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# BETWEEN THE SCYLLA AND CHARYBDIS: PHYSICIANS AND THE CLASH OF LIABILITY STANDARDS AND COST CUTTING GOALS WITHIN ACCOUNTABLE CARE ORGANIZATIONS

*Christopher Smith*\*

## I. INTRODUCTION

Physicians must often feel as if they are caught between a veritable rock and a hard place. On the one hand, the movement to reform the health care system is heavily focused on cost containment in the provision of health care services.<sup>1</sup> This push for cost containment is manifested in managed care organizations<sup>2</sup> (MCOs), pay-for-performance programs<sup>3</sup> (P4P) and consumer-driven health care (CDHC) programs<sup>4</sup> demanding high quality

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1. Mercedes Varasteh Dordeski & Kelly N. Stephens, *Immigrants and Healthcare: A Voice for Coverage*, 23 Health Law 35, 39 (2010) (discussing the slew of cost cutting reforms contained within the new federal health care legislation).

2. Katherine L. Record, *Wielding the Wand Without Facing the Music: Allowing Utilization Review Physicians to Trump Doctors' Orders, but Protecting them from the Legal Risk Ordinarily Attached to the Medical Degree*, 59 Duke L.J. 955, 978 (2010) (describing MCOs' imposition of cost containment measures on medical providers).

3. Thomas Bodenheimer et al., *Can Money Buy Quality? Physician Response to Pay for Performance*, 3 Ind. Health L. Rev. 445, 445-46 (2006) (describing pay for performance arrangements as the provision of financial incentives to medical providers to meet certain goals, including cost containment).

4. William P. Kratzke, *Tax Subsidies, Third-Party Payments, and Cross-Subsidization: America's Distorted Health Care Markets*, 40 U. Mem. L. Rev. 279, 404-05 (2009) (describing consumer-driven health care as an effort encourage providers to reduce their

care from physicians, while requiring those same physicians to contain health care costs. While physicians are being bombarded by these cost containment initiatives, the common law medical malpractice liability standard of care fails to account for cost cutting in setting the standard of care.<sup>5</sup> Accordingly, physicians are stuck in the middle as they seek to meet both cost cutting goals and avoid liability under a standard of care that ignores cost containment. Such is their quandary, and this article seeks to explore this dilemma within the context of the new Accountable Care Organizations (ACOs).

ACOs are the new kids on the block in the ongoing struggle to achieve the ever-elusive dual goals of health care reform: cost containment and high quality care within the United States health care system.<sup>6</sup> Under the new health care reform law, the Patient Protection and Affordable Care Act (PPACA), the Department of Health and Human Services (HHS) is required to promulgate guidance for the creation of ACOs by January 1, 2012.<sup>7</sup> ACOs are legal entities—comprised of primary care physicians, specialists and hospitals—that provide care to Medicare patients and receive a share in savings for meeting cost containment and quality standards that are set by HHS.<sup>8</sup>

As with any new government program, policy makers, analysts and scholars will likely be focused on predicting whether ACOs will effectively achieve their goals and identifying policy problems that are likely to arise within the ACO context. This article focuses on the latter issue, and more particularly, whether and how ACOs will impact the tension that physicians face: meeting cost containment goals while also satisfying medical liability standards of care that do not account for cost containment.<sup>9</sup> Part I of this Article provides a brief overview of the high level of health care spending that has been and continues to be the impetus for cost containment efforts

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costs through new efficiencies and innovation).

5. M. Gregg Bloche, *The Emergent Logic of Health Law*, 82 S. Cal. L. Rev. 389, 452 (2009) (arguing that the professional standards embodied with the standard of care are minimally sensitive to cost); Dionne Koller Fine, *Physician Liability and Managed Care: A Philosophical Perspective*, 19 Ga. St. U. L. Rev. 641, 642 (arguing that the medical liability standard of care rejects the notion of cost-control as a defense to medical malpractice claims).

6. See generally David G. Owen, *Dangers in Prescription Drugs: Filling a Private Law Gap in the Healthcare Debate*, 42 Conn. L. Rev. 733 (2010) (identifying cost reduction and quality improvement as central goals of health care reform).

7. 42 U.S.C. § 1395jjj(a)(1) (2010).

8. See *id.* § 1395jjj(a)(1)(A-B), (a)(2)(A-D).

9. James F. Blumstein, *Medical Malpractice Standard-Setting: Developing Malpractice "Safe Harbors" as a New Role for QIOs?*, 59 Vand. L. Rev. 1017, 1024-26 (2006) [hereinafter *Medical Malpractice*] (describing the tension between provider cost containment care rationing and a medical malpractice doctrine that views economic trade-offs as having virtually no role in treatment decisions).

within the health care system. Part II analyzes how tension arises between cost containment efforts and medical liability standards, and summarizes recent scholarly literature examining this issue within various contexts, such as MCOs, P4P initiatives and CDHC programs. Part III provides some background on ACOs in general, and discusses the PPACA-created ACOs. Finally, Part IV examines and analyzes how ACOs may exacerbate the cost containment/liability standard tension and how that tension may impact ACOs' effectiveness.

## II. THE RISING COST OF HEALTHCARE IN THE UNITED STATES

The starting point for understanding ACOs, the cost containment efforts in the health care system, and the connection and impact that the two have on medical malpractice liability, is to explore why there is a push for health care cost containment efforts in the first place. Essentially, the drive for cost containment is due to large health care costs and health care spending that continue to spiral upwards. However, increasing costs and spending, in and of themselves, are not necessarily evidence of a broken system, provided the increase in spending and costs correlates with equal or greater improvements in patient outcomes and quality.

Unfortunately, within the health care system, increasing health care costs “do not appear to be correlated with better quality.”<sup>10</sup> In fact, compared with other countries, the United States spends more of its GDP on healthcare than many other nations, with little to show in terms of better quality outcomes.<sup>11</sup> This means that within our health care system “there is room for improvement in efficiency; that is, costs could be reduced without harming quality.”<sup>12</sup> Hence, there is a strong push for cost containment within the health care system.

Statistics at both the macro- and microeconomic levels demonstrate that health care costs are spiraling out of control. Starting at the macroeconomic level, in 1998, the United States spent \$1.208 trillion on healthcare.<sup>13</sup> By 2009, a mere eleven years later, that number had more than doubled to over

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10. Medicare Payment Advisory Comm'n, Report to the Congress: Improving Incentives in the Medicare Program 49, 53 (2009), available at [http://www.medpac.gov/documents/Jun09\\_EntireReport.pdf](http://www.medpac.gov/documents/Jun09_EntireReport.pdf) [hereinafter MedPac] (citing large regional variations in Medicare costs and growth).

11. Mark A. Hall & Carl E. Schneider, *When Patients Say No (To Save Money): An Essay on the Tectonics of Health Law*, 41 Conn. L. Rev. 743, 747 (2009) (arguing that the United States spends too much money on health care).

12. MedPac, *supra* note 10, at 53 (arguing that it is easy to conceptualize savings within the United States health care system).

13. Ctrs. for Medicare and Medicaid Servs., Dep't of Health & Human Servs., National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Calendar Years 1960-2009, Table 1 (2009), available at <http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf>.

\$2.486 trillion.<sup>14</sup> This 2009 statistic represents 17.6% of the Gross Domestic Product (GDP) and a spending growth rate of 4%.<sup>15</sup> This rate was higher than both the rate of inflation and the growth rate for national income.<sup>16</sup>

The projected national health care spending statistics look no better for the future. By 2019, the government estimates that the United States will spend over \$4.482 trillion on health care costs, almost double the spending level for 2008.<sup>17</sup> Furthermore, the projected spending for 2019 will be 19.3% of the GDP, a higher percentage of the GDP than health care spending in 2008.<sup>18</sup> Moreover, the government predicts that the rate of health care spending will increase between 3.9% and 7% every year between 2010 and 2019.<sup>19</sup>

The United States' health care spending also appears out of control when compared to other industrialized countries. A recent study found that the United States spent \$7,290 per capita on healthcare in 2007—more than Australia, Canada, the Netherlands, Germany, United Kingdom and New Zealand.<sup>20</sup> Each of the other six industrialized countries spent less than \$4,000 per capita on healthcare in 2007.<sup>21</sup> Looking at the data in a different manner, in 2007, United States health care spending was around 16% of its GDP, while each of the other six countries spent a substantially lower percentage of their respective GDPs on healthcare.<sup>22</sup>

Unfortunately, the macroeconomic picture of health care spending looks no brighter than its microeconomic counterpart. For example, in 1999, the average family employer sponsored health plan cost \$5,791 per year in premiums and by 2009, that same plan cost \$13,375 per year, an increase of

14. *Id.*

15. *Id.*

16. Eric Kimbuende et al., U.S. Health Care Costs, (2010), available at [http://www.kaiseredu.org/topics\\_im.asp?imID=1&parentID=61&id=358](http://www.kaiseredu.org/topics_im.asp?imID=1&parentID=61&id=358) (noting that health care expenditures have outpaced inflation and income growth). See also Hall & Schneider, *supra* note 11, at 747 (noting that “Medical spending has outstripped inflation for decades”).

17. Ctrs. for Medicare & Medicaid Servs., Dep’t of Health & Human Servs., National Health Expenditure Projections 2009-2019, Table 1 (2009), available at <http://www.cms.gov/NationalHealthExpendData/downloads/proj2009.pdf>.

18. *Id.*

19. *Id.* at Table 2.

20. Karen Davis et al., Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally 2 (2010), available at [http://www.commonwealthfund.org/~media/Publications/Fund%20Report/2010/Jun/1400\\_Files/Davis\\_Mirror\\_Mirror\\_on\\_the\\_wall\\_2010.pdf](http://www.commonwealthfund.org/~media/Publications/Fund%20Report/2010/Jun/1400_Files/Davis_Mirror_Mirror_on_the_wall_2010.pdf).

21. *Id.* (noting that the other countries studied had per capita expenditures between \$2,454 and \$3,895).

22. *Id.* at 12 (noting that the percentage of GDP spent by the other six countries ranged between 8.4% and 10.4%).

131%.<sup>23</sup> Breaking these statistics down into employee versus employer health care spending contributions, the average employee's contribution increased from \$1,543 per year in 1999 to \$3,515 per year in 2009, while the average employer's contribution increased from \$4,247 per year in 1999 to \$9,860 per year in 2009.<sup>24</sup> Combining the cost of health insurance premiums with all other out-of-pocket expenses, the average person with employer-sponsored coverage spent \$2,827 in out-of-pocket health care expenditures in 2001, and by 2006, that same person was spending \$3,744, a 30% increase.<sup>25</sup>

Whether viewed at the macro- or microeconomic level, health care costs are high and getting higher, and the burden on individuals and employers is becoming increasingly heavy. These pressures serve as the genesis for the many of the cost containment efforts within the health care sector.

### III. THE CONFLICT BETWEEN COST CONTAINMENT AND MEDICAL MALPRACTICE LIABILITY

#### *A. The Rationale Behind the Cost Containment/Liability Standard Conflict*

##### 1. Cost Cutting and the Medical Care Cost Curve

At the center of the tension between cost containment goals and the malpractice liability standard is the debate on whether economic factors, primarily cost containment, should play a role in medical decision making and how medicine is practiced. Some contend that the introduction of economics into medical decision making at any level corrupts medical judgment.<sup>26</sup> Others contend that it is acceptable for cost cutting efforts to influence medical judgment within certain limits.<sup>27</sup> Still others view the interconnectedness of the two concepts to be inevitable.<sup>28</sup>

Although there is debate over whether cost containment should play a role in medical decision making, there is less of a debate regarding whether

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23. Gary Claxton et al., *Employer Health Benefits 2009 Annual Survey* 21, 32 (2009), available at <http://ehbs.kff.org/pdf/2009/7936.pdf>.

24. *Id.* at 71.

25. Michael Halle & Meena Seshamani, Office of Health Reform, *Hidden Costs of Health Care: Why Americans are Paying More but Getting Less*, *Hidden Costs of HealthCare Report (2010)*, available at <http://www.healthreform.gov/reports/hiddencosts/index.html>.

26. James F. Blumstein, *Of Doctors and Hospitals: Setting the Analytical Framework for Managing and Regulating the Relationship*, 4 *Ind. Health L. Rev.* 211, 212 (2007) [hereinafter *Of Doctors and Hospitals*] (outlining the various views on whether economic considerations should factor into treatment decisions).

27. *Id.*

28. *Id.*

or not it is acceptable to introduce cost containment initiatives at the flat point of the medical care cost curve. At that point on the curve, any cost cutting is merely clear cut waste control, or the elimination of medical spending which yields no additional benefits.<sup>29</sup> For example, few, if any, would argue that private insurers, Medicare, or Medicaid should pay for a cholesterol test for a patient dying of terminal cancer with two weeks left to live. To do so would be to increase costs with no return in benefits.

The true heart of the cost containment debate lies in whether costs should be cut at the cost control point of the medical care cost curve, or the point at which additional spending yields benefits, but marginally so in light of the costs expended.<sup>30</sup> Hypothetically, such a situation might occur when an MRI yields a 95% accurate diagnosis of a brain aneurysm, but an additional spinal tap on top of the MRI would yield a 99.9% accurate diagnosis. Therein lies the point at which physicians will resist cost containment initiatives for fear of incurring medical liability. For at that point on the cost curve, such cost cutting may actually involve cutting marginally beneficial care within the standard of care.

## 2. Ethical and Legal Restrictions on Cost Cutting

In part, as a reflection of the central debate regarding whether or not cost saving concepts should play a role in medical decision-making, liability standards conflict with cost containment goals in a number of ways. To start with, as a matter of current law and medical ethics, the medical standard of care cannot vary according to ability to pay.<sup>31</sup> This non-cost-conscious standard is entrenched in our legal system — as demonstrated when patients try to fully or partially waive liability in exchange for less costly, but suboptimal care. In those situations, courts generally refuse to enforce such a waiver because of the fiduciary relationship between a doctor and patient.<sup>32</sup>

There are two core beliefs behind the legal and ethical standard of

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29. *Id.* at 215 (arguing that “[e]liminating zero-benefit diagnoses and treatments is uncontroversial.”).

30. *Id.* at 215-16 (arguing that it is more difficult to achieve a goal of eliminating marginally beneficial care in the name of cost savings).

31. See generally Gail B. Agrawal & Mark A. Hall, *What if You Could Sue Your HMO? Managed Care Liability Beyond the ERISA Shield*, 47 St. Louis U. L.J. 235, 285 (2003) (arguing that the medical standard of care exists based on a fallacy that there is one correct treatment to be determined without reference to cost); Mark A. Hall, *Paying for What You Get and Getting What You Pay For: Legal Responses to Consumer-Driven Health Care*, 68 Law & Contemp. Probs. 159, 176 (2006) (noting that the “medical malpractice standard of care does not vary according to a patient’s insurance or financial situation”); Fine, *supra* note 5, at 651 (noting that the medical profession has long believed that cost should never be a part of the treatment relationship).

32. Hall, *supra* note 31, at 176.

entitlement to care regardless of cost and ability to pay. First, is the core belief that every individual is entitled to all beneficial medical care, regardless of cost.<sup>33</sup> Second, and related, is the belief that it would be socially unjust and ethically repulsive for the law to hold that the indigent and uninsured are entitled to a lower standard of care than the insured population, and allow physicians to lower their standard of care for such indigent, uninsured patients.<sup>34</sup> The general problem with this non-cost-conscious standard of medical liability is that it falsely assumes that society has unlimited resources to devote to healthcare.<sup>35</sup>

### 3. Defensive Medicine

Medical liability standards also conflict with cost containment efforts through physicians' fear of liability and how that fear incentivizes physicians to provide as much care as possible in hopes of covering every conceivable basis for a lawsuit.<sup>36</sup> This fear-driven increase in the amount of care also increases the costs of care.<sup>37</sup> Out of such fear is born the concept of defensive medicine, under which the fear of being sued for malpractice encourages physician overutilization and over-deterrence in diagnostic testing and treatment.<sup>38</sup>

Defensive medicine and the tendency to promote overutilization is a result, to some extent, of a medical malpractice system in which the standard of care is not officially set until after the injury has occurred and expert witnesses, during trial, define the standard *post-hoc*.<sup>39</sup> This *ex ante* uncertainty as to the contours of the standard of care is exacerbated by evidence of widespread "variation in practice patterns unexplained by

33. Fine, *supra* note 5, at 663 (arguing "that the dominant view is that there is an absolute moral prohibition against physicians considering the costs of treatment").

34. Hall & Schneider, *supra* note 11, at 752-53 (arguing that "judges are loath to have tort law ratify the social injustice of unaffordable health care").

35. Fine, *supra* note 5, at 664-65 (arguing that current law prohibiting the consideration of costs in treatment decisions ignores economic and medical realities).

36. Hall & Schneider, *supra* note 11, at 748 (arguing that providers follow the belief that the more thorough the care, the less likely they are to be sued).

37. Fine, *supra* note 5, at 685-86 (arguing that liability suits have created pressure to escalate treatment costs).

38. Claire Bartholome, *Leveraging Our Strengths: Reinforcing Pay-For-Performance Programs as the Solution for Defensive Medicine*, 4 J. Health & Biomedical L. 333, 333-34 (2008) (describing defensive medicine as providers avoiding high-risk procedures and patients, and ordering clinical-excessive tests in an effort to guard against malpractice claims); *Medical Malpractice*, *supra* note 9, at 1020-21 (defining defensive medicine as over-deterrence in medical practice driven by an effort to conform to uncertain standards of care).

39. *Medical Malpractice*, *supra* note 9, at 1028-29 (noting the practice standards are not definitively established until after an injury has occurred).



outcomes data.”<sup>40</sup> Too often, the applicable standard of care may be somewhat of a mystery at the time of diagnosis or treatment.

The practice of defensive medicine is exponentially promoted through the traditional third-party payment system for insurance, where neither the doctor nor the patient fully “feels” the financial impact of the treatment decisions being made.<sup>41</sup> In the end, physicians provide excessive care to adjust for clinical and structural uncertainty in the medical malpractice doctrine, and are rewarded for such behavior by a third-party fee-for-service (FFS) payment system.<sup>42</sup>

#### 4. The Professional Paradigm Philosophy

The historically dominant philosophical view of how medical decisions should be made and how medicine should be practiced also promotes the conflict between malpractice liability standards and cost containment concepts. That philosophy is embodied within the scientific or professional view, which considers medical decision-making to be entirely scientific and views the introduction of economic criteria into that decision making process as a corruption of scientific purity.<sup>43</sup> The scientific paradigm considers costs to be irrelevant because it follows the belief that there is a single unitary standard of care to be followed within medicinal practice.<sup>44</sup>

Medical malpractice liability as a legal doctrine embodies the professional or scientific model of medical decision-making.<sup>45</sup> By contrast, traditional tort law, outside of the medical malpractice context, evaluates allegedly negligent conduct using a “reasonableness” standard that incorporates costs and benefits, and risks and rewards into the analysis of whether negligence has occurred.<sup>46</sup> The existence of a third-party payment system, mentioned earlier, takes cost and benefit balancing out of the equation in the medical malpractice context.<sup>47</sup>

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40. *Id.* at 1026.

41. *Id.* at 1025 (arguing that “third-party medical insurance allows patients and physicians to ‘overutiliz[e] . . . medical resources’”).

42. *Id.* at 1031.

43. *Of Doctors and Hospitals*, *supra* note 26, at 220 (arguing that the professional model “assumes that diagnosis and treatment decisions are not influenced by financial incentives.”).

44. Agrawal & Hall, *supra* note 31, at 285-86 (discussing medical malpractice doctrine as encompassing a one-right-way approach to the practice of medicine); *Medical Malpractice*, *supra* note 9, at 1024 (arguing that medical malpractice assumes “that science has established a single or unitary standard of practice”).

45. *Medical Malpractice*, *supra* note 9, at 1023.

46. *Id.* at 1025 (arguing that traditional tort law views the customary practice standard as a market-validated standard that encompasses cost and benefits).

47. *Id.* at 1025.

### 5. Paramount Patient Interests

Also embodying the conflict between medical liability standards and cost cutting concepts is the requirement of medical ethics and the medical liability standard that “physicians [] promote their [individual] patients’ interests above all others.”<sup>48</sup> This requirement directly conflicts with cost cutting concepts because this standard cannot be met on an individual patient basis for all patients; health care resources are finite, limited, and require rationing at some point along the health care spending continuum.<sup>49</sup> As a result, for a physician to strive to meet cost cutting goals “exposes the physician to potential liability for ‘failing to do the impossible.’”<sup>50</sup>

### 6. The Non-Cost-Conscious Liability Standard

The most self-evident way in which liability standards and cost saving efforts conflict is through the failure of the medical liability standard to take cost containment goals into consideration.<sup>51</sup> As long as the medical liability standard fails to consider cost cutting, the goal of cost containment is nearly impossible to achieve. Physicians will resist rationing care and cost containment efforts, so long as they know that such efforts are disregarded in determining the standard of care in the medical liability determination.<sup>52</sup> In the world of a non-cost-conscious medical liability standard, there is no reward for cutting costs, only potential punishment.

#### *B. The Cost Containment/Liability Standard Conflict Across Contexts*

Scholars have explored the tension between cost containment and medical malpractice liability in a variety of contexts over the years, including consumer-driven health care cost containment efforts, Medicare cost containment efforts and private insurer managed care cost containment efforts.<sup>53</sup> The following section explores some of the more recent literature

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48. Fine, *supra* note 5, at 665.

49. *Id.* at 665 (arguing that it is a false assumption to assume that society has unlimited resources for medical care).

50. *Id.* at 666.

51. *Id.* at 685 (arguing that the current liability standard undermines cost containment objectives because it subjects providers “to liability for rationing care as a way to control costs”).

52. *Id.* (arguing that the current liability scheme results in providers who “will not and do not fully embrace cost containment efforts”).

53. See generally Hall & Schneider, *supra* note 11, at 753, citing E. Haavi Morreim, Holding Health Care Accountable, 83, 96 (Oxford 2001); James F. Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 Tex. L. Rev. 1345, 1397 (1981); Randall Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 1975 Duke L.J. 1375, 1408 (1975); Jonathan J. Frankel, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 Yale L.J. 1297, 1322 (1994); Barry R. Furrow, *Medical Malpractice and*

on this tension across a few different contexts.

### 1. Managed Care Organizations

The starkest example of the tension between health care cost containment and the malpractice liability standard arises within the context of managed care, where MCOs “control health care costs by controlling physician behavior and limiting patients’ utilization of services.”<sup>54</sup> In these situations, physicians’ ethical and legal obligations to see that the patient’s needs come first and that patients receive a high quality of care, regardless of cost, clash with the MCOs’ efforts to push physicians to ration care and cut costs.<sup>55</sup>

The clash between MCO cost containment and medical liability standards tends to arise when the physician and managed care insurer disagree on a treatment, such that the physician believes that the treatment is medically necessary, but the insurer refuses to provide coverage, believing that the treatment is not medically necessary.<sup>56</sup> The MCO’s decision usually trumps the physician’s decision because most patients cannot afford treatment without insurance.<sup>57</sup> As a result, what all too often happens is that the patient does not receive the physician recommended treatment, suffers a resulting injury from the coverage/treatment decision and files a malpractice suit when he or she discovers that the physician’s treatment recommendation—not the MCO’s coverage decision—was correct.<sup>58</sup> This scenario illustrates how MCO-imposed cost cutting may

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*Cost Containment: Tightening the Screws*, 36 Case W. Res. L. Rev. 985, 989-94 (1986); Mark A. Hall, *The Malpractice Standard Under Health Care Cost Containment*, 17 L. Med. & Health Care 347, 351 (1989); Marshall B. Kapp, *Legal and Ethical Implications of Health Care Reimbursement by Diagnosis Related Groups*, 12 L. Med. & Health Care 245, 252 (1984); Andrea Jean Lairson, Comment, *Reexamining the Physician’s Duty of Care in Response to Medicare’s Prospective Payment System*, 62 Wash. L. Rev. 791, 803-807 (1987); Robert C. Macaulay, Jr., *Health Care Cost Containment and Medical Malpractice: On a Collision Course*, 21 Suffolk U. L. Rev. 91, 103-08 (1987); Maxwell J. Mehlman, *The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?*, 25 Conn. L. Rev. 349, 361-67 (1993); Laura Athens Mellas, *Adapting the Judicial Approach to Medical Malpractice Claims Against Physicians to Reflect Medicare Cost Containment Measures*, 62 U. Colo. L. Rev. 287, 300-303 (1991); Rand E. Rosenblatt, *Rationing “Normal” Health Care: The Hidden Legal Issues*, 59 Tex. L. Rev. 1401, 1416-19 (1981); Peter H. Schuck, *Malpractice Liability and the Rationing of Care*, 59 Tex. L. Rev. 1421, 1421 (1981); John A. Siliciano, *Wealth, Equity, and the Unitary Medical Malpractice Standard*, 77 Va. L. Rev. 439, 458-60 (1991); Note, *Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting*, 98 Harv. L. Rev. 1004, 1015-19 (1985).

54. Fine, *supra* note 5, at 647; Record, *supra* note 2, at 977 (describing the essence of MCOs as having control over provider decision making).

55. Fine, *supra* note 5, at 641-42 (discussing the providers’ increased liability risk as a result of MCO imposed health care rationing).

56. Record, *supra* note 2, at 956-57.

57. *Id.* at 965.

58. *Id.* at 957.

actually cause the physician to cut care “that may be beneficial and within the current standard of care.”<sup>59</sup>

Ironically, even though the MCO exerts extensive control over the physician’s treatment decision, the Employee Retirement and Income Security Act of 1974 (ERISA) preempts most state law claims against many MCOs, and therefore, the physician usually remains solely liable for any adverse outcome.<sup>60</sup> Most MCOs generally avoid any form of liability for their coverage decisions. ERISA applies to MCOs that are employer-sponsored health plans and preempts state law malpractice claims against those MCOs, while also failing to provide for a federal tort remedy against them.<sup>61</sup> This is a bit of an oversimplification of the confusing and complex liability standards and case law governing the application of ERISA to MCO liability, but for purposes of this article it is sufficient to note three summarizing principles from the ERISA statute and guiding case law. First, plan beneficiaries can bring ERISA claims in federal court for breach of contract and collect breach of contract damages against ERISA covered MCOs, but there are no ERISA tort claims or ERISA tort damages to be had against ERISA covered MCOs.<sup>62</sup> Second, ERISA preempts plan beneficiaries’ state tort claims against ERISA governed MCOs as to any claims involving eligibility decisions<sup>63</sup> or administration of benefits decisions.<sup>64</sup> Lastly, ERISA preempts tort claims founded upon MCO coverage decisions involving both treatment and plan benefit decisions, provided the patient’s treating physician was not involved in the utilization review decision<sup>65</sup> and/or “the medical judgment was made by a utilization

59. Fine, *supra* note 5, at 642.

60. Record, *supra* note 2, at 977 (explaining that federal preemption shields most MCOs from state malpractice “liability even when they make coverage decisions regarding the medical necessity of care”).

61. The Employee Retirement and Income Security Act of 1974, 29 U.S.C. §§ 1132(a), 1144 (2006); Record, *supra* note 2, at 957 (noting that ERISA preempts state law “liability for employer-sponsored health plans relating to the administration of health benefits, but does not impose parallel federal liability in its place”).

62. Fine, *supra* note 5, at 660 (noting that ERISA allows injured plan beneficiaries to recover only the benefits due under the terms of the health plan and not compensatory or punitive damages); Record, *supra* note 2, at 965 (noting that ERISA “allows plan beneficiaries to challenge coverage decisions for breach of contract, but not for negligence”).

63. Record, *supra* note 2, at 968 (“refusing to allow a claim filed under ERISA to allege breach of fiduciary duty where the contested action involved an element of a treatment decision, rather than a pure eligibility decision”) (citing *Pegram v. Herdrich*, 530 U.S. 211, 229-31 (2000)).

64. *Id.* at 968-69 (“reasoning that a state or common law cause of action ‘based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly meet[s] the criteria for pre-emption’”) (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987)).

65. Record, *supra* note 2, at 970-71 (“holding that a claim challenging denial of coverage that entails a mixed eligibility and coverage decision is not preempted when that

review physician who never saw the patient.”<sup>66</sup>

The important point is that plaintiffs have few, if any, remedies against MCOs that are subject to ERISA, and instead must focus their grievances against their physicians.<sup>67</sup> Accordingly, as stated at the outset, the physicians are essentially caught in the middle as the standard of care to which they are subject ignores costs, does not account for the cost saving pressures from MCOs, and even treats the physician as “having a duty to *resist* being tainted by the pressures of managed health care and cost containment.”<sup>68</sup> In some areas, physicians may sustain liability “for not working hard enough through appeals [of MCO utilization decisions] or otherwise to secure treatment for the patient.”<sup>69</sup> The bottom line is that the managed care system forces the physician to ration care at the bedside and then face potential malpractice liability for engaging in MCO-imposed rationing behavior.

Turning to why the tension between cost cutting and liability arises in the managed care context, the tension arises, to some extent, because physicians and MCOs have different perspectives regarding how they view treatment decisions. Physicians focus on the individual patient and what is best for him or her, whereas MCO cost containment efforts focus on what is best for society as a whole by attempting to efficiently utilize limited health care resources.<sup>70</sup>

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decision was made by either the treating physician or his employer”) (citing *Land v. CIGNA Healthcare of Fla.*, 381 F.3d 1274, 1276 (11th Cir. 2004) (per curiam)).

66. Record, *supra* note 2, at 968; *see, e.g.*, *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1, 7 (1st Cir. 1999) (holding that the plaintiffs’ state tort claims against the defendant insurance company for negligent supervision and training of personnel and negligent infliction of emotional distress were preempted by ERISA because they “create[d] a threat of conflicting and inconsistent state and local regulation of the administration of ERISA plans”); *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 941-43 (6th Cir. 1995) (holding that the plaintiffs’ state law claims against the defendant insurance company for wrongful death, improper refusal to authorize benefits, medical malpractice, and insurance bad faith were preempted by ERISA because they related to the insurance plan); *Corcoran v. United HealthCare Inc.*, 965 F.2d 1321, 1331 (5th Cir. 1992) (holding that, because the defendant insurance company had made “medical decisions incident to benefit determinations,” the plaintiffs’ state tort action for wrongful death of their child was preempted by ERISA (emphasis added)); *Elsesser v. Phila. Coll. of Osteopathic Med.*, 802 F. Supp. 1286, 1290-91 (E.D. Pa. 1992) (holding that the plaintiffs’ state tort negligence claims, founded on the defendant insurance company’s refusal “to pay for the [requested medical device],” were preempted by ERISA when the plaintiffs sought to hold the company “directly liable” for negligence, explaining that “such a claim. . .clearly has a [connection to] a benefit plan” (second alteration in original)).

67. Record, *supra* note 2, at 957 (noting that the provider often pays the price for injuries resulting from MCO coverage decisions, not the MCO).

68. Fine, *supra* note 5, at 642. *See also* Record, *supra* note 2, at 984 (noting that providers “must formally protest a plan’s denial of coverage for medically necessary care”).

69. Fine, *supra* note 5, at 675.

70. Fine, *supra* note 5, at 644, 646 (contrasting the fee-for-service focus on what is best

The cost containment/liability standard conflict also exists within the MCO context because physicians are subject to conflicting incentives in the MCO world. On one hand, the physician's level of income is tied to successfully meeting managed care cost cutting goals.<sup>71</sup> On the other hand, the physician has an ethical incentive to ensure patient well-being, regardless of cost, as well as a medical liability based incentive to provide the patient with any and all care within the standard of care, regardless of cost.<sup>72</sup> Even if the physician stands to benefit financially from cutting costs, the fiduciary relationship between physicians and patients requires physicians to place their patients' interests above their own.<sup>73</sup>

Related to the conflicting incentives faced by physicians, the MCOs' incentives in making treatment decisions are not aligned with the physicians' incentives in providing treatment. As discussed above, the former can generally cut costs at will with little fear of liability due to ERISA preemption, whereas the substantial fear of potential malpractice liability causes the latter to engage in costly defensive medicine.<sup>74</sup> ERISA allows MCOs "to behave as they choose with little accountability to their members or to the public."<sup>75</sup> ERISA promotes a legal framework that fails to deter negligent coverage denials by MCOs.<sup>76</sup> The physician, on the other hand, bears responsibility for everything despite the fact that the MCO exerts great control over treatment decisions through the power of the purse.<sup>77</sup> In the end, the respective liability to which physicians and MCOs are subject is inverse to the control that each one has over treatment decisions.<sup>78</sup>

The ERISA system also promotes the cost containment/liability standard conflict by encouraging lawsuits against physicians, but not against MCOs. Plaintiffs, knowing the ERISA obstacles for a successful tort claim against a MCO, will try to couch their medical tort claims as negligence claims

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for the individual patient with the MCO focus on what is the best treatment from society's perspective); Record, *supra* note 2, at 980 (discussing the physician's duty of loyalty to individual patients).

71. *Id.* at 649.

72. *Id.* (describing how physicians' incomes within MCOs are in conflict with patient well-being).

73. *Id.* at 655 (discussing provider's duty to serve their patients' interests above their own).

74. Record, *supra* note 2, at 957-58, 964-65 (discussing how providers serve as the "deep pockets" for patients to recover for injuries caused by MCO coverage decisions, while MCOs escape from liability even when the denial of coverage is negligent).

75. Fine, *supra* note 5, at 660.

76. Record, *supra* note 2, at 987-88 (arguing that "applying contract law [under ERISA] to utilization review decisions fails to deter negligent coverage denials").

77. *Id.* at 981-83 (noting that providers may bear the entire burden of liability when an MCO wrongfully denies coverage).

78. *Id.* at 994.

against physicians, even if those claims are more appropriately directed at the MCO.<sup>79</sup> The beneficiary's incentive to sue the physician instead of the MCO is even stronger because the damages available in tort actions against physicians are much greater than those available in contract actions against MCOs.<sup>80</sup> Recognizing the beneficiary's strong incentive to sue the physician over the MCO, physicians are more likely to practice defensive medicine than if MCOs faced a similar liability risk with regard to their treatment decisions. However, these mounting tort liability pressures on physicians, occur at the same time as and are in conflict with MCO imposed cost cutting pressures.

Physicians face competing pressures from all sides within the MCO context and the extent of pressure on the physician to ration care from the MCO side is exacerbated by the very real possibility that if the physician does not meet the MCO's cost cutting expectations, then he or she may be terminated from the MCO's physician network and from providing care to the MCO's patients.<sup>81</sup> This pressure is significant, given that MCOs have substantial market power, physicians economically rely on MCOs for a sufficient pool of patients to sustain their practices, and, once terminated, physicians' reputations suffer and they are less likely to be able to join another MCO.<sup>82</sup>

One particularly disturbing consequence of the physician fear of termination is that physicians may be reluctant to take on severely ill or chronically ill patients due to cost concerns.<sup>83</sup> Similarly, the pressure to cut costs combined with the fear of termination can also cause a physician to place his or her self-preservation interest above the patient's best interests, which could ultimately result in liability.<sup>84</sup>

In terms of solutions to the cost containment/liability standard conflict within the MCO context, Katherine Record suggests aligning the incentives of physicians with the incentives of MCOs by applying the same standard of care to physicians and MCOs, with some limitations on the MCOs' liability.<sup>85</sup> This is essentially a proposal to have Congress remove ERISA

79. *Id.* at 982 (arguing that the "ERISA scheme incentivizes wronged beneficiaries to reshape their claim into one relating to the quality of care delivered by the treating physician . . .").

80. *Id.* at 987.

81. Fine, *supra* note 5, at 659, 673 (describing how MCOs terminate providers from their networks if they fail to comply with MCO cost containment goals).

82. *Id.* at 675.

83. *Id.* (discussing that some provider privately admit "that they are reluctant to take on new patients who may be severely or chronically ill because of the high costs involved in treating such patients").

84. *Id.* at 675-76 (discussing how threat of de-selection may cause a provider to place his or her livelihood and the MCO's interest ahead of a patient's needs).

85. Record, *supra* note 2, at 994 (arguing that the foundation for needed legal reform is

preemption from the MCO environment.

Aligning physician and MCO incentives by applying tort liability standards to MCOs would arguably incentivize MCOs to act in a more reasonable manner during the utilization review process.<sup>86</sup> Nonetheless, Record argues that the tort liability standard, must be limited in its application to MCOs in order to avoid over-deterrence, or MCOs will cease to implement any cost-containment policies, including those that are beneficial.<sup>87</sup> Accordingly, Record proposes the following parameters for MCO liability: 1) MCO liability should not attach when coverage is clearly excluded by the policy; 2) a MCO, in court, must be allowed to introduce, as evidence, cost-effectiveness research to demonstrate reasonableness under a cost-containment policy; and 3) damages must be capped.<sup>88</sup> In other words, there should be similar liability-based incentives imposed on both physicians and MCOs, but the possible scope of MCO liability should be limited to avoid deterring the MCOs from implementing cost-containment policies that maintain quality outcomes.

Professors Agrawal and Hall posit an alternative solution to the cost containment/liability standard conflict within the MCO context, advocating for the imposition of liability on MCOs for the process by which they reach their utilization review or coverage decisions.<sup>89</sup> Agrawal and Hall contend that applying the existing medical liability standard of care to MCO coverage decisions is problematic in that such a standard of care is open to differing subjective opinions and could overly deter MCOs from legitimate cost cutting that maintains quality.<sup>90</sup> Instead, they argue that a process-based MCO liability standard will provide more precise predictive guidance for MCOs as to the acceptable parameters of medical decision making, as the MCOs would only be held liable if “they use a procedure that is not designed to acquire and consider relevant clinical factors, or if they depart materially from normal procedures without adequate justification.”<sup>91</sup>

A third solution to the cost containment/liability standard conflict within

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to align the standard of care of practicing providers with the liability standard for providers conducting utilization review).

86. *Id.* at 995-96 (arguing that holding utilization review physicians liable for breaches of the standard of care would “incentivize the exercise of reasonable caution in denying coverage”).

87. *Id.* at 996.

88. *Id.*

89. Agrawal & Hall, *supra* note 31, at 297-98 (arguing that efforts “to improve the process of coverage determinations [are] . . . socially constructive response[s] to tort law’s deterrence signal.”).

90. *Id.* (arguing that application of a standard of ordinary care to MCOs would result in “[e]xcessive second-guessing of the substance of coverage decisions [and] could over-deter insurers’ socially beneficial efforts to contain costs.”).

91. *Id.* at 298.



the MCO context comes from Professor Fine, who argues that the medical profession needs to reform the standard of care to incorporate or reflect cost containment goals.<sup>92</sup> Fine argues that the medical profession, as opposed to the legislature, should be responsible for creating a revised cost-conscious standard of care because doing so recognizes that physicians have a duty to participate in lowering high health care costs, while also respecting physician autonomy to define the practice of medicine.<sup>93</sup> More specifically, Fine urges the medical profession to incorporate cost containment principles into clinical practice guidelines and then to incorporate those guidelines into the standard of care.<sup>94</sup> Fine contends that the use of such guidelines will help minimize unnecessary care and geographic-based treatment variations, alert physicians to the greatest cost-benefit treatment patterns, and reduce the likelihood that a MCO will terminate a physician for practicing high cost medicine.<sup>95</sup>

## 2. Consumer-Driven Health Care Programs

Another context in which the cost containment/liability standard conflict arises is within CDHC programs.<sup>96</sup> CDHC describes a system whereby insured patients are required to pay a large part of their medical costs out-of-pocket, usually through tax-sheltered “health savings accounts.”<sup>97</sup> CDHC promotes cost-containment and high quality care through the idea that if patients are given information about the costs and benefits of health care treatment options, as well as having to shoulder more of the financial burden of paying for their healthcare, then they will have more “skin in the game” and greater incentive to reduce their volume of health care spending on wasteful care or care with few benefits.<sup>98</sup> Although, CDHC operates under the belief that patients will reduce spending on unnecessary care, there is also a very real risk that patients will forgo even necessary care

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92. Fine, *supra* note 5, at 693-94 (arguing that the best solution to the cost containment/liability conflict policy problem is for the medical profession to “responsibly and effectively incorporate considerations of cost into the treatment decision”).

93. *Id.* at 695-96 (discussing the importance of allowing the medical profession to redefine the goals of medical practice).

94. *Id.* at 697 (explaining how clinical practice guidelines have attracted attention as a tool for defining the medical malpractice standard of care).

95. *Id.* at 700.

96. See Hall, *supra* note 31, at 159-161 (examining legal and regulatory issues arising when patients are forced or choose to pay a major portion of their medical costs out of pocket); see Hall & Schneider, *supra* note 11, at 743 (examining the effects of health care consumerism on achieving cost constrain and quality standards).

97. Hall, *supra* note 31, at 160.

98. Hall & Schneider, *supra* note 11, at 747-48 (stating the principal tenet of consumer-driven health care is the idea that if patients have reliable information about the cost and quality of care and pay more for that care out of pocket, then they “will make decisions that drive costs down and the quality up”).

within CDHC programs because of the high costs associated with medical care in general.<sup>99</sup> In other words, medical costs are expensive across the board and there is a fear that patients will refuse non-wasteful, necessary medical treatment simply because it is too expensive.

Focusing more on the fear of patients forgoing any and all expensive medical care, the conflict between CDHC and malpractice liability standards arises when a patient refuses treatment or requests suboptimal care on the basis of cost, and then suffers an injury that would have been avoided had the optimal, more costly care been provided.<sup>100</sup> Under such a scenario, physicians may assert the defenses of waiver and/or assumption of risk, but they bear the burden of litigating both defenses with the corresponding risk that their understanding of the patient's refusal will be second-guessed by juries.<sup>101</sup> Accordingly, the medical liability standard, which imposes a standard of care on the physician regardless of the resources available, may result in liability against the physician, even though the patient, on the basis of cost concerns, refused the optimal standard of care in favor of a lesser standard of care or no care at all.<sup>102</sup>

To harmonize the medical liability standard with the patient choice of suboptimal care in the CDHC context, Professor Hall has argued that the standard of care should be split into two components, one focusing on the resources available and one focusing on the skill that must be applied to those resources.<sup>103</sup> Under this suggested liability modification, a physician would be required to meet a set skill-focused standard of care regardless of the patient's choice of a costly, optimal treatment or a less costly, suboptimal treatment.<sup>104</sup> However, the standard of care applied to the resources used in treating the patient would vary according to the level of resources chosen by the patient.<sup>105</sup> Hall further proposes, at least with regard to the resources component of the proposed standard of care, that courts recognize a defense whereby physicians can demonstrate, through informed consent, that the patient was aware of more expensive treatment

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99. See *id.* at 749, for an example where a physician thinks a patient might have a sprain or torn ligament and the patient chooses to avoid getting an MRI to definitively identify a torn ligament for repair because the MRI is too expensive.

100. Hall, *supra* note 31, at 175-76 (examining whether providers can be held liable for delivering suboptimal treatment when the patient chooses to receive less expensive care or buys more limited insurance).

101. Hall & Schneider, *supra* note 11, at 762-67 (arguing that the doctrines of waiver and assumption of risk do not provide physicians with sufficient guidance to determine when it is safe to provide suboptimal care).

102. Hall, *supra* note 31, at 175.

103. *Id.* at 177 (arguing for dividing the standard of care determination into a resources component and skill component).

104. *Id.* at 177.

105. *Id.*

alternatives, yet chose the low cost, suboptimal treatment.<sup>106</sup>

### 3. Pay For Performance Programs

Along with MCOs and CDHC programs, P4P programs represent another context in which the tension between malpractice liability standards and cost containment efforts arise. Somewhat similar to ACOs, P4P programs tie physician reimbursement to performance, with financial incentives offered to physicians who achieve lower costs, while maintaining high quality.<sup>107</sup>

Within P4P programs, the cost containment/liability standard conflict arises because defensive medicine drives up health care spending in the hope of driving down malpractice costs, while the cost cutting incentives of the P4P program encourages less spending in an effort to control treatment costs.<sup>108</sup> Physicians are pulled in diametrically opposing directions as they simultaneously try to engage in high and low cost treatment at the same time in an effort to reduce different sets of medical costs.

To resolve this conflict, Claire Bartholome has proposed a solution similar to Professor Fine's proposal above, essentially incorporating the cost-conscious P4P clinical quality guidelines into the medical liability standard of care.<sup>109</sup> Bartholome argues that such an approach will harmonize the two because adherence to the P4P cost-conscious clinical guidelines will reduce treatment costs, while also reducing the risk and cost of malpractice liability.<sup>110</sup>

### 4. Quality Improvement Organizations

With an eye towards resolving the broader cost containment/liability standard conflict, Professor Blumstein proposes using Quality Improvement Organizations (QIOs) to align the standard of care with cost containment considerations.<sup>111</sup> More specifically, Blumstein proposes using QIOs to set

106. *Id.* at 178-79 (arguing that recognizing assumption of risk or informed refusal of recommended treatment as a defense along with the recommended dual standard of care would further promote adoption of the dual standard of care).

107. Bartholome, *supra* note 38, at 333 (describing P4P as linking "provider reimbursement with adherence to certain criteria aimed at reducing costs and increasing quality").

108. *Id.* at 334 (describing P4P and defensive medicine as having conflicting ends, with the former focused on reducing health care treatment costs and the latter focused on reducing medical malpractice costs).

109. *Id.* at 336.

110. *Id.* (arguing that "the cost and quality control of P4P will provide physicians with an incentive to adhere to responsible clinical guidelines, reducing their risk of malpractice liability.").

111. *Medical Malpractice*, *supra* note 9, at 1048-49 (arguing that the solution for the cost containment/liability standard tension is for Quality Improvement Organizations to set

the standard of care *ex-ante* through the formulation of QIO protocols that incorporate costs and benefits.<sup>112</sup> QIOs are a federal statutory creation, originally known as Professional Standards Review Organizations and were created as “self-regulatory organizations of physicians . . . charged with monitoring individual physicians’ decisions affecting the use of health care resources under federal health programs.”<sup>113</sup> The federal statute provides immunity to physicians who act in compliance with or in reliance on the standards set by the QIOs.<sup>114</sup>

Blumstein proposes to use the QIO statute to allow QIOs to set practice standards that incorporate quality and cost concerns.<sup>115</sup> In doing so, physicians following those standards would be able to avoid state malpractice liability under the statutory-based QIO federal immunity.<sup>116</sup> Blumstein argues that the QIO practice standards will effectively prevent the practice of defensive medicine if they are narrowly designed as safe harbors, such that physicians know that they will be immune from liability if they strictly adhere to the protocols, but will conclusively be in breach of those standards if they deviate from the protocols.<sup>117</sup> To be most effective, Blumstein contends that the protocols must target narrow, specific circumstances, including diagnostic medicine and the use of new technology in medicine, areas where “defensive practices are sub-optimal and . . . quality can be maintained while reducing cost.”<sup>118</sup>

As demonstrated above, a variety of scholars have examined the cost containment/liability standard conflict across various contexts, and they have proposed a diverse array of possible solutions. Their analyses provide the backdrop for predicting whether and/or how the cost containment/liability standard conflict will operate within the ACO context and what impact the conflict will have on the ACOs and their success or effectiveness. Before conducting such an analysis of the cost containment/liability standard conflict within the ACO context, the next section examines the structure and operation of ACOs and, more

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ex-ante practice standards that incorporate cost concerns and that become the standard of care).

112. *Id.* at 1048 (discussing the benefits of ex ante liability standard-setting “as a tool for reducing uncertainty faced by medical providers).

113. *Id.* at 1038 (quoting Clark C. Havighurst & James F. Blumstein, *Coping with Quality/Cost Trade-offs in Medical Care: The Role of PSROs*, 70 Nw. U. L. Rev. 6, 8 (1975)).

114. *Medical Malpractice*, *supra* note 9, at 1038.

115. *Id.* at 1048-49.

116. *Id.*

117. *Id.* at 1048 (arguing that the controlling standards must serve as a sword and shield, defending against liability if they are followed and establishing liability if they are breached).

118. *Id.* at 1049.

particularly, the PPACA created ACOs.

#### IV. ACCOUNTABLE CARE ORGANIZATIONS

##### *A. Overview of Accountable Care Organizations*

In 2009, MedPac issued a report to Congress calling for the creation of ACOs as a way to control Medicare spending, while improving the quality of care provided to Medicare beneficiaries.<sup>119</sup> In its report, MedPac's concept of an ACO was an organization of primary care physicians, specialists and at least one hospital that would be assigned a population of Medicare beneficiaries and would be held jointly accountable for the quality of care and Medicare spending costs associated with that population.<sup>120</sup>

The MedPac Report envisioned Medicare facilitating joint accountability within the ACOs through financial bonus incentives given to ACO providers and ACOs as a reward for lowering costs and achieving higher quality.<sup>121</sup> ACO providers would strive to meet set quality standards while also controlling patient volume or excessive patient use of Medicare services. Controlling patient volume or excessive utilization would, in turn, result in a cut in Medicare spending, thereby qualifying the ACO and its providers for financial incentives. Broadly speaking, the MedPac ACOs would be categorized as falling somewhere between a Medicare FFS system and a managed care fully capitated plan system.<sup>122</sup>

In its report to Congress, MedPac examined two different types of ACO models. The first model was a voluntary, bonus only model, in which ACO participation would be voluntary and accountability would come in the form of financial bonuses to ACOs for improving the quality of patient outcomes while reducing Medicare spending.<sup>123</sup> The second model was a mandatory model, in which ACO participation would be mandatory with the same financial bonuses for good performance and penalties for poor performance.<sup>124</sup>

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119. MedPac, *supra* note 10, at 39 (discussing the goals of ACO's as creating an incentive for ACO providers to "constrain volume growth while improving the quality of care").

120. *Id.*

121. *Id.*

122. *Id.* at 54-55 (discussing how Medicare associated ACOs would fall somewhere on the spectrum between Medicare FFS and Medicare Advantage).

123. *Id.* at 40 (describing the two different proposed ACO models).

124. *Id.*

*B. The Patient Protection and Affordable Care Act Accountable Care Organizations*

In 2010, Congress, through the PPACA, provided for the creation of ACOs through an incentive-based Medicare Shared Savings Program (MSSP).<sup>125</sup> The MSSP is to be established by January 1, 2012 and will promote the establishment of ACOs for Medicare FFS beneficiaries.<sup>126</sup>

As with the ACOs outlined in the MedPac Report, a PPACA ACO is to be comprised of primary care physicians, specialists, and hospitals that monitor Medicare expenditures spent on that ACO's assigned beneficiaries, as well as the quality of care provided to those beneficiaries.<sup>127</sup> Also, similar to the MedPac Report ACOs, if a PPACA ACO meets certain quality standards and achieves certain Medicare cost savings standards, then providers within that ACO will receive a percentage of the savings in Medicare expenditures that the ACO achieves.<sup>128</sup> The goal of the PPACA ACO program "is to afford health care providers financial incentives to promote delivery of care to Medicare patients in a coordinated manner across a continuum of care."<sup>129</sup>

Turning to the structural details of the PPACA ACOs, eligible ACO entities include: group practice arrangements; practice networks; partnerships; joint venture arrangements; or hospitals employing physicians.<sup>130</sup> The ACOs must also include the following characteristics: 1) accountability for the quality, cost, and overall care of the Medicare beneficiaries assigned to it; 2) a legal structure allowing for the receipt and distribution of shared savings to participating physicians and hospitals; 3) a sufficient number of primary care physicians to care for the number of beneficiaries assigned to the ACO; 4) responsibility for at least 5,000 beneficiaries assigned to the ACO; 5) a "leadership and management structure that includes clinical and administrative systems"; 6) defined processes "to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care"; and 7) meeting patient-centeredness criteria to be specified by HHS.<sup>131</sup> Along with these structural requirements, eligible ACOs must also meet certain quality reporting requirements to be set by HHS, which will include, but are not limited to, reporting on: "(i) clinical processes and outcomes; (ii) patient

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125. 42 U.S.C. § 1395jjj(a)(1) (2010).

126. *Id.*

127. *Id.* § 1395jjj(d).

128. *Id.*

129. Jay L. Levine, *Meeting the New Challenges for Mergers in the Health Care Realm*, Understanding Antitrust Issues in Health Care 89, 90 (Aspatore 2010), available at 2010 WL 3252502 (discussing antitrust implications of PPACA's ACO's).

130. 42 U.S.C. § 1395jjj(b)(1) (2010).

131. *Id.* § 1395jjj(b)(2).

and, where practicable, caregiver experience of care; and (iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).<sup>132</sup>

On the incentive payments side of the PPACA, ACOs, physicians and providers within an ACO are eligible for bonus payments based on savings produced from meeting HHS designated Medicare spending benchmarks, as well as achieving HHS designated quality standards.<sup>133</sup> ACO physicians and providers will continue to be paid on a Medicare FFS basis for the services that they provide, but they will also be eligible for incentive payments if their “estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least [an HHS designated percentage below an HHS designated expenditure benchmark.]”<sup>134</sup>

Focusing on the savings evaluation, HHS will evaluate savings on an annual basis and will base the designated expenditure benchmark, which the savings are to be measured against, on “the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO.”<sup>135</sup> HHS is also required to adjust this benchmark based on beneficiary characteristics and other appropriate factors, and is required to update it based on “the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary.”<sup>136</sup> The actual incentive payments to ACOs and their members will be an HHS designated percentage of the difference between the ACOs average per capita Medicare expenditures in a year and the benchmark for that year.<sup>137</sup>

While Congress focused on the positive incentives for promoting quality and cost cutting within PPACA ACOs, there was one legislative provision regarding penalties. The PPACA includes a penalty provision that permits HHS to impose sanctions or terminate an ACO’s participation in the MSSP if HHS determines that an ACO has taken steps to avoid providing services to at-risk patients in order to decrease Medicare expenditures.<sup>138</sup>

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132. *Id.* § 1395jjj(b)(3)(A).

133. *Id.* § 1395jjj(d)(1)(A).

134. *Id.* § 1395jjj(d)(1)(B).

135. *Id.* § 1395jjj(d)(1)(B)(ii).

136. 42 U.S.C. § 1395jjj(d)(1)(B)(ii) (2010).

137. *Id.* § 1395jjj(d)(2).

138. *Id.* § 1395jjj(d)(3).

*C. Centers for Medicare & Medicaid Services' Proposed Rule  
Implementing Accountable Care Organizations*

In April, 2011, the Centers for Medicare & Medicaid Services released a proposed rule implementing the PPACA ACOs.<sup>139</sup> The proposed rule expands on the details of the PPACA created ACOs. With an eye toward the liability, cost cutting and quality issues raised herein, there are few aspects of the proposed rule that require highlighting.

Generally, the proposed rule provides for ACOs to choose one of two tracks for participation. Under the first track, for the first two years of the ACO agreement, the ACO would share in savings, assuming it meets set quality and cost cutting standards, but it would not be at risk for sharing in any losses generated or spending increases.<sup>140</sup> For the third year of the ACO agreement, the ACO would be required to share responsibility for any spending above the set spending benchmark, as well as sharing in any savings.<sup>141</sup>

Under the second track, the ACO would share in any savings generated and would be required to share responsibility for any losses generated throughout all three years of the ACO agreement.<sup>142</sup> Under the second track, the ACO would be eligible for up to 60% of the savings generated based on the ACO's quality performance, whereas ACOs under the first track would only be eligible for up to 50% of the savings generated.<sup>143</sup> Additionally, track two ACOs would be subject to a maximum shared loss cap percentage of 10% of their spending benchmark which would be based on their quality performance.<sup>144</sup> While ACOs, depending on the track chosen, are entitled to up to 50% or 60% of the savings generated, CMS has proposed to cap the amount of savings that can be paid to any one ACO at between 7.5% and 10% of the ACO's benchmark.<sup>145</sup>

Structurally, the proposed rule provides that ACOs may be structured as a "corporation, partnership, limited liability company, foundation or other entity permitted by State law."<sup>146</sup> Whatever form the ACO legal entity takes, it must be capable of receiving and distributing shared savings, repaying shared losses, establishing, reporting, and ensuring that its ACO providers comply with the ACO program requirements and performing other ACO functions identified in the PPACA.<sup>147</sup>

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139. 76 Fed. Reg. 19528 (to be codified at 42 C.F.R. pt. 425).

140. *Id.* at 19602-03.

141. *Id.*

142. *Id.*

143. *Id.* at 19593.

144. *Id.* at 19621-22.

145. 76 Fed. Reg. 19528, 19616 (to be codified at 42 C.F.R. pt. 425).

146. *Id.* at 19540.

147. *Id.*



Another structural aspect to the ACOs relates to how beneficiaries will be assigned to an ACO. The proposed rule would require each primary care physician, who chooses to participate in an ACO, to join a single ACO, while other provider types could be members of multiple ACOs.<sup>148</sup> By having each primary care physician associated with a single ACO, each patient would be assigned to a single ACO through his or her primary care physician.<sup>149</sup> Beneficiaries would have to be notified when they are seeking services from an ACO provider or facility through written notifications and signs posted in the facility, which would note the organization's status and the implications for the beneficiary.<sup>150</sup>

Operationally, the proposed rule would require that ACOs meet the following key requirements, among others:

(1) ACO providers hold at least 75% of control of the ACO's governing body<sup>151</sup>;

(2) Management of the ACO's operations by an executive, officer, manager, or general partner, whose appointment and removal are under control of the ACO's governing body<sup>152</sup>;

(3) Management of the clinical aspects of the ACO by a medical director who is a board-certified physician licensed in the state in which the ACO operates and who is physically present in that state<sup>153</sup>;

(4) ACO providers with a sufficiently meaningful commitment to the ACO's clinical integration program to ensure its likely success, including a meaningful financial or human investment in the "ACO, such that the potential loss or recoupment of the investment is likely to motivate the participant to make the clinical integration program succeed"<sup>154</sup>;

(5) A physician-directed quality assurance and improvement program<sup>155</sup>; and

(6) Implementation of "evidence-based medical practice or clinical guidelines and processes for delivering care consistent with the goals of better care for individuals, better health for populations, and lower growth in expenditures."<sup>156</sup>

In addition to these operational elements, ACOs must also develop and report to CMS certain information regarding ACO providers, including the ACO's processes for promoting evidence-based medicine, patient

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148. *Id.* at 19563.

149. *Id.*

150. *Id.* at 19567-68.

151. 76 Fed. Reg. 19528, 19541 (to be codified at 42 C.F.R. pt. 425).

152. *Id.* at 19543.

153. *Id.*

154. *Id.*

155. *Id.*

156. *Id.*

engagement, coordination of care and reporting on quality and cost measures.<sup>157</sup>

Turning to quality measures, the proposed rule proposes sixty-five measures for use in establishing quality standards.<sup>158</sup> These quality measures are intended to assess five domains, including the patient/caregiver's experience with the ACO, care coordination within the ACO, the ACO's patient safety record, ACO efforts at promoting preventive health, and the health of at-risk, frail, and elderly ACO beneficiaries.<sup>159</sup> Some of the quality measures that could have a connection to medical malpractice liability include, but are not limited to rates of hospital readmission, medication management and reconciliation, measurements related to health care acquired conditions, mammography screenings, colorectal cancer screenings and monitoring related to diabetes, coronary artery disease, heart failure and hypertension.<sup>160</sup>

CMS has proposed to use one of two methods to determine whether quality standards are met by a given ACO. The first option would involve scoring ACOs on the sixty-five quality measures to arrive at a composite performance score, which would then be used to calculate the ACO's percentage of shared savings.<sup>161</sup> This measure focuses on better performance and the higher the ACO's score, the higher the ACO's percentage of shared savings.<sup>162</sup> The second option uses the same composite score methodology to determine whether an ACO meets a minimum quality threshold.<sup>163</sup> If the ACO meets the threshold, then it obtains a portion of the shared savings and if it does not meet the threshold, then it does not receive a portion of the shared savings.<sup>164</sup>

Along with proposals related to quality standards, CMS also developed proposals related to determining shared savings. More specifically, CMS intends to set an expenditure benchmark projecting what an ACO's expenditures would have been for that ACO's beneficiary population had there been no ACO.<sup>165</sup> CMS then will compare that number to the actual per capita Medicare spending for the ACO population.<sup>166</sup> Both measures will be risk-adjusted to ensure that apparent savings in comparing the two measures are due to the ACO's efforts and not due to treating a more

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157. 76 Fed. Reg. 19528, 19546-47 (to be codified at 42 C.F.R. pt. 425).

158. *Id.* at 19570.

159. *Id.*

160. *Id.* at 19571-91.

161. *Id.* at 19593.

162. *Id.*

163. 76 Fed. Reg. 19528, 19593 (to be codified at 42 C.F.R. pt. 425).

164. *Id.*

165. *Id.* at 19603-04.

166. *Id.*

favorable patient mix.<sup>167</sup>

While comparison of the two measures above will demonstrate the ACO's generated savings, for each ACO, CMS will also calculate a minimum percentage threshold of savings above an annual benchmark amount, which each ACO must meet or exceed in order to be eligible for any savings.<sup>168</sup> This threshold calculation ensures that savings are due to the ACO's cost cutting measures and not other factors.<sup>169</sup> Notably, some rural ACOs and those serving underserved patient populations may be exempt from the threshold requirement or entitled to a shared savings rate increase, if they meet certain specified characteristics.<sup>170</sup>

#### *D. MedPac's Views on Accountable Care Organizations*

While implementation of the ACO concept is recent and many of the strengths and weaknesses of ACOs will become more apparent as ACOs develop, within the context of liability standards, quality standards and cost cutting efforts, MedPac's Report outlines some important anticipated issues. For example, MedPac proposed that the division of ACO bonuses among physicians and providers be in the form of a fixed percentage add-on to their FFS payments, in order to avoid conflicts among providers over the division of bonuses.<sup>171</sup> Despite MedPac's suggestion, under the proposed rule bonuses would be directly payable to the ACO entity and it would be up to the ACO on how to distribute those bonuses to individual ACO providers.<sup>172</sup>

Turning to spending targets, MedPac's Report raises issues regarding ACOs and existing regional variations in Medicare spending. In high-use, high Medicare spending areas, the employment of ACOs could help "reduce the regional variation in care [by providing incentives] to lower[] the use of unnecessary services."<sup>173</sup> Conversely, MedPac expressed concerns that ACOs in low-use areas may have more difficulty cutting costs and finding efficiencies than ACOs in high-use regions.<sup>174</sup> In other words, there will be fewer incentives for the ACO development in low-use regions as it will be more difficult to generate cost savings, and thus more difficult to earn savings-based bonuses. To some extent these difficulties may be remedied by CMS' proposal to risk adjust the spending benchmark

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167. *Id.* at 1906-07.

168. *Id.* at 19603-04.

169. 76 Fed. Reg. 19528, 19603-04 (to be codified at 42 C.F.R. pt. 425).

170. *Id.* at 19611-14.

171. MedPac, *supra* note 10, at 48 (discussing ways to avoid conflict among providers over the division of bonuses).

172. 76 Fed. Reg. at 19544-45.

173. MedPac, *supra* note 10, at 43.

174. *Id.* at 44.

and the calculation of actual beneficiary spending,<sup>175</sup> as well as CMS' proposal to exempt certain ACOs who serve rural or underserved areas from the threshold savings percentage requirement and/or to provide them with additional savings rate increases.<sup>176</sup>

On the spending side, MedPac expressed concern that the current Medicare FFS system encourages physicians and providers in both high and low-use areas to provide the maximum amount of services in order to drive up reimbursements.<sup>177</sup> MedPac was concerned as to whether the use of ACO bonuses for cost cutting without corresponding overspending penalties would sufficiently counter this strong incentive.<sup>178</sup> At the same time, MedPac recognized that the use of bonus incentives combined with penalties for overspending would create stronger incentives to control volume against the lure of the Medicare FFS payment system.<sup>179</sup>

Even though the proposed rule allows for ACOs to choose to be bonus-only entities, ultimately, even those ACOs who choose track one will be forced into a combined bonus and penalty ACO model.<sup>180</sup> Accordingly, the PPACA-created ACOs should have relatively strong incentives to control spending volume. The only question is whether the cap on penalties allows for penalties strong enough to overcome an individual ACO provider's incentive to provide the maximum FFS Medicare services possible, while also not being so strong as to deter the creation of ACOs.

Finally, MedPac raised concerns that Medicare spending in a given area randomly varies over time and changes based on patient health.<sup>181</sup> In other words, not all decreases in spending are due to intentional cost cutting measures and not all increases in spending are due to waste; some variation is just random and natural. Accordingly, MedPac argued that the ACO bonus structure must be set up such that ACOs are not rewarded with shared savings for random decreases in spending,<sup>182</sup> as Medicare is not really saving any money,<sup>183</sup> and would be giving up some of the savings

175. 76 Fed. Reg. at 1906-07.

176. *Id.* at 19603-04, 19611-14.

177. MedPac, *supra* note 10, at 43.

178. *Id.* (discussing the need "to counterbalance the incentives under FFS payment to increase volume").

179. *Id.* at 48.

180. 76 Fed. Reg. at 19602-03.

181. MedPac, *supra* note 10, at 49-50, 52-53 (finding in an empirical study that random variations in Medicare spending growth varied by five percent below or above the national average from year to year).

182. *Id.* at 49, 52-53 (arguing that bonuses should reflect "actual earned changes in performance-and not just random variation").

183. *Id.* at 53 (arguing that minimizing bonuses paid for random variation ensures that Medicare saves money through ACO practices).

that would have occurred with or without the ACOs.<sup>184</sup> CMS is attacking this issue through the use of the threshold savings percentage, but it remains to be seen whether the size of the threshold savings percentage is large enough to account for random and natural changes in annual spending.<sup>185</sup>

#### V. ACCOUNTABLE CARE ORGANIZATIONS AND THE COST CONTAINMENT/LIABILITY STANDARD CONFLICT

The fundamental focus of this article is what impact the PPACA created ACOs and the ACO structure itself will have on the tension that physicians face in implementing and achieving cost cutting goals, while also meeting the medical malpractice liability standard of care. The short answer is that the PPACA created ACOs will probably not exacerbate the tension to the same extent that MCOs have done, but neither will the PPACA ACOs completely eliminate the tension either. The clearest way to examine ACOs in terms of the cost containment/liability standard conflict is to examine how the PPACA addresses physician liability in an ACO environment, how the PPACA addresses ACO liability issues, and how the cost containment/liability standard conflict will likely impact the success and effectiveness of ACOs.

##### *A. Accountable Care Organizations and the Provider Liability Standard*

The PPACA fails to specifically address the malpractice liability standard for ACO physicians and providers.<sup>186</sup> Nonetheless, predictions can still be made as to how the cost containment/liability standard conflict will operate within the ACO context based on a review of the scholarly works above. Within those works there appears to be a consensus that physicians will continue to face some tension in implementing cost cutting provisions in the delivery of healthcare until the malpractice liability standard incorporates the concepts of cost containment and efficiency.<sup>187</sup> Unfortunately, the PPACA provision creating ACOs does not address the intersection of cost containment concerns and malpractice liability standards for ACO physicians and providers.<sup>188</sup>

Given the silence of the PPACA on medical liability standards for ACO physicians and providers, it is likely that ACO physicians and providers will continue to face the same non-cost-conscious state medical malpractice standards of care that they face in the current practice setting. Any change

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184. *Id.*

185. 76 Fed. Reg. at 19603-04.

186. 42 U.S.C. § 1395jjj (2010).

187. Bartholome, *supra* note 38, at 336; *Medical Malpractice*, *supra* note 9, at 1048-49; Fine, *supra* note 5, at 693-94; Hall, *supra* note 31, at 175-77; Record, *supra* note 2, at 984.

188. 42 U.S.C. § 1395jjj.

in the medical liability standard, within the ACO context or more generally, will have to await the incorporation of cost concerns through further national or state statutory revisions or the evolution of common law through the court system. If the scholarly consensus is correct about what must happen before physicians will fully embrace cost cutting goals, it is highly unlikely, within the ACO context, that ACOs will fully address and resolve the tension that physicians face in meeting both the goals of cost cutting and the non-cost-conscious standard of care.

It may be tempting to assume that linking ACO cost cutting goals with achieving high quality care will alleviate physician concerns that cost cutting will subject them to possible liability. This is a false assumption for two reasons. First, like ACOs, MCOs also claim to address the dual goals of cutting costs and providing high quality care.<sup>189</sup> Nonetheless, despite the dual aim of MCOs, physicians within the MCO context still face the cost containment/liability standard conflict.<sup>190</sup>

The difference between the ACO and MCO context is that physicians in the MCO context face possible termination if they do not achieve cost cutting goals,<sup>191</sup> whereas physicians and providers in the ACO context fail to receive a bonus if they do not cut costs and achieve certain quality standards.<sup>192</sup> Of course, HHS may terminate the ACO's agreement if the ACO does not meet the ACO quality standards<sup>193</sup> and ACOs, including track one ACOs, will ultimately be subject to overspending penalties.<sup>194</sup> Still, within the ACO context, the absence of a Sword of Damocles of termination hanging over individual ACO providers, likely alters how the cost containment/liability standard conflict will operate within the ACO versus MCO context.

In the MCO context, the fear of termination probably causes physicians to strive harder to meet cost cutting goals over stringently meeting liability standards. In contrast, within the ACO context, it seems more likely that ACO physicians and providers will strive harder to meet liability standards over cost cutting goals. While the threat of termination of an ACO's agreement and the threat of overspending might strengthen the individual provider's cost cutting incentive within the ACO, the termination and/or penalty would occur at the ACO entity level, not at the individual provider

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189. Benjamin Saunier, *The Devil is in the Details: Managed Care and the Unforeseen Costs of Utilization Review as a Cost Containment Mechanism*, 35 Okla. City U. L. Rev. 483 (2010) (noting that the HMO Act was passed to encourage the development of MCOs in order to cut costs and achieve high quality care).

190. Fine, *supra* note 5, at 641-42.

191. *Id.* at 673.

192. § 1395jjj.

193. *Id.* § 1395jjj(d)(4).

194. 76 Fed. Reg. at 19602-03.

level. Accordingly, the threat of those two negative incentives is not as direct, immediate, and menacing as the threat to an individual provider of MCO termination if he or she does not meet the MCO's cost cutting goals. Simply put, individual ACO physicians and providers lose shared bonuses or incur shared penalties if they fail to meet cost cutting goals, whereas MCO physicians lose their livelihood.

The second reason why it is wrong to assume that linking ACO cost cutting goals with achieving high quality care will alleviate physician liability concerns is because quality standards set by an ACO may not match up with the same quality standards embodied within the standard of care. The proposed rule makes some attempt at alignment, but the effort is not comprehensive and provides no guarantee of absolute alignment between the two sets of quality standards.

For example, the proposed rule's measure of hospital readmissions, medication management, health care acquired conditions, mammography screenings, and colorectal cancer screenings<sup>195</sup> are measures connected to outcomes associated with the basis for many malpractice cases, such as a failure to screen for cancer. However, physicians following these ACO quality standards may still be subject to liability for violating the standard of care set by experts in a malpractice case. The standard of care, unlike the sixty-five quality standards identified within the proposed rule, is variable, somewhat unpredictable and only identifiable *post hoc*, in the course of litigation.<sup>196</sup> Accordingly, ACO physicians and providers will remain concerned that even if they meet the ACO quality and cost-cutting standards, they may still face liability under a different *post-hoc* liability standard.

In terms of the liability standard being imposed on an ACO physician or provider, the PPACA ACOs do nothing to ease ACO physician and provider fears that they may be subject to state malpractice liability even if they meet the cost cutting and quality standards of the ACO. Short of the passage of additional statutory immunity for liability when an ACO physician or provider meets ACO quality standards, or the incorporation of cost concerns within the standard of care, ACO physician and provider difficulties in meeting cost cutting goals while also avoiding liability will not dissipate.

#### *B. Accountable Care Organizations and the Accountable Care Organization Liability Standard*

Given that the PPACA fails to address the medical liability standard of care within the ACO setting, the only other possibility for alleviating the

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195. *Id.* at 19571-91.

196. *Medical Malpractice*, *supra* note 9, at 1026-29.

cost containment/liability standard conflict hinges on the standard governing the ACO's own exposure to liability. By analogy to the MCO context, if the ACO can cut costs without fear of liability for violating the standard of care, while ACO physicians and providers must implement those cuts and bear the burden of potential liability, then the incentives of the two are not aligned and the physician or provider tension in meeting both cost cutting and liability standards is exacerbated by the ACO system.<sup>197</sup>

As with the liability standard applied to physicians and providers, the PPACA is mostly silent on the liability standard governing ACO's for malpractice committed by an ACO physician or provider.<sup>198</sup> The PPACA does not specifically address whether ACOs may be held liable for injuries flowing from ACO cost cutting measures, under what theory they may be held liable, or what liability standard would apply, assuming an ACO can be held liable for malpractice.

There are many questions that remain unanswered in terms of ACO malpractice liability: Will ACOs maintain liability insurance? Will they self-insure? What will be the most popular legal structure of the statutory options available? In other words, will most ACOs organize as corporations, partnerships, limited liability companies or some other state recognized legal structure?<sup>199</sup> Will individual ACO physicians and providers serve as employees, independent contractors or in some other legal capacity? How will liability work with regard to the governing board of ACOs?<sup>200</sup> How will liability be distributed between individual ACO providers and the ACO entity for malpractice committed by an individual ACO physician or provider? How will the concept of joint and several liability function within the ACO context? These are all open questions that will have to be answered in the future.

One certainty is that ERISA will not apply to ACOs and, therefore, will not pose a preemption barrier to state law malpractice claims against ACOs. ERISA only applies to employer sponsored benefit plans or plans sponsored by an employee organization.<sup>201</sup> Unlike many MCOs, ACOs are neither of these types of plans, but rather are legal structures, recognized under applicable state law, through which a group of physicians and providers provide care and treatment to a designated group of Medicare beneficiaries.<sup>202</sup>

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197. Record, *supra* note 2, at 957-58, 964-65.

198. 42 U.S.C. § 1395jjj.

199. 76 Fed. Reg. at 19540.

200. *Id.* at 19541.

201. Employee Retirement Income Security Act, 29 U.S.C. § 1003(a) (2006).

202. 42 U.S.C. § 1395jjj(a)(1)(A); 76 Fed. Reg. at 19540.



Without ERISA preemption, courts will likely extend malpractice liability in some form to ACOs for the decisions that they make, especially if courts follow a similar course to the managed care liability case law. A similar course would seem likely, given the similarities between the intended impact of MCO and ACO decision making on physician decision making and the quality of patient care.

MCOs impact the quality of patient treatment by conducting utilization review of physician treatment decisions, approving or denying coverage,<sup>203</sup> and terminating or penalizing physicians who fail to control costs by failing to provide treatment in accord with utilization review decisions.<sup>204</sup> Similarly, under the PPACA, ACOs will set quality and cost containment standards and then incentivize ACO physicians and providers for meeting those standards through the provision of bonuses and/or imposition of overspending penalties.<sup>205</sup> Under both scenarios, the entity, be it an ACO or MCO, attempts to impose or strongly encourage certain standards of practice and/or treatment decisions that are driven by quality and cost, though some may argue that the MCOs standards are driven more by cost than quality.<sup>206</sup>

In light of the similarities in how MCOs have impacted and how ACOs will impact the way that physicians practice medicine and the quality of patient care, Agrawal and Hall's summary of MCO malpractice liability case law is helpful in predicting how medical liability standards may apply to ACOs.<sup>207</sup> First, if courts view the ACOs as providing direct care to Medicare beneficiaries, analogous to hospitals, then the courts may apply a direct corporate negligence theory to ACOs, imposing upon them a duty to "select and retain competent caregivers, to oversee the care they provide, and to establish and adhere to policies to ensure quality care."<sup>208</sup> Within the MCO context, courts extended this concept of direct corporate negligence even where the MCO did not employ the physician, but rather arranged "for the provision of services by contracting with independent caregivers and institutions."<sup>209</sup> Courts expanded the theory of direct liability beyond the employment relationship because of the central role that MCOs played in the delivery of health care services.<sup>210</sup>

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203. Record, *supra* note 2, at 960.

204. Fine, *supra* note 5, at 641-42.

205. 42 U.S.C. § 1395jjj(a)(1)(B); 76 Fed. Reg. at 19602-03.

206. Record, *supra* note 2, at 961-62 (noting that MCO utilization review may be, but is not necessarily antithetical to promoting quality care).

207. Agrawal & Hall, *supra* note 31, at 241-45 (summarizing and analyzing court treatment of MCOs for state law claims of direct corporate and vicarious liability).

208. *Id.* at 241.

209. *Id.*

210. *Id.* at 242 (discussing how courts hinged MCO liability on their "central role in the

The legal reasoning for imposing direct liability on MCOs applies equally to PPACA ACOs. Like MCOs, each PPACA ACO will also select which physicians and providers will be a member of that ACO, as well as oversee the care that is provided, including the quality of that care through the setting of quality and cost standards and incentivizing individual ACO providers to meet those standards.<sup>211</sup> Given the direct impact on ACO beneficiaries of the ACO's setting of cost and quality standards and the strong influence that the availability of ACO bonuses and penalties will likely have on individual ACO providers, it seems likely that courts will find that ACOs play a central role in providing quality healthcare to ACO beneficiaries. Furthermore, it seems likely that courts will find this ACO role to be so central to the healthcare received by ACO beneficiaries that courts will impose direct liability on ACOs, even if individual ACO providers are not employees of the ACO.

The second theory of liability that courts might apply to ACOs is the theory of vicarious liability. Within the MCO context, courts extended vicarious liability to MCOs to hold them liable for the negligence of their independent contractor physicians.<sup>212</sup> The courts imposed vicarious liability on MCOs using the doctrine of “apparent or ostensible agency to find an agency relationship between a managed care organization and an independent physician.”<sup>213</sup> Generally, but with some variation, apparent agency requires a plaintiff to establish that the MCO or ACO “held itself out as a provider of health care, and that [the plaintiff] relied upon that conduct, looking to the managed care organization rather than to the individual physician to obtain health care services.”<sup>214</sup>

Given that the proposed rule requires ACOs to post signs in their facilities and provide written notification to beneficiaries that a particular provider is an ACO provider,<sup>215</sup> the doctrine of apparent agency should apply within the ACO context. It is difficult to understand how an ACO could mount a defense to an apparent agency claim, where the use of such written notification and signage plainly communicates to a beneficiary that they are receiving care from an ACO. Through the signage and notification requirements, the proposed rule essentially requires ACOs to hold themselves out as health care providers.

That said, in the ACO context, the reliance element of an apparent

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total health care’ of enrollees”).

211. 42 U.S.C. § 1395jjj(a)(1)(b), (b)(2)(E)-(G), (b)(3)(C) (2010).

212. Agrawal & Hall, *supra* note 31, at 243 (discussing how courts applied vicarious liability to MCOs for network provider negligence as an analogy to imposing vicarious liability on hospitals for the negligence of independent medical staff physicians).

213. *Id.*

214. *Id.*

215. 76 Fed. Reg. at 19567-68.

agency claim might be difficult for plaintiffs to prevail on, depending on the factual circumstances. Unlike MCOs, “ACOs cannot require Medicare beneficiaries to only use certain providers. Rather, ACOs must obtain savings through efficiency and recommendations to their patients.”<sup>216</sup> Accordingly, an ACO may argue more strongly that the plaintiff, in seeking care from the individual ACO provider, was really looking toward that individual ACO provider and not the ACO for the provision of care, since ACO patients can choose to see any primary care provider or specialist that they want.<sup>217</sup> By contrast, many MCOs require their patients to see certain MCO selected providers, thereby creating a much strong reliance argument for a MCO plaintiff.<sup>218</sup> Therefore, MCO plaintiffs, overall, have a stronger apparent agency argument when suing a MCO for a MCO provider’s malpractice contrasted with an ACO plaintiff suing an ACO for an individual ACO provider’s malpractice.

Even if ACOs are able to avoid vicarious liability through apparent agency principles, courts may still use an implied authority theory to hold them vicariously liable for independent contractor physicians and providers, as they have done in the MCO context.<sup>219</sup> In the past, courts have held MCOs vicariously liable under “the doctrine of *respondeat superior* for the medical malpractice of an independent physician if the managed care organization had implied authority to exercise sufficient control over the physician to negate an independent contractor status.”<sup>220</sup> Whether such a theory would apply to ACOs depends on what the courts determine to be sufficient control. There can be no doubt, however, that the setting of quality and cost cutting standards with bonus and penalty-based incentives imposes some level of control from the ACO onto the individual ACO physician or provider. Accordingly, the implied authority theory of vicarious liability is a doctrine that may apply to ACOs for the negligence of individual ACO physicians or providers, at least where the ACO uses independent contractor physicians and providers.

The important point to draw from the above discussion is that without ERISA preemption, it is possible, if not likely, that courts will impose some form of liability on ACOs for the negligence of ACO physicians and providers. To that extent, both the ACO physician/provider and the ACO

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216. Solomon et al., *Future Models*, 33-OCT L.A. Law. 34, 35 (2010).

217. 76 Fed. Reg. at 19562.

218. Joshua Tenzer, *Reaching the Final Frontiers in Medicaid Managed Care*, 62 N.Y.U. Ann. Surv. Am. L. 329, 367 (2006) (arguing that the general population has restricted health care choices because MCOs restrict patient provider choice).

219. See Agrawal & Hall, *supra* note 31, at 244 (discussing state law expansions of the common law bases for holding MCOs liable for the negligence of independent providers with whom they contract).

220. *Id.*

have somewhat aligned incentives. Both face liability if the ACO imposes cost cutting that goes too far and impedes the ability of the ACO physician or provider to deliver treatment in a manner that meets the non-cost-conscious standard of care.<sup>221</sup> Certainly, the threat of liability against the ACO somewhat eases the cost containment/liability standard conflict faced by ACO physicians and providers, so that, unlike MCO physicians, they do not feel stuck in the middle between non-cost-conscious liability standards and cost cutting pressures being imposed by an entity that is practically immune from liability.<sup>222</sup> Still, the extent to which ACO physician and provider liability-based incentives and ACO liability-based incentives will be aligned remains an open question until courts determine how they will allocate joint liability between ACOs and ACO physicians and providers.<sup>223</sup>

*C. The Interference of the Cost Containment/Liability Standard Conflict with the Goals of Accountable Care Organizations*

Along with examining the impact of ACOs on the cost containment/liability standard conflict, it is important to consider what impact that tension will have on the ACOs functionality and their goals of cutting costs and achieving high quality care. There are two likely impacts, one on the physician or provider side and one on the entity side. Both impacts are troubling.

On the physician or provider side, the MedPac Report noted that within the ACO framework there exists a “tragedy of the commons” problem in that the individual physician or provider’s incentive to choose a costly, revenue producing surgical procedure tends to override the ACO-group incentive to choose a less costly, lower revenue producing procedure.<sup>224</sup> Under the FFS system, the revenue from the more expensive procedure inures solely to the benefit of the individual physician choosing that procedure.<sup>225</sup> It is reduced only by that physician’s share of the savings that would have been realized in a bonus had he or she chosen the less expensive procedure.<sup>226</sup> The individual incentive to increase revenue outweighs any incentive to save costs for the benefit of the group, so that

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221. See Record, *supra* note 2, at 988-90 (arguing that imposing liability on MCOs “for negligent coverage determinations incentivizes reasonable care in making these determinations and would help reduce tension between the physicians providing care and the insurers challenging their treatment decisions.”).

222. See Fine, *supra* note 5, at 642.

223. Record, *supra* note 2, at 998 (discussing that courts have not addressed the issue of allocating liability between physicians and insurers in the MCO context).

224. MedPac, *supra* note 10, at 51 (providing a practical example of the “tragedy of the commons” problem examining the impact of an interventional cardiologist’s decision to treat angina through use of a stent versus treating it medically).

225. *Id.*

226. *Id.*

there is a small financial incentive to reduce costs through individual actions.<sup>227</sup>

This “tragedy of the commons” problem is likely to be exacerbated by the existence of the cost containment/liability standard conflict. As discussed earlier, the threat of a malpractice liability standard that does not account for costs along with an ethical directive to provide all beneficial care regardless of cost<sup>228</sup> encourages physicians to engage in costly defensive medicine.<sup>229</sup> Defensive medicine together with the “tragedy of the commons” problem and the FFS system will likely push ACO physicians and providers even further towards providing more expensive care instead of meeting the cost cutting and quality standards of the ACO. ACO physicians and providers may make an individual judgment that the risk of liability combined with the individual financial value of providing a more expensive treatment or test outweighs any shared savings or bonuses that that individual physician or provider would realize from adopting a less expensive treatment or test.

Given the “tragedy of the commons” problem, MedPac contended that “the [ACO] financial incentives would have to change joint practice-level decisions to be effective.”<sup>230</sup> MedPac identified those decisions as including “care protocols, equipment purchases, recruitment strategies, and incentive structures offered to physicians (e.g., do not tie physician income to increased revenue generation).”<sup>231</sup> To eliminate the overriding individual financial incentives, MedPac argued that ACOs would need to structure themselves such that individuals “give up some autonomy and make clinical practice and technology acquisition decisions jointly.”<sup>232</sup> However, in making this suggestion MedPac does not appear to have considered the problem of defensive medicine and the non-cost-conscious liability standard of care, or how those two factors interact with the “tragedy of the commons” problem. Those two factors will likely make the “tragedy of the commons” problem worse, as there should be great concern that the group bonus incentives may not be strong enough to overcome the trifecta of defensive medicine, FFS payment individual incentives and the “tragedy of the commons” problem.

Turning to the impact of the cost containment/liability standard conflict

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227. See *id.* at 50 (contending that “individual [ACO] physicians have very little direct financial incentives to restrain volume because they would receive 100 percent of the revenue from increases in their patients’ volume but only [a small share] of the ACO bonus from restraints in their patients’ volume”).

228. Fine, *supra* note 5, at 651, 663.

229. Hall & Schneider, *supra* note 11, at 748.

230. MedPac, *supra* note 10, at 52.

231. *Id.*

232. *Id.*

on the entity side of the equation, there should also be concern about whether the conflict will undermine the ability of the ACO to be effective or to achieve its goals as an entity. If ACOs can be held liable for physician or provider negligence and/or the impacts of the ACO's cost cutting measures, then there should be concern as to whether imposing on ACOs a liability standard that does not consider costs will chill or overly deter ACO cost cutting. In other words, the specter of ACO liability may be so strong as to completely undermine the entire ACO concept and deter even beneficial cost cutting that does not impact care within the standard of care, *i.e.* cost cutting of wasteful care.

Looking at concerns raised in the debate over whether or not MCOs should be subject to malpractice liability, it is possible, within the ACO context, that the specter of tort liability could chill cost cutting innovations or could lead ACOs to abandon cost-control entirely and cease to exist.<sup>233</sup> Even worse, given that ERISA preemption is likely lifted in the ACO context, ACOs might also collapse under the weight of increasing numbers of massive punitive tort awards.<sup>234</sup> Though the imposition of liability would encourage higher-quality care with regard to ACO services, it would also likely increase the cost of care.<sup>235</sup>

The threat of overspending penalties<sup>236</sup> at the ACO entity level should provide somewhat of a counterbalance to the incentive to provide as much care as possible in order to avoid liability costs. However, the optimal level of counterbalancing will not occur unless the overspending penalties are large enough to deter overspending on care and the bonuses are large enough to offset any increased liability costs flowing from cost cutting measures. Otherwise, the ACOs face a zero sum game. Even worse, if injured ACO patients are allowed to sue the ACO governing board, who set the ACO cost cutting and quality standards, the fear of liability may impede the ability of ACOs to form and even get off of the ground.<sup>237</sup> At this point in time, whether or not PPACA and the ACO proposed rule have struck the appropriate balance on the bonus and penalty side of ACOs is an open question, to which the answer will only be apparent once ACOs begin to operate.

The concerns raised in this section are about a balancing game. Liability imposed on either ACOs or their physicians and providers is valuable

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233. Agrawal & Hall, *supra* note 31, at 262.

234. *Id.* at 271.

235. Fine, *supra* note 5, at 692-93 (discussing the costs and benefits of imposing liability on MCOs).

236. 76 Fed. Reg. at 19602-03.

237. *Medical Malpractice*, *supra* note 9, at 1045 (expressing concern that QIO cost and quality standard setting would be impeded by placing those responsible for setting the standards at risk for liability).

insofar as that liability standard does not interfere with cutting wasteful care and discourages cutting costs that result in providing care below the standard of care. However, if the liability standards are overly aggressive and the fear of liability at either the physician and provider level or the ACO entity level outweighs the savings reaped from beneficial cost cutting or ACO penalties for overspending, then liability will undermine ACOs, their purposes, and discourage them from forming or functioning as they should. Policymakers and courts should take care to ensure the proper balance between setting liability standards that properly discourage poor quality care and encouraging cost cutting incentives that properly cut wasteful care.

## VI. CONCLUSION

An ever repeating chain reaction exists within the health care system. Health care spending continuously spirals upwards and insurers and innovative health care delivery programs react by imposing cost cutting measures on physicians. The problem is that the liability standards faced by physicians do not react to increased health care spending in the same way that insurers and health care delivery programs react. Accordingly, the physicians face the cost cutting measures, while also facing a lagging non-cost-conscious medical liability standard.

This tension that physicians face is not new. What is new is how this tension will operate within the new PPACA ACOs. In some ways, within the ACO context, the tension will merely be a reiteration of a similar tension that already exists within the MCO environment. In other ways it will be different. The non-cost-conscious liability standard will be the same within the ACO environment as it has been within the MCO environment. In creating ACOs, the PPACA does nothing to alter the medical liability standard of care. To that extent, ACO physicians and providers' lack of enthusiasm for embracing the cost cutting goals of ACOs will probably be similar to their lack of enthusiasm for embracing the cost cutting goals of MCOs.

The major distinction between the cost containment/liability standard conflict within the ACO context versus the MCO context is that the former entities face a much higher likelihood of shouldering liability for cost cutting decisions that negatively impact physician or provider treatment of ACO patients, while ERISA often provides a federal preemption barrier for MCOs. As a result, ACOs should be much less likely than MCOs to encourage unrestrained cost cutting on physicians and providers. The threat of liability to the ACO entity should work to align the ACO entity's incentive to avoid liability with similar risk avoidance incentives that will exist for the ACO physicians and providers.

Despite the likely close alignment of an ACO's liability-based incentives with similar incentives for ACO physicians and providers, there should be substantial concern as to whether the threat of liability for both ACO physicians and providers and ACOs as entities will undermine efforts to achieve cost cutting associated with wasteful, non-beneficial treatment and diagnostic testing. Courts and policymakers should be concerned that the threat and cost of liability may overwhelm the bonus and penalty-based incentives, which encourage ACOs and their physicians and providers to cut costs while achieving quality standards. Accordingly, as ACOs develop and move forward, Congress, HHS, and the judicial system should be cognizant of the possibility that the positive goals of ACOs may be undermined by the existing medical malpractice system and should carefully balance the goal of cost cutting with the imposition of malpractice liability on both ACOs and ACO physicians and providers.