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MASSACHUSETTS AND OREGON LAWS ENCOURAGE EARLY RESOLUTION OF MEDICAL
MALPRACTICE CLAIMS: DHHS THREATENS TO HINDER REFORM

By
Jena Druck*

I. INTRODUCTION

Concerns regarding the impact of our nation's medical liability system on the cost and availability of insurance has prompted numerous reforms modifying the rules of medical malpractice litigation.¹ In recent years, reform efforts have focused more on reducing claims and promoting safety.² This article seeks to discuss the impact of national reporting requirements of medical malpractice payments on modern reform efforts. Specifically, this article will examine a recent ruling from the Department of Health and Human Services ("DHHS") interpreting requirements to report payments for medical malpractice claims to the National Practitioner Data Bank ("NPDB"), how those requirements affect legislative programs enacted and implemented in Massachusetts and Oregon, and whether they serve to hamper reform efforts that encourage alternative dispute resolution. Despite their goal to monitor physician competence and ultimately improve patient safety, the NPDB reporting requirements may actually serve to encourage litigation rather than alternative dispute resolution. Thus, by affirming the applicability of the NPDB reporting requirements to recent legislation, the DHHS ruling may serve to hamper efforts at reform.

II. CONTEXT FOR MASSACHUSETTS AND OREGON REFORMS

A. Traditional Malpractice Reform

The usual avenue for medical malpractice claims through the tort liability system serves to compensate injured patients and guard against future error.³ Goals of litigation include justice, compensation, and deterrence.⁴ Although justice may be achieved,

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¹ Fred J. Hellinger and William E. Encinosa, *Review of Reforms to Our Medical Liability System*, AHRQ.GOV, <http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/liability/reforms.html> (last visited October 15, 2014).

² *Id.*

³ Edward A. Dauer & Leonard J. Marcus, *Medical Malpractice: External Influences and Controls: Article: Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement*, 60 LAW & CONTEMP. PROB. 185, 185 (1997).

⁴ Haavi Morreim, *Moral Hazard: The Pros and Cons of Avoiding Data Bank Reports*, 4 DREXEL L. REV. 265, 267 (2011).

evidence suggests the goals of compensation and deterrence are not well met.⁵ Traditional tort reform can generally be classified into three categories based upon the reform's intention to (1) limit liability and control awards; (2) decrease the number of claims; or (3) facilitate settlement.⁶ Reforms that limit liability include caps on damages, modifications to the collateral source rule,⁷ provision of periodic payments rather than lump sum payments, modifications to pleading damages, modifications to joint and several liability rules, limiting or prohibiting punitive damages, and altering burden of proof and evidentiary rules.⁸ Reforms initiated to decrease the number of claims include rules surrounding statutes of limitations, limiting contingency fees, awarding costs for frivolous suits, and requiring a certificate of merit as a condition of filing.⁹ Reforms intended to facilitate settlement include requiring notice to sue, encouraging or requiring arbitration, and instituting pre-trial screening panels.¹⁰ Unfortunately, many of these traditional reforms ignore the goals of improving patient safety and encouraging communication regarding negative outcomes.¹¹

B. Recent Efforts in Malpractice Reform Focus on Patient Safety

In recent years, reform efforts have focused more on reducing claims and promoting safety.¹² Reforms that promote full disclosure, early offers, and collection of

⁵ Morreim, *supra* note 4 at 268. The goal of compensation is poorly served because most negligently caused injuries never result in a claim, a large proportion of filed claims are not connected with negligent injury, and the majority of damage awards go toward paying attorney fees and expenses rather than compensating claimants. *Id.* Litigation's deterrence function poorly serves quality improvement because most adverse events result not from result provider error, but from system flaws that can only be solved through communication between physicians, nurses, administrators, patients, and families; and, the fear of litigation leads to defensive practices and inhibits much-needed communication. *Id.* at 268-69.

⁶ JAMES E. LUDLAM, 3-15 TREATISE ON HEALTH CARE LAW §15.05 (Matthew Bender & Company, Inc. 2014).

⁷ The collateral source rule is a common-law doctrine permitting an injured party to recover full compensatory damages regardless of payment received through benefits or other forms of compensation independent of the tortfeasor (i.e. insurance, worker's compensation, unemployment, etc.). James J. Watson, Annotation, *Validity and Construction of State Statute Abrogating Collateral Source Rule as to Medical Malpractice Actions*, 74 A.L.R. 4TH 32, Note 1 (1989).

⁸ LUDLAM, *supra* Note 6, at §15.05[1].

⁹ *Id.* at §15.05[2].

¹⁰ *Id.*

¹¹ See Kelly Bogue, *Innovative Cost Control: An Analysis of Medical Malpractice Reform in Massachusetts*, 9J. HEALTH & BIOMED. L. 87, 96 (2013).

¹² Hellinger and Encinosa, *supra* note 1.

the causes of medical errors focus on patient safety as one of the primary goals.¹³ A number of medical institutions and insurers operate programs that require practitioners to disclose medical errors to patients, leading to rapid and fair compensation, as well as collection of data.¹⁴ When a provider discovers an error, efforts to disclose that error, apologize to the patient or family, and work together toward an early resolution provide the opportunity to not only compensate the patient, but also preserve relationships, save costs, shorten resolution times, reduce lawsuits, and promote the exploration necessary to improve quality.¹⁵

Passed in March 2010, the Patient Protection and Affordable Care Act (“PPACA”) focused on improving access to health care as well as cost-containment.¹⁶ The PPACA recommended Congress develop programs to explore alternatives to the current litigation system and encouraged states to develop and test alternatives.¹⁷ An amended section of the Public Health Service Act authorized the Secretary of DHHS to award grants to states “for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations.”¹⁸

As a result, the DHHS awarded \$25 million in grants for medical liability reform projects through the Agency for Healthcare Research and Quality’s (“AHRQ”) Patient Safety and Medical Liability Reform Initiative.¹⁹ The initiative intended to “improve[d]

¹³ Hellinger and Encinosa, *supra* note 1.

¹⁴ *Id.*

¹⁵ Morreim, *supra* note 4 at 270.

¹⁶ See Patient Protection and Affordable Care Act, 111 Pub. L. No. 148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.).

¹⁷ *Id.* at 804. Section 6801 states:

It is the sense of the Senate that – (1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance; (2) States should be encouraged to develop and test alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual’s right to seek redress in court; and (3) Congress should consider establishing a State demonstration program to evaluate alternatives to the existing civil litigation system with respect to the resolution of medical malpractice claims. *Id.*

¹⁸ 42 U.S.C. § 280g-15(a) (2010).

¹⁹ Press Release, United States Department of Health and Human Services, HHS Announces Patient Safety and Medical Liability Demonstration Projects (June 11, 2010), *available at* <http://wayback.archive-it.org/3926/20131018160402/http://www.hhs.gov/news/press/2010pres/2010.html#June>. “The projects we have funded help create measurable differences in the safety of health care for patients and help bring rationality and fairness to our medical liability system.” *Id.* (quoting Carolyn M. Clancy, M.D., AHRQ director.)

the overall quality of health care by making patient safety the primary goal.”²⁰ The AHRQ issued 20 grants, allocating \$23 million to support efforts to create, implement, and evaluate patient safety and medical liability reform and \$2 million to evaluate the initiative.²¹ The funds received through this initiative supported efforts that laid the groundwork for the Massachusetts law discussed below.²² Programs developed in Massachusetts and Oregon not only encourage disclosure and open discussion between practitioners and patients, but also provide the opportunity for financial restitution outside of the court system.²³

III. MASSACHUSETTS AND OREGON LAWS: ENCOURAGING EARLY RESOLUTION OF MEDICAL MALPRACTICE CLAIMS

A. Massachusetts: Disclosure, Apology, and Offer

As part of a package of statutory reform entitled “An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation,”²⁴ Massachusetts instituted a Disclosure, Apology and Offer (“DA&O”) program.²⁵ The law stipulates a pre-litigation period of alternative dispute resolution characterized by patient notice, sharing of medical records, disclosure of errors, and inadmissibility of providers’ statements of apology.²⁶ Six hospitals initially operationalized the DA&O program through the Communication, Apology, and Restitution (“CARE”) model.²⁷

²⁰ Carolyn M. Clancy, *Patient Safety and Medical Liability Reform: Putting the Patient First*, AHRQ.GOV, <http://www.ahrq.gov/news/newsroom/commentaries/putting-patients-first.html> (last visited October 1, 2014).

²¹ *Id.*

²² See Memo from Mary K. Wakefield, Ph.D., R.N., Administrator, Department of Health and Human Services, to Kathleen Sebelius, Secretary, Department of Health and Human Services (May 20, 2014), 2 [hereinafter DHHS Memo](on file with author), available at <http://www.citizen.org/documents/2211%20Enclosure.pdf>.

²³ *Id.*

²⁴ Enacted August 6, 2012.

²⁵ An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation, 2011 Mass. S.B. 2400.

²⁶ See Dan McDonald, *Massachusetts Bar Association Moves to Stem Skepticism as Med-Mal Reforms Take Effect*, MASSACHUSETTS LAWYERS WEEKLY, June 12, 2013.

²⁷ See DHHS Memo *supra* note 22 at 3. See also, MASSACHUSETTS ALLIANCE FOR COMMUNICATION AND RESOLUTION FOLLOWING MEDICAL INJURY, <http://www.macrmi.info> (last visited October 26, 2014). (“CARE is about timely communication of important information and supporting families though an adverse outcome.”)

Under the Massachusetts law, an injured party must provide a pre-litigation notice to the health care provider 182 days before commencing a court-based action.²⁸ This six month period provides “an opportunity to clear the air and put the cards on the table.”²⁹ Once notice is received, the provider has 150 days to furnish a written response to the injured party.³⁰ If the provider fails to do so, the injured party may file a claim alleging medical malpractice.³¹ To encourage provider response, interest on subsequent judgment is calculated from the date the notice is filed, rather than the date the suit is filed.³²

The law also requires an injured party to allow the health care provider access to medical records within his or her control, and provide a release for records not within his or her control, within 56 days after giving notice.³³ A provider must “fully inform” the patient about unanticipated outcomes with significant medical complications that arose from the provider’s mistake.³⁴ The provider will meet with the injured patient or family to explain what happened and how it will affect the patient’s care.³⁵ To encourage apology, any statement of regret, mistake, or error by the provider is inadmissible in a later malpractice action unless the person who makes the statement also makes a contradictory or inconsistent statement during trial.³⁶ After information is shared between the parties, the provider can work with the insurer to determine an appropriate settlement amount.³⁷ If the provider determines there will be no settlement offer, the provider informs the claimant in writing within the notice period, and the claimant is free to commence an action.³⁸

²⁸ MASS. GEN. LAWS 231 §60L(a).

²⁹ See, McDonald, *supra* Note 26 (quoting Martin W. Healy, Chief Legal Counsel for Massachusetts Bar Association).

³⁰ MASS. GEN. LAWS 231§60L(g).

³¹ MASS. GEN. LAWS 231§60L(h).

³² MASS. GEN. LAWS 231§60L(h), see also A.L.M. G.L. ch. 231§60K.

³³ MASS. GEN. LAWS ch. 231, §60L(f).

³⁴ MASS. GEN. LAWS ch. 233 §79L(b).

³⁵ See, MASSACHUSETTS ALLIANCE FOR COMMUNICATION AND RESOLUTION FOLLOWING MEDICAL INJURY, *About CARE*, <http://www.macrmi.info> (last visited October 26, 2014).

³⁶ MASS. GEN. LAWS ch. 233 §79L.

³⁷ See, Bogue, *supra* note 11 at 108.

³⁸ MASS. GEN. LAWS ch. 231, §60L(i).

B. Oregon: Early Discussion and Resolution

Oregon's Early Discussion and Resolution program, created through Senate Bill 483,³⁹ includes three distinct phases of medical liability: (1) early discussion and resolution; (2) mediation; (3) and access to the legal system.⁴⁰ The program aims to improve patient safety by providing an alternative way for patients to resolve conflict with providers and giving them a "safe space to learn, heal[, and] then move on."⁴¹ If resolution is not achieved, the parties can seek help from a mediator before moving on to litigation.⁴²

The Early Discussion and Resolution program enables providers and patients to resolve serious medical events through discussion rather than traditional adjudication within the court system.⁴³ When an "adverse health care incident"⁴⁴ occurs, a provider, provider's employer, health care facility, or patient may file a notice of adverse event with the Oregon Patient Safety Commission ("OPSC"),⁴⁵ and a copy is provided to the patient.⁴⁶ This notice triggers a voluntary confidential discussion between the patient and provider, which may include an explanation of what happened, an apology, information about how the provider will prevent harm in the future, and compensation if appropriate.⁴⁷ A facility or provider who files, or is named in the notice, may engage in a discussion with the patient, communicate the steps the facility or provider will take to prevent future occurrences of the incident, and determine whether an offer of compensation is warranted.⁴⁸ If an offer is warranted, the facility or provider extends the

³⁹ Senate Bill 483 was enacted March 25, 2013, became operative July 1, 2014, and is set to expire December 31, 2023. 2013 ORE. LAWS 5, 2013 at §§20, 21.

⁴⁰ *Governor Kitzhaber Testimony on SB 483*, States News Service, February 14, 2013.

⁴¹ Saerom Yoo, *New Program to Mediate Health Care Problems*, STATESMAN JOURNAL, July 2, 2014 at A-14 (quoting Oregon Patient Safety Commission, Executive Director Bethany Walmsley).

⁴² *Id.*

⁴³ *Id.*

⁴⁴ An "adverse health care incident" is defined as an "objective, definable and unanticipated consequence of patient care that is usually preventable and results in the death of or serious physical injury to the patient." 2013 ORE. LAWS 5, 2013 at §1(1).

⁴⁵ The OPSC is a state agency comprised of a 17-member board of directors appointed by the Governor of Oregon and is charged with reducing the risk of serious adverse events and encouraging patient safety. OREGON PATIENT SAFETY COMMISSION, <http://www.oregonpatientsafety.org/who-we-are> (last visited Oct. 26, 2014).

⁴⁶ 2013 ORE. LAWS 5, 2013 at §2.

⁴⁷ Nick Budnick, *New Oregon Program Allows Mediation for Medical Errors Instead of Suing*, THE OREGONIAN, July 1, 2014. *See also*, OREGON PATIENT SAFETY COMMISSION, *Early Discussion and Resolution*, <http://edr.oregonpatientsafety.org/reports/content/edr> (last visited October 26, 2014).

⁴⁸ 2013 ORE. LAWS 5, 2013 at §3(1).

offer in writing to the patient and advises the patient of his or her right to seek legal advice before accepting the offer.⁴⁹ If the patient accepts the offer, the facility or provider must then notify the OPSC.⁵⁰ But, if discussions do not result in resolution, the parties may enter mediation.⁵¹ As in early discussion, the facility or provider must advise the patient of his or her right to seek legal advice before accepting an offer of compensation through mediation.⁵²

Early discussion or mediation under this Act does not prevent a patient from bringing a civil action.⁵³ Discussions and offers, however, do not constitute admissions of liability,⁵⁴ and expressions of regret or apology are not admissible in adjudicatory proceedings.⁵⁵ Evidence of an offer of compensation and the amount, payment, or acceptance of compensation is inadmissible as well; any adjudicated judgment in favor of the patient, however, must be reduced by the amount of compensation paid under this Act.⁵⁶ The law specifically designates that payments made as result of early discussion or mediation do not constitute payments resulting from written claims or demands for payment.⁵⁷ Therefore, they are excluded from the NPDB reporting requirement.⁵⁸

The OPSC will use notices of adverse health incidents to establish quality improvement techniques to reduce patient care errors, develop evidence-based prevention practices, and assist facilities and providers in reducing the frequency of particular incidents.⁵⁹ The OPSC may use and disclose information regarding discussions and offers to assist facilities and providers in determining the cause and potential mitigation of the incident; the OPSC may not, however, disclose information regarding discussions

⁴⁹ 2013 ORE. LAWS 5, 2013 at §3(5).

⁵⁰ 2013 ORE. LAWS 5, 2013 at §3(8).

⁵¹ 2013 ORE. LAWS 5, 2013 at §5(1). The parties may choose a mediator from a panel of qualified mediator maintained by the Oregon Patient Safety Commission, or they may choose from outside this list. *Id.* at §5(2).

⁵² 2013 ORE. LAWS 5, 2013 at §5(5).

⁵³ 2013 ORE. LAWS 5, 2013 at §7(1).

⁵⁴ 2013 ORE. LAWS 5, 2013 at §4(2)(a). A party may move the court to admit as evidence discussion that contradicts a statement made during the subsequent adjudicatory proceeding, and the court shall allow it as evidence only if it is material to the claim presented. *Id.* at §4(3)(a).

⁵⁵ 2013 ORE. LAWS 5, 2013 at §4(2)(c).

⁵⁶ 2013 ORE. LAWS 5, 2013 at §7(5).

⁵⁷ 2013 ORE. LAWS 5, 2013 at §6(1).

⁵⁸ *Id.*

⁵⁹ 2013 ORE. LAWS 5, 2013 at §9(2).

and offers to a regulatory agency or licensing board.⁶⁰ This Act also establishes the Task Force on Resolution of Adverse Health Care Incidents,⁶¹ which evaluates the implementation and effects of the Act and reports to the Legislative Assembly on recommendations to improve resolution of incidents if needed.⁶²

IV. MEDICAL MALPRACTICE PAYMENTS AND THE NATIONAL PRACTITIONER DATA BANK

In 1986, Congress enacted the Health Care Quality Improvement Act (“HCQIA”)⁶³ which established the NPDB to aid physicians in peer review activities by collecting information on adverse professional review actions, state medical board license sanctions, and medical malpractice payments.⁶⁴ The NPDB aims to prevent negligent physicians from moving to another state in an effort to escape a record of incompetence and to improve peer review.⁶⁵ Each hospital is required to query this database when credentialing a provider, and every two years thereafter.⁶⁶

A. NPDB Reporting Requirements

Any healthcare or insurance provider who makes a payment in satisfaction of a medical malpractice action or claim is required to report information regarding that payment and circumstances thereof to the NPDB.⁶⁷ The HCQIA defines a “medical malpractice action or claim” as “a written claim or demand for payment based on a health

⁶⁰ 2013 ORE. LAWS 5, 2013 at §10(2).

⁶¹ The task force is comprised of 14 members appointed by Oregon Governor John Kitzhaber. OREGON PATIENT SAFETY COMMISSION, *Discussion and Resolution Task Force*, <http://oregonpatientsafety.org/discussion-resolution/task-force> (last visited October 26, 2014).

⁶² 2013 ORE. LAWS 5, 2013 at §17.

⁶³ Health Care Quality Improvement Act, 42 U.S.C. §§11101-11152 (2006).

⁶⁴ See Julie Barker Pape, *Physician Data Banks: The Public’s Right to Know Versus the Physician’s Right to Privacy*, 66 FORDHAM L. REV. 975, 977 (1997).

⁶⁵ See *id.* at 981. See also, Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101(2) (2006). (“There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician’s pervious damaging or incompetent performance.”); 42 U.S.C. §11135(b) (2006). (“With respect to a medical malpractice action, a hospital which does not request information respecting a physician or practitioner as required [] is presumed to have knowledge of any information reported under this part to the Secretary with respect o the physician or practitioner.”)

⁶⁶ Health Care Quality Improvement Act, 42 U.S.C. §§11135(a) (2006).

⁶⁷ Health Care Quality Improvement Act of 1986, 42 U.S.C. §11131 (2006).

care provider's furnishing (or failure to furnish) health care services...⁶⁸ A claim is reportable when four elements are met: (1) payment, (2) by a third party, (3) for the benefit of a health care practitioner, (4) against whom a medical malpractice claim or judgment was made.⁶⁹ By requiring reports of payments on an action or claim, the HCQIA requires reports when cases are settled as well as when litigation results in judgment against practitioners; these reports are made regardless of whether providers are found responsible for the injury.⁷⁰

B. Concerns Regarding the Reporting Requirement

Although the NPDB is intended to facilitate the link between compensation and risk reduction, some suspect it actually exacerbates the difficulties of achieving more effective forms of claim resolution.⁷¹ Because records are permanent, early settlement resulting in payment of a claim leads to a "permanent 'black mark' in the NPDB," even if settlement is the best choice for those involved.⁷² Providers are faced with the choice of working toward an early mediated resolution, which will result in an almost immediate report to the NPDB, or going to trial, the lengthy nature of which will delay reporting of the claim to the NPDB.⁷³ Because the NPDB requires reporting of medical malpractice payments regardless of whether the physician is found negligent, it prompts physicians to take their chances in litigation, where they have a better chance at winning, rather than settle through mediation.⁷⁴ This chilling effect on mediation is in conflict with Congress' intent as expressed in the PPACA.⁷⁵

The NPDB's effect of deterring physicians from entering into early dispute resolution can be more harmful to quality improvement than the benefits of the reporting

⁶⁸ Health Care Quality Improvement Act, 42 U.S.C. §11151(7) (2006).

⁶⁹ *Id.* at 2.

⁷⁰ See DHHS Memo, *supra* Note 22 at 2.

⁷¹ Edward A. Dauer & Leonard J. Marcus, *Medical Malpractice: External Influences and Controls: Article: Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement*, 60 LAW & CONTEMP. PROB. 185, 185 (1997).

⁷² Morreim, *supra* note 4 at 272-73.

⁷³ See *id.* at 272.

⁷⁴ Teresa M. Waters et al., *Impact of the National Practitioner Data Bank on Resolution of Malpractice Claims*, 40 INQUIRY 283, 290 (2003) (finding NPDB concerns made physicians less willing to settle cases).

⁷⁵ Applicants for grant awards authorized by the DHHS Secretary were asked to show, *inter alia*, how their proposal would increase the availability of prompt and fair resolution of disputes, encourage efficient dispute resolution, encourage error disclosure, and enhance patient safety by reducing errors and adverse events. 42 U.S.C. §280g-15(c)(2) (2006).

system, and may make avoiding reporting to the NPDB more desirable.⁷⁶ Although the HCQIA requires reporting of all medical malpractice payments, “the reality is that a number of avenues permit legitimate escape,” thus diminishing the effect of the NPDB’s usefulness as a means of warning hospitals and medical boards of incompetence.⁷⁷ Several options have been identified that give providers the ability to make a payment to the injured party without prompting the duty to report which include paying the claim out of pocket,⁷⁸ waiving the patient’s debt, or refunding the patient’s payment.⁷⁹ Additionally, because the trigger for an NPDB report is a “written claim or demand for payment,” a provider may avoid the reporting requirement when a patient makes an unwritten claim or demand, regardless of whether contact is initiated by the patient or the physician.⁸⁰ A physician can also utilize the “corporate shield”⁸¹ when an entity such as a hospital makes a payment on a claim without identifying the individual practitioner, or the practitioner is dismissed from the suit prior to settlement or judgment.⁸²

To compound these concerns, reports of medical malpractice payments to the NPDB may not be a reliable indication of physician incompetence, and may have become partly anachronistic and superfluous.⁸³ The NPDB reports do not capture the overall picture of malpractice well for several reasons: (1) there is little connection between negligence and filed claims,⁸⁴ (2) reports resulting from litigation are delayed whereas reports resulting from settlement are immediate,⁸⁵ (3) penalties for failure to report are

⁷⁶ See Morreim, *supra* note 4 at 275.

⁷⁷ Morreim, *supra* note 4 at 274-75.

⁷⁸ See e.g., *Am. Dental Ass’n v. Shalala*, 3 F.3d 445, 446 (D.C. Cir. 1993).

⁷⁹ Health Res. & Servs. Admin., U.S. Dep’t of Health and Human Servs., Pub. No. HRSA-95-225, NATIONAL PRACTITIONER DATA BANK GUIDEBOOK, E-12 (2001) [hereinafter NPDB GUIDEBOOK], available at <http://www.npdb.hrsa.gov/resources/npdbguidebook.pdf>. (“For the purposes of NPDB reporting, medical malpractice payments are limited to exchanges of money. A refund of a fee is reportable only if it results from a written complaint or claim demanding monetary payment for damages... A waiver of debt is not considered a payment and should not be reported to the NPDB.”)

⁸⁰ Health Care Quality Improvement Act, 42 U.S.C. §11151(7) (2006).

⁸¹ A payment made as a result of a claim solely against an entity that does not name an individual practitioner, is not reportable. NPDB GUIDEBOOK, *supra* note 79 at E-8.

⁸² *Id.* (“A payment made as a result of a suit or claim solely against an entity (for example, a hospital, clinic, or group practice) and that does not identify an individual practitioner is not reportable under the NPDB’s current regulations.”). *Id.* at E-12 (“A payment made to settle a medical malpractice claim or action is not reportable to the NPDB if the defendant health care practitioner is dismissed from the lawsuit prior to the settlement or judgment. However, if the dismissal results from a condition in the settlement or release, then the payment is reportable.”).

⁸³ See Morreim, *supra* note 4 at 278-291.

⁸⁴ See *id.* at 278-279.

⁸⁵ See *id.* at 279.

not enforced,⁸⁶ (4) not all physicians' insurance contracts contain "consent to settle" clauses,⁸⁷ (5) different standards exist for reporting government physicians,⁸⁸ and (6) physicians providing charity work or work for the state may be shielded from liability via charitable or sovereign immunity.⁸⁹ Additionally, understanding of the causes of adverse outcomes has changed since the implementation of the NPDB reporting requirements,⁹⁰ as has the relationship between practitioners and hospitals,⁹¹ both of which work to decrease the NPDB's usefulness.⁹² Finally, because a problematic practitioner is likely to be reported to the NPDB for other reasons, the medical malpractice payment reporting may be unnecessary.⁹³

⁸⁶ See Morreim, *supra* note 4 at 279-283. Despite the possibility of an \$11,000 penalty for failure to report, underreporting occurs and the Health Service Resource Administration is reluctant to impose penalties because the cost of levying and collecting those penalties may exceed the maximum amount that can be assessed. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-01-130, NATIONAL PRACTITIONER DATA BANK: MAJOR IMPROVEMENTS ARE NEEDED TO ENHANCE DATA BANK'S RELIABILITY, 5, 10-13 (2000), available at <http://www.gao.gov/assets/240/230998.pdf>.

⁸⁷ See Morreim, *supra* note 4 at 283-285. Some insurance contracts feature a "consent-to-settle" clause permitting the physician to veto efforts to settle. *Id.* at 283.

⁸⁸ See *id.* at 285-287. For example, military physicians can be reported only after several layers of evaluation determine that the physician committed malpractice, and the malpractice caused the injury. *Id.* at 285. See also, HEALTH RES. & SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL PRACTITIONER DATA BANK 2012 ANNUAL REPORT, 7 (2014), available at <http://www.npdb.hrsa.gov/resources/reports/2012NPDBAnnualReport.pdf> ("To obtain information from government entities, the Secretary of HHS entered into memorandums of agreement (MOA) with all relevant Federal agencies and departments.")

⁸⁹ Morreim, *supra* note 4 at 286.

⁹⁰ When it was passed, the HCQIA presumed adverse outcomes were the product of individual carelessness; and through peer review systems, the identification, discipline, and restriction of those individuals would lead to fewer adverse events. However, current understanding is that adverse outcomes may be more a product of system-level flaws. *Id.* at 287-290.

⁹¹ In addition, when HCQIA was passed, hospitals held considerable leverage over physicians because nearly all physicians needed to hold credentials and privileges therein. However, due to physician concerns for efficiency and the establishment of free-standing centers providing services once only available in hospitals, the current relationship between physicians and hospitals has changed dramatically, limiting the importance of hospital credentials, thus decreasing the usefulness of NPDB reporting. *Id.* at 287-290.

⁹² *Id.*

⁹³ A problematic physician may be reported to the NPDB as a result of adverse credentialing actions or license restrictions; disciplinary actions are better indicators of competence than medical malpractice. *Id.* at 293-94. See also, U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-01-130, NATIONAL PRACTITIONER DATA BANK: MAJOR IMPROVEMENTS ARE NEEDED TO ENHANCE DATA BANK'S RELIABILITY, 5, 4 (2000), available at <http://www.gao.gov/new.items/d01130.pdf>.

V. DHHS RULING: APPLICABILITY OF THE NPDB REPORTING REQUIREMENTS TO RECENTLY IMPLEMENTED PROGRAMS IN MASSACHUSETTS AND OREGON

In response to requests from stakeholders, then-Secretary of DHHS, Kathleen Sebelius, issued a ruling on May 22, 2014, interpreting NPDB reporting requirements in light of the Oregon and Massachusetts laws.⁹⁴ The requests included that of Public Citizen⁹⁵ asking the DHHS to designate payments under Oregon’s law as reportable to NPDB;⁹⁶ Oregon’s Governor John Kitzhaber asking the DHHS to deem payments under Oregon’s law non-reportable;⁹⁷ and the Massachusetts Alliance for Communication and Resolution Following Medical Injury (“MACRMI”)⁹⁸ asking the DHHS to require reports of settlement payments only when a provider was found to violate the standard of care.⁹⁹

The DHHS identified the Massachusetts and Oregon models as the only models based on legislation that go beyond the basic elements of apology and disclosure by incorporating the potential for compensation outside the court system, but speculated its decision could influence other states as they develop similar models.¹⁰⁰ Two issues were resolved by the ruling: (1) “[w]hether payments made under Massachusetts’ DA&O model and Oregon’s [E]arly [D]iscussion and [R]esolution law are reportable to the NPDB” and (2) “[w]hether medical malpractice payments from all demands for payment, verbal or written, must be reported to the NPDB.”¹⁰¹

⁹⁴ Andis Robeznieks, *HHS Memo on Med-Mal Reporting Could Hamper Mediation*, MODERN HEALTHCARE, August 18, 2014, at 9.

⁹⁵ Public Citizen is an advocacy group that purports to serve as the people’s voice, challenging abusive practices of the pharmaceutical, nuclear and automobile industries, and others as the “countervailing force to corporate power.” PUBLIC CITIZEN, <http://www.citizen.org> (last visited Oct. 26, 2014).

⁹⁶ Public Citizen alleged the Oregon law sought to “create a loophole that would allow physicians to avoid reporting to the Data Bank any malpractice payments that are negotiated through a mediation process specified under the new law.” Letter from Michael Carome, M.D., Director, Public Citizen’s Health Research Group & Sidney Wolfe, M.D., Founder, Senior Advisor, Public Citizen’s Health Research Group to Secretary of Health and Human Services Kathleen Sebelius, Secretary, Department of Health and Human Services (September 10, 2013), *available at* <http://www.citizen.org/hrg2155>. (last accessed October 18, 2014).

⁹⁷ DHHS Memo, *supra* note 22 at 6.

⁹⁸ MACRMI is “an alliance of patient advocacy groups, teaching hospitals and their insurers, and statewide provider organizations committed to transparent communication, sincere apologies and fair compensation in cases of avoidable medical harm” through the CARE model. MASSACHUSETTS ALLIANCE FOR COMMUNICATION AND RESOLUTION FOLLOWING MEDICAL INJURY, <http://www.macrmi.info> (last visited Oct. 26, 2014).

⁹⁹ DHHS Memo, *supra* note 22 at 6.

¹⁰⁰ *Id.* at 1.

¹⁰¹ *Id.* at 6, 8.

The ruling interprets the NPDB statute as requiring all payments made as a result of a medical malpractice settlement to be reported to the NPDB if it included a written claim or demand for payment.¹⁰² Thus, Massachusetts' pre-litigation notice and Oregon's notice of an adverse event qualify as "written claims" when they include a written demand for payment.¹⁰³ The DHHS found this approach preferable because it is consistent with the NPDB's policies and practices, there is no statutory authority allowing for reporting requirements to be based on whether the practitioner met the standard of care, and it ensures standard reporting requirements across the country regardless of state law.¹⁰⁴ The DHHS declined, however, to include payment as a result of a verbal demand in the reporting requirement.¹⁰⁵ Instead, the ruling maintained current policy by clarifying that only payments resulting from written demands are reportable to the NPDB.¹⁰⁶ The DHHS reasoned this approach is consistent with the interpretation of the NPDB, preserves the value of information by keeping unverifiable claims out, and enables maintenance of a more enforceable and verifiable requirement.¹⁰⁷

The DHHS acknowledged its ruling could be viewed as a barrier to the goal of improving patient safety and the quality of care, and an unwillingness to support initiatives to reform medical malpractice liability.¹⁰⁸

VI. ANALYSIS

On the surface, the DHHS ruling has the potential to drastically impact the effectiveness of both the Massachusetts and Oregon reforms; upon closer examination, however, consequences may not be so dire. The DHHS ruling clarifies which kinds of claims are reportable to the NPDB, requiring Massachusetts and Oregon practitioners to report out-of-court settlements to the NPDB in cases where their respective state laws purport to waive that requirement.¹⁰⁹

The Massachusetts law proposed to only report cases where it was determined that a practitioner failed to meet the standard of care.¹¹⁰ The DHHS ruling, however,

¹⁰² DHHS Memo, *supra* note 22 at 6.

¹⁰³ *Id.* at 6.

¹⁰⁴ *Id.* at 6-7

¹⁰⁵ *Id.* at 8.

¹⁰⁶ *Id.* at 8.

¹⁰⁷ DHHS Memo, *supra* note 22 at 9.

¹⁰⁸ *Id.* at 7.

¹⁰⁹ Andis Robeznieks, *HHS Memo on Med-Mal Reporting Could Hamper Mediation*, MODERN HEALTHCARE, August 18, 2014, at 9.

¹¹⁰ *Id.* at 9.

compels reports to the NPDB, regardless of whether the standard of care was met, thus bringing the Massachusetts' pre-litigation notice into the reporting requirement.¹¹¹ Oregon's Early Discussion and Resolution program aimed to exempt claims not proceeding to litigation,¹¹² and specifically stipulated a payment made through mediation is "not a payment resulting from a written claim or demand for payment."¹¹³ The DHHS ruling specifically targeted Oregon's law when it determined that a notice of an adverse event qualifies as a written claim, regardless of attempts to define it otherwise, thus triggering an obligation to report when payment is made as a result of that notice.¹¹⁴

Because the pre-litigation notice in Massachusetts, and the patient notice of an adverse event in Oregon trigger an obligation to report when a payment is made regardless of whether the claim is resolved through discussion, mediation, or litigation, the NPDB continues to diminish any incentive physicians have to actively participate in early discussion and mediation. Rather than participating in discussions and fully disclosing information to patients in the hopes of reaching a settlement, practitioners may be more inclined to take their chances at litigation, thereby frustrating the overall effectiveness of both the Massachusetts and Oregon reforms as methods to reduce litigation and encourage resolution. In addition, because the DHHS ruling requires reporting of all written demands or claims by patients, discussions initiated by providers will result in a report to the NPDB if the patient makes a written claim at any time during the process.¹¹⁵ Applying this ruling to provider-initiated discussions under Oregon's Early Discussion and Resolution program could decrease providers' willingness to file notices of adverse events that initiate the early discussion process. If fewer notices are filed, fewer opportunities for patients and providers to come to the table for settlement will be realized, thereby diminishing the overall effectiveness of the Oregon program.¹¹⁶

When read carefully, however, the DHHS ruling actually provides guidance that may enable providers to work around the reporting requirement because it only requires reports of payments resulting from *written* demands.¹¹⁷ Because the pre-litigation notice qualifies as a written demand, Massachusetts providers will see no relief from this specific stipulation, but Oregon providers may be able to interpret it in a way that enables

¹¹¹ Robeznieks, *supra* note 109 at 9.

¹¹² See DHHS Memo, *supra* note 22 at 5. In addition, reporting providers who have met the standard of care can unduly harm their reputations. *Id.* at 4. To address this concern, HRSA will consider revising the NPDB report to include a check box indicating whether the standard of care was met. *Id.* at 6.

¹¹³ *Id.* at 6. See also, 2013 ORE. LAWS 5, 2013 at §6(1).

¹¹⁴ DHHS Memo, *supra* note 22 at 7.

¹¹⁵ *Id.* at 3.

¹¹⁶ See Robeznieks, *supra* note 109 at 9. (quoting Rep. Jason Conger who said, "If by filing a notice of an adverse event you're triggering an obligation to report an incident of malpractice, there would be a lot fewer notices filed.").

¹¹⁷ See DHHS Memo, *supra* Note 22 at 8.

them to utilize the Early Discussion and Resolution program without triggering a report to the NPDB. Because reporting is only required when a written demand is made, there are two situations where a payment may be made without requiring a report to the NPDB: payments resulting from provider-initiated claims that do not include a written claim or demand for payment,¹¹⁸ and payments resulting from non-written claims or demands.¹¹⁹ As a result of this “loophole,” providers in Oregon may be encouraged to initiate claims themselves by filing a notice of adverse event rather than waiting for patients to do so. As long as the patient does not make a written claim or demand during the discussion and resolution process, even if a verbal demand is made, the practitioner will be insulated from the reporting requirement.

Regardless of whether a written claim or demand for payment is made, providers in both Oregon and Massachusetts may still find ways to participate in the programs and reach settlement agreements without triggering the reporting requirement. Avenues to avoid reporting to the NPDB that were available prior to the enactment of these reforms are still available. These include resolutions such as making a payment out of pocket, waiving the patient’s debt, refunding the patient’s payment, or utilizing the corporate shield. These workarounds, however, will require support from the larger entities involved. If hospitals and healthcare entities are willing to provide protection to individual practitioners within their organization, they may enable those practitioners to remain involved, and encourage them to work toward settlement without worrying about receiving a permanent black mark in the NPDB as a result. By avoiding reporting to the NPDB, these solutions counteract the negative effect the NPDB reporting requirement has on practitioners’ willingness to engage in discussions with patients and work toward an early resolution. If practitioners are more willing to engage in these discussions to reach early resolution, the newly enacted programs in both Oregon and Massachusetts will have a greater likelihood of success.

VII. CONCLUSION

Medical malpractice reform has produced many changes throughout the years, including the development of alternative dispute resolution programs that provide an opportunity for increased communication between patients and providers and improve patient safety. In direct conflict with its own stated goal of improving patient safety, the DHHS specifically targeted reforms in Massachusetts and Oregon when it ruled reports of medical malpractice payments are required any time a written claim is made, thereby diminishing incentives for providers to engage in the early discussion and resolution process. Although the ruling does nothing to prevent practitioners from pursuing avenues already available to avoid the reporting requirement, many of these options are only viable if healthcare entities are willing to protect individual practitioners by waiving debts, refunding payments, or providing a corporate shield. Without this assistance, practitioners will be forced to choose between settling a claim through early discussion

¹¹⁸ DHHS Memo, *supra* Note 22 at 3.

¹¹⁹ *Id.* at 8.

which will result in a permanent black mark on their record, or pursuing litigation which is more likely to result in a verdict for the practitioner. Thus, through their support of individual practitioners, healthcare entities will have an integral role in ensuring the success and effectiveness of newly enacted reforms in Massachusetts and Oregon and any similar reform efforts modeled after them.