managed care as a major health care delivery vehicle. Nonetheless, many of the activities that have been the subject of enforcement activities in those jurisdictions have substantial application in private pay managed care programs.

A. Recruitment/Marketing Practices

- In June of 1995 seventeen Maryland HMO recruiters, along with social workers who sold names of recipients to the recruiters, pled guilty to deceiving beneficiaries by telling them they would not have to switch doctors, and offering prizes to recipients to get them to join the HMO.
- In March of 1996 HCFA imposed sanctions on Blue Cross/Shield of Massachusetts for allegedly

claiming that a number of non-contracted physicians were a part of the Medicare HMO network.

- A TennCare HMO contracted with a marketing company to enroll beneficiaries. Company employees subsequently visited jail facility and signed up ineligible inmates, and operated under explicit instructions to avoid pregnant women or those with physical problems.

B. Quality of Care

- Perhaps the most serious concern about managed care arrangements is the fear that needed care will be denied due to the economic pressures inherent in a capitated care system. This topic has been a focus of a number of commentators. See e.g. Mjoseh, Underutilization in Managed Care: New Target of Joint Fraud Efforts, 4 Health L. Rep. 1809 (BNA, Dec. 7, 1995); Bradman, Keeping Managed Care on the Straight and Narrow, 14 Behavioral Health Mgmt. 8, 9 (July, 1996).

C. Fraudulent Reporting

- In April of 1999 Vencor, Inc. agreed to \$90 million repayment plan (over 60 months) for submission of billings which overstated reimbursement rates.
- Recent changes requiring all plans to certify the correctness of data ultimately utilized by the government in establishing the applicable community rate for computation of capitated payments will certainly open the door for enforcement activity based upon inaccurate data.

For a comprehensive discussion of the various types of fraud which are susceptible in the context of managed care, see Davies and Jost, Managed Care: Placebo or Wonder Drug for Health Care Fraud and Abuse?, 31 Ga. L. Rev. 373 (1997); Bloom, Fraud in Managed Care -- New Games by Old Players, Managed Care 16 (1997).

**STRATEGIES FOR THE CORPORATE ADVOCATE
MANAGED HEALTH CARE LITIGATION**

LEGISLATIVE UPDATE/LITIGATION AND COMPLIANCE ISSUES

PREPARED FOR ACCA

BY

**Mr. Philip H. Stern
Senior Managing Director and Counsel
DSFX, LLC
555 West 5th Street, Suite 3100
Los Angeles, CA 90013
Phone: 213/996-8317
Fax: 213/996-8318
pstern@dsfx.com**

Fraud and Abuse in the evolving managed care market has provided increased legislative activity and created new areas of potential litigation that must be of concern to corporate counsel. These areas include potential litigation in such areas as:

- Provider Self-disclosure Protocols And Patient Bill of Rights Issues
- Class Actions and Civil Rico Suits
- Liability to Consumers
- Compliance Programs-Implementation of Investigations
- Medicare Integrity Program Violations

The following laws are implicated and will invariably provide part of the framework for this litigation as well as any new legislation to correct abuses:

1. Medicare/Medicaid fraud and abuse (anti-kickback) statute.
2. Self-referral laws (Start I and II).
3. False Claims Act (and Qui Tam).
4. Health Insurance Portability and Accountability Act.
5. Patient Bill of Rights (State and Federal)
6. Antitrust
7. ERISA 502(a)
8. Telemedicine

I. Emerging Litigation And Legislation.

A. Rico Suits

The United States Supreme Court recently issued a unanimous opinion affirming that insurance companies (HMO's) engaged in a pattern of fraud can be sued under the RICO statute. See: Humana, Inc. v. Forsyth, 119 S. Ct. 710.(1999)

B. ERISA (Employee Retirement Income Security Act of 1974) 502(a)

On January 21, 1999 a San Bernadino County Court jury awarded \$120.5 million in damages to the widow of an attorney, David Goodrich. Significantly, \$116 million were for punitive damages.

See Goodrich v. Aetna, US. Healthcare of California, Inc. No. RCV020499; and Moscovitch v. Danbury Hospital, 25 F. Supp. 2d 74 (D. Conn. 1998)

Counsel should note that generally, ERISA prohibits lawsuits against private-sector HMO's except to recover the cost of treatment. (ERISA does not cover public sector plans.) However, there is pending legislation in California that would give members of private sector HMO's legal remedies, including the right to seek compensatory and punitive damages. Also, in Moscovitch, the court seemed to indicate that the health plan was engaged in the practice of medicine or at least in making medical determinations thereby increasing the likelihood of more traditional tort or breach of contract litigation under a state statutory scheme. In fact, a recent New York case held that an HMO decision (by a nurse) to release a patient from the hospital breached the

contractual obligations of the plan and therefore was not “within the scope of the grievance provisions as written.” (See Batas v. The Prudential Life Insurance Company of America, NYS Sup. CT 107881/97. Filed May 20, 1999.)

**C. Federal/State Patient Bill of Rights And Cost Reduction Programs
(See Health Insurance Portability and Accountability Act and California
Independent Review Legislation)**

The Patient Bill of Rights, if passed, could have the effect of lowering the ERISA obstacles on a national level. In addition, new programs such as New York Empire Blue Cross & Blue Shield’s “Systematic Analysis Review and Assistance” program, which is designed to reduce high risk patient health costs, will deeply involve managed care companies in medical decisions and potentially make them responsible in the courts for the consequences. Patient Privacy legislation will also subject managed care companies to intense scrutiny and potential litigation, particularly in states such as California.

**D. Compliance Program Guidance For Medicare + Choice Organizations
Offering Coordinated Care Plans – June 1999**

The Compliance Guidance focuses on Federal health care regulations governing marketing, enrollment, disenrollment, underutilization, data collection, anti-kickback statute and anti-dumping compliance.

(See Guidance @ <http://www.hhs.gov/vig/modcom/cpgm.htm>)

A key ingredient, and perhaps most controversial, is the suggestion by the OIG that health plans rank their own anti-fraud priorities. In the document, the OIG made seven main recommendations for plans to have:

1. Written Policies and Procedures.
2. Designate a Compliance Officer and a Compliance Committee.
3. Conduct Effective Training and Education.
4. Develop Effective Lines of Communication.
5. Audit and Monitor Compliance
6. Publicize Disciplinary Guidelines and Policies Regarding Dealings With Ineligible Persons.
7. Respond to Detected Offenses and Develop Corrective Initiatives.

The 40 page package contains suggestions focused on managed care's specific challenges, including the problems of plans trying to cherry pick the healthiest patients to save money and plans requiring emergency room patients to obtain prior authorization before obtaining services, thus violating the federal patient anti-dumping statute. (See 42 U.S.C. §1395dd).

Additionally, the compliance program guide identifies several fraud risk areas on which managed health plans should focus:

- Certification of enrollment.
- Selective marketing to healthier beneficiaries.
- Formulary kickbacks.
- Marketing of materials to beneficiaries.

The Compliance Program Guidance should be the operational road map for all managed care companies. It provides the exposure parameters for all forms of litigation and corrective legislation if guidelines are violated.

E. Disclosure Rules Under §6104(d) of the Internal Revenue Code as Amended by the Tax and Trade Relief Extensions Act of 1998.

Nearly all healthcare and health related organizations are tax-exempt and will be subject to these rules. Violation may cause loss of status as well as suits derived from disclosed data.

See also Technical Advice Memorandum (TAM) – IRS Guidance on HMO Exemption. [98TNT 243-2 (Doc. 98-3729)] – I.R.S. National Office Technical Advice Memorandum. Loss of status will create tax liabilities and lengthy litigation as the IRS seeks new sources of revenue.

F. Economic Espionage Act of 1996

Section 1832 of the EEA makes it a federal crime to knowingly appropriate without authorization, duplicate without authorization, or possess stolen trade secrets. The government will begin active prosecution under EEA in 2001. Any health care entity that owns or uses intellectual property should take notice, particularly when obtaining patient lists. Compliance programs should proactively take steps to prevent misappropriation.

G. Telemedicine

(See N.Y. Education Law §6525-A and Cal. Bus. Prof. Code §2290.5(a)(i)).

A new and novel area evolving in healthcare is the practice of medicine on the internet and related interactive electronic media. Care should be given when entering this field especially in light of recent litigation such as Moscovitch, supra. National managed care organizations may find it cost effective to use telemedicine as an alternative to threshold office visits or more traditional prior approval (cost reduction) systems – caution is the operative word least we see an eruption of tort litigation.

H. ADR for Managed Care

(See ABA/AMA/AAA Due Process Protocols)

Congress is considering various patient rights proposals that address dispute resolution. The law of managed care liability is developing in state courts. ERISA preempts remedies for health benefit plans, but that may change. ADR may be the newest solution for the resolution of health care disputes. Consumer skepticism is leading to litigation and legislation, therefore a commitment by managed care companies to level playing-field dispute resolution by neutral, non-partisan, third party facilitators may avoid the consequences of this trend.

Conclusion

In the world of managed care, government regulation, voluntary disclosure programs and compliance guidance have become operational burdens that must be addressed. Failure to do so will result in costly litigation and legislation imposing standards that may seriously affect the corporate bottom line.