California Negotiated Health Care: Implications for Malpractice Liability

Wilfred Knottnerus
This Comment addresses the impact of California's new Medi-Cal payment system, selective provider contracting, on physician, hospital and state liability. Selective provider contracting encourages provider cost efficiency by contractually binding providers to a pre-determined cost allowance, thereby creating cost-consciousness in medical decision-making. Such consideration may affect the physician's standard of care. Change in the physician's duty to the beneficiary would also affect hospital liability under respondeat superior and corporate negligence principles. Additionally, selective provider contracting may expose the state to liability for negligent provider selection and review.

INTRODUCTION

Medicaid\(^1\) is a federal-state cooperative medical assistance program designed to provide high quality medical care to specific persons.\(^2\) The program operates under state direction. Each state is responsible for formulating and administering a Medicaid plan which conforms to broad federal regulations.\(^3\) Eligible state Medicaid plans are subsidized by the federal government. California's Medicaid program is called Medi-Cal.\(^4\)

In recent years, cost has become an important issue for Medicaid administrators. California, in 1982, adopted a program of direct contracting with selected providers.\(^5\) Selective provider contracting is a new Medi-Cal payment strategy directed at cost containment. This Comment addresses the potential impact of the new payment method on the standard of care in medical malpractice actions and its implications for physician, hospital and state liability.

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2. Id. See also Silver, Medicaid: Title XIX of the Social Security Act: A Review and Analysis, Part I, 4 CLEARINGHOUSE REV. 239 (1970). Generally, Medicaid is available to persons with low incomes. Each state, however, establishes its own Medicaid eligibility requirements.
5. Id.
Selective provider contracting, California's present payment method, differs significantly from prior Medi-Cal payment schemes. An overview of past payment methods is essential to an understanding of the significance of the recent changes.

Originally, Medi-Cal payments were made on a fee-for-service basis. Federal regulations required Medicaid agencies to pay the reasonable cost of hospital inpatient services. California's Health Department determined reasonable cost by post-service audits conducted at the end of the hospital's fiscal year. Hospitals were reimbursed at the lesser of the reasonable cost of services or hospital charges.

The fee-for-service method, however, provided little incentive for hospitals to limit costs. The Department of Health Services became concerned about increasing medical expenditures. In response to this concern, the Department periodically altered its method of determining reasonable cost, but payment methods continued to be cost-based.

In 1972, then-governor Reagan implemented a pre-paid health plan (PHP) as an alternative to the traditional fee-for-service payment system. The PHP program shifted Medi-Cal cost risks to the private sector. The state contracted with select providers to furnish Medi-Cal benefits to beneficiaries who voluntarily choose to enroll in the program. Enrolled beneficiaries used only contracting providers

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7. Id.
8. Id. at 8.
9. Id.
10. Id. at 12. The fee-for-service system, under which reasonable cost determines payment, has been criticized for failing to create cost-saving incentives among providers, because reasonable cost reimbursement guarantees hospitals reimbursement for virtually all expenditures. See, e.g., COMPTROLLER GENERAL OF THE UNITED STATES, RISING HOSPITAL COSTS CAN BE RESTRAINED BY REGULATING PAYMENTS AND IMPROVING MANAGEMENT (1980).
11. Id. at 9. In 1975, the Department of Health Services attempted to limit each hospital's reimbursement to 110% of the previous year's reimbursement. Id. The reimbursement limitation was intended to curb Medi-Cal costs. The 110% limitation was successfully challenged in California Hosp. Ass'n v. Obledo, 602 F.2d 1357 (9th Cir. 1979). The court invalidated the reimbursement limitation because the program had not been sufficiently evaluated by the Department of Health, Education and Welfare. 602 F.2d at 1361-62.
13. See, e.g., Schneider & Stern, Health Maintenance Organizations and the Poor: Problems and Prospects, 70 NW. U. L. REV. 90, 129 (1975). The authors analyze the objectives and consequences of contracting under the PHP program. Contracting and its shifting of risk of Medi-Cal costs to the private sector are explained in the context of then-Governor Reagan's policies for Medi-Cal reform.
14. 1982 CALIFORNIA DEP'T OF HEALTH SERVS., ANN. REP. TO THE GOVERNOR
for virtually all medical care needs. Providers were responsible for costs in excess of contract price, as based on a prospective assessment of yearly cost. Payments were usually made on a per capita basis.

The PHP program was adopted as a cost-control measure. Its cost saving potential, however, was significantly reduced by the limited number of enrolled beneficiaries. Apparently, the Department was unable to create sufficient incentive for beneficiaries to enroll. Criticisms concerning the quality of care provided under the program may have contributed to the low level of beneficiary participation in the program. At any rate, the program failed to solve the Medi-Cal cost problem.

In 1982, California attempted to place a cap on provider reimbursement under the fee-for-services system. Provider reimbursement was to be limited to no more than 106% of the average reimbursement per patient received by the hospital in the previous year.

The California Hospital Association, the United Hospital Association, and the Association of Children's Hospitals sued in federal court to enjoin implementation of the 106% limitation. The court ruled that the 106% limitation failed to satisfy federal requirements that reimbursement rates be adequate to meet the costs of efficiently

AND THE LEGISLATURE: PREPAID HEALTH PLANS AND PILOT PROGRAMS, DUAL CHOICE I [hereinafter cited as PHP REPORT].

15. Id.
16. Id.
17. Id.
18. Id. In 1982, less than six percent of the total Medi-Cal beneficiary population chose to participate in the PHP program.
19. During its initial years, the program was beset with criticisms concerning profiteering, fraud, and marketing abuses. Schneider & Stern, supra note 13 at 129-30 n.203 (citing L.A. Times, May 23, 1974, pt. 1 at 1, col. 1. In 1975, the program was reviewed and evaluated to determine its viability. The Department of Health Services made revisions in the implementation and regulation of the program. 1981 CALIFORNIA DEP'T OF HEALTH SERVS., ANN. REP. TO THE GOVERNOR AND THE LEGISLATURE: PREPAID HEALTH PLANS, PILOT PROGRAMS. Still, the PHP program has been criticized for quality of care abuses. Schneider & Stern, supra note 13, at 134. The authors disclose evidence that contracting providers underuse the PHP program. Complaints filed with the National Health Law Program by beneficiaries indicate incidents where beneficiaries were unable to receive medical treatment. For example, one incident involved a three-year-old girl who, after breaking her arm, sat in pain at a participating hospital from 10 a.m. until 6 p.m. without receiving medical attention. After being sent home to await further word, the girl, at 9 p.m., was taken to a nonparticipating hospital where she received immediate medical treatment. Payment was made by the patient's family.
20. Peer Grouping Hospitals, supra note 6, at 14 (citing CAL. WELF. & INST. CODE § 5538 (West 1982)).
and economically operated hospitals. Thus, California's scheme for cost containment by flat percentage increases was invalidated.

**Prior State Quality Control Measures**

As previously noted, each state is responsible for regulating health care quality under its Medicaid plan. Under the fee-for-service system, California's quality management measures were limited primarily to licensing and certification activities conducted by the Licensing and Certification Division of the State Department of Health Services. The Division inspects and qualifies all health care providers, including those not participating in Medi-Cal, as fit to serve the public.

Under the PHP program, the Department of Health Services used additional quality control measures, including annual medical audits conducted by the Audit and Investigations Division of the Department of Health Services. Audits included facility inspection and evaluation of health care based on patient medical chart reviews. Additionally, the Department monitored enrollee satisfaction by reviewing enrollee complaints, determining the number and type of monthly voluntary disenrollments, and conducting beneficiary satisfaction surveys.

Prior state quality control measures did not subject the state to liability to the Medi-Cal beneficiary for the malpractice of Medi-Cal providers. A governmental immunity statute precludes state liability for injury resulting from the inappropriate licensure or certification of a medical care provider. Apparently, PHP program quality control measures were not sufficiently extensive so as to expose the state

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22. Id. In 1981, Congress removed the requirement that hospitals be reimbursed the reasonable cost of services provided. Instead, the state is required to pay an amount adequate to meet the costs of efficiently and economically operated hospitals. 31 U.S.C.A. § 7305 (West 1983). See also Peer Grouping Hospitals, supra note 6, at 13.

23. T. Christofel, *Health and the Law* 80 (1982). Licensing laws control entry into the medical occupation as well as enforce standards of practice among providers. Generally, certification is "the process by which a non-government agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association." Id. at 91. In this sense, certification is a term of art referring to a particular type of provider qualification. In California, however, "certification" is implemented by a governmental agency. Apparently, the term "certification" is used in a general sense, rather than as a term of art.

24. Id. at 80, 85. Generally, licensing boards carry out the following functions: (1) examination of applicants, (2) issuance of licenses, (3) suspension, revocation, and restoration of licensure, (4) enforcement of the licensing statute, and (5) approval of professional schools. Id. at 85.


26. Id.

27. Id. at 3. In 1982, voluntary beneficiary disenrollment was approximately two percent on a statewide basis.

to liability for injury resulting from negligent quality management.\textsuperscript{29} The new Medi-Cal payment method may, however, expose the state to liability for injury to beneficiaries.

\textbf{Selective Provider Contracting: California's New Payment System}

California's new Medi-Cal legislation, through a system of selective provider contracting, attempts to contain spiralling Medi-Cal costs.\textsuperscript{30} The legislation enables the state to contract with individual or group providers to furnish Medi-Cal beneficiaries inpatient medical care.\textsuperscript{31} With limited exceptions,\textsuperscript{32} beneficiaries must receive medical services from only those providers selected by the state in the contracting process.\textsuperscript{33} Beneficiary participation is no longer a matter of choice as it was under the PHP program.\textsuperscript{34}

\textit{The Contracting Process}

Under the new legislation, the Department of Health Services is authorized to enter into contracts after either negotiation or competitive bidding.\textsuperscript{35} The governor appointed a special negotiator to implement the contracting process.\textsuperscript{36} The negotiator was given maximum

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  \item The absence of litigation resulting in state liability indicates that state quality control measures under the PHP program failed to place these state activities within the purview of a state liability statute. \textsuperscript{30} CAL. WELF. & INST. CODE § 14081 (West Supp. 1983). The purpose of the legislation enabling contracts with select providers is: to ensure that the Medi-Cal program shall be operated in the most cost-effective and efficient manner possible . . . In order to carry out the purpose it is the specific intent of the Legislature that the special negotiator have maximum discretion and flexibility in order to select among various methods of arranging for the provision of health services while achieving significant cost savings. \textit{Id.}
  \item Certain hospitals are excepted from the contract process. CAL. WELF. & INST. CODE § 14086 (West Supp. 1983). "The provisions of this article relating to contracts with hospitals . . . shall not apply to hospital inpatient services rendered by health maintenance organizations and other organized health systems . . . or state hospitals." \textit{Id.}
  \item This article shall be the exclusive means of providing inpatient hospital services to recipients qualifying for such care . . ." \textit{Id.}
  \item CAL. WELF. & INST. CODE § 14082 (West Supp. 1983).
  \item CAL. WELF. & INST. CODE § 14082 (West Supp. 1983) provides the authority
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flexibility in arranging contracts to achieve significant cost savings. The contracting process began with an invitation letter sent to providers in a given area determined by, “population density, natural boundaries, travel time, and customary health service delivery patterns.” Hospitals choosing to participate submitted data showing cost and facility utilization for the previous four years and made offers for their services on an all-inclusive per diem rate.

The negotiator was permitted to consider many factors including price, accessibility, and quality of care in accepting offers. Hospital offers were considered in relation to bed need estimates, services historically rendered by hospitals in the area, and the historical cost of those services. Each hospital’s offer of contract terms and price was also compared with the offers of other hospitals in the area. Consequently, to enhance their competitive position, hospitals were encouraged to assume as much risk as possible. For example, hospitals were expected to assume the risk of subcontracting for a needed service they had not historically provided. Also, hospitals submitting offers for a lesser charge, indicating willingness to assume more risk of expenditures in excess of contract price, were viewed more favorably in the contracting process. Medi-Cal provider contracts were awarded to the most cost-effective and efficient hospitals, in compliance with legislative intent.

Selective provider contracting as a cost containment device is for the Governor to designate a special negotiator.

38. CALIFORNIA OFFICE OF SPECIAL HEALTH CARE NEGOTIATIONS, REPORT TO THE LEGISLATURE ON THE OPERATIONS OF THE OFFICE OF SPECIAL HEALTH CARE NEGOTIATIONS 8 (May 1983) [hereinafter cited as REPORT: HEALTH CARE NEGOTIATIONS].
39. Id. at 10-16.
40. CAL. WELF. & INST. CODE § 14083 (West Supp. 1983). Factors to be considered by the negotiator in arranging contracts include:
(a) Beneficiary access.
(b) Utilization controls.
(c) Demonstrated ability to provide or arrange needed specialized services.
(d) Ability to render quality services efficiently and economically.
(e) Protection against fraud and abuse.
(f) Any other factor which would reduce costs, promote access, or enhance the quality of care.
(g) The capacity to provide a given tertiary service, such as specialized children's services, on a regional basis.
(h) Recognition of the variation in severity of illness and complexity of care.
(i) Existing labor-management collective bargaining agreements.
41. REPORT: HEALTH CARE NEGOTIATIONS, supra note 38, at 16-17.
42. Id.
43. Id. at 5.
44. Id.
45. Id. Even though quality of care is a factor to be considered in contracting with providers, the primary purpose of the legislation is to limit Medi-Cal cost growth. Providers submitting offers for a lesser per diem charge were probably viewed more favorably by the negotiator whose function was to obtain significant cost savings. See, e.g., supra note 30.
founded on the assumption that providers will furnish all medical care necessitated by the patient's medical condition, absorbing cost in excess of contract price. As a practical matter, hospitals, as profit-making institutions, may be reluctant to accept loss. Contracting will create the desired cost-saving incentive among providers. Because provider profit decreases in proportion to the amount of medical care provided, limiting costs may result in limiting the quantity and quality of medical services provided. Cost will likely become a consideration in medical decision-making. Less costly medical services are not always inadequate. The line between frugal medical decisions and purely cost-conscious medical decisions, however, is a fine one. Thus, selective provider contracting, by shifting cost risks to the private sector, strains the quality of health care services furnished by Medi-Cal providers.

The enabling legislation requires maintenance of the pre-contracting quality of care. As previously noted, the state must formulate a Medicaid program which comports with federal regulations. To adopt the contracting system, California was required to obtain a waiver of Social Security Act provisions. The waiver allows California to restrict Medicaid beneficiaries' choice of provider to those selected through the contracting process by the Department of Health Services. The waiver required state assurance that beneficiaries would continue to receive high quality medical care under the new program. Presently, federal officials of the Health Care Financing Administration are closely monitoring California's implementation of the new program to ensure compliance with the assurances given in exchange for the waiver.

46. "Hospitals which negotiate at-risk contracts will have additional incentives to improve efficiency and to assure all provided services are cost effective." FEDERAL WAIVER REQUEST: CALIFORNIA'S SELECTIVE PROVIDER CONTRACTING PROGRAM 14 (1982). "The hospital is responsible for all costs of providing inpatient care and may look only to the negotiated per diem rate for reimbursement." REPORT: HEALTH CARE NEGOTIATIONS, supra note 38, at 4.

47. The term profit-making institution is not used in its generic sense. The author recognizes that most hospitals are non-profit organizations. This does not mean, however, that hospitals can operate without showing a net cash inflow.

48. FEDERAL WAIVER REQUEST: CALIFORNIA'S SELECTIVE PROVIDER CONTRACTING PROGRAM (1982). Selective provider contracting did not meet federal requirements for state Medicaid plans because the state restricts beneficiary provider choice under the plan. Therefore, the Department had to obtain a waiver of the federal regulations which selective provider contracting violated.

49. Letter from Carolyne Davis to Governor Brown (Sept. 21, 1982) (granting the Department of Health Services' waiver request).

50. Id.

51. Id. The waiver is for a two-year period, subject to renewal in October 1984
Quality Management Measures Under Selective Provider Contracting

California's Department of Health Services has taken numerous steps to control the quality of selected providers' services. First, the contracts between the state and the providers require the providers to furnish beneficiaries and non-beneficiaries equivalent medical services. Performance of this promise is an express condition precedent to the state's obligation to pay. Providers also promise not to discriminate against Medi-Cal beneficiaries in any manner, including admission practices.

Second, the Department of Health Services periodically reviews provider performance to ensure compliance with contractual provisions. Reviews include on-site evaluations of the level and quality of care furnished by the provider. Presently, these reviews are conducted by the Licensing and Certification Division of the Department.

Finally, the Department of Health Services has implemented an incident report system as a state-wide quality of care monitoring device. Anyone, including physicians in contracting or non-contracting institutions, may report a perceived incident to the Department provided that provider quality remains at the level prior to the contracting system.

52. REPORT: HEALTH CARE NEGOTIATIONS, supra note 38, app. J., at 10 (Model Contract). The Model Contract for Hospital Inpatient Services provides:

As express conditions precedent to maturing the State's payment obligation under the terms of this Contract . . . the Provider shall:

(3) provide inpatient services in the same manner to beneficiaries as it provides to all patients to whom it renders inpatient services.

(4) Not discriminate against Medi-Cal beneficiaries in any manner, including admission practices, placement in special or separate wings or rooms, provision of special or separate meals, or waiting time for surgical procedures.

Each contract is negotiated individually and remains confidential. The Model Contract provides an example of the contract sought to be arranged by the Office of Special Health Care Negotiations of the Department of Health Services. Id. at 1.

53. Id.
54. Id.
55. CAL. WELF. & INST. CODE § 14087.1 (West Supp. 1983). Reviews are conducted pursuant to a statutory mandate which provides:

The department or its authorized agents shall conduct periodic audits or reviews, including on-site reviews of performance under any contract made pursuant to this article. These audits or reviews may evaluate the following:

(a) Level and quality of care, and the necessity and appropriateness of the services provided.

(b) Internal procedures for assuring efficiency, economy and quality of care.

(c) Grievances relating to medical care and their disposition.

(d) Financial records only when determined necessary by the department to protect public funds.

56. Telephone interview with Nancy Bookbinder, Office of Tom Elkin, Department of Health Services (June 24, 1983).
57. Id.
58. Id.
The Department then will conduct a preliminary investigation. If the incident raises a valid quality-of-care issue, the matter is referred to the Licensing and Certification Division. A team from the Division may then investigate the suspect provider, questioning both hospital staff members and patients and examining the provider's medical records. The team reports its findings to the Deputy Director of the Medi-Cal Operations Division of the Department of Health Services. If the provider is rendering inadequate medical care, the Department may seek contractual remedies against the provider, including termination of contract. The Department may also take licensing action against the provider.

The state, recognizing the tension placed on health care quality by provider contracting, seeks to avoid adverse impact on patients by closely monitoring the activities of providers. As a practical matter, the quality control measures will not counteract the cost-consciousness created by selective provider contracting. Indeed, the rationale of contracting is that by shifting cost risks to the private sector the needed cost saving incentive will be created. The state is not implementing a true quality management system. The cost of a quality management system sufficient to guard against poor practice would likely eliminate any cost saving under the new program. Because good medical practice is beyond the range of knowledge of most laymen, a quality management system would necessarily include frequent on-site reviews and evaluations by physicians. Thus, state quality control will not prevent poor practice by providers. As cost consciousness increases, providers will be tempted to reduce access to care. Providers will face the risk of medical malpractice since the legal standard of care does not recognize reduced quality resulting

59. Id.
60. Id.
61. Id.
62. Id.
63. Telephone interview with Donna Hyatt, Legal Services Division, Department of Health Services (June 29, 1983).
64. Id.
65. Telephone interview with Nancy Bookbinder, Office of Tom Elkin, Department of Health Services (June 24, 1983). The Department will likely expand provider quality supervision as contracting continues.
66. See supra note 46 and accompanying text.
67. A quality control measure sufficient to prevent poor practice among providers treating more than two million beneficiaries would require virtually constant provider supervision by physicians. The cost of such a program would likely exceed the cost savings of provider contracting.
from financial restraints. Nevertheless, selective provider contracting, by tying care to available financing, may afford providers a defense to malpractice liability for injury resulting from their cost-based care.

**STANDARD OF CARE**

Medical malpractice law defines the physician's duty of care by a customary practice standard. The physician is under a duty to exercise that degree of skill, knowledge and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. Under general negligence law, duty is defined by independent judicial assessment of risk reasonableness. Malpractice law does not incorporate such an assessment when defining the duty owed. Rather, the standard of care is usually established by expert testimony as the conduct of similarly situated physicians in good standing. A physician, however, is not held to a single course of conduct. When a "respectable" minority of physicians support a certain course of conduct, a physician may act accordingly without breaching a duty to the patient.

Historically, the standard of care was defined by the locality doctrine. A physician was held to the standard of customary practice of similarly situated physicians in the same locality. The doctrine emerged because physicians practicing in rural areas had relatively limited access to medical resources. The locality rule gradually disappeared as communication systems improved and medical resources

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68. The physician is held to the standard of customary practice of similarly situated physicians in good standing. Landeros v. Flood, 17 Cal. 3d 399, 551 P.2d 389, 131 Cal. Rptr. 69 (1976). To date, a physician's financial situation has not been incorporated into the standard to which a physician is held. This may be due, in part, to the fact that, in the past, physicians have not had to render treatment to patients without the opportunity for reimbursement.


70. See Meier v. Ross Gen. Hosp., 69 Cal. 2d 420, 455 P.2d 519, 71 Cal. Rptr. 903 (1968) (usually, a physician's breach of duty can be shown only by expert testimony). See also Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 1975 Duke L.J. 1375, 1377. The customary standard fails to define the optimum level of risk permissible and therefore needlessly encourages defensive medicine—an impediment to cost efficiency.


73. Comment, *Medical Malpractice: The Locality Rule in Relation to BAJI 6.00 and Sinz v. Owen, 7 U.S.F.L. Rev. 163* (1972) (concludes that the malpractice standard no longer incorporates the locality doctrine).


75. Comment, supra note 73 at 771.
became more readily available to the rural physician.\textsuperscript{76}

Hospitals may also be liable to patients. Hospital liability can be separated into three categories. First, a hospital may be vicariously liable for the negligence of employees.\textsuperscript{77} Second, a hospital may be liable for the negligence of independent contractor physicians if it acted negligently in selecting and reviewing these persons.\textsuperscript{78} Finally, a hospital may be liable for its own independent negligent conduct.\textsuperscript{79} Provider contracting, to the extent that it affects the physician's duty to beneficiaries, may have implications for hospital liability under either the doctrine of respondeat superior or the doctrine of corporate negligence.

Under the doctrine of respondeat superior, hospitals are vicariously liable for the negligent acts of employees and others over whom the hospital has a significant degree of control.\textsuperscript{80} Under these circumstances, the hospital is liable only if the employee could be held liable.\textsuperscript{81} Consequently, if the employee can show no breach of duty, the hospital will not be liable. Where the hospital employee is a physician, any change in the customary practice standard will be determinative of hospital liability under the doctrine of respondeat superior.

Similarly, any change in the customary practice standard will affect hospital liability under the doctrine of corporate negligence. Under this doctrine, a hospital owes patients the duty to carefully select and review physicians with whom the hospital contracts.\textsuperscript{82} Conceivably, a hospital could be negligent in review and selection even if the independent contractor physician had not acted negligently. However, liability requires a showing of causation and damages as well as negligence.\textsuperscript{83} If the physician were not negligent, then

\begin{itemize}
\item \textsuperscript{76} Id.
\item \textsuperscript{79} Vistica v. Presbyterian Hosp. & Medical Center, 67 Cal. 2d 465, 432 P.2d 193, 62 Cal. Rptr. 577 (1967) (hospital failed to render sufficient care, resulting in a mental patient jumping from a hospital window).
\item \textsuperscript{80} Seneris v. Haas, 45 Cal. 2d 811, 291 P.2d 915 (1955) (anesthesiologist was “on call” at the hospital); see also Hanson & Strimberg, Hospital Liability for Negligence, 21 Hastings L.J. 1, 7 (1969).
\item \textsuperscript{81} Seneris v. Haas, 45 Cal. 2d 811, 291 P.2d 915 (1955).
\item \textsuperscript{83} United States Liab. Ins. Co. v. Haidinger-Hayes Inc., 1 Cal. 3d 586, 463 P.2d 770, 83 Cal. Rptr. 418 (1970) (actionable negligence requires a legal duty to use due
there could be no causation or damages. Consequently, the hospital would not be liable to a plaintiff-patient even if it could be shown that it acted negligently in its selection and review. Because of the apparent difficulty in finding hospital liability in the absence of independent contractor negligence, hospital liability under the corporate negligence doctrine seems to be dependent on a prior showing of independent contractor negligence. If an independent contractor physician can show he acted as similarly situated physicians in good standing would have acted, he will not be negligent and, consequently, not liable.\textsuperscript{84} If the physician is not liable, then the hospital will not be liable since causation and damages could not be shown. Therefore, a change in the physician's standard of care is determinative of hospital liability under the corporate negligence doctrine.

Situations of hospital liability based on either respondeat superior or corporate negligence must be distinguished from situations where the hospital is liable for its own independent negligence. Hospitals are under a duty to exercise such reasonable care toward a patient as his mental and physical condition requires and to exercise ordinary care to provide suitable supplies, equipment and facilities.\textsuperscript{85} Essentially, a hospital may be liable for failing to act reasonably towards the patient. Under such circumstances, hospital liability is not dependent upon employee or independent contractor liability.\textsuperscript{86} Therefore, change in physician's standard of care would not affect hospital liability for independent acts of negligence. In these circumstances, provider contracting will leave hospitals in a predicament. In the event that costs of necessary medical services, supplies and equipment exceed the contract payment price, the hospital will be forced to absorb excess cost or risk liability.

Thus, any change in the physician's legal standard of care affects both physician and hospital liability. The malpractice standard of care changes as customary medical practice changes. Selective provider contracting encourages cost consciousness in medical decision-making. Providers, laden with cost-saving incentives, will be charged with the medical care of some two to three million beneficiaries.\textsuperscript{87} If a "respectable minority"\textsuperscript{88} of the medical profession considers cost in medical decision-making, then cost-based medical decisions may become part of an accepted practice standard. Such a change would result in a standard of care reminiscent of the locality doctrine.

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\textsuperscript{84} See supra notes 69-72 and accompanying text.
\textsuperscript{85} See supra note 79 and accompanying text.
\textsuperscript{86} Id.
\textsuperscript{87} PHP REPORT, supra note 14, at 1. In 1982, 2.9 million persons qualified as Medi-Cal eligible.
\textsuperscript{88} See Bovbjerg, supra note 70, at 1385.
where money rather than medical resources is determinative of the physician’s standard of care. Customary practice among contracting providers would be unique, resulting in a separate Medi-Cal practice standard. Such a standard would enhance cost containment objectives. Physicians, basing medical decisions on cost, would be shielded from malpractice liability for injury resulting from cost-based decisions. Without the threat of malpractice liability, physicians would tend to develop innovative cost-saving methods.89

The Professional Standards Review Organization’s (PSRO) norm is an example of a practice standard which incorporates a consideration of cost. PSROs were established by Congress to review claims for Medicare and Medicaid payment.89 Claim reviews include a determination of whether provider health service quality conforms to recognized standards.91 PSRO quality decisions furnish a practice standard on which a provider can rely when treating beneficiaries.92 Providers are immune from liability when conforming to PSRO norms.93 The PSRO immunity statute was intended as a cost containment measure.94 By shielding conforming providers from malpractice liability, the PSRO legislation “eliminates the need for unnecessary medical treatment as a precaution against malpractice liability.”95

Nevertheless, a special Medi-Cal practice standard would be fundamentally inconsistent with tort law principles. Malpractice law aspires to the twin goals of victim compensation and quality assurance.96 The duty owed should be defined accordingly. Reliance on customary medical practices to set the standard of care under malpractice law is justified for two reasons. First, medical decisions are typically beyond the competency of laymen.97 Judges and juries are usually unable to assess risk appropriateness. Second, the aggregate of professional medical judgment best sets the socially appropriate level of risk.98 The concept of medical professionalism, which makes

89. Id. at 1386.
91. Id.
92. Blumstein, supra note 71, at 1397.
93. Id. (citing 42 U.S.C. § 1320c-16(e) (1976)).
94. Blumstein, supra note 71, at 1397.
95. Id.
96. Id. at 1395.
97. Bovbjerg, supra note 70, at 1392.
98. Id. at 1393.
the customary practice standard appropriate, is devoted to the patient's best interests.\footnote{99} Thus, malpractice law emphasizes quality of care. Cost containment objectives emphasize reduced quantity of care which may result in reducing the quality of care.

For this reason, malpractice law and cost containment objectives are inconsistent. Cost-based medical treatment is an objective foreign to the concept of medical professionalism underlying the customary standard of care. A Medi-Cal practice standard, incorporated into the legal standard, would subvert malpractice law objectives by denying Medi-Cal recipients compensation for injury resulting from medical care where quality is defined in terms of cost-saving objectives. The general quality of care for all Medi-Cal recipients would be decreased. Permitting lower standards of care for Medi-Cal than for non-Medi-Cal patients would deny Medi-Cal patients the potential for recovery available to non-Medi-Cal patients. As such, beneficiaries could be denied equal protection of the law.\footnote{100}

A special Medi-Cal practice standard would also result in a conflict between the provider's contractual obligation to the state and its tort duty to the patient. Under Medi-Cal contracts, providers expressly promise to furnish beneficiaries and non-beneficiaries equivalent quality health care.\footnote{101} The state may pursue contract remedies if a provider fails to comply with this covenant.\footnote{102} Coincidentally, the beneficiary may be denied a tort remedy because of the Medi-Cal practice standard. A contract obligation is not dispositive of a tort duty. Nevertheless, a contracting provider should not be able to shield itself from tort liability while simultaneously deviating from prior quality of care assurances.

Thus, change in the customary practice of Medi-Cal providers should not affect the physician's duty to the Medi-Cal patient. Under the new Medi-Cal program, the customary practice standard may afford providers a shield to malpractice liability, undermining the goals of malpractice law. The customary practice standard should be applied only to the extent that it permits quality assurance. Without such limitation the physician's standard of care fails its essential purpose of defining a socially appropriate level of risk.

The effect of Medi-Cal provider contracting on the malpractice standard of care becomes an issue of increased significance when

\footnote{100} A discussion of the constitutional law issues resulting from differing standards of care owed to beneficiaries and non-beneficiaries is beyond the scope of this Comment. For a discussion of constitutional issues raised by rationed health care, see Blumstein, \textit{supra} note 71, at 1356-92.
\footnote{101} \textit{See supra} note 52 and accompanying text.
\footnote{102} Telephone interview with Donna Hyatt, Legal Services Division, Department of Health Services (June 29, 1983).
considering recent moves toward a completely competitive health care system. Recent California legislation indicates such a move. Along with the selective provider contracting legislation, another bill passed enabling the private sector—insurance companies—to contract with hospitals for medical services. In a competitive system, cost would very likely become a primary concern for most of the medical community. Practice standards would change. Consequently, the customary practice standard of care would change, shielding physicians from liability for cost-based medical decisions. The malpractice standard of care, to meet its goals, cannot continue to be defined in terms of customary practice in a competitive health care system. Rather, the malpractice standard of care must continue to incorporate as its primary objective a consideration of the patient’s best interests.

STATE LIABILITY UNDER SELECTIVE PROVIDER CONTRACTING

In addition to its potential effect on physician and hospital liability, selective provider contracting has implications for state liability. Increased state involvement in the disbursement of services under Medi-Cal makes the state particularly susceptible to liability under the Tort Claims Act, California’s statute limiting sovereign immunity. The Act sets forth two sources of liability upon which a plaintiff-beneficiary might base an action against the state.

Torts of an Independent Contractor

California law permits public entity liability for injury caused by the tort of an independent contractor. The liability is generally the same as that of a private person, with the limitation that the state will only be liable to the extent it would be liable if the independent contractor were a state employee. The exception seems to make

104. CAL. GOV’T CODE §§ 810-996.6 (West 1980). The Tort Claims Act is a comprehensive set of government liability statutes. The legislation eliminates common law liabilities of the state. The state may be liable only as provided by statute.
105. CAL. GOV’T CODE § 815.4 (West 1980) provides:
A public entity is liable for injury proximately caused by a tortious act or omission of an independent contractor of the public entity to the same extent that the public entity would be subject to such liability if it were a private person. Nothing in this section subjects a public entity to liability for the act or omission of an independent contractor if the public entity would not have been liable for the injury had the act or omission been that of an employee of the public entity.
In Van Arsdale v. Hollinger, 68 Cal. 2d 245, 253, 437 P.2d 508, 513, 66 Cal. Rptr. 20, 25 (1968), the court noted:
applicable those statutory immunity provisions relating to state liability for employee torts. Thus, the state may be liable for injury caused by the malpractice of a provider if a private person in the state's position would be liable and no statutory immunities apply.\textsuperscript{106}

A private person, meaning an individual or corporation,\textsuperscript{107} would be subject to liability for injury caused by the tort of an independent contractor. Hospitals often contract with physicians to furnish medical services to hospital patients. As previously discussed, hospitals may be liable to patients for the torts of independent contractor physicians.\textsuperscript{108} Two duties, owed directly to the patient by the hospital, are recognized under the corporate negligence doctrine. First, hospitals owe patients the duty to use reasonable care to select competent physicians.\textsuperscript{108} Second, hospitals owe patients the duty to use reasonable care to review the practice of the contracting physician once hired.\textsuperscript{110} A California court, in \textit{Elam v. College Park}, gave judicial recognition to the corporate negligence principle, holding that a hospital has the duty to carefully select independent contractor physicians and to evaluate the quality of medical treatment rendered by these persons.\textsuperscript{111} The court reasoned that since hospitals undertake to provide medical care, the patient can expect that the hospital will be responsible for physicians with whom it contracts.\textsuperscript{112} Additionally, the court noted that imposition of such duty would have a "prophylactic" effect, encouraging hospitals to assure the competence of their medical staffs by careful selection and review.\textsuperscript{113} Thus, hospitals are liable for the torts of independent contractors if the duties of careful selection and review have been breached. If a hospital were to contract with providers to furnish Medi-Cal services, the hospital would owe beneficiaries the duty to carefully select and review providers. If the hospital failed to use reasonable care to discharge these duties, it would be liable for the provider's tort. Therefore, the state,

\textit{It is clear that the liability of an employer of an independent contractor for the latter's tortious conduct is broad, and it must be assumed that the Legislature was aware of the extent of liability when, by adopting section 815.4 of the Government Code, it chose with one exception . . . to waive the defense of sovereign immunity in cases involving tortious conduct of independent contractors.}\textsuperscript{106}

\textit{The Model Contract identifies the state-provider relationship as follows: "The State and Provider hereby acknowledge that they are independent contractors to one another and neither is an officer, agent, or employee of the other for any purposes."}\textsuperscript{107}

\textit{REPORT: HEALTH CARE NEGOTIATIONS, supra note 38, app. J at 31 (Model Contract).}\textsuperscript{107}

\textit{CAL. Gov'T CODE § 17 (West 1980) provides: "'Person' includes any person, firm, association, organization, partnership, business trust, corporation, or company."}\textsuperscript{108}

\textit{See supra notes 82-84 and accompanying text.}\textsuperscript{108}


\textit{Id.}\textsuperscript{110}

\textit{Id.}\textsuperscript{111}

\textit{Id.}\textsuperscript{112}

\textit{Id. at 346, 183 Cal. Rptr. at 164.}\textsuperscript{113}
having potential liability for independent contractor torts to the same extent as a private person in the state's position, owes beneficiaries similar duties of selection and review under the state independent contractor statute. Consequently, the breach of such duties would expose the state to liability for provider torts.

State Medi-Cal contracting is sufficiently similar to hospital physician contracting so as to warrant imposition of liability under corporate negligence principles as disclosed in Elam. The state is controlling the medical care that beneficiaries receive under the Medi-Cal program through its selection and qualification of hospitals as Medi-Cal providers. As previously discussed, beneficiaries are directed to seek out contracting providers for medical needs. Essentially, the state is making a quality choice for the beneficiary. The state is impliedly telling the beneficiary that adequate care can be received at the mandated hospital. The beneficiary then can expect that the state will carefully select and review these providers to ensure their medical competence. Therefore, the state owes beneficiaries the duty to carefully select and supervise the providers it has chosen for the beneficiary. Recognition of this duty would encourage the state to assure the competence of providers by careful selection and review.

If the provider were an employee of the state, the state would still be liable. The statute makes governmental immunity provisions a valid defense to state liability. The state is immune from liability for injury resulting from an exercise of official discretion vested in public employees. "Operational" level torts, such as ordinary medical malpractice in diagnosis and treatment of patients, are not excepted from state liability. Therefore, plaintiff beneficiaries' recov-

114. See supra note 34.
115. Duty is an expression of public policy entitling a particular plaintiff to protection. Duty is measured by the foreseeability of risk resulting from negligent conduct. Dillon v. Legg, 68 Cal. 2d 728, 441 P.2d 912, 69 Cal. Rptr. 72 (1968). Medi-Cal contracting, by limiting beneficiary health care to providers selected on the basis of cost efficiency, creates the risk of injury resulting from purely cost-based medical decisions. State duties of careful provider selection and review would provide beneficiary protection from such risk.
117. CAL. GOV'T CODE § 820.2 (West 1980).
118. Bohrер v. County of San Diego, 104 Cal. App. 3d 155, 160, 163 Cal. Rptr. 419, 423 (1980). A hospital employee negligently administered drugs to the patient after notice of the patient's drug abuse, causing the patient to commit suicide. The court rejected defendant's assertion of discretionary immunity, reasoning that discretionary immunity applied to basic policy decisions. Here, the negligent employee's decision was not a policy-making decision that warranted application of blanket governmental immunity. See also Jackson v. Kelly, 557 F.2d 735 (10th Cir. 1977); United States v. Canon, 217 F.2d 70 (9th Cir. 1954) (both cases admitting liability for operational torts such as ordi-
ery from the state for injury resulting from provider negligence in diagnosis and treatment is possible under the state independent contractor statute, since it is not precluded by state employee immunity provisions.

**Failure to Discharge a Mandatory Duty**

An alternative to state liability for failure to carefully review providers is the mandatory duty theory. California law recognizes public entity liability for injury resulting from failure to use reasonable diligence to discharge a mandatory duty that is designed to protect against the injury which occurred. A mandatory quality management provision is included among the selective provider contracting statutes. The statute requires the Department of Health Services to review and evaluate, among other things, the quality of care among providers. Arguably, the statute was enacted to protect beneficiaries from injury resulting from provider malpractice. Therefore, failure of the state to exercise reasonable diligence to ensure beneficiaries quality health care may result in a presumption of negligence. State liability would then result if proximate cause can be shown.

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119. **CAL. GOV'T CODE** § 815.6 (West 1980) provides:

Where a public entity is under a mandatory duty imposed by an enactment that is designed to protect against the risk of a particular kind of injury, the public entity is liable for an injury of that kind proximately caused by its failure to discharge the duty unless the public entity establishes that it exercised reasonable diligence to discharge the duty.

120. **CAL. WELF. & INST. CODE** § 14087.1 (West Supp. 1983). See also supra note 55 and accompanying text.

121. **Id.**

122. **Id.** See also supra note 55. The Legislative Council Digest does not indicate the intention of the Legislature in enacting the review provision. However, the first of the review subjects mentioned is quality of care. Additionally, the Department of Health Services, in the Federal Waiver Request, warranted that "utilization and quality assurance systems already in place in the California Medi-Cal program and already approved in our existing State Plan will be maintained in order to assure that quality care is provided to all beneficiaries . . . . In addition periodic hospital reviews will be continued." **FEDERAL WAIVER REQUEST: CALIFORNIA'S SELECTIVE PROVIDER CONTRACTING PROGRAM** 16 (1982). Therefore, since the review statute contains quality of care as the first-mentioned review subject and the Department of Health Services, in the Federal Waiver Request, warrants health quality control, it seems that statute was enacted to protect beneficiaries from injury resulting from poor provider practice.

123. Reasonable diligence depends on the particular facts and circumstances of a case as determined by the jury. Sullivan v. County of Los Angeles, 12 Cal. 3d 710, 527 P.2d 865, 117 Cal. Rptr. 241 (1974) (trial court decision, nonsuiting plaintiff on grounds of governmental immunity, was reversed and remanded for determination of reasonable diligence); Morris v. Marin County, 18 Cal. 3d 901, 559 P.2d 606, 136 Cal. Rptr. 251 (1977) (where decision granting defendant's demurrer on grounds of governmental immunity was reversed and the issue of reasonable diligence left to the trier of fact).
State Immunities

California's Tort Claims Act is structured such that any applicable statutory immunity will defeat a claim based on a statute providing liability. In an action by a plaintiff-patient, the state may assert immunity through several immunity statutes. These statutes may, in varying degrees, interpose barriers to state liability based on either the independent contractor or mandatory duty statute. However, present state activity in Medi-Cal fails to invoke any of the immunity statutes.

The state is immune from liability for injury caused by the failure of a public entity or employee to make a physical examination to determine whether a particular person has a medical condition hazardous to himself or others. Because the independent contractor liability statute makes applicable immunity provisions applying to public employees in the contractor's position, the state might assert immunity for injury resulting from a contractor's inadequate diagnosis of a beneficiary's health condition. However, the immunity provision is not intended to apply to negligent examination of patients for purposes of treatment. Rather, the provision applies to the negli-

124. CAL. GOV'T CODE § 815(b) (West 1980) provides:
The liability of a public entity established by this part (commencing with section 814) is subject to any immunity of the public entity provided by statute, including this part, and is subject to any defenses that would be available to the public entity if it were a private person.

See also CAL. GOV'T CODE §§ 815.2(b), 820(b) (West 1980).

125. CAL. GOV'T CODE § 855.6 (West 1980) provides:
Except for an examination or diagnosis for the purpose of treatment, neither a public entity nor a public employee acting within the scope of his employment is liable for injury caused by the failure to make a physical or mental examination, or to make an adequate physical or mental examination, of any person for the purpose of determining whether such person has a disease or physical or mental condition that would constitute a hazard to the health or safety of himself or others.

(Emphasis added).

126. Recommendation Relating to Sovereign Immunity, 4 CALIFORNIA L. REVI-
SION COMM’N REP. 801, 831 (1963):
Public entities and public health officials and other public employees who are required to examine persons to determine their physical condition should not be liable for failing to examine or to make an adequate examination of any person for the purpose of determining whether such person has a communicable disease or any other condition that might constitute a hazard to the public or to the person examined. This immunity from liability would not cover an examination or diagnosis for the purpose of treatment, but would cover such examinations as public tuberculosis examinations, examinations for the purpose of determining whether persons should be isolated or quarantined, eye examinations for prospective drivers, and examinations of athletes—such as boxers or high school football players—to determine whether they are qualified to engage in athletic
gent failure to discover a public health hazard.\textsuperscript{127} Therefore, the immunity would apply only to situations where the provider inade-
quately diagnosed a beneficiary, resulting in a danger to public health at large as opposed to danger to the individual himself. The statute seems to contemplate an action by a member of the public who contracted a communicable disease rather than an action by a beneficiary for the negligence of a provider in treating an individual health problem.

A second statute which seems applicable provides for governmental immunity from liability for injury caused by adopting or failing to adopt an enactment or by failing to enforce any law.\textsuperscript{128} The statute applies to the discretionary acts of lawmakers and law enforc-
ers.\textsuperscript{129} The state may argue immunity from liability for the injurious repercussions of the Medi-Cal legislation. However, action upon ei-
ther the independent contractor or mandatory duty statute is not based on the policy decision of the legislature to implement a new Medi-Cal payment system. Rather, it is based, in the instant situa-
tion, on the Department of Health Services' failure to discharge its duty to supervise Medi-Cal contractors. More specifically, the immunity statute does not preclude an action based on the failure to discharge a mandatory duty statute.\textsuperscript{130} The legislature drafted a statute

\textsuperscript{127} Id.
\textsuperscript{128} \textsc{cal. gov't code} § 818.2 (West 1980) provides: "A public entity is not lia-
ble for an injury caused by adopting or by failing to adopt an enactment or by failing to enforce any law."

\textsuperscript{129} Law Revision Commission Comment:
This section would be unnecessary except for a possible implication that might arise from section 815.6 which imposes liability upon public entities for failure to exercise reasonable diligence to comply with a mandatory duty imposed by an enactment. This section recognizes that the wisdom of legislative or quasi-legis-
lative action, and the discretion of law enforcement officers in carrying out their duties, should not be subject to review in tort suits for damages if political re-
sponsibility for these decisions is to be retained.

\textsc{cal. gov't code} § 818.2 Law Revision Commission Comment (West 1980).

\textsuperscript{130} See, e.g., Elton v. County of Orange, 3 Cal. App. 3d 1053, 84 Cal. Rptr. 27 (1970). The Orange County Probation Department placed a dependent child with foster parents who physically abused the child. The State Department of Social Welfare had certified the foster home. The plaintiff child sued the state on two grounds: that the County was negligent in placing the child in the foster home, and that the County had failed to enforce Social Welfare Department regulations, requiring the County to inspect, supervise, and control child placement in foster homes. On the issue of County negligence, the County asserted governmental immunity under California Government Code section 820.2, providing that, "a public employee is not liable for an injury resulting from his act or omission where the act or omission was the result of an exercise of discretion vested in him, whether or not such discretion be abused." \textsc{cal. gov't code} § 820.2 (West 1980). The court held that while the decision to classify the child as dependent was a basic policy decision, the subsequent ministerial act of placing the child in the home fell outside the purview of section 820.2. On the issue of failure to discharge a mandatory duty, the County asserted immunity under California Government Code § 818.2 (West 1980) (see supra note 128) and California Government Code § 818.6 (West
requiring the Department of Health Services to review providers. Consequently, deciding whether or not to review the contractor is not a decision which falls within the purview of the Department's discretion. Therefore, this discretionary immunity statute does not preclude plaintiff beneficiary recovery on either the mandatory duty or independent contractor statute.

Finally, Government Code section 818.4 provides governmental immunity from liability for injury resulting from licensing and certification decisions. The state may argue that provider qualification for Medi-Cal involvement is an activity covered by the statute. However, provider qualification, under selective provider contracting, goes beyond the normal licensing and certification activities conducted by the Licensing and Certification Division of the Department of Health Services. Under the present Medi-Cal plan, the state qualifies certain licensed and certified hospitals as Medi-Cal providers. The state is not approving the medical institutions held open to the public. Rather, it is selecting certain already licensed medical providers as appropriate for Medi-Cal participation based on their ability to render medical services in a cost-efficient fashion.

CONCLUSION

Selective provider contracting emerged as the legislature's answer to escalating Medi-Cal costs. By creating cost-saving incentives, the system encourages providers to alter their standard of practice to one which is cost conscious. Therefore, the customary practice standard could conceivably change to include recognition of costs as a factor in medical decision-making. However, such a standard would subvert malpractice law objectives by failing to permit quality assurance and victim compensation. Regardless of cost-saving goals, providers should continue to provide beneficiaries quality health care. A stan-

1980) (providing for government immunity for negligent inspection of property). The court rejected the County on both grounds, holding that section 818.2 did not preclude liability for failure to discharge a mandatory duty. The court also noted that the action was not precluded by section 818.6 because the action was based on failure to discharge the duty to supervise and not improper certification.


132. CAL. GOV'T CODE § 818.4 (West 1980) provides:
A public entity is not liable for an injury caused by the issuance, denial, suspension or revocation of or by the failure or refusal to issue, deny, suspend or revoke, any permit, license, certificate, approval, order, or similar authorization where the public entity or an employer of the public entity is authorized by enactment to determine whether or not such authorization should be issued, denied, suspended or revoked.
A standard of care divorced from cost considerations would aid in striking a balance between cost saving and health care quality. Providers would render quality care or face the risk of malpractice liability. Similarly, recognition of a state duty to supervise provider quality would force the state to ensure provider quality or face the risk of liability. State tort liability resulting in financial loss would be an ironic result of a plan directed at cost containment. Nevertheless, tort law, in defining the duty owed, should recognize the importance of protecting individuals from harm as opposed to protecting the state or providers from financial loss.

Wilfred Knottnerus