Managed Care Organization (MCO) & Hospital Liability & Medical Staff Privileges
MCO Liability Theories

1. Vicarious Liability
2. Ostensible Agency
3. Medical Malpractice
4. Bad Faith Denial of Benefits
5. Negligent Utilization Review
6. Breach of Contract
7. Negligent Credentialling
8. Corporate Negligence
9. Fraud/Misrepresentation
10. Antitrust
Vicarious Liability

- Respondeat Superior
- Imputes Liability to Employer or Principal
- Wrongful Act of Employee or Agent
Vicarious Liability Asserted

- Malpractice of MCO Affiliated Physicians
- Negligent Acts of Non-Physician MCO Employees or Agents
MCO Physician Employee

- Physician Employed by HMO
- Salary Paid by HMO
- Directed by HMO Personnel
- Outside Employment Prohibited
Independent Contracting Physicians

- Agency Relationship
- MCO Representations to Enrollees
- MCO Degree of Control
Ostensible Agency

- “Apparent Agency”
- Conduct of Principle or Agent
- Third Party Reasonably Led to Believe
- Agency Relationship Exists
Medical Malpractice

- Institutional or Corporate Negligence
- Vicarious Liability
- Ostensible Agency
Negligent Utilization Review

- Bad Faith Denials of Benefits
- MCO Determination to Deny Care or Treatment
- Punitive Damages
HMO Institutional or Corporate Negligence

- Negligent Credentialing

- Illinois Supreme Court landmark case: *Darling v. Charleston Community Memorial Hospital, 1965*
AMA Model MCO Contract

- AMA Revised Model Managed-Care Contract
Breach of contract

- Contracts with physicians
- Contracts with enrollees
Fraud and Misrepresentation

- False Representations
- Concealed Material Facts
- Purpose of Deceiving Another into Acting or Remaining Passive
Antitrust Violations

- Federal and State Antitrust Laws
- Liability Exposure can be Enormous
Hospital Staff Legalities: Administrative (Hospital) Remedies

- Hospital Administrative Proceedings
  - Medical Staff Review Committee
  - Judicial Review Committee
  - Appellate Review Committee
  - Board of Governors Review
Hospital Disciplinary Board Proceedings

- Peer Review Process – Use or Misuse
- Restriction of Previously Granted Hospital Privileges – Require:
  - Procedural Due Process, and
  - Substantive Due Process
Hospital Staff Legalities: Court Review & Judicial Evaluation

- Constitutional Rights – Due Process
- Anti-Trust Violations
- Breach of Contract
- Defamation
- Restraint of Trade
- Tortious Interference w/Business Relations
Court Involvement in Hospital Staffing Decisions

- **Private Hospital** – Follow Bylaws, Rules & Regulations.
- **Public Hospitals** – “State Action”; Complete Procedural & Substantive Due Process.
- **Some States**: No Hospital Differentiation
General Hospital “Negligence”

- Hospital “Personal” Liability
  - Legal Obligation
  - Maintain Equipment & Facility
  - Good Condition
  - Efficient Working Order
Hospital Responsibility as a “Master/Employer”

- Respondeat Superior
  - Direct Responsibility
    - Employees
    - Agents
  - Ostensible, or Apparent, Agency
    - Independent Contractor (ER)
Hospital: “Duty of Care” to Patients

- OIG (Office of Inspector General) &
- JCAHO (Joint Commission on Accreditation of Hospital Organization):
  - Hospitals’ credentialing practices will come under increased scrutiny.
Hospital “Credentialing” Duty

Hospitals are obligated to:

1. Demonstrate and document an effective evaluation process of individual requests for medical staff privileges;

2. Show what criteria were used for granting these privileges.
Process of Credentialing & Re-credentialing

- **Traditionally**, Credentialing has been the core of the quality process for hospitals for decades.
- **Focus:** Physician’s competency and professional behavior.
Process of Credentialing & Re-credentialing

- Most dramatic change is the idea that:

  *Privileges are temporal.*
Hospital Medical Staff Privileges (HMSP)

- State Medical Licensure:
  - No Right to Acquire HMSP

- Initial Application for HMSP:
  - No Constitutional Right

- Acquired HMSP, or “Membership”:
  - Constitutional “Property” Right
  - Vests on Appointment Date
Process of Hospital Privileging Renewal

- **Before 1990’s**: Initially granted privileges were renewed almost automatically (**entitlement**).

- **After 1990’s**: Privileges are “loaned” to the applicant for a period of time (**No entitlement**).
Why are Privileges “Loaned”?

1. Increasing legal risks of deficient credentialing and re-credentialing process since 1965.
2. Poor credentialing practices equate to poor business practice as well.
Remedy for Patients Injury: Corporate Negligence/Liability

- Basis: Poor Credentialing Practices

- Patients allege: Credentialing system failed to protect them from a bad physician
  - Darling v. Charleston Community Memorial Hospital
  - Johnson V. Miseriocordia Community Hospital
Darling v. Charleston Community Memorial Hospital (Illinois 1965)

- 18-yr-old college football player was badly treated for a broken leg by an on-call non employee emergency room physician.
- Charitable immunity no longer applied.
- Corporate negligence introduced.
In Darling: Illinois Sup. Ct. Ruled:

- Standards for hospital accreditation, state licensing regulations and hospital’s bylaws demonstrated that the medical profession and other responsible medical authorities regarded it as both desirable and feasible that a hospital assume certain direct responsibilities for patient care.
Johnson v. Miseriocordia Community Hospital (1980)

- Surgeon unsuccessfully attempted to remove a pin fragment from Johnson’s right hip damaging patient’s common femoral nerve and artery resulting in a permanent paralysis of his right thigh muscles.
Johnson v. Miseriocordia Community Hospital (1980)

- Hospital admitted to failing to contact any of the surgeon’s references or check alleged credentials.
- Hospital records were devoid of any information concerning the procedure used to approve surgeons appointment.
Johnson v. Miseriocordia Community Hospital (1980)

Supreme Court of Wisconsin held:

- **Failure** of a hospital to **investigate** a surgeon’s **qualifications** for the privileges requested gives rise to a **foreseeable risk of unreasonable harm** and therefore, the hospital has a **duty to exercise due care** in selection of its medical staff.
Johnson v. Miseriocordia Community Hospital (1980)

Court stated:

- Hospital was required to “solicit information from applicant’s peers, including those not referenced in his application, who are knowledgeable about his education, training, experience, health, competence, and ethical character.”
Johnson v. Miseriocordia Community Hospital (1980)

Court also stated:

- Hospital will be charged with gaining and evaluating the knowledge that would have been acquired ("Constructive Knowledge") had it exercised ordinary care in investigating its medical staff applicants and its failure to do is negligence.
Patients who are injured by a hospital independent contracting physician may sue the hospital under the expanded exposure of the Doctrine of Apparent Agency or Ostensible Agency.
Kafri V. Greenwich Hospital (U.S. District Court for CT 2000)

Denied defendant hospital’s Motion for Summary Judgment who had been sued for the alleged negligence of Greenwich Radiology, an independent contractor, on the theory of apparent agency.
“...the Court finds several reasons for applying the doctrine of apparent agency to a hospital. No reasonable patient in the position of the plaintiff would assume anything else but that the medical staff physicians were employees of the hospital.
Kafri V. Greenwich Hospital (U.S. District Court for CT 2000)

Indeed, a patient has the right to rely on the reputation of the hospital when she agrees to have a medical procedure performed at the hospital.
Kafri V. Greenwich Hospital (U.S. District Court for CT 2000)

As such, it is reasonable for the public to assume that a hospital to which it goes for treatment exercises medical supervision over, and is responsible for the negligence of, medical personnel providing services whether they are independent contractors or not.”
Summary: Hospitals as Secondary Insurers

- Hospitals are at increased risk of becoming **secondary insurers**, in effect, for radiology, anesthesiology, pathology, and other contracted service groups regardless of their status as “**independent contractor**”.
Remedy of Physician Victimized by Hospital Credentialing System

- Physicians who believe they were victimized by a credentialing system driven by an anti-competitive agenda may sue the hospital.
Polmer v. Presbyterian Hospital of Dallas

- $366 million jury verdict in favor of a cardiologist and against a Hospital Chair of Internal Medicine, Chief of Cardiology and Director of Cath Lab who summarily suspended his privileges to perform certain cardiac procedures for 6 months.
Hospitals: “Old” Risks

- Hospitals and medical staff physicians have been “at risk” for acts and omissions of individual physicians in areas of:
  - Clinical competency and
  - Professional behavior
Hospitals: “New” Risks

Legal claims of:
- Corporate negligence,
- Breach of fiduciary duty,
- Fraud and Deceit,
- Anti-trust, and
- False Claims Act violations.
Legal and Regulatory Backdrop

- 21 Century – Intense and growing focus in the health care industry on issues of:
  - *Patient safety, and*
  - *Quality.*
Legal and Regulatory Backdrop

- State and federal regulators are scrutinizing the *effectiveness of the systems* the hospitals have put in place to protect and promote *patient safety* – i.e.
  - Credentialing, and
  - Peer review.
“Hospitals must also take an active part in monitoring the quality of medical services provided by appropriately overseeing the credentialing and peer review of their medical staffs.”
DOJ Suing Hospitals

- High profile criminal and civil cases have been brought by DOJ against Hospitals based on allegations of *negligent or reckless credentialing* process.
Redding Medical Center, Tenet Health Care Corp.

- A $350 million settlement arose out of negligent credentialing of its Chief of Cardiology and Chair of Cardiovascular Surgery relative to their alleged performance of unnecessary cardiac procedures.
False Claims Act  Lawsuit
U.S. v. Tremoglie

In 1997, a Pennsylvania HMO, Keystone Health Plan East, learned that David Tremoglie fraudulently presented himself as a psychiatrist and was employed by a behavioral health organization to treat Keystone patients.
The Government took the position that all claims for reimbursement based on Tremoglie’s work violated the False Claims Act.
In 2003, United Memorial Hospital signed a federal guilty plea agreement in which it admitted to fraud in connection with the alleged over utilization of pain management surgical procedures, one of which resulted in the death of a patient.
The Hospital also admitted to inadequate credentialing of the Chair of Anesthesia and agreed to pay $750,000.
Credentialing is a truly **peer based** process.

- Individuals being considered for privileges must be reviewed with the information and detail necessary to answer the **core** question:

  "**Will this individual deliver high quality care to the first and every subsequent patient?**"
“Old” System of Approval or Re-Approval of Privileges

No longer acceptable to use the question:

“Can we prove the individual is awful enough to not approve or re-approve privileges?”
“New” System of Approval or Re-Approval of Privileges

Instead organizations should be answering the question:

“Do we have sufficient information to prove that the individual continues to be as good as we require?”
New System of Hospital Privileging

- Privileges are not deemed “lifetime entitlements” or *true privileges*.
- Credentialing combines:
  - Thorough *initial evaluation* of an individual’s qualifications, and
  - Ongoing *monitoring process*.
- Candidates must continuously prove themselves to be worthy of trust.
Core Components of Competency

Core components of competency are:

- Judgment,
- Technical performance, and
- Outcome
Competency Component: 
Judgment

Judgment refers to the decisions made during the course of care:
- selecting the right clinical protocol
- the correct medication
- appropriate tests
- requesting necessary consultations
Competency Component: *Technical Performance*

Technical Performance focuses on execution of professional skills used:

- Surgical technique
- History and physical exam
- Interpretation of laboratory values
- Adequacy of communications with other professionals
**Competency Component: Outcomes**

Outcomes is the public’s ultimate measure of professional success:

- Case specific outcomes - “The operation was a success but the patient died” sums up the ultimate negative outcome.
- Cost of case,
- Customer satisfaction, and
- Time it takes to achieve improvement.
Difficult Credentialing Decisions

- Whether or not to grant privileges to an applicant who uses more *costly and dangerous procedures*.
- Even if the applicant’s outcomes have been acceptable, the Credentialing Committee is expected to consider the *costs and risks* incurred in exposing patients to *outdated procedures*.
That’s All Folks