Health Care Alert

PULLMAN & COMLEY

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2016 Round-Up: Key Decisions Affecting Connecticut Health Care Providers

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Connecticut state and federal courts faced a number of significant health care issues last year. We have summarized those cases that we think are particularly relevant to Connecticut hospitals, group practices and individual practitioners. If you would like to discuss any of the matters addressed in these cases, please contact one of our Health Care Law attorneys.

Please also visit Connecticut Health Law, a Pullman & Comley, LLC blog where we provide insights on developments in the law affecting hospitals, physician groups, pharmaceutical and medical device companies and other health care providers and suppliers.

Hospital Liability for the Acts of its Non-Employee Physicians

Resolving confusion in the lower courts, the Supreme Court of Connecticut decided that the doctrine of "apparent agency" can apply in medical malpractice actions to hold a hospital vicariously liable for the negligence of a person whom the hospital holds out as its agent or employee -- such as a physician who has privileges at, but is not directly employed by, the hospital. In Cefaratti v. Aranow, the court set forth two alternative standards for establishing whether a principal can be held liable for an agent's wrongdoing, and remanded the case to the trial court to give the plaintiff an opportunity to present the case under one of the new standards. (See a more detailed discussion of this case in our prior blog.)

Compare our Supreme Court's decision in Cefaratti with the opinion of the Connecticut Appellate Court in Gagliano, et al. v. Advanced Specialty Care, P.C., et al., decided just two months after Cefaratti. In Gagliano, the plaintiffs (a surgical patient and her husband) claimed that a medical resident enrolled at the defendant hospital was an "actual agent" of the hospital and was therefore liable

for the injuries suffered by the patient during surgery in which the medical resident assisted. The Appellate Court held that the plaintiffs produced insufficient evidence from which a jury could find that the resident was the hospital's actual agent. The Connecticut Supreme Court recently agreed to review the case.

Federal Peer Review Privilege Recognized in EMTALA Case

In Grenier v. Stamford Hospital, et al., the District Court of Connecticut (Bryant, J.) denied a plaintiff's motion to compel documents from a hospital in an action brought under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and state medical malpractice law for injuries and, ultimately, the death of a patient while in the care of the hospital. More specifically, the plaintiff sought production of the hospital's peer review materials concerning the care of the decedent to ascertain whether they contained any admission of wrongdoing on the part of hospital staff or violations of EMTALA. The hospital invoked Connecticut's peer review privilege (CGS §19a-17b) as a defense. Because the case involved both federal and state law claims and the facts necessary to prove both claims overlapped, the court applied the general rule that the federal, not the state, law governing privileges was applicable, but, according to the court, neither the United States Supreme Court nor the Second Circuit Court of Appeals has ruled on a federal peer review privilege in the context of medical malpractice.

On balance, the Grenier court determined that the facts of the case warranted recognition of a federal peer review privilege. In support of its decision, the court found that lower courts and other circuits have applied the state peer review privilege in cases involving both state malpractice actions and claims under federal law, such as EMTALA or the Federal Tort Claims Act. The court also agreed with the defendant that the federal Patient Safety and Quality Improvement Act (which provides that documents constituting patient safety work product furnished by or to a patient safety organization are privileged) while not directly applicable, was further evidence warranting the existence of a federal peer review privilege. In addition, the court noted that the plaintiff presented no evidence that the peer review materials he sought would contain relevant information that he could not obtain from other sources, only that these materials *might* contain affirmative admissions of wrongdoing by the hospital.

This case offers a measure of assurance that the confidentiality of the peer review process will be maintained in both federal and state malpractice actions, but note that the court left open the possibility that the privilege might not be recognized in a malpractice case involving federal law if a plaintiff were able to establish that it could not obtain relevant information from other sources.

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Hospitals Can Be Both Urban and Rural under Medicare

Under Medicare, hospitals are initially classified as either "urban" or "rural" based on their geographic location and this classification determines, among other things, the amount of reimbursement the hospital receives under Medicare and the hospital's wage index. Hospitals in urban areas are generally assigned a higher wage index than hospitals in rural areas, but the Medicare statute allows rural hospitals that meet certain criteria to apply to become "urban" for the limited purpose of receiving the higher wage index. (This is particularly attractive to rural hospitals that need to compete with their urban counterparts for trained staff.) Hospitals which are initially classified as "urban" may apply to be reclassified as "rural" for some purposes, such as to obtain easier access to more favorable drug pricing that is available to rural hospitals.

Lawrence + Memorial Hospital was initially classified as an urban hospital but sought rural classification in order to take advantage of the favorable drug pricing available to rural hospitals. It thereafter applied to be reclassified as urban for wage reimbursement purposes and sought a preliminary injunction to prevent the U.S. Secretary of Health and Human Services (HHS) from applying a federal regulation which would have prohibited an urban hospital that had been reclassified as rural from thereafter receiving an additional reclassification to urban. In Lawrence + Memorial Hospital v. Burwell, the Second Circuit Court of Appeals reversed the District Court's grant of summary judgment to HHS, invalidated the federal regulation on the basis that the regulation was inconsistent with the plain language of the Medicare law and remanded the case to the District Court for the imposition of appropriate remedies.

In light of this decision and a similar decision reached by the Third Circuit in 2015, CMS amended the federal reclassification regulation last year to permit an urban hospital to acquire rural status and subsequently to apply for reclassification as an urban hospital in order to receive the higher urban wage index, as well as to allow a rural hospital, which was reclassified as urban to receive the urban wage index, to maintain its rural status for other purposes.

Informed Consent

In McBreairty v. Body Cosmetica, LLC, the Superior Court (J.D. Waterbury) denied a physician's motion to strike portions of the plaintiff's claim that the physician failed to obtain informed consent from the plaintiff prior to her breast augmentation surgery because he did not inform her that his medical license in New York had been subject to discipline, that his medical license in Connecticut was on probation and that he had multiple complaints lodged against him over the years for reasons related to patient safety and/or his skills as a plastic surgeon. The plaintiff also alleged that the physician did not inform her of certain risks associated with the surgery, including disfigurement and infection.

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The court acknowledged that state regulatory authorities do not uniformly impose an obligation on a physician whom they discipline to inform patients of that discipline but noted that a jury could still find that disciplinary information might be material to a reasonable patient and that it would not be unreasonably burdensome to impose a duty on a physician to disclose disciplinary information as a condition precedent to securing informed consent from a patient.

This case illustrates the fact-specific nature of an informed consent claim in Connecticut and recognizes that disclosure of a provider's disciplinary history may be relevant in certain instances.

Hospital's Termination of Nurse Upheld Despite Having Saved Patient's Life

In Morrissey-Manter v. Saint Francis Hospital and Medical Center, et al., the plaintiff, a hospital nurse with a 32-year tenure, was terminated because she altered a piece of medical equipment while assisting other members of the nursing staff in treating an unstable cardiac patient. The hospital determined that the act of altering the medical equipment violated hospital policy and exposed the patient to potentially lethal consequences (though the patient did improve after the equipment was altered). The nurse advanced a number of claims against the hospital's motion for summary judgment, including: (1) that she was working under an implied employment contract; and (2) that her termination violated various public policies, such as the public policy inherent in the state statute requiring hospitals to report adverse events and the public policy prohibiting an employer from terminating an employee in order to cover its own negligence.

The Connecticut Appellate Court found each of the nurse's claims unavailing and affirmed summary judgment in favor of the hospital. The Supreme Court of Connecticut denied review of the case.

Note that while the Appellate Court dismissed all of the nurse's arguments that her termination was in violation of the public policies she raised, the court found that she failed to raise on appeal the argument that the hospital's termination of her employment after she had saved a life violated the public policy of "saving lives." The court deemed that she had abandoned this claim and so it did not rule on it.

Administrator and Director at Rehab Center Not Liable for Negligence of Nurse's Aides

In Colonial Health & Rehab Center of Plainfield, LLC v. State of Connecticut Department of Public Health, a nursing facility dismissed two nurse's aides for their failure to provide appropriate treatment to two incontinent residents of the facility, and the facility self-reported the incidents. Based on the reports, the Connecticut Department of Public Health (DPH) issued a citation for violations of the state Public Health Code on the part of the facility's administrator and director of nurses based on the general regulatory principle that the administrator and director of nurses have overall responsibility for patient care at the facility. DPH also classified the violations as "Class B," indicating that the neglect presented a probability of death or serious harm in the reasonably foreseeable future. The facility contested the findings of DPH and the parties

participated in a formal hearing in which the hearing officer decided in favor of DPH. The facility appealed that decision to the Superior Court (J.D. New Britain).

The court, ruling on issues of first impression, vacated the citation, noting that, normally, judicial review of an agency decision is very restricted, but that the deference accorded to agency decisions is not warranted if the matter involves "pure questions of law." The court found that the issue of whether the facility's administrator and director of nurses could be held strictly liable for the acts of the nurse's aides was a question of law, as was the question of whether the actions of the nurse's aides constituted Class B violations. The court found that DPH failed to establish that the administrator and director of nurses violated any standard of care or provision of the Public Health Code and found no support for DPH's position that because the nurse's aides engaged in neglect, the administrator and director of nurses necessarily violated their duties regarding overall management of the facility. In addition, the court determined that the violations were not Class B because there was no evidence presented during the hearing that the conditions that the residents were subjected to presented a probability of death or serious harm in the reasonably foreseeable future.

Note that the question of whether the facility, as an employer, could be liable for the negligence of the nurse's aides was not at issue here.

Patients Obligated to Pay Hospital Charges Not Covered by Employers' Self-Funded Plans

A Superior Court (J.D. New London) granted summary judgment to a hospital claiming breach of contract against several former patients who refused to pay the balances due for health care services not covered by their employers' self-funded insurance plans.

In William W. Backus Hospital v. Belisle, et al., the court agreed with the hospital that the patients promised to pay the hospital's regular charges (that is, the published pricemaster rates) for the periods of their hospitalization not covered by insurance. Key to the hospital's position was that it could not excuse the patients' unpaid balances as this would violate Connecticut General Statutes §19a-646(b), which prohibits hospitals from providing a discount or different rate of reimbursement from the filed rates or charges to any payer unless an exception applied (such as a written discount agreement executed by the hospital and the payer). The court found no such exception applied and rejected all of the patients' defenses.

Some employers find self-funded plans attractive because they are exempt from state insurance laws and some of the requirements of the Affordable Care Act. Self-insured plans also afford the employer more flexibility as to the plan design and benefits offered and may be less costly to administer. Because Connecticut's prohibition on balance billing does not apply when the insured is covered by a self-funded plan, hospitals might consider what additional steps they can take so that their patients understand the ramifications of being covered by a self-funded plan.

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Psychiatrists Cannot Sue Insurers on Behalf of Patients under ERISA or MHPAEA

In American Psychiatric Ass'n v. Anthem Health Plans, Inc., et al., two psychiatrists and three psychiatric associations brought suit against several health insurers on the basis that the insurers systemically reimbursed providers treating mental health and substance abuse disorders at a less favorable rate than they reimbursed for other health care services, thereby: (1) discriminating against patients suffering from these disorders in violation of the federal Mental Health Parity and Addiction Equity Act (MHPAEA); and (2) breaching their fiduciary duties under the Employee Retirement Income Security Act (ERISA). The plaintiffs claimed that these practices prevented many psychiatrists from accepting health insurance and limited patients' access to psychiatric services. The psychiatrists brought suit on behalf of themselves and their patients, while the associations brought suit on behalf of their members and their members' patients.

The Second Circuit Court of Appeals affirmed the opinion of the District Court of Connecticut that the psychiatrists lacked standing to bring a cause of action under a provision of ERISA that authorizes civil action by a "participant, beneficiary, or fiduciary" arising from the insurer's alleged MHPAEA violations. The court found that the language of the ERISA provision strictly limits the universe of plaintiffs who can bring civil actions -- even with respect to one of the psychiatrists who held an assignment from her patients. The court also held that the three psychiatric associations lacked standing to pursue their claims because their individual members lacked standing.

This case highlights the limitations under ERISA that permit only certain individuals to bring a cause of action against an insurer on behalf of a patient, even under circumstances where the "hot button" issue of parity for mental health coverage is at stake.

Disability Discrimination Claims Against Medical Practice Dismissed

The District Court of Connecticut (Hall, J.) found that a former patient of a professional network of physicians did not have standing to sue the network for discrimination on the basis of disability. In Nastu v. Stamford Health Integrated Practices, et al., the plaintiff made several post-operative visits to his surgeon, both scheduled and unscheduled. During some of these visits the plaintiff became emotional and in some cases, uncontrollable. The surgeon felt that his conduct was improper and she became uncomfortable in his presence. She contacted the network's personnel department to express her concerns and the network sent a letter to the patient informing him that he was not permitted to see any physicians in the network. The plaintiff then filed suit claiming that the network discriminated against him on the basis of a disabling psychiatric disorder under Title III of the federal Americans with Disabilities Act (ADA). He also sued under state law for intentional and negligent infliction of emotional distress, breach of fiduciary duties and defamation.

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The court found that in order to establish standing under Article III of the ADA, the plaintiff must demonstrate, among other things, that it would be reasonable to infer that the plaintiff intended to return to the defendant in the future. The court noted that the plaintiff did not allege an intent to return to the network for medical treatment and that he had in fact found other physicians to treat him. The court also found it implausible that the plaintiff would seek or even reasonably be expected to obtain medical treatment from the very physician group whom he sued. The court declined to extend its federal jurisdiction over the remaining state law claims that the plaintiff raised.

This case emphasizes the care and attention that must be paid to ensuring that appropriate reasons and supporting documentation (including any necessary plans for the patient's future treatment) are in place when health care providers dismiss a patient from their practice or facilities.