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The Health Care Quality Improvement Act of 1986 and Its Impact on Hospital Law

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THE HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986 AND ITS IMPACT ON HOSPITAL LAW

MARK A. COLANTONIO*

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I. INTRODUCTION

In November of 1986, Congress took strong measures to thwart the ever-increasing occurrence of medical malpractice litigation by enacting the Health Care Quality Improvement Act of 1986 (HCQIA).¹ Unlike prior attempts by the states,² HCQIA does not discourage malpractice litigation by limiting recovery. Rather, it seeks to eliminate incompetent medical care.³

HCQIA promotes censorship of inadequate medical care through encouragement of good faith "peer review"⁴ and continued identification of incompetent physicians.⁵ In findings related to HCQIA, Congress stated that the threat of lawsuits, including federal antitrust actions, against hospitals that engage in peer review activity has discouraged effective peer review and has permitted incompetent physicians to move from state to state without disclosing prior incompetent conduct.⁶ HCQIA's answer to this dilemma is to provide broad-based immunity to hospitals that engage in peer review activity while assisting in the establishment of a national data bank of information from which incompetent physicians can be identified.⁷

The content of HCQIA can be distilled into three basic elements. First, it provides immunity from liability for all peer review activity which meets due process and other standards established in its provisions.⁸ Second, hospitals and insurance carriers⁹ alike are required

1. 42 U.S.C.A. § 11101 (West Supp. 1988) [hereinafter HCQIA or "the Act"].

2. Many states have enacted statutes which limit the amount of damages recoverable in medical malpractice actions. *See, e.g.*, W. VA. CODE § 55-7B-8 (Supp. 1988); OHIO REV. CODE ANN. §§ 2307.42-2307.43 (Anderson 1981).

3. 42 U.S.C.A. § 11101 (West Supp. 1988); *see also* H.R. Rep. No. 903, 99th Cong., 2d Sess. 2, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384.

4. "Peer review" is a procedure commonly utilized by health care entities to evaluate the competency of health care practitioners. *See* W. VA. CODE § 30-3C-1 (1986 Repl. Vol.).

5. National Data Bank for Adverse Information on Physicians and Health Care Practitioners [hereinafter Proposed HCQIA Regulations], 53 Fed. Reg. 9264, 9264 (1988) (to be codified at 45 C.F.R. part 60) (proposed Aug. 18, 1987) .

6. 42 U.S.C.A. § 11101 (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9264-65.

7. 42 U.S.C.A. §§ 11111 - 11115 (West Supp. 1988); 42 U.S.C.A §§ 11131 - 11134 (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9268-70 (1988) (to be codified at 45 C.F.R. §§ 60.4-60.8) (proposed Aug. 18, 1987).

8. 42 U.S.C.A. §§ 11111 - 11115 (West Supp. 1988).

9. HCQIA's relationship to insurance carriers is outside the scope of this article.

to report to a national data bank specified information relating to professional competence of physicians and other health care practitioners.¹⁰ Finally, HCQIA requires that hospitals request information from this national data bank for all physicians who apply for or maintain privileges at their facilities.¹¹ Importantly, HCQIA offers substantial benefits for those hospitals that comply with its requirements and effectively penalizes those that fail to do so.

Although not all of HCQIA's elements are yet in place,¹² the Act is designed to have a substantial impact on hospital law. Its intent is to deter the current mass of litigation regarding the granting and termination of medical staff privileges.¹³ In theory, HCQIA will foster higher quality health care and diminish medical malpractice by permitting hospitals to measure the quality of patient care at its source.¹⁴ Although this approach is logical, it remains to be seen whether HCQIA's provisions will facilitate more effective peer review or whether they will result in increased litigation under the Act's standard of "reasonable belief."¹⁵ In any event, it is essential that all health care facilities have a basic understanding of HCQIA's relationship to existing law and have a formula for compliance with its terms.¹⁶

II. HCQIA'S CONTENT

A. Peer Review Immunity

HCQIA provides broad-based immunity from liability for all professional review actions which meet its standards and which are

10. 42 U.S.C.A. §§ 11131 - 11134 (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9268-70 (1988) (to be codified at 45 C.F.R. §§ 60.4-60.8) (proposed Aug. 18, 1987).

11. 42 U.S.C.A. § 11135 (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270-71 (1988) (to be codified at 45 C.F.R. §§ 60.9-60.12) (proposed Aug. 18, 1987).

12. A national data bank has not yet been established due to lack of funding. See Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9264 (1988).

13. H.R. Rep. No. 903, 99th Cong., 2d Sess., 2-3, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384-85.

14. *Id.*

15. HCQIA's reasonable belief and other standards are contained in 42 U.S.C.A. § 11112 (West Supp. 1988).

16. The body of this article provides hospitals and similarly situated health care providers with a basic understanding of HCQIA's content. The Appendix provides more detailed guidelines for compliance with its requirements. Much of the content of this article and its appendix is based on proposed regulations regarding HCQIA. Final regulations are expected to appear sometime in the early part of 1989.

made in the conduct of professional review activity.¹⁷ This immunity encompasses all peer review activity relating to the nature and extent of a physician's privileges at the hospital, including the initial application or any change or modification to already existing privileges.¹⁸ Excluded from protection are review actions primarily based upon matters unrelated to the competence or professional conduct of a physician.¹⁹

Immunity regarding professional review actions extends to all individuals participating in the peer review, including the hospital itself, its governing body, any committee conducting the review activity, any person acting as a member of or staff to the review body, any person under contract or agreement with the review body or anyone who assists or participates in the action.²⁰ Also protected are those providing information to the review body, as a witness or otherwise, unless the information provided is false and the informant knew of its falsity.²¹

Entitlement to peer review immunity is based upon compliance with specified "standards." To qualify, a review action must have been taken: 1) in the "reasonable belief" that it was in the furtherance of quality health care; 2) after a "reasonable" effort to obtain the facts; 3) after adequate notice and hearing procedures were afforded the physician; and 4) in the "reasonable belief" that it was warranted after a reasonable effort to obtain facts and to provide the affected physician adequate notice and a hearing.²² There is a presumption that all review actions have met these requirements;²³ therefore, the physician carries the burden of proof to establish that a particular review action failed to meet these standards.

17. 42 U.S.C.A. §§ 11111, 11151(9) (West Supp. 1988).

18. 42 U.S.C.A. § 11151(9) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9268 (1988) (to be codified at 45 C.F.R. § 60.3) (proposed Aug. 18, 1987).

19. 42 U.S.C.A. § 11151(9) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9268 (1988) (to be codified at 45 C.F.R. § 60.3) (proposed Aug. 18, 1987). *See infra* notes 34-38 and accompanying text.

20. 42 U.S.C.A. § 11111(a)(1) (West Supp. 1988).

21. 42 U.S.C.A. § 11111(a)(2) (West Supp. 1988).

22. *Id.*

23. *Id.*

1. HCQIA Due Process Standards

To provide a physician "adequate notice and hearing," a hospital must follow due process procedures set forth in HCQIA. The affected practitioner must be given notice of any proposed action and an opportunity for a hearing.²⁴ During the hearing, the physician must have the right to be represented by an attorney, to call witnesses on his or her own behalf, and to cross-examine those witnesses called by the hospital.²⁵ The hearing itself must be conducted before a mutually acceptable arbitrator or a panel of persons appointed by the hospital who are not in direct economic competition with the physician whose privileges are at issue.²⁶ Importantly, however, the hospital is not required to provide for appellate review of the decision reached as a result of every hearing.²⁷ The hospital need not provide this aspect of due process where it takes no adverse action against the physician or where a failure to immediately suspend or restrict privileges may result in imminent danger to any patient.²⁸

2. Hospital's Burden

As a further means of discouraging litigation regarding peer review activity, HCQIA provides for the recovery of attorney fees and costs by a hospital defending an action based upon the denial, revocation, or modification of physician staff privileges.²⁹ However, before attorney fees can be awarded, the hospital must show that it substantially prevailed in the underlying lawsuit and that the physician's claim or conduct in the action was frivolous, unreasonable, without foundation, or in bad faith.³⁰

3. Effective Date and Applicability

The effective date of HCQIA's peer review immunity provisions differs in its application to state and federal law. For causes of

24. 42 U.S.C.A. § 11112(a)(3), (b) (West Supp. 1988).

25. 42 U.S.C.A. § 11112(b)(3)(c)(i)-(iii) (West Supp. 1988).

26. 42 U.S.C.A. § 11112(b)(3)(A) (West Supp. 1988).

27. 42 U.S.C.A. § 11112 (West Supp. 1988).

28. 42 U.S.C.A. § 11112(c) (West Supp. 1988).

29. 42 U.S.C.A. § 11113 (West Supp. 1988).

30. *Id.*

action based upon federal law, HCQIA's immunity applies to review actions taken after the effective date of the Act, November 17, 1986.³¹ The states, however, may choose when the immunity provisions will apply to state law. If a state legislature takes no action whatsoever, immunity applies to state law for all review actions commenced on or after October 14, 1989.³² If a state legislature elects to "opt in" early, the immunity provisions will apply to state law for all review actions commenced on or after the effective date chosen by the state legislature.³³ A state legislature may also except the application of HCQIA to its law altogether. In that event, HCQIA's immunity provisions will have no application to actions based upon state law.³⁴

There are other important exceptions to the professional review immunity provisions of HCQIA. Immunity does not apply to a violation of civil rights³⁵ or to an action by the United States Attorney General, including those under the Clayton Act or similar federal statutes.³⁶ Additionally, immunity is inapplicable where a hospital's name has been published in the Federal Register for failing to report information required by HCQIA.³⁷ The most significant exception, however, lies in the fact that HCQIA's immunity was intended to prevent only the recovery of compensatory damages. A physician who questions a hospital's decision regarding staff privileges may seek substantive review in the form of an injunction or declaratory judgment action.³⁸

B. Reporting Requirements

The second primary focus of HCQIA is the establishment of a mechanism for collecting and disseminating specified information regarding physicians and other health care practitioners.³⁹ Creation

31. 42 U.S.C.A. § 11111(c) (West Supp. 1988).

32. 42 U.S.C.A. § 11111(c)(1) (West Supp. 1988).

33. 42 U.S.C.A. § 11111(c)(2)(A) (West Supp. 1988).

34. 42 U.S.C.A. § 11111(c)(2)(B) (West Supp. 1988).

35. 42 U.S.C.A. § 11111(a)(1) (West Supp. 1988).

36. *Id.*

37. 42 U.S.C.A. § 11111(b) (West Supp. 1988); *see infra* note 52 and accompanying text.

38. H.R. Rep. No. 903, 99th Cong., 2d Sess. 9, *reprinted in* 1987 U.S. CODE CONG. & ADMIN. NEWS 6384, 6391.

39. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9267 (1988) (to be codified at 45 C.F.R. § 60.1) (proposed Aug. 18, 1987).

of a “national data bank” and utilization of existing state medical licensing boards accomplish this goal. While HCQIA originally envisioned that the operation of the national data bank with mandatory reporting by hospitals would begin within one year after the Act’s effective date of November 14, 1986,⁴⁰ a shortage of available funds has prevented the bank’s establishment as of the date of this article.⁴¹ Therefore, HCQIA’s mandatory reporting requirements will be implemented after the national data bank is established.⁴² Notice of this date is to be provided in the Federal Register.⁴³

1. Information Required

To comply with HCQIA’s reporting requirements, a hospital must report two types of information. First, it must report to the national data bank and the appropriate state licensing board any payment under an insurance policy or otherwise made in satisfaction or settlement of a medical malpractice claim or judgment against a physician, dentist,⁴⁴ or other licensed health care practitioner.⁴⁵ With respect to each payment, the hospital must submit information which identifies the practitioner on whose behalf payment was made and which states the nature of the claim for which it was made.⁴⁶

Secondly, a hospital must report information to the national data bank when: 1) it takes adverse professional review action affecting the privileges of a physician or dentist for a period of more than thirty days, or 2) a practitioner surrenders privileges while under investigation for competency or in exchange for not conducting such an investigation.⁴⁷ The required information includes an identifi-

40. 42 U.S.C.A. § 11134(a) (West Supp. 1988).

41. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9264 (1988).

42. *Id.*

43. *Id.*

44. The term physician includes licensed doctors of medicine, osteopathy, medical dentistry, and oral surgery. 42 U.S.C.A. § 11151(8) (West Supp. 1988).

45. A licensed health care practitioner includes any individual licensed or authorized by the state to provide health care services. 42 U.S.C.A. § 11151(6) (West Supp. 1988).

46. 42 U.S.C.A. § 11131(b) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269 (1988) (to be codified at 45 C.F.R. § 60.6) (proposed Aug. 18, 1987).

47. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269 (1988) (to be codified at 45 C.F.R. § 60.8(a)(1)) (proposed Aug. 18, 1987). Hospitals are provided the option of reporting similar information regarding other licensed health care practitioners. 42 U.S.C.A. § 11133(a)(2) (West Supp. 1988).

cation of the practitioner and a description of the acts which prompted the review action.⁴⁸ Similarly, state licensing boards are required to report to the national data bank when they revoke or suspend any license to practice medicine or otherwise censure or reprimand a physician.⁴⁹

2. Enforcement

HCQIA's reporting requirements are enforced through fines and loss of peer review immunity. Where a hospital fails to report information regarding medical malpractice payments, it could be subject to a fine of up to \$10,000 for each unreported payment.⁵⁰ A more severe consequence lies in a hospital's failure to report information regarding professional review actions. Where the Secretary of Health and Human Services believes that a hospital has failed to report peer review information, the Department of Health and Human Services will conduct an investigation and provide the hospital a hearing on the matter.⁵¹ If noncompliance is found, the Secretary will publish the hospital's name in the Federal Register.⁵² Hospitals which have their names published are not entitled to HCQIA immunity for any review action taken during a three year period commencing thirty days after the publication.⁵³

3. Disputed Information

A physician, dentist, or health care practitioner may acquire reported information relating to his or her own conduct from the

48. 42 U.S.C.A. § 11133(a)(3); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270 (1988) (to be codified at 45 C.F.R. § 60.8(a)(3)(i), (vi)) (proposed Aug. 18, 1987).

49. 42 U.S.C.A. § 11132 (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269 (1988) (to be codified at 45 C.F.R. § 60.7(a)) (proposed Aug. 18, 1987). The state's responsibilities in this regard have since been expanded by enactment of the Medicare and Medicaid Patient and Program Protection Act of 1987. This Act requires state licensing boards to report information concerning any adverse action taken by the state board against licensed health care practitioners or entities to the national data bank established under HCQIA. See 42 U.S.C.A. § 1396(r)-1396(s) (West Supp. 1988).

50. 42 U.S.C.A. § 11131(c) (West Supp. 1988); Civil Money Penalties for Failure To Report Medical Malpractice Payments and for Breaching the Confidentiality of Information [hereinafter referred to as "Proposed Civil Money Penalty Regulations"], 53 Fed. Reg. 9260 (1988) (to be codified at 42 C.F.R. Part 1003) (proposed July 15, 1987).

51. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270 (1988) (to be codified at 45 C.F.R. § 60.8(c)(1)) (proposed Aug. 18, 1987).

52. *Id.*

53. *Id.*

national data bank.⁵⁴ The reported information may then be challenged by informing the Secretary of Health and Human Services and the reporting entity that the particular information is in dispute and by stating the reasons for the dispute.⁵⁵ If the reporting entity refuses to revise the challenged information, the Secretary will review the information and either: 1) note the data as “disputed” and provide a brief statement as to the nature of the dispute, or 2) correct the information and forward this new data to those who have made previous inquiries regarding that physician.⁵⁶

C. *Duty To Request Information*

In addition to information reports, HCQIA requires that a hospital request information from the national data bank under certain circumstances. For example, hospitals must request reported information regarding any physician, dentist, or licensed health care practitioner who applies for clinical privileges.⁵⁷ In addition, a hospital must request information every two years regarding these categories of individuals who maintain privileges at its facilities.⁵⁸ The request for information must seek all data required to be reported under HCQIA, including incidents of medical malpractice payments and adverse peer review actions.⁵⁹ A hospital is not required to request this information until such time as the national data bank is established.⁶⁰

The primary incentive for compliance with the requirement to request information lies in its effect on potential medical malpractice liability. Where a hospital fails to request information, the hospital is presumed in any subsequent medical malpractice action to have knowledge of all reported data regarding the physician for whom

54. *Id.* (to be codified at 45 C.F.R. § 60.10(a)(2)) (proposed Aug. 18, 1987).

55. *Id.* at 9271 (1988) (to be codified at 45 C.F.R. § 60.13(b)(1)) (proposed Aug. 18, 1987).

56. *Id.* (to be codified at 45 C.F.R. § 60.13(c)(2)) (proposed Aug. 18, 1987).

57. 42 U.S.C.A. § 11135 (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270 (1988) (to be codified at 45 C.F.R. § 60.9(a)(1)) (proposed Aug. 18, 1987).

58. 42 U.S.C.A. § 11135 (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270 (1988) (to be codified at 45 C.F.R. § 60.9(a)(2)) (proposed Aug. 18, 1987).

59. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269-70 (1988) (to be codified at 45 C.F.R. §§ 60.6, 60.8, 60.9) (proposed Aug. 18, 1987).

60. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9264.

it failed to request information.⁶¹ Plaintiffs' attorneys may obtain reported information from the national data bank where available evidence suggests that a hospital which is a party to a medical malpractice action failed to request information regarding a physician whose conduct is at issue.⁶² A hospital that complies with HCQIA's terms may rely on the national data bank information and may not be held liable for such reliance unless the hospital knew the provided information to be false.⁶³

All information either reported to or requested from the national data bank or the appropriate state licensing board is strictly confidential.⁶⁴ Any person breaching this confidentiality is subject to a civil penalty of up to \$10,000.⁶⁵

III. THE IMPACT OF HCQIA ON EXISTING HEALTH CARE LAW

HCQIA's impact on existing health care law focuses on two areas of hospital law. The first encompasses the liability of health care facilities for alleged negligence in permitting incompetent physicians to exercise staff privileges. The second area embraces liability for denial or termination of physician staff privileges. To completely understand HCQIA's effect, one must review both kinds of liability

61. 42 U.S.C.A. § 11135(b) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270 (1988) (to be codified at 45 C.F.R. § 60.9(b)) (proposed Aug. 18, 1987).

62. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270 (1988) (to be codified at 45 C.F.R. § 60.10(a)(4)) (proposed Aug. 18, 1987).

63. 42 U.S.C.A. § 11135(c) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270 (1988) (to be codified at 45 C.F.R. § 60.9(c)) (proposed Aug. 18, 1987). The statute itself fails to provide a definition of "knowledge"; however, the legislative history states that "hospitals may rely on information provided to them pursuant to the bill and shall not be held liable for such reliance in the absence of the hospital's *actual knowledge* that the information provided was false." H.R. Rep. No. 908, 99th Cong., 2d Sess. 6, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6344, 6402 (emphasis added). From the "actual knowledge" language, it would appear that the fiction of "apparent knowledge" will not be employed in this context; however, a final determination of the definition of "knowledge" will inevitably be given by the courts.

64. 42 U.S.C.A. § 11137(b)(7) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9271 (1988) (to be codified at 45 C.F.R. § 60.12(a)) (proposed Aug. 18, 1987).

65. 42 U.S.C.A. § 11137(b)(2) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9271 (1988) (to be codified at 45 C.F.R. § 60.12(b)) (proposed Aug. 18, 1987). Note that 42 U.S.C.A. § 11137(b)(2) (West Supp. 1988) specifically uses the word "person." Also, the extent of the civil money penalty imposed is governed by the circumstances of each case; see Proposed Civil Money Penalty Regulations 53 Fed. Reg. 9260 (to be codified at 45 C.F.R. pt. 1003) (proposed July 15, 1987).

and examine the current status of each under existing health care law.

A. *Liability to Patients*

1. Common Law

A growing number of jurisdictions have recognized a claim based upon a hospital's negligence in granting staff privileges to an incompetent physician or in permitting an incompetent physician to continue to exercise privileges at its facilities.⁶⁶ The recent decision in *Johnson v. Misericordia Community Hospital*⁶⁷ is an example of this trend. In *Johnson*, the plaintiff brought an action against a hospital and alleged that the hospital negligently appointed the plaintiff's treating physician to its medical staff. The jury awarded damages to the plaintiff and the hospital appealed.⁶⁸ The Wisconsin Supreme Court affirmed the jury verdict, holding that a hospital has a duty to exercise reasonable care in the selection of its medical staff.⁶⁹

The *Johnson* court based its holding on a contemporary analysis of a hospital's relationship to the patients it serves. The court recognized that negligence is inextricably intertwined with the concept of foreseeability and reasoned that the fundamental issue was whether the hospital should have foreseen that its failure to verify a physician's training, experience, and qualifications, as well as to pass judgment on the applicant, would present an unreasonable risk of harm to patients.⁷⁰ Answering this inquiry in the affirmative, the court stated that its holding was consistent with the present state of health care and the public's reasonable expectations of receiving quality medical care at hospital facilities.⁷¹ *Johnson* is also consistent

66. The West Virginia Supreme Court of Appeals has recently recognized that a plaintiff may recover from a hospital for negligently permitting an incompetent physician to practice at its facilities. *Roberts v. Stevens Clinic Hospital, Inc.*, 345 S.E.2d 791 (W. Va. 1986).

67. *Johnson v. Misericordia Community Hosp.*, 99 Wis. 2d 708, 301 N.W.2d 156 (1981).

68. *Id.*

69. *Id.* at 723, 301 N.W.2d at 164.

70. *Id.* at 722-23, 301 N.W.2d at 163-64.

71. *Id.* at 721, 301 N.W.2d at 164.

with the complex manner in which a modern medical facility operates, including the manner in which it appoints physicians to its staff, hires employees, residents, and nurses, and receives payment for services through private or public insurance.⁷²

2. Outlook Under HCQIA

A hospital's compliance with HCQIA could significantly reduce its potential liability for alleged negligence in granting staff privileges or in permitting a physician to continue to exercise privileges at its facilities. HCQIA requires that a hospital request information regarding any physician who applies for staff privileges, and, once every two years, the hospital must request information concerning all physicians who exercise privileges at its facilities.⁷³ Where a hospital complies with HCQIA's information requirement, the hospital may rely on information provided to it and may not be held liable for such reliance.⁷⁴ It follows that where a hospital requests information from the national data bank regarding an applicant for staff privileges and is told that no such record exists, the hospital may rely on the absence of reported information and may not be held liable in a subsequent malpractice action for alleged negligence for permitting that physician to exercise privileges at its facilities.⁷⁵ The same theory should hold true for physicians already possessing staff privileges, where the hospital requests HCQIA information once every two years regarding physicians on its medical and dental staffs.⁷⁶ In fact, permitting reliance in this fashion may prompt hospitals to request information on a more frequent basis than required in the Act.

3. New Problems Under HCQIA Reliance

Should a defense based upon the absence of reported HCQIA information prove successful, several additional issues will arise. For

72. *Id.*

73. *See supra* notes 56 to 63 and accompanying text.

74. *Id.*

75. *Id.*

76. *Id.*

instance, HCQIA only requires reporting of information related to acts which occur after the establishment of the national data bank.⁷⁷ Therefore, to what extent may a hospital rely on the absence of HCQIA information during the first few years after the creation of the national data bank?

An additional question is whether HCQIA's confidentiality provisions preclude a plaintiff in a medical malpractice action from discovering what reported information a hospital actually considered in its decision to grant a particular physician staff privileges. For instance, suppose a hospital is considering a new applicant for membership to its medical staff, and it receives a national data bank report indicating prior medical malpractice payments and a review action. Notwithstanding this information, the hospital grants staff privileges. The physician is subsequently sued for acts of medical malpractice which occurred within the scope of hospital privileges. Can the plaintiff now discover whether the hospital knew of the reported information? Is the consideration of this data evidence of hospital negligence? The confidentiality provisions of the Act appear to resolve this question in the negative because they prohibit disclosure of information reported to the national data bank.⁷⁸ However, resolution of these important questions is left to the courts.

B. Liability to Staff

The second aspect of HCQIA's impact lies in its effect on a hospital's liability with respect to denial or termination of physician staff privileges. However, a review of current law reveals that this impact will vary from jurisdiction to jurisdiction and will depend upon the protection already afforded hospitals under existing peer review statutes and related state law.⁷⁹

77. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269 (1988) (to be codified at 45 C.F.R. § 60.5) (proposed Aug. 18, 1987).

78. 42 U.S.C.A. § 11137(b) (West Supp. 1988).

79. For a compilation of cases relating to the denial or termination of physician staff privileges, see Annotation, *Exclusion of or Discrimination Against Physician or Surgeon by Hospital* 37 A.L.R.3d 645 (1971).

1. Due Process Liability

Generally, the ability of a hospital to terminate physician staff privileges depends upon the hospital's status as public or private. A public hospital's denial or termination of physician staff privileges is deemed "state action."⁸⁰ As a result, public hospitals must comply with constitutional principles of due process when making decisions which affect physician staff privileges.⁸¹

On the other hand, a majority of courts, including the West Virginia Supreme Court of Appeals, have held that private hospitals, like private corporations, are not subject to due process requirements.⁸² Therefore, decisions of private hospitals are not subject to judicial review⁸³ as long as a private hospital complies with terms of its own bylaws when denying or revoking physician privileges.⁸⁴ In determining whether a breach of the bylaws occurred, courts in recent decisions have adopted a more appropriate standard of "substantial compliance" and have permitted recovery only where there is considerable deviation from the bylaws.⁸⁵

The general principle of non-review for private hospitals has come under increasing attack in recent years. A small minority of courts has interjected a substantive standard of review into this general rule and has held that the hospital's decision to deny or terminate staff privileges is reviewable under an arbitrary or capricious standard.⁸⁶

80. Generally, the term "private hospital" covers all privately owned and managed facilities. However, the actions of any facility become "public" where there is a sufficient nexus between the state and the challenged action of the hospital so that the challenged action may fairly be treated as that of the state itself. *Modaber v. Culpeper Memorial Hospital, Inc.*, 674 F.2d 1023 (4th Cir. 1982). The West Virginia Supreme Court of Appeals outlined those factors which should be considered in determining the public-private distinction in *Orteza v. Monongalia County Gen. Hosp.*, 318 S.E.2d 40 (W. Va. 1984).

81. See *Orteza*, 318 S.E.2d 40; *Darlak v. Bobear*, 814 F.2d 1055 (5th Cir. 1987); *State ex rel. Sams v. Ohio Valley Gen. Hosp. Assoc.*, 149 W. Va. 229, 140 S.E.2d 457 (1965).

82. *Sams*, 149 W. Va. 229, 140 S.E.2d 457; *Gotsis v. Lorain Community Hosp.*, 46 Ohio App. 2d 8, 345 N.E.2d 641 (1974); *Pepple v. Parkview Memorial Hosp., Inc.*, 511 N.E.2d 467 (Ind. Ct. App. 1987).

83. *Sams*, 149 W. Va. 229, 140 S.E.2d 457.

84. *Id.*

85. *Willman v. St. Joseph Hosp.*, 684 S.W.2d 408 (Mo. Ct. App. 1984); *Kirk v. Jefferson County Medical Soc'y*, 577 S.W.2d 419 (Ky. Ct. App. 1979); *Terre Haute Regional Hosp., Inc. v. El-Issa*, 470 N.E.2d 1371 (Ind. Ct. App. 1984) [hereinafter referred to as *El-Issa*].

86. *El-Issa*, 470 N.E.2d at 1382; *Pepple*, 511 N.E.2d 467.

Substantive review has apparently been based upon a gratuitous concept of due process and has often resulted in conflicting decisions. The inappropriateness of this standard and the conflict it generates is readily apparent in a recent Indiana appellate court decision. In *Pepple v. Parkview Memorial Hospital*,⁸⁷ a physician sought judicial review of a private hospital's decision to limit his privileges. His claim to a substantive review was based upon another Indiana appellate court's adoption of the arbitrary or capricious standard in *Terre Haute Regional Hospital, Inc. v. El-Issa*.⁸⁸ Upon appeal, the *Pepple* court held that, notwithstanding *El-Issa*, a private hospital's decision was not subject to substantive judicial review.⁸⁹

At the outset, the *Pepple* court recognized that other Indiana courts had gratuitously added an arbitrary or capricious standard to the general rule of no judicial review.⁹⁰ The court reasoned, however, that review of a private hospital's decision under these standards effectively added a substantive aspect to an unadorned procedural matter⁹¹ and that authority for such review was lacking because due process is inapplicable without state action.⁹² Therefore, a private hospital's decision may not be reviewed for arbitrariness or capriciousness.⁹³

2. Antitrust Liability

In addition to the theories of liability discussed above, both public and private hospitals alike have been increasingly subject to state and federal antitrust claims. Antitrust actions are far more detrimental to effective peer review because hospitals incur enormous defense costs in this complex and protracted litigation.⁹⁴ For ex-

87. *Pepple*, 511 N.E.2d 467.

88. *El-Issa*, 470 N.E.2d 1371.

89. *Pepple*, 511 N.E.2d at 469.

90. *Id.*

91. *Id.*

92. *Id.*

93. *Id.*

94. Congress specifically cited the specter of antitrust litigation as a principal reason for the enactment of HCQIA's peer review immunity provisions. 42 U.S.C.A. § 11101(4) (West Supp. 1988); see also H.R. Rep. No. 903, 99th Cong. 2d Sess. 9, reprinted in U.S. CODE CONG. & ADMIN. NEWS 6384, 6391-92.

ample, a thoracic surgeon in *Robinson v. Magovern*⁹⁵ brought suit against a hospital at which he was denied staff privileges. The physician's complaint contained antitrust claims based on violations of sections one and two of the Sherman Act.⁹⁶ The action was finally resolved in favor of the hospital after three years of extensive discovery, substantial testimony from expert witnesses relating to the hospital's relevant market area, and a ten week bench trial.⁹⁷

3. Effect of State Peer Review Statutes

The advent of state peer review statutes has altered theories on which hospitals, both public and private, can be held liable for terminating or modifying physician staff privileges.⁹⁸ Nearly all states now provide immunity to hospitals which engage in peer review.⁹⁹ This immunity commonly extends to all individuals participating in the review unless their actions are grossly negligent or malicious.¹⁰⁰ Public and private hospitals can be held liable under these statutes for failing to follow their bylaws in denying or terminating staff privileges only if the physician can show that the noncompliance was willful or malicious.¹⁰¹

The United States Supreme Court has held that state peer review statutes do not protect hospitals from possible antitrust litigation. In *Patrick v. Burget*¹⁰² the Court held that the state action doctrine¹⁰³

95. *Robinson v. Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981), *aff'd per curiam*, 688 F.2d 824 (3d Cir. 1982), *cert. denied*, 459 U.S. 971 (1982).

96. *Robinson*, 521 F. Supp. at 886. Section one of the Sherman Act declares every contract, combination, or conspiracy in restraint of interstate commerce to be illegal. 15 U.S.C. § 1 (1982). Section two of the Sherman Act prohibits anyone from monopolizing, attempting to monopolize, or conspiring to monopolize any part of interstate commerce. 15 U.S.C. § 2 (1982).

97. *Robinson*, 521 F. Supp. at 848. The case was also appealed to the Third Circuit Court of Appeals which affirmed, *per curiam*, the rulings of the district court, and eventually was appealed to the United States Supreme Court, which denied certiorari.

98. The West Virginia Peer Review Statute is contained in W. VA. CODE §§ 30-3C-1 to -3 (Repl. Vol. 1986).

99. See W. VA. CODE § 30-3C-3 (Repl. Vol. 1986).

100. W. VA. CODE § 30-3C-2(b) (Repl. Vol. 1986).

101. See *Adkins v. Sarah Bush Lincoln Health Center*, 158 Ill. App. 3d 982, 511 N.E.2d 1267 (1987); *Veldhuis v. Allan*, 164 Mich. App. 131, 416 N.W.2d 347 (1987).

102. *Patrick v. Burget*, 108 S. Ct. 1658, 1662 (1988).

103. In *Parker v. Brown*, 317 U.S. 341 (1943), the United States Supreme Court held that the Sherman Act does not prohibit anticompetitive actions of a state. The "state-action doctrine" is an

does not prohibit physicians from initiating federal antitrust actions despite the immunity provided under state peer review statutes. The Court reasoned that the state action doctrine applies only where anticompetitive conduct is actively supervised by the state itself.¹⁰⁴ However, states do not supervise or exercise "ultimate control" over the conduct of peer review because no state agency reviews hospital peer review decisions.¹⁰⁵ Therefore, immunity provided under state peer review statutes does not affect antitrust actions.¹⁰⁶

4. Outlook Under HCQIA

HCQIA was intended to have a substantial impact on litigation concerning denial or termination of physician staff privileges. Public hospitals will now have an express standard by which to measure the notice and hearing procedures.¹⁰⁷ Those that comply with HCQIA standards will no longer be subject to due process claims.¹⁰⁸ HCQIA's standard of reasonable belief will replace other theories on which a hospital can be liable to a physician.¹⁰⁹ Most importantly, HCQIA's immunity provisions include all actions based upon antitrust violations.¹¹⁰ In summary, what was once a complex area of the law, often dependent upon public, private, or other distinctions, will now fall under the due process and reasonable belief standards of one Act.

extension of the *Parker* holding. The "state-action doctrine" extends immunity from Sherman Act liability to private parties whenever such private parties' anticompetitive acts were truly the product of state regulation. The Court applies a rigid, two-part test for determining whether a private party should be afforded such immunity. First, the Court will ask whether state policy has clearly articulated and affirmatively expressed the challenged restraint. Second, the Court will determine whether the state itself actively supervised the anticompetitive conduct of the private party. Only if the Court answers both of these inquiries in the affirmative will the anticompetitive act of a private party be attributed to the state. *Patrick*, 108 S. Ct. at 1662-63. *But see Bolt v. Halifax Hosp. Medical Center*, 851 F.2d 1273 (11th Cir. 1988) (holding that Florida hospitals are entitled to immunity under the "state action doctrine" since the state had actively supervised peer review through the court system).

104. *Patrick*, 108 S. Ct. at 1662-63.

105. *Id.* at 1664.

106. *Id.* at 1665.

107. 42 U.S.C.A. § 11112 (West Supp. 1988).

108. 42 U.S.C.A. § 11111 (West Supp. 1988).

109. 42 U.S.C.A. § 11112(a) (West Supp. 1988).

110. 42 U.S.C.A. § 11111(a) (West Supp. 1988).

5. New Problems Under HCQIA Reasonable Belief

It remains unclear whether HCQIA's immunity provisions will reduce litigation concerning medical staff privileges. Importantly, HCQIA does not prohibit a physician from seeking judicial review of a hospital's decision through declaratory or injunctive relief.¹¹¹ Such actions will remain the province of existing law.

In addition, HCQIA's reasonable belief standards may precipitate issues of fact to be resolved by a jury. In fact, typical antitrust allegations may circumvent HCQIA altogether because a denial of staff privileges, when made in furtherance of a conspiracy in restraint of trade, cannot be based upon a reasonable belief that the action was warranted.¹¹² The possibility that attorney fees will be awarded to a successful defendant under HCQIA should not dissuade prospective plaintiffs because imposition of fees requires proof that the plaintiff's action was frivolous—a standard similar to the conservative approach under Rule 11 of the Federal Rules of Civil Procedure. It simply will be left to the courts to utilize the presumption¹¹³ that a hospital has met HCQIA's requirements in order to resolve these and other potential issues at an early stage of litigation.

IV. CONCLUSION

All health care facilities should become familiar with HCQIA's content for a number of reasons. First, many of HCQIA's immunity provisions have already taken effect. Second, the mandated national physician malpractice data bank will soon be established, and each health care facility will want to make every effort to comply with HCQIA's terms for reporting and requesting information because the benefits are substantial and the consequences of non-compliance are equally severe. Finally, each facility should consider amending its bylaws to reflect notice and hearing procedures required under HCQIA.

111. 42 U.S.C.A. § 11111(a)(1) (West Supp. 1988); See H.R. Rep. No. 903, 99th Cong., 2nd Sess. 9, reprinted in 1987 U.S. CODE CONG. & ADMIN. NEWS 6384, 6391.

112. 42 U.S.C.A. § 11112(a)(4) (West Supp. 1988).

113. See *supra* note 21 and accompanying text.

The enactment of HCQIA could prove to be a substantial step in the direction of controlling incompetent medical care. Under the current state of affairs, a facility which terminates or denies staff privileges because of concerns about a physician's competence is often faced with the expense of protracted litigation regarding its decision. On the other hand, if the hospital permits the physician to exercise privileges, it faces the prospect of patient litigation as a result of the physician's acts of medical malpractice. HCQIA eliminates this "Catch-22" in favor of promoting effective peer review and granting immunity to facilities which are in compliance with HCQIA. The end result should be that oversight of quality medical care is placed in the hands of those most qualified—the hospital's experts.

The courts will ultimately be called upon to enforce the provisions of HCQIA. Although Congress clearly intended the Act to severely limit judicial participation in decisions regarding physician staff privileges, the Act incorporates a standard of reasonable belief and thereby constructs a door through which courts may entertain substantive reviews of hospital review boards' decisions. Clearly, HCQIA's goals will only be accomplished if a court utilizes the Act's presumption that a hospital has met the Act's standards and then resolves the action on a motion to dismiss or a motion for summary judgment. Should this not occur, HCQIA has the potential to create a new wave of litigation which will again deter effective peer review.

APPENDIX

*A Practical Guide to the Health Care Quality Improvement Act and Corresponding Regulations*¹¹⁴

Immunity Provided by HCQIA

I. WHAT KINDS OF IMMUNITY ARE PROVIDED TO THE HOSPITALS THAT COMPLY WITH HCQIA?

HCQIA provides immunity from civil liability in three circumstances:

- A. a person or entity that reports information to the national data bank under HCQIA is not liable for the information reported unless the information is reported with knowledge that it was false;¹¹⁵
- B. a hospital that requests and then relies upon HCQIA information about a physician, dentist or health care practitioner is not liable unless the hospital knew the information requested was false;¹¹⁶ and
- C. a hospital is provided broad-based immunity from civil liability under any federal or state law for peer review activity regarding physicians.¹¹⁷

II. WHAT MUST A HOSPITAL DO IN ORDER TO QUALIFY FOR PEER REVIEW IMMUNITY UNDER HCQIA?

The peer review immunity provisions of HCQIA apply to a hospital that:

- A. is licensed to provide health care services by the state of its location;¹¹⁸
- B. falls within the definition of "hospital" contained in 42 U.S.C. §§ 1395x(e)(1) through (7);¹¹⁹
- C. meets due process and other standards of HCQIA for peer review actions;¹²⁰
- D. is not published in the Federal Register for failing to meet the reporting requirements of HCQIA.¹²¹

114. 42 U.S.C.A. § 11101 (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264-65.

115. 42 U.S.C.A. § 11137(c) (West Supp. 1988).

116. 42 U.S.C.A. § 11135(c) (West Supp. 1988).

117. 42 U.S.C.A. §§ 11111(a)(1), 11151(9), 11151(10) (West Supp. 1988).

118. 42 U.S.C.A. §§ 11111(a)(1), 11151(4)(A)(i), 11151(10) (West Supp. 1988).

119. 42 U.S.C.A. §§ 11111(a)(1), 11151(5) (West Supp. 1988).

120. 42 U.S.C.A. § 11111(a)(1) (West Supp. 1988).

121. 42 U.S.C.A. § 11111(b) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270 (1988) (to be codified at 45 C.F.R. § 60.8(c)(1)) (proposed Aug. 18, 1987).

III. WHAT IS THE SCOPE OF A HOSPITAL'S IMMUNITY WITH RESPECT TO PEER REVIEW ACTIVITY?

HCQIA provides immunity for professional review activity which results in professional review action.¹²²

A. Professional review activity includes activity:

1. to determine whether a physician may have clinical privileges or membership in the hospital;¹²³
2. to determine the scope or conditions of such privileges or membership;¹²⁴ or
3. to change or modify such privileges or membership.¹²⁵

B. Professional review action includes:

1. an action or recommendation by a hospital that:¹²⁶
 - a) is taken or made as the result of peer review or professional review activity;¹²⁷
 - b) is based on the competence or professional conduct of a physician whose conduct affects or could adversely affect the health or welfare of patients;¹²⁸ and
 - c) affects or may adversely affect the privileges of a physician.¹²⁹
2. a formal decision not to take action or make the recommendations described in 1) above, including peer review or professional review activities relating to a review action.¹³⁰

C. Professional review action does not include actions which are primarily based on:

1. the physician's association or lack of association with a professional society or association;¹³¹
2. the physician's fees, advertising, or engagement in other competitive acts designed to solicit or retain business;¹³²
3. the physician's participation in prepaid group health plans, salaried employment, or engagement in any other means of delivering health services, whether on a fee-for-service or other basis;¹³³
4. the physician's association with, supervision of, delegation of authority to,

122. 42 U.S.C.A. §§ 11111(a)(1), 11151(9), 11151(10) (West Supp. 1988).

123. 42 U.S.C.A. § 11151(10) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9268 (1988) (to be codified at 45 C.F.R. § 60.3) (proposed Aug. 18, 1987).

124. 42 U.S.C.A. § 11151(10)(B) (West Supp. 1988).

125. 42 U.S.C.A. § 11151(10)(C) (West Supp. 1988).

126. 42 U.S.C.A. § 11151(9) (West Supp. 1988).

127. 42 U.S.C.A. § 11151(9) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9268 (1988) (to be codified at 45 C.F.R. § 60.3) (proposed Aug. 18, 1987).

128. See *supra* note 127.

129. *Id.*

130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.*

support for, training of, or participation in a private group practice with a member or members of a particular class of health care practitioners;¹³⁴ or 5. any other matter that does not relate to the competence or professional conduct of the physician.¹³⁵

IV. WHO IS ENTITLED TO IMMUNITY FOR PROFESSIONAL REVIEW ACTION OF A HOSPITAL?

The following individuals and entities fall within the purview of HCQIA's peer review immunity:

- A. the hospital itself;¹³⁶
- B. the hospital governing body participating in the review activity;¹³⁷
- C. any hospital committee participating in the review activity;¹³⁸
- D. any committee of the hospital medical staff assisting in conducting the review activity;¹³⁹
- E. any person acting as a member or as staff to parts A through D above;¹⁴⁰
- F. any person under contract or other formal agreement with members A through D;¹⁴¹
- G. any person who participates in or assists with parts A through D;¹⁴²
- H. any person who as a witness or otherwise in parts A through D provides information in regard to the competence or professional conduct of a physician, dentist, or health care practitioner.¹⁴³

V. WHEN DO THE PEER REVIEW IMMUNITY PROVISIONS OF HCQIA TAKE EFFECT?

The peer review immunity provisions of HCQIA are effective:

- A. for review actions based on federal law that were commenced after November 14, 1986;¹⁴⁴ or
- B. for review actions based on state law:
 1. on or after October 14, 1989 where a state takes no legislative actions;¹⁴⁵ or
 2. on the date a state legislatively adopts HCQIA if the state adopts HCQIA

134. *Id.*

135. *Id.*

136. 42 U.S.C.A. §§ 11111(a)(1)(A), 11151(11), 11151(4)(A)(i), 11151(5) (West Supp. 1988).

137. 42 U.S.C.A. §§ 11111(a)(1)(A), 11151(11) (West Supp. 1988).

138. *Id.*

139. *Id.*

140. 42 U.S.C.A. § 11111(a)(1)(B) (West Supp. 1988).

141. 42 U.S.C.A. § 11111(a)(1)(C) (West Supp. 1988).

142. 42 U.S.C.A. § 11111(a)(1)(D) (West Supp. 1988).

143. 42 U.S.C.A. § 11111(a)(2) (West Supp. 1988).

144. 42 U.S.C.A. § 11111(c)(1) (West Supp. 1988).

145. *Id.*

prior to October 14, 1989;¹⁴⁶ but

3. immunity provisions will not apply if the state legislatively elects to opt out of such treatment.¹⁴⁷

VI. WHAT ARE THE EXCEPTIONS TO THE REVIEW IMMUNITY OF HCQIA?

The peer review immunity provided under HCQIA does not apply to:

- A. a violation of civil rights;¹⁴⁸
- B. action by the United States or the Attorney General, including actions under the Clayton Act;¹⁴⁹
- C. any person providing information of peer review activity where the information is false and the person knew of its falsity;¹⁵⁰
- D. actions brought by physicians for injunctive or declaratory relief;¹⁵¹
- E. peer review actions which do not meet the due process or other standards of HCQIA;¹⁵² or
- F. those hospitals which are published in the Federal Register for failing to report information required by HCQIA.¹⁵³

VII. HOW DOES A HOSPITAL MEET THE DUE PROCESS AND OTHER STANDARDS OF HCQIA WITH RESPECT TO REVIEW ACTIVITY?

- A. A hospital complies with the due process and other standards of HCQIA where the review action at issue was taken:
 - 1. in the reasonable belief that the action was in the furtherance of quality health care;¹⁵⁴
 - 2. after a reasonable effort to obtain the facts of the matter;¹⁵⁵
 - 3. in the reasonable belief that the action was warranted by the facts known after such reasonable efforts to obtain facts;¹⁵⁶ and
 - 4. after the physician, dentist or health care practitioner is afforded the hearing and notice procedures set forth in HCQIA or such other procedures as are fair under the circumstances.¹⁵⁷

146. 42 U.S.C.A. § 11111(c)(2) (West Supp. 1988).

147. 42 U.S.C.A. § 11111(c)(2)(B) (West Supp. 1988).

148. 42 U.S.C.A. § 11111(a)(1) (West Supp. 1988).

149. *Id.*

150. 42 U.S.C.A. § 11111(a)(2) (West Supp. 1988).

151. *See supra* note 38 and accompanying text.

152. 42 U.S.C.A. § 11111(a) (West Supp. 1988).

153. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270 (1988) (to be codified at 45 C.F.R. § 60.8) (proposed Aug. 18, 1987).

154. 42 U.S.C.A. § 11112(a)(1) (West Supp. 1988).

155. 42 U.S.C.A. § 11112(a)(2) (West Supp. 1988).

156. 42 U.S.C.A. § 11112(a)(4) (West Supp. 1988).

157. 42 U.S.C.A. § 11112(a)(3) (West Supp. 1988).

B. A hospital is presumed to have met the due process and other standards of HCQIA unless rebutted by a preponderance of the evidence.¹⁵⁸

C. To comply with the adequate notice and hearing procedures (“due process”) of HCQIA a hospital must:

1. provide the physician against whom an action is contemplated with a written notice stating:
 - a) that a professional review action has been proposed to be taken against him;¹⁵⁹
 - b) the reasons for the proposed action;¹⁶⁰
 - c) that he has the right to request a hearing on the proposed action;¹⁶¹
 - d) a time limit within which he must request a hearing (this time limit cannot be less than 30 days);¹⁶² and
 - e) a summary of the rights required in the hearing.¹⁶³
2. provide a physician who has requested a hearing with additional written notice stating:
 - a) the place, time, and date of the hearing (the hearing date cannot be less than 30 days after the date of the notice);¹⁶⁴ and
 - b) a list of witnesses expected to testify at the hearing.¹⁶⁵
3. any hearing provided a physician must be held before:
 - a) an arbiter mutually acceptable to the physician and hospital;¹⁶⁶
 - b) any hearing officer appointed by the hospital who is not in direct economic competition with the physician whose privileges are at issue;¹⁶⁷ or
 - c) a panel of individuals appointed by the hospital and not in direct economic competition with the physician whose privileges are at issue.¹⁶⁸
4. At the hearing the physician whose privileges are at issue must have the right:
 - a) to be represented by an attorney or other person of his choice;¹⁶⁹
 - b) to have a record made of the hearing and receive a copy of the same;¹⁷⁰
 - c) to call, examine and cross-examine witnesses;¹⁷¹
 - d) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law;¹⁷² and
 - e) to submit a written statement at the close of hearing.¹⁷³

158. 42 U.S.C.A. § 11112(a) (West Supp. 1988).

159. 42 U.S.C.A. § 11112(b)(1)(A)(i) (West Supp. 1988).

160. 42 U.S.C.A. § 11112(b)(1)(A)(ii) (West Supp. 1988).

161. 42 U.S.C.A. § 11112(b)(1)(B)(i) (West Supp. 1988).

162. 42 U.S.C.A. § 11112(b)(1)(B)(ii) (West Supp. 1988).

163. 42 U.S.C.A. § 11112(b)(1)(C) (West Supp. 1988).

164. 42 U.S.C.A. § 11112(b)(2)(A) (West Supp. 1988).

165. 42 U.S.C.A. § 11112(b)(2)(B) (West Supp. 1988).

166. 42 U.S.C.A. § 11112(b)(3)(A)(i) (West Supp. 1988).

167. 42 U.S.C.A. § 11112(b)(3)(A)(ii) (West Supp. 1988).

168. 42 U.S.C.A. § 11112(b)(3)(A)(iii) (West Supp. 1988).

169. 42 U.S.C.A. § 11112(b)(3)(C)(i) (West Supp. 1988).

170. 42 U.S.C.A. § 11112(b)(3)(C)(ii) (West Supp. 1988).

171. 42 U.S.C.A. § 11112(b)(3)(C)(iii) (West Supp. 1988).

172. 42 U.S.C.A. § 11112(b)(3)(C)(iv) (West Supp. 1988).

173. 42 U.S.C.A. § 11112(b)(3)(C)(v) (West Supp. 1988).

5. After the hearing is concluded the physician must have the right:
 - a) to receive the written recommendation of the arbiter, officer or panel, including a statement of the basis for the recommendation;¹⁷⁴ and
 - b) to receive a written decision of the hospital, including a statement of the basis for the decision.¹⁷⁵
- D. A hospital can still meet the due process requirements of HCQIA notwithstanding its failure to provide each of the items in § VII(C)(1) through (5) above.¹⁷⁶
- E. HCQIA does not require a hospital to provide a physician due process:
 1. when a physician forfeits his right to a hearing by failing to attend without good cause;¹⁷⁷ or
 2. in those instances where adequate notice and hearing is not required, which include those instances when:
 - a) no adverse review action is taken;¹⁷⁸
 - b) there is a suspension or restriction of privileges for 14 days or less and an investigation is conducted to determine the need for further review action;¹⁷⁹ or
 - c) the failure to take action may result in imminent danger to the health of any one individual and the notice and hearing requirements will subsequently be provided.¹⁸⁰

Reporting Requirements of HCQIA

I. WHEN DO THE REPORTING REQUIREMENTS OF HCQIA TAKE EFFECT?

Hospitals are not responsible for complying with the reporting requirements of HCQIA until a national data bank is established for the purpose of collecting the reported information. Notice of its establishment will be provided in the Federal Register.¹⁸¹

II. HOW DOES A HOSPITAL COMPLY WITH THE REPORTING REQUIREMENTS OF HCQIA?

A. A hospital complies with the reporting requirements of HCQIA by reporting two types of information:

174. 42 U.S.C.A. § 11112(b)(3)(D)(i) (West Supp. 1988).
175. 42 U.S.C.A. § 11112(b)(3)(D)(ii) (West Supp. 1988).
176. 42 U.S.C.A. § 11112(b) (West Supp. 1988).
177. 42 U.S.C.A. § 11112(b)(3)(B) (West Supp. 1988).
178. 42 U.S.C.A. § 11112(c)(1)(A) (West Supp. 1988).
179. 42 U.S.C.A. § 11112(c)(1)(B) (West Supp. 1988).
180. 42 U.S.C.A. § 11112(c)(2) (West Supp. 1988).
181. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9264 (1988).

1. *Medical Malpractice Payments*: A hospital must report each time it makes a payment under an insurance policy, under self-insurance or otherwise in settlement of, or in satisfaction in whole or in part of, a judgment or claim in a medical malpractice action or claim against a physician, dentist or licenced health care practitioner.¹⁸²

- a) For each medical malpractice payment a hospital must report:
 - 1) with respect to the physician, dentist or licensed health care practitioner¹⁸³ for whose benefit the payment is made;
 - i) his name;
 - ii) his work and home address;
 - iii) his license number(s);
 - iv) his Drug Enforcement Administration ("DEA") registration number;
 - v) his social security number, if known, and if obtained pursuant to the privacy act; and
 - vi) the name of each hospital with which he is affiliated, if known;¹⁸⁴
 - 2) with respect to the reporting hospital;
 - i) the name and address of the hospital making the payment;
 - ii) the name, title and telephone number of the responsible official submitting the information on behalf of the hospital; and
 - iii) the relationship of the reporting hospital to the physician, dentist or health practitioner on whose behalf the payment was made.¹⁸⁵
 - 3) with respect to the judgment or settlement resulting in payment;
 - i) the adjudicatory body and the case number where a claim has been filed;
 - ii) the date or dates on which the acts giving rise to the action or claim occurred;
 - iii) the date of the judgment or settlement;
 - iv) the amount paid and the date of payment;
 - v) the judgment or settlement amount and any conditions attached thereto, including the terms of payment; and
 - vi) a description of the acts, omissions, or injuries upon which the action or claim was based.¹⁸⁶
- b) A hospital must also report other information requested from time to

182. 42 U.S.C.A. §§ 11131(a), 11151(7) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269 (1988) (to be codified at 45 C.F.R. § 60.6(a)) (proposed Aug. 18, 1987).

183. The term "physician" includes both doctors of medicine and osteopathy. The term "licensed health care practitioner" includes any individual other than a physician who is licensed or otherwise authorized by a state to provide health care services. The term "dentist" includes a doctor of dental surgery or doctor of medical dentistry licensed to practice dentistry by a State or one who holds himself out to be so licensed. 42 U.S.C.A. §§ 11151(6), (8) (West Supp. 1988); *see also* proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9268 (1988) (to be codified at 45 C.F.R. § 60.3) (proposed Aug. 18, 1987).

184. 42 U.S.C.A. §§ 11131(b)(1), (3) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269 (1988) (to be codified at 45 C.F.R. § 60.6(b)(1)) (proposed Aug. 18, 1987).

185. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269 (1988) (to be codified at 45 C.F.R. § 60.6(b)(2)) (proposed Aug. 18, 1987).

186. *Id.* (to be codified at 45 C.F.R. § 60.6(b)(3)) (proposed Aug. 18, 1987).

time in the Federal Register.¹⁸⁷

c) A hospital must report information regarding medical malpractice payments within 30 days from the date that payment is made.¹⁸⁸

d) A hospital must report all information simultaneously to:

- 1) the national bank, the identity of which will be published in the Federal Register;¹⁸⁹ and
- 2) the appropriate state medical licensing board in the state where the medical malpractice claim arose.¹⁹⁰

2. Professional Review Actions:

a) A hospital *must* report whenever it:

- 1) takes professional review action that adversely affects (i.e., restricting, reducing, suspending, revoking, denying or failing to renew) privileges of a physician or dentist for period of greater than 30 days;¹⁹¹ or
- 2) accepts the surrender of a physician or dentist's privileges:
 - i) while under investigation regarding incompetence or improper conduct;¹⁹² or
 - ii) in return for not conducting an investigation.¹⁹³

b) A hospital *may* report when the same circumstances occur with respect to a licensed health care practitioner who is not a physician or dentist.¹⁹⁴

c) When a hospital makes a report regarding a review action, it must submit the following information:

- 1) the name of the physician or practitioner involved;
- 2) the work and home address of the physician or practitioner involved;
- 3) the physician or health practitioner's license number;
- 4) the physician's Drug Enforcement Administration registration number;
- 5) the physician's social security number, if known and if obtained under the privacy act;
- 6) a description of the acts or omissions or other reasons for the privilege loss or, if known, for surrender;
- 7) the action taken, the date the action was taken, and the effective date of the action; and
- 8) other information as is announced from time to time in federal re-

187. *Id.* (to be codified at 45 C.F.R. § 60.6(b)(3)(vii)).

188. 42 U.S.C.A. § 11134(a) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269 (1988) (to be codified at 45 C.F.R. § 60.5(a)) (proposed Aug. 18, 1987).

189. 42 U.S.C.A. § 11134(b) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269 (1988) (to be codified at 45 C.F.R. § 60.6(a)) (proposed Aug. 18, 1987).

190. 42 U.S.C.A. § 11134(c)(1) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269 (1988) (to be codified at 45 C.F.R. § 60.6(a)) (proposed Aug. 18, 1987).

191. 42 U.S.C.A. § 11133(a)(1)(A) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269 (1988) (to be codified at 45 C.F.R. § 60.8(a)(1)(i)) (proposed Aug. 18, 1987).

192. 42 U.S.C.A. § 11133(a)(1)(B)(i) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269 (1988) (to be codified at 45 C.F.R. § 60.8(a)(1)(ii)(A)) (proposed Aug. 18, 1987).

193. 42 U.S.C.A. § 11133(a)(1)(B)(ii) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269 (1988) (to be codified at 45 C.F.R. § 60.8(a)(1)(ii)(B)) (proposed Aug. 18, 1987).

194. 42 U.S.C.A. § 11133(a)(2) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269-70 (1988) (to be codified at 45 C.F.R. § 60.8(a)(2)) (proposed Aug. 18, 1987).

gulations.¹⁹⁵

d) When a hospital is required to report information regarding peer review action it must report this information to the appropriate state board of medical examiners within 20 days from the date of the adverse action.¹⁹⁶ If the Secretary of Health and Human Services determines that the state board of medical examiners has failed to report information to the national data bank, the Secretary will designate another qualified entity to whom hospitals shall report this information.¹⁹⁷

III. WHAT HAPPENS IF A HOSPITAL FAILS TO REPORT INFORMATION?

A. *Medical Malpractice Payments*: A hospital that fails to report information regarding medical malpractice payments is subject to a civil money penalty of up to \$10,000 for each payment involved.¹⁹⁸

B. *Professional Review Actions*:

1. If a hospital fails to report information regarding a professional review action or the Secretary of Health and Human Services has reason to believe that a hospital is not reporting this information,¹⁹⁹ then the Secretary of Health and Human Services will conduct an investigation.²⁰⁰
2. If the investigation shows that the hospital has not complied with the reporting requirements, the Secretary shall provide notice of noncompliance to the hospital and state that the entity may request, within 30 days thereafter, a hearing with respect to the noncompliance.²⁰¹
3. If the hospital requests a hearing, the request must contain a statement of the material factual issues in dispute to demonstrate that there is cause for a hearing. The issues must be both substantive and relevant.²⁰²
4. The Secretary will deny a hearing to the hospital if:
 - a) the request is untimely;
 - b) the hospital does not provide a statement of material factual issues in dispute; or

195. 42 U.S.C.A. § 11133(a)(3) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270 (1988) (to be codified at 45 C.F.R. § 60.8(a)(3)) (proposed Aug. 18, 1987).

196. 42 U.S.C.A. § 11134(a) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269 (1988) (to be codified at 45 C.F.R. § 60.5(c)) (proposed Aug. 18, 1987).

197. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270 (1988) (to be codified at 45 C.F.R. § 60.8(c)(2)) (proposed Aug. 18, 1987).

198. 42 U.S.C.A. § 11131 (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269 (1988) (to be codified at 45 C.F.R. § 60.6(c)) (proposed Aug. 18, 1987).

199. Proposed regulations require state boards of medicine to report any known instance in which a hospital has failed to report information regarding adverse peer review action to the Secretary of Health and Human Services. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269 (1988) (to be codified at 45 C.F.R. § 60.8(c)) (proposed Aug. 18, 1987).

200. 42 U.S.C.A. § 11111(b) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269 (1988) (to be codified at 45 C.F.R. § 60.8(c)) (proposed Aug. 18, 1987).

201. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270 (1988) (to be codified at 45 C.F.R. § 60.8(c)) (proposed Aug. 18, 1987).

202. *Id.*

- c) the statement of factual issues in dispute is frivolous or inconsequential.²⁰³
- 5. If the Secretary denies a hearing or if, as a result of a hearing, the hospital is found to be in noncompliance, the Secretary will publish the name of the hospital in the Federal Register.²⁰⁴
- 6. When the hospital's name is published in the Federal Register, it is not entitled to HCQIA immunity with respect to review actions during a 3 year period beginning 30 days after the date of publication.²⁰⁵

What Are The Continuing Obligations Of A Hospital To Update The Reported Information?

When it is discovered by a reporting hospital that there are errors in reported information, the hospital must submit additional or corrected information to the national data bank and/or the appropriate medical licensing board.²⁰⁶

What Is A Hospital's Liability With Respect To Reported Information?

A hospital cannot be held liable for reporting information to the national data bank or appropriate state board unless it has knowledge that such information was false.²⁰⁷

Hospitals to Request Information

I. WHEN DO THE REQUIREMENTS TO REQUEST INFORMATION TAKE EFFECT?

Hospitals are not responsible for requesting information under HCQIA until the national data bank is established. Notice of its establishment will be provided in the Federal Register.²⁰⁸

II. HOW DOES A HOSPITAL COMPLY WITH THE REQUIREMENT OF REQUESTING INFORMATION?

A hospital must request HCQIA information in two circumstances:

203. *Id.*

204. *Id.*

205. *Id.*

206. 42 U.S.C.A. § 11137(c) (West Supp. 1988).

207. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9264 (1988).

208. 42 U.S.C.A. § 11135(a) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9264 (1988).

A. when a physician, dentist or licensed health care practitioner applies for a medical staff position (courtesy or otherwise) or for privileges at the hospital's facilities;²⁰⁹ and

B. once every two years the hospital must request information regarding all physicians, dentists or licensed health care practitioners who are on the hospital medical staff (courtesy or otherwise) or who maintain clinical privileges at the hospital.²¹⁰

III. FROM WHOM MUST A HOSPITAL REQUEST HCQIA INFORMATION?

A hospital must request information regarding physicians, dentists or licensed health care practitioners from the national data bank.²¹¹

IV. WHAT INFORMATION MUST A HOSPITAL REQUEST?

A hospital must request all information regarding a physician, dentist or licensed health care practitioner which is required to be reported under HCQIA, including:

A. all information concerning medical malpractice payments made on behalf of the physician, dentist or licensed health care practitioner;²¹²

B. all information concerning sanctions taken by any state board of medical examiners with respect to the physician, dentist or licensed health care practitioner;²¹³ and

C. all review actions taken by any hospital or other health care entity with respect to the physician, dentist or licensed health care practitioner.²¹⁴

V. HOW IS A HOSPITAL'S LIABILITY AFFECTED BY COMPLYING WITH THE REQUIREMENTS TO REQUEST INFORMATION UNDER HCQIA?

A hospital that requests information under HCQIA regarding a physician, dentist or other licensed health care practitioner may rely

209. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270 (1988) (to be codified at 45 C.F.R. § 60.9(a)(1)) (proposed Aug. 18, 1987).

210. *Id.* (to be codified at 45 C.F.R. § 60.9(a)(2)).

211. 42 U.S.C.A. §§ 11135(a)(1), 11131(a), 11131(b) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270 (1988) (to be codified at 45 C.F.R. § 60.9(a)) (proposed Aug. 18, 1987).

212. 42 U.S.C.A. §§ 11131(a), 11135(a)(1) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269, 9270 (1988) (to be codified at 45 C.F.R. §§ 60.6, 60.9) (proposed Aug. 18, 1987).

213. 42 U.S.C.A. §§ 11132(a), 11135(a)(1) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9269, 9270 (1988) (to be codified at 45 C.F.R. §§ 60.7, 60.9) (proposed Aug. 18, 1987).

214. 42 U.S.C.A. §§ 11135(a)(1), 11133(a) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270 (1988) (to be codified at 45 C.F.R. §§ 60.8, 60.9) (proposed Aug. 18, 1987).

on the information requested and may not be held liable in a subsequent medical malpractice action for such reliance unless the hospital knew the information was false.²¹⁵

VI. WHAT ARE THE CONSEQUENCES IF A HOSPITAL FAILS TO REQUEST INFORMATION UNDER HCQIA?

If a hospital fails to request information regarding a physician, dentist or other licensed health care practitioner, then, for purposes of any medical malpractice action, that hospital is presumed to have knowledge of any information reported under the HCQIA regarding that physician, dentist or licensed health care practitioner.²¹⁶

VII. WHO MAY REQUEST INFORMATION FROM THE NATIONAL DATA BANK?

The following individuals and entities or their authorized agents may request information from the national data bank concerning any physician, dentist or licensed health care practitioner:

- A. a hospital that requests information concerning a physician, dentist or licensed health care practitioner who is on its medical staff (courtesy or otherwise) or who has clinical privileges at the hospital;
- B. a physician, dentist or licensed health care practitioner who requests information concerning himself or herself;
- C. an attorney or individual acting in his own behalf who has filed a medical malpractice action or claim in state or federal court or in another adjudicative body against a hospital, and who requests information regarding a specific physician, dentist or licensed health care practitioner also named in the action or claim. (This information will *only* be disclosed upon a submission of evidence that the hospital failed to obtain the information from the national data bank as required in HCQIA. The information may be used solely with respect to litigation resulting from the action or claim against the hospital.);
- D. a health care entity for purposes of a professional review activity; and
- E. a person or entity who requests information in a form which does not permit the identification of any particular hospital physician or other health care entity or practitioner or patient.²¹⁷

215. 42 U.S.C.A. § 11135(c) (West Supp. 1988); Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270 (1988) (to be codified at 45 C.F.R. § 60.9(c)) (proposed Aug. 18, 1987).

216. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270 (1988) (to be codified at 45 C.F.R. § 60.9(b)) (proposed Aug. 18, 1987).

217. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270-71 (1988) (to be codified at 45 C.F.R. § 60.10(a)) (proposed Aug. 18, 1987).

VIII. WHAT COSTS ARE ASSOCIATED WITH REQUESTING INFORMATION FROM THE NATIONAL DATA BANK?

Fees will be imposed upon those who request information from the national data bank in an amount to be published periodically in the Federal Register.²¹⁸

Reasonable Attorney Fees and Costs

I. WHAT IS THE SCOPE OF THE ATTORNEY FEES AND COST PROVISIONS OF HCQIA?

Where any action is based upon professional review activity, then the prevailing defendant is entitled to attorney fees and costs of defending if three requirements are met:

- A. the defendant must have met the due process requirements of the HCQIA in the review activity at issue;²¹⁹
- B. the defendant must have substantially prevailed in the action (A defendant does not substantially prevail where the plaintiff obtains a damage award, permanent injunction or declaratory relief.);²²⁰ and
- C. the plaintiff's claim or conduct during the action must have been frivolous, unreasonable, without foundation, or in bad faith.²²¹

II. WHEN DO THE COST PROVISIONS OF HCQIA TAKE EFFECT?

The cost provisions of HCQIA apply to all civil actions based upon review activity commenced on or after November 14, 1986.²²²

Miscellaneous Provisions

I. DISPUTING THE ACCURACY OF INFORMATION REPORTED TO THE NATIONAL DATA BANK

A. Who may dispute national data bank information?

Any physician, dentist or health care practitioner may dispute the accuracy of information in the national data bank concerning himself or herself.²²³

218. 42 U.S.C.A. § 11113 (West Supp. 1988).

219. *Id.*

220. *Id.*

221. *Id.*

222. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270-71 (1988) (to be codified at 45 C.F.R. § 60.11 (proposed Aug. 18, 1987).

223. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9271 (1988) (to be codified at 45 C.F.R. § 60.13(a) (proposed Aug. 18, 1987).

B. How does a physician dispute the accuracy of the information?

A physician, dentist or licensed health care practitioner may dispute national data bank information by:

1. informing the Secretary of Health and Human Services and the reporting hospital or other entity, in writing, of the disagreement with the reported information and the basis for the disagreement;
2. requesting, simultaneously, that the disputed information be entered into a "disputed" status and be reported to inquirers as "disputed"; and
3. entering into discussions with the reporting hospital or entity to resolve the dispute.²²⁴

C. What is the procedure for revising disputed information?

If the reporting hospital or entity revises the information originally submitted to the national data bank, the Secretary will notify all persons or entities to whom reports have been sent that the original information has been revised.²²⁵ If the reporting entity fails to revise the reported information, the Secretary will, upon request, review all submitted related information. After review, the Secretary will either:

1. continue to note the information as "disputed", if the Secretary concludes that the information is accurate, and include a brief statement by the physician, dentist or licensed health care practitioner describing the disagreement concerning the information, or
2. send corrected information to those making previous inquiries if the Secretary concludes that the reported information was incorrect.²²⁶

II. CIVIL MONEY PENALTIES

A. To what activities do the civil money penalty provisions of HCQIA apply?

The civil money penalty provisions of HCQIA apply to two types of conduct:

1. a failure to report medical malpractice payments as required by HCQIA, and
2. a breach of the confidentiality provisions of HCQIA.²²⁷

B. What are the limits on the penalties which can be imposed?

HCQIA permits imposing a penalty of not more than \$10,000 against any person or entity, including an insurance company or hospital, for each occurrence of proscribed conduct.²²⁸

C. What factors are used to determine the amount of the penalty?

The amount of a penalty imposed for a violation of HCQIA depends upon consideration of five criteria:

1. the nature of and circumstances surrounding a failure to report medical malpractice payments or the improper disclosure of information;
2. the degree of culpability of the person or entity, including an insurer,

224. *Id.* (to be codified at 45 C.F.R. § 60.13(b)).

225. *Id.* (to be codified at 45 C.F.R. § 60.13(c)).

226. 42 U.S.C.A. §§ 11131, 11137 (West Supp. 1988).

227. *Id.*

228. Proposed Civil Money Penalty Regulations, 53 Fed. Reg. 9260 (1988) (to be codified at C.F.R. pt. 1003) (proposed July 15, 1987).

- in failing to provide timely and complete payment data or in breaching the confidentiality of reported information;
- 3. the materiality of, or significance of omission in, the information to be reported or improperly disclosed;
- 4. any prior history of the individual or entity as it relates to the violation at issue; and
- 5. such other matters as justice may require.²²⁹

D. Who is liable to pay a civil money penalty?

Each person or entity who fails to report malpractice payments as required by HCQIA or who breaches a confidentiality provision is liable for civil money penalties. Where more than one party is responsible for the violation, each may be imposed with a penalty up to the \$10,000 limit.²³⁰

E. How are the penalties imposed?

If a civil penalty is to be imposed, the offender must first be notified by certified mail that he has the right to request a hearing within thirty days and must be provided with a description of the reasons why the penalty is being imposed.²³¹

III. CONFIDENTIALITY OF INFORMATION REPORTED OR REQUIRED UNDER HCQIA

A. All information reported or requested under HCQIA is confidential and may not be disclosed except:

- 1. with respect to a hospital review action;²³²
- 2. with respect to a medical malpractice action where a hospital has failed to request information regarding a physician who is also a party to the action;²³³
- or
- 3. with respect to an application for clinical privileges at a hospital.²³⁴

B. Any person who violates the confidentiality requirements of HCQIA is subject to a civil money penalty up to \$10,000.²³⁵

229. *Id.*

230. *Id.*

231. Proposed Civil Money Penalty Regulations, 53 Fed. Reg. 9260, 9263 (1988) (to be codified at 45 C.F.R. § 1003.109(a)) (proposed July 15, 1988).

232. Proposed HCQIA Regulations, 53 Fed. Reg. 9264, 9270, 9271 (1988) (to be codified at 45 C.F.R. §§ 60.10(a)(5), 60.12(a)) (proposed Aug. 18, 1987).

233. *Id.* (to be codified at 45 C.F.R. §§ 60.10(a)(4), 60.12(a)).

234. *Id.* (to be codified at 45 C.F.R. §§ 60.9(a)(1), 60.12(a)) (proposed Aug. 18, 1987).

235. 42 U.S.C.A. § 11137(b)(2) (West Supp. 1988).