

Medical Malpractice Liability and Accountability: Potential Legal Ramifications and Solutions for Florida Accountable Care Organizations

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I.	INTRODUCTION	1073
II.	THE ACCOUNTABLE CARE MOVEMENT.....	1076
	A. <i>Background on ACOs</i>	1076
	B. <i>The Accountable Care Movement in Florida</i>	1080
	C. <i>The Relevancy of Making Predictions</i>	1081
III.	MEDICAL MALPRACTICE LIABILITY AND THE ACA: A GENERAL OVERVIEW....	1082
IV.	WHY ACOs ARE PREDICTED TO EXPERIENCE INCREASED MEDICAL MALPRACTICE LIABILITY	1085
	A. <i>Risks Arising from Developing and Transitioning to Accountable Care Models</i>	1086
	B. <i>Risks Arising from Sharing Electronic Medical Records and Other Data</i> ..	1087
	C. <i>Risks Arising from Hospitals' Medical Staff Becoming Members of the ACOs to Which the Hospitals Belong</i>	1089
V.	MEDICAL ETHICS AND THEIR POTENTIAL CLASH WITH ACOs' GOALS	1089
VI.	COMPARING MODERN ACOs TO 1990s-ERA MCOs: WHAT WILL ACO MEDICAL MALPRACTICE LITIGATION LOOK LIKE?	1090
VII.	PREPARING FOR ACO MEDICAL MALPRACTICE LITIGATION IN FLORIDA	1093
	A. <i>Theories of Liability</i>	1093
	B. <i>Patients' Right to Know</i>	1094
	C. <i>License Revocation</i>	1096
	D. <i>Increasingly Stringent Requirements</i>	1096
	E. <i>Managed Care Medical Malpractice Litigation in Florida</i>	1097
VIII.	PERHAPS ACO PROVIDERS DESERVE MORE OF THE BENEFIT OF THE DOUBT ...	1099
IX.	PROPOSED SOLUTIONS	1101
	A. <i>Enacting State ACO Legislation</i>	1101
	B. <i>Establishing Guidelines as Safe Harbors</i>	1102
	C. <i>Creation of Captive Insurance Companies</i>	1104
	D. <i>Detailed Documentation and Open Communication</i>	1104
	E. <i>Enterprise Liability</i>	1105
X.	CONCLUSION	1106

I. INTRODUCTION

Today is an exciting time in the evolution of health care delivery system reform. While delivery of care was once producer-centered, fragmented, and focused on fee-for-service payment systems that incen-

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tivized volume, current trends are shifting toward patient-centered, coordinated care systems that incentivize positive patient health outcomes.¹ Modern systems and policies that incorporate these new goals include, among others, value-based purchasing, episode-based payments, quality and cost transparency, and accountable care organizations (“ACOs”).²

The Centers for Medicare & Medicaid Services (“CMS”) define ACOs as “groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high quality care to the Medicare patients they serve.”³ Such coordinated and high-quality health care delivery “helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors,” so that “[w]hen an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.”⁴ Therefore, ACOs offer a win-win for both providers and patients: When provider networks work together to keep patients healthy, the providers receive financial rewards.⁵

This note focuses on ACOs, arguing that with the new accountability structures of ACOs come potential new litigation-related risks. ACOs aim to hold health care providers accountable by tying incentive payments to improved care and lower costs.⁶ However, with increased coordination of care and the accompanying shared responsibility among providers, medical malpractice liability concerns arise: If an entire ACO holds itself accountable for patient health outcomes, who is to blame for one participating provider’s medical error? How can an ACO protect both itself and its patients? Further, some have argued that as ACOs attempt to lower costs of health care delivery, they are subjecting them-

1. Patrick H. Conway, M.D., Deputy Adm’r for Innovation & Quality and Chief Med. Officer, Ctrs. for Medicare & Medicaid Servs., Address at the University of Miami Business of Health Care Conference: Disruptive Technology, Access and Efficiency (Mar. 23, 2015) [hereinafter Conway Address] (on file with Patrick H. Conway).

2. *Id.*

3. *Accountable Care Organizations (ACOs): General Information*, CMS.gov, <http://innovation.cms.gov/initiatives/ACO/> (last visited Apr. 24, 2015) [hereinafter *Accountable Care Organizations (ACOs)*]. The term “health care provider” or “provider” is used to refer to those authorized by their state to practice a particular field of medicine and who are performing within the scope of their practice as defined by law. See *Who Is Considered a Health Care Provider/Practitioner?*, BERKELEY HR, <http://hrweb.berkeley.edu/faq/1178> (last visited Aug. 15, 2015); see also, e.g., FLA. STAT. § 456.053(3)(i).

4. *Id.*

5. See *id.*

6. See Ctrs. for Medicare & Medicaid Servs., *Summary of Final Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program*, CMS.gov, 1, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Summary_Factsheet_ICN907404.pdf (last updated Apr. 2014).

selves to heightened medical malpractice liability.⁷

Patient protection and improved delivery of care should serve as malpractice avoidance.⁸ Medical malpractice law, however, often encourages physicians to practice costly defensive medicine, where physicians alter their decisionmaking because of the threat of medical malpractice liability.⁹ With no ACO litigation to date, scholars and practitioners can only predict how these two goals of ACOs will affect medical malpractice litigation in the future.

While other written publications examine ACOs and malpractice liability generally,¹⁰ this note discusses medical malpractice liability for ACOs in Florida specifically. This note attempts to predict how a medical malpractice suit involving an ACO will take shape in Florida, taking into account Florida-specific potential liability risks, and discusses ways that Florida ACOs can protect themselves from medical malpractice lawsuits.

Part II of this note begins with a discussion of the accountable care movement and its impact on Florida. Part III discusses medical malpractice liability and the Affordable Care Act generally. Part IV provides an overview of why ACOs are predicted to experience increased liability. Part V examines medical ethics and their potential clash with the goals of ACOs. Part VI explores the likelihood of ACOs' medical malpractice liability by comparing managed care organizations ("MCOs"), which include health maintenance organizations ("HMOs"), to ACOs generally. Part VII predicts outcomes of ACO medical malpractice litigation in Florida by turning to past Florida managed care medical malpractice litigation and by analyzing Florida medical malpractice legislation. Part VIII asserts that ACOs could have a more positive effect on physicians' behavior than some critics have predicted. Finally, Part IX concludes

7. See H. Benjamin Harvey & I. Glenn Cohen, *The Looming Threat of Liability for Accountable Care Organizations and What to Do About It*, 310 J. AM. MED. ASS'N 141 (2013), available at <http://amaproduct.silverchaircdn.com/data/Journals/JAMA/927264/jvp130087.pdf.gif>.

8. The idea here is that improved treatment of patients would theoretically decrease medical mishaps and therefore eliminate reasons to bring medical malpractice claims.

9. See Laura D. Hermer, *Aligning Incentives in Accountable Care Organizations: The Role of Medical Malpractice Reform*, 17 J. HEALTH CARE L. & POL'Y 271, 275 (2014) (arguing that because physicians fear the "threat of suit is omnipresent," they must protect themselves "through the use of costly defensive medicine"); see also Carolyn M. Hettrich et al., *The Costs of Defensive Medicine*, AAOS Now (Dec. 2010), <http://www.aaos.org/news/aaosnow/dec10/advocacy2.asp>.

10. See, e.g., Ezekiel J. Emanuel, *Why Accountable Care Organizations Are Not 1990s Managed Care Redux*, 307 J. AM. MED. ASS'N 2261 (2012); Jessica L. Mantel, *Accountable Care Organizations: Can We Have Our Cake and Eat It Too?*, 42 SETON HALL L. REV. 1393 (2012); Christopher Smith, *Between the Scylla and Charybdis: Physicians and the Clash of Liability Standards and Cost Cutting Goals Within Accountable Care Organizations*, 20 ANN. HEALTH L. 165 (2011).

with proposed solutions to the potential medical malpractice liability concerns facing ACOs in Florida.

II. THE ACCOUNTABLE CARE MOVEMENT

The enactment of the 2010 Patient Protection and Affordable Care Act (“Affordable Care Act” or “ACA”)¹¹ has brought new opportunities for growth and redevelopment across the nation’s health care landscape. One such opportunity for provider group innovation is the formation of ACOs. The ACO movement comes at a time when all physicians face the reality of defensive medicine and the pressures driving the practice of overtreatment.¹² The fee-for-service model, the traditional health care delivery structure, involves individual physicians ordering all services that they deem “medically necessary,” without consideration of the costs of those services rendered.¹³ The ACO model, in contrast, involves the coordinated efforts of many parts.

In the current health care system, “[t]here is the fear that if a test is not ordered or a treatment not offered there could be liability down the line if a patient gets sicker,” and “patients often have expectations that include pressure to test, test, test. There is an expectation that patients will receive a prescription or a treatment for every complaint.”¹⁴ Therefore, the success of ACOs will depend in part on a change in behavior of both physicians and patients alike, and although ACO supporters believe that physicians and patients will be able to make such behavioral changes, ACO critics are quite skeptical.¹⁵ Before discussing the implications of ACOs and the potential risks they present, this Part lays the foundation for a basic understanding of ACO background and structure.

A. Background on ACOs

An ACO is a legal structure that involves imposing accountability on health care providers across the spectrum of medical care for patient

11. Patient Protection & Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care & Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified as amended in scattered sections of 25, 26, and 42 U.S.C.).

12. See Lee J. Johnson & Frank J. Weinstock, *Malpractice Risks Rise with New Pressure on Doctors to Undertreat*, MEDSCAPE (Aug. 4, 2011), <http://www.medscape.com/viewarticle/746785> (“Defensive medicine is a reality to all doctors.”).

13. See Dionne Koller Fine, *Physician Liability and Managed Care: A Philosophical Perspective*, 19 GA. ST. U. L. REV. 641, 644–45 (2003) (“The fee-for-service model did not incorporate the view that doctors needed to or should control health-care costs.”).

14. Johnson & Weinstock, *supra* note 12.

15. See generally Clayton Christensen et al., *Christensen, Flier and Vijayaraghavan: The Coming Failure of ‘Accountable Care’: The Affordable Care Act’s Updated Versions of HMOs Are Based on Flawed Assumptions About Doctor and Patient Behavior*, WALL ST. J. (Feb. 18, 2013), <http://online.wsj.com/news/articles/SB10001424127887324880504578296902005944398>.

populations, both financially and clinically.¹⁶ All ACOs share a common goal: to improve the quality of delivered health care while decreasing overall costs.¹⁷ Thus, “[a]n ideal ACO will focus on keeping patients from entering a hospital *and* cost-effectively treating those that are admitted.”¹⁸ ACOs exist both in the public and private sectors.¹⁹ Public sector participation, specifically, has grown rapidly with the growth in Medicare ACOs.²⁰

ACOs aim to move the health care system away from a fee-for-service model toward a structure that upholds accountability both for patient outcomes and spending.²¹ ACOs are making this transition because of the fragmentation in care and wasteful, duplicative use of resources frequently linked with the practice of defensive medicine that is emblematic of the traditional fee-for-service model.²² ACOs can specifically achieve this goal “by preventing medical errors and eliminating duplication of medical services, including tests, examinations, and other procedures.”²³ Thus, while fragmented fee-for-service systems involve different providers receiving different and disjointed payments, ACOs aim to maintain a patient-focused unified system in which providers and patients work together to best treat patients and manage an ACO’s resources.²⁴

CMS offers several different types of ACO programs, including the

16. See Sandra L. Berkowitz, *Accountable Care Organizations: Operational Risk and Financial Responsibility*, HEALTHTREK, Mar. 2012, at 1, available at http://www.willis.com/documents/publications/industries/healthcare/HealthTrek_March2012_v5.pdf (explaining that providers working in preventive, primary, specialty, emergency, acute, and post-acute care must work together in an ACO); see also Stephen H. Siegel, *The Law of Unintended Consequences: Will ACOs and Clinical Integration Increase Malpractice Liability?*, BROAD & CASSEL, http://www.broadandcassel.com/articles/SHS_Liability.pdf (last visited Feb. 8, 2015) (explaining that the reasons for the transition to ACOs include that the “traditional fee-for-service system for delivering health care items and services . . . is not financially sustainable and frequently not in the best interest of individual patients or patient populations. Increasing the efficiency of the health care delivery system, patient satisfaction and better addressing the health care needs of individual patients and patient populations, while reducing the cost of health care are all cited as reasons for promoting clinical integration and the resulting team approach.”).

17. See Hermer, *supra* note 9, at 286 (“Regardless of the model chosen, participants are responsible for managing and coordinating their patients’ care in an effort to both reduce costs and improve quality.”).

18. David Muhlestein, *Continued Growth of Public and Private Accountable Care Organizations*, HEALTH AFF. BLOG (Feb. 19, 2013), <http://healthaffairs.org/blog/2013/02/19/continued-growth-of-public-and-private-accountable-care-organizations>.

19. See Muhlestein, *supra* note 18.

20. See Conway Address, *supra* note 1.

21. See *Accountable Care Organizations (ACOs)*, *supra* note 3.

22. See *id.*

23. *A New Risk Management Frontier: Accountable Care Organizations*, MARSH 1 (Oct. 2012), <https://usa.marsh.com/Portals/9/Documents/AccountableCareOrganizations.pdf> [hereinafter *A New Risk Management Frontier*].

24. See *Accountable Care Organizations (ACOs)*, *supra* note 3.

Medical Shared Savings Program (“MSSP”), the Advance Payment ACO Model, and the Pioneer ACO Model.²⁵ This note focuses primarily on MSSP ACOs. Section 3022 of the Affordable Care Act largely lays out the format for Medical Shared Savings Program ACOs, outlining the specific eligibility, accountability structure, and quality assessment measure reporting requirements.²⁶ Thus, MSSP ACOs tend to maintain similar structures and payment models while private ACOs, not outlined in the legislation, are able to form payment systems and general structures more flexibly.²⁷

MSSP ACOs are required to “promote evidence-based medicine and beneficiary engagement, internally report on quality and cost metrics, and coordinate care,” and to “[a]dopt a focus on patient centeredness that is promoted by the governing body and integrated into practice by leadership and management working within the [ACO’s] health care teams”²⁸ MSSP ACOs must additionally create, evaluate, and update processes that help to promote evidence-based medicine, patient engagement, and various compliance measures, among others.²⁹

As laid out in Section 3022(b)(2) of the Affordable Care Act, MSSP ACOs “shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to [them].”³⁰ Other MSSP ACO requirements incorporate specific accountability structures, including that each ACO establish a governing body to represent ACO providers, suppliers, and Medicare beneficiaries, and that the ACO create processes to promote evidence-based medicine, promote patient engagement, internally report on qual-

25. See *Accountable Care Organizations (ACO): What’s an ACO?*, CMS.GOV, <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html> (last visited Apr. 25, 2015).

26. Section 3022 of the Affordable Care Act is codified at 42 U.S.C. § 1395jjj (2011). Section 1395 jjj(a) states the purpose of the program. See § 1395jjj(a)(1) (“(A) groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization . . . and (B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings”). Section 1395 jjj(b) dictates that the following entities are eligible to participate in the formation of MSSP ACOs: “(A) ACO professionals in group practice arrangements. (B) Networks of individual practices of ACO professionals. (C) Partnerships or joint venture arrangements between hospitals and ACO professionals. (D) Hospitals employing ACO professionals. (E) Such other groups of providers of services and suppliers as the Secretary of the Department of Health and Human Services deems appropriate.” § 1395jjj(b)(1); see also 42 C.F.R. §§ 425–485.810 (2012) (code provisions for the Medicare Shared Savings Program).

27. See Muhlestein, *supra* note 18.

28. 42 C.F.R. § 425.112(a) (2012).

29. See § 425.112(b).

30. 42 U.S.C. § 1395jjj(b)(2)(A); see also Patient Protection & Affordable Care Act, Pub. L. No. 111-148, § 3022, 124 Stat. 395 (2010).

ity and cost, and coordinate care.³¹

The ACO structure creates the opportunity for providers to receive a bonus for keeping their patients healthy, thereby decreasing the need for costly hospitalization.³² If the Secretary of the Department of Health and Human Services (“HHS”) determines that an ACO has met specific quality assessment measures (“benchmarks”), the Secretary may deem that ACO eligible to receive a percentage of the savings for which it is responsible.³³ CMS is tasked with computing each ACO’s per capita Medicare Parts A and B benchmark expenditures and annually update each ACO’s cost benchmarks.³⁴

There are thirty-three quality measurements that are used to assess whether ACOs have achieved their overall goal of providing top-notch care while lowering costs.³⁵ These measurements fall into four overall categories: patient/caregiver experience, preventive health, at-risk population, and care coordination/patient safety.³⁶ In order to prevent MSSP ACOs from cherry-picking low-risk patients to improve the likelihood of meeting the established quality measures, the Affordable Care Act specifically states, “[i]f the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.”³⁷

MSSP ACOs follow common payment arrangements that are outlined in the Affordable Care Act.³⁸ Some private ACOs have created very similar payment arrangements to those of MSSP ACOs, while others look quite different, using “full or partial capitation models, bun-

31. See § 1395jjj(b)(2).

32. See Johnson & Weinstock, *supra* note 12 (“ACOs wouldn’t completely do away with fee for service. But the idea is that providers would get paid more for keeping their patients healthy and out of the hospital.”).

33. See § 1395jjj(d)(1)(B)(ii) (“The Secretary shall estimate a benchmark for each agreement period for each ACO using 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. Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by 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. Such benchmark shall be reset at the start of each agreement period.”).

34. See 42 C.F.R. § 425.602(a)–(b).

35. See *Quality Measures and Performance Standards*, CMS.GOV, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Quality_Measures_Standards.html (last visited Apr. 25, 2015).

36. See *id.*

37. 42 U.S.C. § 1395jjj(d)(3).

38. See Patient Protection & Affordable Care Act, Pub. L. No. 111-148, § 3023, 124 Stat. 119 (2010) (codified at 42 U.S.C. § 1395cc-4 (2011)); see also Muhlestein, *supra* note 18 (“MSSP ACOs are structurally similar with common payment arrangements . . .”).

dled payments, retainer agreements, in-kind services and subsidies provided by payers, and pay-for-performance incentives.”³⁹ Similar to MSSP ACOs, private ACOs also often require that quality benchmarks be met for providers to receive bonus payments.⁴⁰

Since the Affordable Care Act’s enactment in 2010, ACOs in both the public and private sectors have experienced growth nationwide.⁴¹ The concept of an ACO, however, is not new.⁴² Preexisting models include, but are not limited to, Geisinger Health, Kaiser Permanente, and Community Care of North Carolina.⁴³ Now, various entities, including providers, hospital systems, physician groups, community-based organizations (“consisting of non-profit, non-medical entities that bring together the payers and providers that will contract to form the actual ACO”), and insurers have created ACOs and are helping to lead the ACO movement.⁴⁴

B. *The Accountable Care Movement in Florida*

As of the January 2015, 424 ACOs had been established under the MSSP and Pioneer ACO programs, with 7.8 million assigned beneficiaries.⁴⁵ These statistics include eighty-nine new ACOs covering 1.6 million beneficiaries that were assigned to the MSSP program in 2015.⁴⁶ In Florida alone, there are currently forty-seven Medicare ACOs, with over 465,000 ACO-assigned beneficiaries residing in the state.⁴⁷ Further, over twenty percent of Florida residents that are fee-for-service beneficiaries with Medicare Parts A and B receive their care from ACO providers.⁴⁸

Florida ACOs are heavily involved in changing the landscape of health care reform throughout the state by redesigning their care processes to improve quality and lower costs. Florida ACOs do this by creating alert systems to inform primary care providers when their patients are admitted to local emergency rooms or are discharged from local hospitals, supporting integrative IT (information technology) ser-

39. Muhlestein, *supra* note 18.

40. *Id.*

41. *See id.*

42. *See* Hermer, *supra* note 9, at 286 (“Models for ACOs predate the ACA.”).

43. *See id.*

44. Muhlestein, *supra* note 18.

45. *Better Care, Smarter Spending, Healthier People: Improving Our Health Care Delivery System*, CMS.gov, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26.html> (last updated Jan. 26, 2015); *see also* Conway Address, *supra* note 1.

46. Conway Address, *supra* note 1.

47. *Id.*

48. *Id.*

VICES with physician-friendly templates and dashboards, revamping primary care practices through integrative patient-centered medical home concepts,⁴⁹ using annual wellness visits to identify gaps in the provision of primary care, and improving engagement with specialists and both acute and post-acute facilities.⁵⁰ Further, Florida currently has ten organizations participating in the CMS Health Care Innovation Awards (rounds one and two).⁵¹

Because health care delivery system reform is actively evolving in Florida, and as providers, hospital systems, insurers, and community-based entities contemplate forming and redesigning ACO structures, it becomes crucial to evaluate and predict potential areas of challenge and uncertainty.

C. *The Relevancy of Making Predictions*

ACOs provide fresh opportunities for restructuring the provision and tracking of health care services throughout the United States; therefore, these organizations have become a topic of much discussion and debate among health law policy analysts, legal analysts, and practitioners alike.⁵² While many have worked to predict and advise the health care and legal communities on ACOs' future successes and shortfalls, most agree that it is too early to tell what will and will not work.⁵³ Nevertheless, even without the Affordable Care Act, CMS is authorized to push providers to participate in shared savings plans.⁵⁴ Thus, while

49. See Health Res. & Servs. Admin., *What Is a Medical Home? Why Is It Important?*, HRSA, <http://www.hrsa.gov/healthit/toolbox/Childrenstoolbox/BuildingMedicalHome/whyimportant.html> (last visited Apr. 15, 2015) (stating that, in the narrowest sense, the medical home is where "the center of [one's] medical records" is kept, but that today it also encompasses the "home base for [one's] medical and non-medical care").

50. Conway Address, *supra* note 1.

51. See *Where Innovation Is Happening*, CMS.gov, <http://innovation.cms.gov/initiatives/map/index.html#state=FL&model=> (last visited Apr. 24, 2015). Health Care Innovation Awards are given by CMS to "fund[] grants to applicants who are implementing the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and Children's Health Insurance Program (CHIP), particularly those with the highest health care needs." *Health Care Innovation Awards Round Two*, CMS.gov, <http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Round-2.html> (last visited May 6, 2015).

52. Jenny Gold, *Accountable Care Organizations, Explained*, NPR (Jan. 18, 2011), <http://www.npr.org/2011/04/01/132937232/accountable-care-organizations-explained> ("Accountable care organizations take up only seven pages of the massive new health law yet have become one of the most talked about provisions.").

53. See, e.g., Ian Morrison, *Chasing Unicorns: The Future of ACOs*, HOSP. & HEALTH NETWORKS (Jan. 4, 2011), http://www.hhnmag.com/display/HHN-news-article.dhtml?dcrPath=/templatedata/HF_Common/NewsArticle/data/HHN/Magazine/2011/Jan/010411HHN_Weekly_Morrison (quoting Mark Smith, M.D., M.B.A., and CEO of the California Health Care Foundation) ("The accountable care organization is like a unicorn, a fantastic creature that is vested with mythical powers. But no one has actually seen one.").

54. See *A New Risk Management Frontier*, *supra* note 23, at 2.

accountable care might be a trending topic now, it is likely to become a permanent fixture in the nation's health care system.⁵⁵

One area of uncertainty that has recently received scholarly attention is ACO medical malpractice liability.⁵⁶ More specifically, there exists concern regarding ACOs' risks of direct and vicarious liability, as well as concerns regarding misalignment of individual ACOs' guidelines with the standards of care that courts apply in medical malpractice cases.⁵⁷

III. MEDICAL MALPRACTICE LIABILITY AND THE ACA: A GENERAL OVERVIEW

Medical malpractice liability is a real concern for health care providers, and the Affordable Care Act has done virtually nothing to impact medical malpractice reform.⁵⁸ As Peter Orszag, former director of the White House Office of Management and Budget Reform, stated, "[l]awmakers missed an important opportunity to shield from malpractice liability any doctors who followed evidence-based guidelines in treating their patients" by largely failing to include medical malpractice reform measures in the ACA.⁵⁹

Over-testing contributes largely to the high costs of health care delivery in the United States: "Americans . . . are more than twice as likely as citizens of other economically-advanced countries to have an MRI or CT scan."⁶⁰ In the traditional fee-for-service system, physicians "might prefer to recommend more than optimum diagnosis or treatment, say an X-ray 'just to be sure.' If they were covered by programs or insurance, patients might insist on more. Whether entirely for these reasons or not, costs soared."⁶¹

In 2011, an American College of Emergency Physicians ("ACEP") survey of over 1,700 emergency room doctors revealed that, of those surveyed, fifty-three percent ordered tests out of fear of lawsuits, and forty-four percent believed that the fear of lawsuits "was the biggest

55. *See id.*

56. *See generally* Harvey & Cohen, *supra* note 7, at 141.

57. *See, e.g., id.* at 141 ("Under 'agency theory' in tort law, a plaintiff in a malpractice suit is permitted to hold a health system liable for the negligent actions of its employee, [i.e.], the treating clinician.").

58. *See* Hermer, *supra* note 9, at 272.

59. Peter Orszag, *Malpractice Methodology*, N.Y. TIMES, Oct. 21, 2010, at A39, available at http://www.nytimes.com/2010/10/21/opinion/21orszag.html?_r=0.

60. David Orentlicher, *Cost Containment and the Patient Protection and Affordable Care Act*, 6 FIU L. REV. 67, 70 (2010).

61. DAN B. DOBBS, PAUL T. HAYDEN & ELLEN M. BUBLIK, DOBBS' LAW OF TORTS § 318 (2d ed. 2014).

hindrance to cutting emergency department costs.”⁶² Because doctors protect themselves from medical malpractice liability by over-testing, they are potentially wasting resources, but correcting this issue can be difficult because “eliminating care of uncertain or insufficient clinical value inevitably involves denying some patients potentially beneficial care.”⁶³

When evaluating the merit of a medical malpractice claim, judges and juries look to the standard of care relevant to the circumstances surrounding that claim: the accepted practice standards of doctors practicing that particular specialty.⁶⁴ A patient’s ability to pay is irrelevant for this inquiry.⁶⁵ Because the standard of care changes over time and depends on the circumstances, it has been aptly dubbed “a moving target.”⁶⁶ During medical malpractice litigation, medical experts testify to the standard of care that the defendant physicians should have used during the provision of a patient’s care.⁶⁷

When providers take cost-effectiveness into account during the treatment or diagnosis of a patient, peculiar issues can arise regarding the appropriate standard of care. As described in an article relating to rationing medical resources, when “private medical practitioners seek to engage in cost containment rationing on their own, they risk running afoul of either the customary or accepted practice rule.”⁶⁸ Because of the

62. *Emergency Room Doctors Say They Order Tests Out of Fear, New Survey Shows*, HUFFPOST HEALTHY LIVING (July 25, 2011), http://www.huffingtonpost.com/2011/05/25/emergency-room-doctors-tests-fear_n_867037.html.

63. Mantel, *supra* note 10, at 1425.

64. See Johnson & Weinstock, *supra* note 12 (“If you undertake to treat someone, you must act with the same level of diligence as other physicians in similar situations. If you don’t, you’ll breach your duty to your patient and may be held liable for any injury resulting from your dereliction.”).

65. See *id.*

66. *Id.* (discussing circumstances under which standards of care evolve over time, “[f]or example, with the HIV epidemic, the testing of blood became the standard of care. Today we have much more technology and a much greater availability of clinical information, which have raised the standard of care to new levels of testing and treatment.”); see also Smith, *supra* note 10, at 172 (“Too often, the applicable standard of care may be somewhat of a mystery at the time of diagnosis or treatment.”).

67. See James F. Blumstein, *Medical Malpractice Standard-Setting: Developing Malpractice “Safe Harbors” as a New Role for QIOs?*, 59 VAND. L. REV. 1017, 1023–24 (2006) [hereinafter Blumstein, *Medical Malpractice Standard-Setting*] (“The assumption—consistent with the scientific model—is that the profession (from its expertise) knows what works and that it has adopted and applied a scientifically-derived standard of practice. That is, a core assumption of conventional medical malpractice doctrine is that, as a scientific matter, a standard of practice exists and that, as an empirical matter, practitioners conform their conduct to that standard. . . . The customary practice standard must be established by appropriate expert medical testimony.”).

68. James F. Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 TEX. L. REV. 1345, 1397 (1981) [hereinafter Blumstein, *Rationing Medical Resources*].

variable nature of standards of care, which are “somewhat unpredictable and only available post hoc, in the course of litigation,” this uncertainty might cause “ACO physicians and providers [to] 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.”⁶⁹ Therefore, tension exists between the goals of ACOs and the basic concept of the medical malpractice litigation system, which turns to a standard of care that ignores the concept of economic effectiveness during treatment.⁷⁰

The entire scenario outlined above welcomes malpractice litigation because of the potential misalignment between the standards found within an ACO’s guidelines and that which is established by a medical expert during the course of litigation. Regarding ACOs’ impact on standards of care, some have opined that “if there are financial incentives or studies showing the limitations or harmfulness of some tests and treatments, it’s possible that the standard may change,” citing as an example certain oncology screening techniques that have been shown not to reduce mortality rates and to involve side effects that may cause more harm than good.⁷¹

This analysis, of course, hinges on whether physicians and patients will actually change their behavior so that ACOs can succeed. Not all policy experts believe they will.⁷² Regarding doctors changing their behavior, such critics point to the fact that “the behavior of doctors today has been shaped by decades of complicated interdependencies with other medical practices, hospitals and insurance plans”; thus, “[s]uch a profound behavior shift would likely require re-education and training, and even then the result would be uncertain.”⁷³ The skeptics maintain that ACOs lack the infrastructure to provide the reeducation and training needed to alter physicians’ behavior to the degree required by ACOs’ operational goals.⁷⁴ Critics also have doubts about the ability

69. Smith, *supra* note 10, at 195–96.

70. See Blumstein, *Medical Malpractice Standard-Setting*, *supra* note 67, at 1024–26.

71. See Johnson & Weinstock, *supra* note 12.

72. See, e.g., Christensen et al., *supra* note 15.

73. *Id.* (providing examples of such drastic measures needed for re-education and training, including that doctors will “need to employ evidence-based protocols more often to determine optimal treatment” and that they will “have to find ways to move some care to lower-cost sites of service, such as more surgery in ambulatory clinics instead of a hospital”); see also Orszag, *supra* note 59 (“One estimate suggests that it takes 17 years on average to incorporate new research findings into widespread [medical] practice.”).

74. See Christensen et al., *supra* note 15 (noting first that managed care in the 1990s, taking the form of HMOs, “left consumers with a bad taste because the HMOs acted as visible gatekeepers to patient care,” and although ACOs have tried to avoid similar negative backlash by enabling Medicare beneficiaries to choose where they receive their care, “there is no preferential pricing, discounting or other way for ACOs to steer patients to the most effective providers”).

of patients to quickly and seamlessly change their behavior because, “[i]n reality, quality-of-care improvements are possible only with increased patient engagement.”⁷⁵ Potentially making matters worse, ACOs are held accountable for patients’ outcomes regardless of the patients’ engagement.⁷⁶ Because the medical profession itself sets the standards of care, only time will tell what the impact of accountable care will be on ever-changing standards.

IV. WHY ACOs ARE PREDICTED TO EXPERIENCE INCREASED MEDICAL MALPRACTICE LIABILITY

Eventually, as ACOs continue to grow and take shape, litigation will become inevitable. Until then, analysts can only predict the type and degree of litigation that ACOs will face.⁷⁷ With the current knowledge of ACO policy, and by comparing ACOs to MCOs, analysts have been able to point to specific risks that ACOs are likely to encounter as they continue to form and expand.⁷⁸

Analysts have recognized that “[w]ith increase in accountability comes the potential for participants in the ACO to be liable if the care provided by one of the other participants is alleged to be substandard,” and that increased liability itself “can come about in a variety of ways.”⁷⁹ Some have asserted that “[d]octors are stuck between a rock and a hard place” when determining how to screen and treat patients; while ACOs may pressure doctors to avoid ordering particular tests and performing specific procedures, “[t]he doctor can be sued for malpractice for failure to diagnose or treat properly.”⁸⁰ Most significantly, “[d]octors are held to the standard of care of the reasonable physician in his specialty at the time of the treatment regardless of financial demand by . . . ACOs.”⁸¹

Note, however, that there are multiple risks of undertreatment associated with ACOs, not all of which are related to cost.⁸² Some ACO providers might undertreat a patient after poorly conducting a patient examination or based on a desire to avoid treatment risks, and some

75. *Id.*

76. *See id.* (raising the following question: “ACOs hold caregivers accountable without requiring patient accountability. How can this work?”).

77. *See generally* Harvey & Cohen, *supra* note 7.

78. *See generally id.*

79. Mark L. Mattioli, *The Year of the ACO and Trends for the Future*, LAW360 (Jan. 18, 2013), <http://www.law360.com/articles/404226/the-year-of-the-aco-and-trends-for-the-future>.

80. Johnson & Weinstock, *supra* note 12.

81. *Id.*

82. *See id.* (providing multiple hypothetical scenarios that could exist in which ACO providers might choose to undertreat a patient).

patients themselves may prefer not to purchase expensive medications.⁸³

This Part focuses specifically on medical malpractice liability risks facing ACOs. Such risks that could increase medical malpractice liability for ACOs include, but are not limited to, errors in the development of and transition to new accountable care models and errors arising from sharing electronic medical records and other data.⁸⁴

Although this Part focuses on the potential medical malpractice liability risks linked to ACO operations and organization, it is important to recognize the need for continued discussion and analysis regarding how ACOs will actually manage medical malpractice litigation realities. For example, in the context of damage payments, if a court finds an ACO-member physician liable for medical malpractice and the ACO must pay a specific amount in damages, “[a]lthough the ACO will pay the insurance deductible as a whole, should the physician or physician’s group be held internally responsible to pay the deductible?”⁸⁵

A. *Risks Arising from Developing and Transitioning to Accountable Care Models*

As ACOs reorganize their personnel, care allocations, and other resources, and as they create new best practices, the possibility exists that patients will experience errors in the care they receive.⁸⁶ While these reorganization processes are necessary for ACOs to determine what will work best to meet the long-term goal of improving patients’ health while decreasing costs, the aforementioned risks are most prevalent in the short term, as the reorganization occurs.⁸⁷ Thus, there exists a pressing need to address malpractice liability concerns in the short term, even before the full ramifications of those risks are understood.

In establishing best practices, ACOs must create clinical guidelines, presumably using evidence-based medicine.⁸⁸ Inherent in the guidelines selection process is the risk that a medical malpractice plaintiff will assert the guideline is inappropriate in a certain setting or that using the guideline in a certain situation was improper.⁸⁹ For example, if deviating from that guideline would have been the wiser choice in a rare circum-

83. *See id.*

84. *See A New Risk Management Frontier*, *supra* note 23, at 4.

85. Edward Vishnevetsky, *Look Before You Leap: Legal and Practical Obstacles with ACOs*, MUNSCH HARDT KOPF & HARR PC 1, 19 (Nov. 16, 2012), http://www.accountablecareexpo.com/files/LasVegas2012/Presentations/ACOs-_Edward_Vishnevetsky.pdf.

86. *See A New Risk Management Frontier*, *supra* note 23, at 4; *see also* Siegel, *supra* note 16.

87. *See A New Risk Management Frontier*, *supra* note 23, at 4 (“No matter the precise structure of the ACO or network that they are joining or forming, it will be critical for participating firms to carefully manage the risks associated with this transition.”).

88. *See* Mattioli, *supra* note 79.

89. *See id.*

stance, a plaintiff could argue that sticking to the guideline constituted medical malpractice.⁹⁰ Because of the risks of error that exist as providers transition to new accountable care structures, providers will need to pay careful attention to this decisionmaking process. Moreover, because of the post hoc nature of malpractice liability standards, even the most stringent ACO guidelines could easily misalign with the standard of care established by a medical expert in court.⁹¹

B. *Risks Arising from Sharing Electronic Medical Records and Other Data*

One of the most important ways that ACOs can improve patient outcomes while decreasing duplicative screening and treatment processes is through stronger communication across the medical network as a whole.⁹² More specifically, by sharing electronic medical records, everyone working in the network, and even providers outside of the network, can easily access the same data regarding each patient. However, with this convenience come risks.⁹³ Aside from the risk of data breaches, errors in reporting on an Electronic Health Record (“EHR”) by one doctor can influence the decisions and treatment options by other doctors.⁹⁴

Malpractice liability risks arise in multiple aspects surrounding the use of EHRs.⁹⁵ These risks include the loss of important information within the vast sea of running notes in a patient’s file and the temptation to simply cut and paste, thereby omitting potentially important pieces of information and creating errors-by-omission in a patient’s file.⁹⁶ EHRs also contain metadata (encompassing timestamps and information regarding who has logged into the system) that provides extremely detailed accounts of a patient’s care, potentially triggering “greater . . .

90. *See id.* (“If this happens, ACO participants who assisted in selection of a particular guideline and in development of policies regarding the use of the guideline could be drawn into a medical-negligence lawsuit, especially in states that recognize a corporate negligence theory.”).

91. *See Smith, supra* note 10, at 194 (“The standard of care, unlike the sixty-five quality standards identified within the proposed [CMS] rule, is variable, somewhat unpredictable and only identifiable post hoc, in the course of litigation.”)

92. *See A New Risk Management Frontier, supra* note 23, at 4.

93. *See id.*

94. *See* Stephen E. Ronai, *The Patient Protection and Affordable Care Act’s Accountable Care Organization Program: New Healthcare Disputes and the Increased Need for ADR Services*, 66 DISP. RESOL. J. 60, 67 (2011) (“The use of EHRs . . . will create an additional category of risk that ACOs will default by failing to comply with the EHR requirements, or by providing inaccurate or incomplete data.”).

95. *See* Christopher E. DiGiacinto et al., *Potential Liability Risks and Solutions for Accountable Care Organizations*, AHRMNY RISK MGMT. Q.J., Summer 2013, at 1, 4, available at <http://www.kbrlaw.com/Irubin2.pdf>.

96. *See id.*

liability for providers with respect to fine-grained details of day-to-day patient care.”⁹⁷ Moreover, the “failure to respond to or act in accordance with a piece of data buried in a patient’s chart” is a significant risk for medical professionals that could result in medical malpractice litigation.⁹⁸ Finally, potential breaches and errors in electronic recordkeeping could also lead to increased risk of medical malpractice litigation, on top of the government-imposed fines and other sanctions that existed prior to the creation of ACOs.⁹⁹

In addition to risks involving the operation of electronic medical record sharing and utilization, liability could arise under an agency theory, potentially making one ACO provider liable for another provider’s acts.¹⁰⁰ While the applicability of the agency theory is not limited to electronic health record data sharing, the theory is particularly relevant to this realm because data sharing is a major way in which ACOs coordinate care.¹⁰¹ As one analyst expressed in discussing potential issues surrounding ACOs, “[because] the hallmark of an ACO is increased coordination, situations will arise where a patient will argue that another provider should have more closely monitored the care that was being provided [by another provider],” and “the increased use of electronic health records may further exacerbate this risk as clinical information provided by other physicians will be available to all providers within the ACO.”¹⁰² Moreover, while agency theory enables patients to sue health systems directly, exposing those systems to malpractice-related institutional liability, ACO liability allows for one “key difference” from the existing institutional liability: the opportunity for patients to claim medical malpractice under the theory that an ACO’s policy led it to “prioritize[] cost savings over patient safety.”¹⁰³

97. *See id.* at 4.

98. *Id.*

99. *See A New Risk Management Frontier*, *supra* note 23, at 4 (“Even before the push toward accountable care, health care organizations that had been victimized by data breaches were well aware of the costs related to a data breach, including those related to patient notification, potential government fines imposed under the Health Information Technology for Economic and Clinical Health Act (HITECH) and the Health Insurance Portability and Accountability Act (HIPAA), and litigation.”).

100. *See* Mattioli, *supra* note 79.

101. *See id.*

102. *See id.*

103. *See* Harvey & Cohen, *supra* note 7, at 141 (“Allegations of institutional malfeasance related to cost-saving efforts could increase liability costs and create a chilling effect on ACOs.”). *See, e.g.*, *Roessler v. Novak*, 858 So. 2d 1158, 1162 (Fla. Dist. Ct. App. 2003) (“[U]nder certain circumstances . . . a hospital may be held vicariously liable for the acts of physicians, even if they are independent contractors, if these physicians act with the apparent authority of the hospital.”).

C. *Risks Arising from Hospitals' Medical Staff Becoming Members of the ACOs to Which the Hospitals Belong*

When hospitals join ACOs, medical malpractice liability risks can increase due to the hospitals' heightened exposure, a byproduct of ACOs' heightened coordination.¹⁰⁴ A hospital's medical staff, however, are mostly independent contractors, and thus are not considered hospital employees.¹⁰⁵ As hospitals join ACOs, those hospitals' medical staff may also decide to join the ACOs as a way to increase their income. Additionally, ACOs have an incentive to employ members of the medical staff because the "employment relationship can assist the ACO in exercising control over [the medical staff's] performance."¹⁰⁶

As cautioned by one commentator in his 2011 article addressing the need for alternate dispute resolution services for ACOs, "ACOs should be aware that if they enter into an employment relationship with [medical staff] participants, their participants would be serving two masters—the ACO and the hospital—simultaneously."¹⁰⁷ *Respondeat superior*, the legal doctrine that holds an employer or principal liable for the wrongful acts of an employee acting within the scope of its employment, heightens the risk to ACOs that employ medical staff members from hospitals participating in that ACO.¹⁰⁸ "[R]espondeat superior . . . render[s] a healthcare employer accountable in damages to patients for negligent care or failure to provide care." Thus,

[W]hen [medical staff] participants become ACO employees, there could be dramatic malpractice liability consequences for the ACO . . . if one of these physicians is found to have committed malpractice in the course of treating the ACO patient. . . . [T]he creation of an employment relationship would open the door for physician employees to institute employment-related lawsuits against the employing ACO."¹⁰⁹

V. MEDICAL ETHICS AND THEIR POTENTIAL CLASH WITH ACOs' GOALS

Physicians have a long tradition of emphasizing clinical autonomy,

104. See *A New Risk Management Frontier*, *supra* note 23, at 4.

105. See Ronai, *supra* note 94, at 65; see also James F. Blumstein, *Of Doctors and Hospitals: Setting the Analytical Framework for Managing and Regulating the Relationship*, 4 *IND. HEALTH L. REV.* 211, 217 (2007) [hereinafter Blumstein, *Setting the Analytical Framework*] ("In the hospital setting, the organizational structure of the hospital, particularly the separate medical staff, supports and insulates professional autonomy of physicians who practice at a hospital.")

106. See Ronai, *supra* note 94, at 65.

107. *Id.*

108. See *id.*

109. *Id.*

which theoretically runs counter-culture to ACOs that stress the use of a collective effort by all participating providers.¹¹⁰ Moreover, “[b]ecause cost containment is counter-cultural for physicians, and because the hospital governance structure compels reliance on coax-and-cajole techniques rather than command-and-control techniques of management, achieving hospitals’ institutional cost containment objectives is even more of a challenge than achieving a hospital’s quality of care objectives.”¹¹¹ Thus, there is a potential clash between a physician’s duty of care and a physician’s efforts to contain costs: “Although the courts never say so directly, [the] duty of care embodied in malpractice doctrine seems to obligate physicians to make their medical decisions without regard to the cost (or cost-effectiveness) of the treatments or tests they are prescribing” and “[p]lans for cost containment thus risk direct collision with the tort system.”¹¹² Further, “[p]hysicians give undue credence to the notion that the threat of suit is omnipresent, and physicians claim this threat must be met through the use of costly defensive medicine.”¹¹³ Therefore, “[i]n many respects, the malpractice deck is stacked against inducing health care providers to favor a more integrated, systems-based approach to patient care.”¹¹⁴

Bioethicist Ezekiel Emanuel and health economist Victor Fuchs described the perceived clash between cost-containment goals and medical ethics in the following way:

Medical school education and postgraduate training emphasize thoroughness. When evaluating a patient, students, interns, and residents are trained to identify and praised for and graded on enumerating all possible diagnoses and tests that would confirm or exclude them. The thought is that the more thorough the evaluation, the more intelligent the student or house officer. Trainees who ignore the improbable “zebra” diagnoses are not deemed insightful. In medical training, meticulousness, not effectiveness, is rewarded.¹¹⁵

VI. COMPARING MODERN ACOs TO 1990s-ERA MCOs: WHAT WILL ACO MEDICAL MALPRACTICE LITIGATION LOOK LIKE?

The Affordable Care Act does not address medical malpractice liability standards for ACOs.¹¹⁶ Thus, it does very little to impact any type

110. See Hermer, *supra* note 9, at 290–91.

111. Blumstein, *Setting the Analytical Framework*, *supra* note 105, at 228.

112. Jonathan J. Frankel, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1315, 1302 (1994).

113. Hermer, *supra* note 9, at 275.

114. *Id.* at 278–79.

115. Ezekiel J. Emanuel & Victor R. Fuchs, *The Perfect Storm of Overutilization*, 299 J. AM. MED. ASS’N 2789, 2789–90 (2011).

116. See generally Patient Protection & Affordable Care Act, Pub. L. No. 111-148, 124 Stat.

of medical malpractice law reform.¹¹⁷ For this reason, and because there is no ACO-related medical malpractice litigation to analyze, many scholars have turned to MCOs for comparison.¹¹⁸

MCOs were the main cost-containment health care structure in the 1990s.¹¹⁹ As such, they “were subject to a wave of member lawsuits that alleged negligent medical decisions . . . supported by a common assertion that MCOs negligently prioritized their financial success” over patient health outcomes.¹²⁰ Moreover, patients’ experiences with MCOs in the 1990s supported a perception that MCOs consistently refused “requests for many diagnostic tests and treatments; . . . requests for seeing physicians outside the network; and . . . requests for experimental treatments.”¹²¹ The need for MCO physicians to “ration” the care they provided to MCO patients subjected those physicians to MCO-specific malpractice liability risks.¹²² Increasing those risks was the fact that “the standard of care not only rejects the notion of rationing or cost-control as a defense,” but also that a physician has a “duty to *resist* being tainted by the pressures of managed health care and cost containment.”¹²³

Put simply, like accountable care, “[m]anaged care operates by interposing a third force between doctor and patient, a kind of economically efficient medical conscience that says no to some diagnoses or treatments.”¹²⁴ The main problem with the concept of standards of care

119 (2010), *amended by* Health Care & Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified as amended in scattered sections of 25, 26, and 42 U.S.C.); *see also* Serene K. Zeni, *The Business of Medicine for the Independent Practitioner Under the Affordable Care Act*, 33 MICH. BUS. L.J., Summer 2013, at 48 (calling attention to new issues facing health care entities post-enactment of the Affordable Care Act, including that “the ACA does not address medical malpractice liability leaving physicians with the burden of dealing with liability and its associated cost”); *see also* Smith, *supra* note 10, at 192 (“The [Affordable Care Act] fails to specifically address the malpractice liability standard for ACO physicians and providers.”).

117. *See* Hermer, *supra* note 9, at 272 (“Traditional tort reform simply found no place in the ACA.”).

118. *See* Harvey & Cohen, *supra* note 7, at 141; *see also* Ronai, *supra* note 94, at 68 (“Although this article has asserted that a wide variety of ACO disputes will arise out of the ACO provisions in Section 3022, these disputes have not yet materialized. . . . To prepare for these disputes, ACOs should consider including an arbitration clause in all employment agreements ACOs have with [medical staff], physician groups and individual physicians and in joint venture agreements with hospitals.”).

119. *See* Harvey & Cohen, *supra* note 7, at 141.

120. *Id.*

121. Emanuel, *supra* note 10, at 2261.

122. *See* Fine, *supra* note 13, at 642 (“MCOs now impose on physicians a significant amount of direct and indirect control over the way they practice medicine. This control often forces physicians to ration care. . . . Such rationing subjects the physician to malpractice liability risks.”).

123. *Id.* at 642, 657 (“Notably, physicians cannot assert as a defense to a malpractice action that they were under pressure from a managed care organization to delay or limit care.”).

124. DOBBS, HAYDEN & BUBLIK, *supra* note 61, § 318.

ignoring cost altogether “is that it falsely assumes that society has unlimited resources to devote to healthcare.”¹²⁵

In 2004, MCOs experienced some relief from the onslaught of medical malpractice lawsuits when the Supreme Court held that state law tort claims were preempted by the federal Employee Retirement Income Security Act (“ERISA”).¹²⁶ A recent article from the *Journal of the American Medical Association* emphasizes that ACOs face similar medical malpractice risks as did MCOs, but that they lack the crucial federally protected immunity that ERISA provided to MCOs.¹²⁷ If ACOs remain unprotected, ACO medical malpractice liability cases could be heard in state courts, and those courts might look to MCO liability case law while making ACO-related liability decisions.¹²⁸ There is potential, though, for a court to harshly scrutinize ACOs’ cost-containment efforts if, unlike MCOs, ACOs continue to lack federal liability protections.¹²⁹

While the “health care marketplace is embracing accountable care [and health care systems] are running as fast as they can to integrate with their physicians to figure out mutually beneficial ways to get higher performance,”¹³⁰ many are unconvinced that these attempts to make ACOs function will actually lead to long-term success in patient outcomes.¹³¹ For instance, one author has summarized surveys finding that

The people most capable of managing the care of populations are the people least trusted to do it. . . . [M]anaged care organizations are the least trusted, are the most deserving of more regulations, and are perceived by physicians to have done more to harm quality than almost any stakeholder; with the exception of malpractice lawyers and the

125. Smith, *supra* note 10, at 171.

126. See Harvey & Cohen, *supra* note 7, at 141 (citing *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004)) (“ERISA protection reduced direct and indirect liability costs for MCOs by preventing constant second-guessing of the motivations behind their medical coverage decisions.”). See generally Employee Retirement Income Security Act, 29 U.S.C. § 1003(a) (2006) (outlining ERISA’s coverage provisions).

127. See Harvey & Cohen, *supra* note 7, at 141 (“ACOs will be walking this same precarious line between cost savings and patient care. Unlike MCOs, however, ACOs will generally not have the benefit of ERISA, which does not cover them; nor are they slated to get comparable federal liability protections.”).

128. See *id.* (“Based on MCO liability case law, state courts may hold ACOs liable in this situation.”). Note, ERISA applies to employer-sponsored health plans, including MCOs.

129. See *id.* (“For example, if a poor outcome occurs in a patient with congestive heart failure (CHF), a plaintiff could challenge an ACO’s more stringent CHF hospital admissions criteria, asserting a prioritization of cost savings over patient care. In the absence of a federal law that could offer protection, this medical liability claim would be judged by state-based standards, which do not consider federal cost containment goals when determining whether a medical decision was appropriate.”).

130. Morrison, *supra* note 53.

131. See *id.*

government.¹³²

MCO malpractice liability can come in various forms.¹³³ These forms of malpractice generally include direct liability for MCO's negligent selection or retention of certain doctors, liability caused by the heightened risks created by cost-containment devices, warranty (based on the idea that MCOs provide an implied warranty for the quality of services provided), informed consent or duty to provide information to patients, and enterprise liability (that "MCOs should bear the exclusive responsibility for negligence of physicians treating their subscribers").¹³⁴

VII. PREPARING FOR ACO MEDICAL MALPRACTICE LITIGATION IN FLORIDA

Florida is one of the nation's leaders in ACO development and expansion.¹³⁵ Thus, the potential ACO litigation that can occur in Florida courts is both relevant and significant to the development of ACO-related laws throughout the country.¹³⁶ With the high number of ACOs in Florida, the state will likely face ACO medical malpractice litigation in the near future. Moreover, because Florida is already trailblazing the ACO movement, the state has the opportunity to set up protective measures to avoid and better manage what could be an onslaught of medical malpractice lawsuits. Therefore, analysis of Florida's relevant statutes and constitutional provisions will help analysts, policymakers, and lawyers determine how to best protect and prepare ACOs for future litigation in that particular state. Further, because there is currently no ACO medical malpractice case law, and because the Affordable Care Act is silent on the issue of medical malpractice liability, state courts will likely use MCO litigation as precedent, or at least as guidance, in deciding ACO medical malpractice cases.¹³⁷

A. *Theories of Liability*

Florida courts treat vicarious liability in an employer-employee relationship essentially the same as vicarious liability in a principal-

132. *Id.*; see also Emanuel, *supra* note 10, at 2261 ("[T]he approach and opaque rules [of MCOs] undermined public trust. Physician and patient dissatisfaction fed off each other, leading to managed care backlash.").

133. *See* DOBBS, HAYDEN & BUBLIK, *supra* note 61, § 318.

134. *Id.*

135. *See* Conway Address, *supra* note 1 (discussing innovation in Florida, including that forty-seven Medicare ACOs serve beneficiaries in Florida).

136. *See* Ctrs. for Medicare & Medicaid Servs., *Fast Facts—All Medicare Shared Savings Program ACOs*, CMS.GOV (Apr. 2015), <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/PioneersMSSPCCombinedFastFacts.pdf>.

137. *See supra* note 116 and accompanying text.

agent relationship.¹³⁸ In holding employers and principals liable for their employees' and agents' tortious acts under respondeat superior, "[Florida] courts reason that a wrongful act of an employee or agent committed in the course of employment [or the principal-agent relationship] resulting in injury to another is binding on the [principal or] employer as his own act thereby constructively placing the employer [or principal] at the scene of the tortious conduct."¹³⁹ Florida courts may also hold hospitals vicariously liable for acts of medical malpractice committed by their employees¹⁴⁰ and by their actual or apparent agents.¹⁴¹

Florida has adopted the corporate negligence doctrine regarding the duty that health care facilities owe their patients "to assure comprehensive risk management and the competence of their medical staff and personnel through careful selection and review, and [health care facilities] are liable for a failure to exercise due care in fulfilling these duties," as outlined in Florida Statute § 766.110.¹⁴² These duties include, among others, adopting written procedures for selecting staff members and for periodic review of the care and treatment rendered,¹⁴³ adopting a comprehensive risk management program,¹⁴⁴ and initiating and diligently administering all processes. Although Florida courts have not authorized enterprise liability as a theory of recovery to date, the possibility of doing so has not been ruled out.¹⁴⁵

B. Patients' Right to Know

There are several aspects of Florida law, aside from MCO-related case law and liability-related statutes, which could affect Florida ACOs' position in medical malpractice litigation.¹⁴⁶ In particular, two provisions in Florida's Constitution could greatly affect ACO medical mal-

138. See THOMAS D. SAWAYA, PERSONAL INJURY & WRONGFUL DEATH ACTIONS, 6 FLA. PRAC. § 15:15 (2014).

139. *Id.* (citing *Columbia by the Sea, Inc. v. Petty*, 157 So. 2d 190 (Fla. Dist. Ct. App. 1963); *Winn-Dixie Stores, Inc. v. Manning*, 143 So. 2d 339 (Fla. Dist. Ct. App. 1962)).

140. See *Wilson v. Lee Mem'l Hosp.*, 65 So. 2d 40 (Fla. 1953).

141. See *Cuker v. Hillsborough Cnty. Hosp. Auth.*, 605 So. 2d 998 (Fla. Dist. Ct. App. 1992).

142. FLA. STAT. § 766.110 (2014).

143. See § 766.110(1).

144. See § 395.0197. The referenced statute concerns relevant factors, such as hospital size, location, physical configuration, and scope of services.

145. See SAWAYA, *supra* note 138, § 7:4 (discussing theories of liability when multiple tortfeasors are involved and it is impossible for the plaintiff to identify which defendant actually caused the plaintiff's injury: "While the market-share alternate theory is the only one to be adopted by the Florida courts to date, application of that theory is restricted to negligence cases which do not involve breach of warranty or strict liability. . . . [Alternative liability, market share liability, and enterprise liability] remain potentially viable theories of recovery in those cases where the market-share alternate theory does not apply and one or more may be adopted by the Florida Supreme Court in the future."). For a discussion of enterprise liability, see *infra* Part IX.E.

146. See, e.g., FLA. CONST. art. X, §§ 25–26.

practice liability.¹⁴⁷ First, Amendment 7, codified in Section 25 of Article X and commonly referred to as the “patients’ right to know about adverse medical incidents,” could raise the threat of medical malpractice litigation for Florida ACOs as compared to ACOs in other states that lack such laws.¹⁴⁸ Section 25 provides that “patients have a right to have access to any records made or received in the course of business by a health care facility or provider relating to any adverse medical incident,”¹⁴⁹ defining “adverse medical incident” as “medical negligence, intentional misconduct, and any other act, neglect, or default of a health care facility or health care provider that caused or could have caused injury to or death of a patient.”¹⁵⁰ Such incidents include, but are not limited to, “those incidents that are required by state or federal law to be reported to any governmental agency or body, and incidents that are reported to or reviewed by any health care facility peer review, risk management, quality assurance, credentials, or similar committee, or any representative of any such committees.”¹⁵¹

Under this constitutional provision, patients in Florida have broad access to records, which could fuel medical malpractice claims in greater numbers than in states that lack laws supporting such a transparent flow of information from health care providers to patients.¹⁵² There are a number of areas in which Florida ACOs could face tension as a result of this law. For example, a Florida ACO must balance its need to engage in detailed recordkeeping for seamless information sharing across the ACO’s network of providers with the mandated transparency of such records detailed in Section 25. Therefore, Florida ACOs must decide how to maintain thorough records while protecting themselves from the harmful effects any use of those records could have against them in a medical malpractice lawsuit.

147. *See id.*

148. *See id.* § 25. Amendment 7 was approved by ballot on November 2, 2004. Since then, the Florida Supreme Court has upheld the ruling numerous times. *See, e.g.,* W. Fla. Reg’l Med. Ctr., Inc. v. See, 79 So. 3d 1 (Fla. 2012); Fla. Hosp. Waterman, Inc. v. Buster, 984 So. 2d 478 (Fla. 2008).

149. FLA. CONST. art. X, § 25(a).

150. *Id.* § 25(c)(3).

151. *Id.*

152. *See generally* Mary Coombs, *How Not to Do Medical Malpractice Reform: A Florida Case Study*, 18 HEALTH MATRIX 373 (2008) (discussing the effects of medical malpractice reform in Florida); *see also* Michael Arnold, *Peer Review Is Threatened, but (P)so What: Patient Safety Organization Utilization in Florida After Amendment 7 as a Troubling Sign for PSQIA*, 46 COLUM. J.L. & SOC. PROBS. 291, 312–18 (discussing health care providers’ four viable options for dealing with Amendment 7). Note that the Patient Safety and Quality Improvement Act of 2005 (“PSQIA”) establishes a “voluntary reporting system designed to enhance the data available to assess and resolve patient safety and health care quality issues.” *Health Information Privacy*, U.S. DEPT. HEALTH & HUM. SERV., <http://www.hhs.gov/ocr/privacy/psa/regulation/> (last visited Aug. 15, 2015).

C. License Revocation

The second constitutional provision that could affect the medical malpractice liability of Florida ACOs is Section 26 of Article X, entitled “Prohibition of Medical License After Repeated Medical Malpractice.”¹⁵³ This provision states that if “a court of law, final administrative agency decision, or decision of binding arbitration”¹⁵⁴ has found that a physician has committed medical malpractice three or more times, the physician’s medical license shall not be renewed or continued.¹⁵⁵ The Florida Constitution provides the following definition of “medical malpractice” for purposes of this provision:

“[M]edical malpractice” means both the failure to practice medicine in Florida with that level of care, skill, and treatment recognized in general law related to health care providers’ licensure, and any similar wrongful act, neglect, or default in other states or countries which, if committed in Florida, would have been considered medical malpractice.¹⁵⁶

Section 26’s mandatory license revocation for physicians who have committed malpractice at least three times could increase the likelihood that Florida ACO providers lose their licenses, as compared with physicians participating in ACOs in states that lack such a provision. While three or more findings may seem like a lot, ACOs do not yet know to what extent their malpractice lawsuits could increase, if at all. Therefore, there is no certainty regarding how or if Section 26 will affect ACOs differently than it has affected other health care delivery models. This premise is further supported by the fact that it is not yet clear how Florida courts will assign medical malpractice accountability within the ACO setting.

D. Increasingly Stringent Requirements

On April 12, 2013, the Florida Senate passed a bill that required more stringent requirements of medical expert witnesses in medical malpractice cases.¹⁵⁷ The bill, intended to bring more fairness to Florida’s tort system, requires that expert witnesses testifying in medical malpractice cases work in the *same* specialties as the defendant doctors, rather than *similar* specialties, as had been the rule previously.¹⁵⁸ The Florida

153. See FLA. CONST. art. X, § 26.

154. *Id.* § 26(b)(2).

155. See *id.* § 26(a).

156. *Id.* § 26(b)(2).

157. See S.B. 1792, 108th Reg. Sess. § 7 (Fla. 2013).

158. The Florida Senate bill amended FLA. STAT. § 766.102(5)(a) to include the following: “If the health care provider against whom or on whose behalf the testimony is offered is a specialist, the expert witness must: 1. Specialize in the *same* specialty as the health care provider against

House passed the bill on May 1, 2013, the Governor approved it on June 5, 2013, and the law took effect on July 1, 2013.¹⁵⁹

This tort reform measure could help ACOs in malpractice litigation by working to ensure that only meritorious claims receive judgments for plaintiffs. The purpose of the bill appears to be that by requiring a testifying expert to be from the same field, the standard of care testified to by an expert will more likely reflect the actual standard of care used in practice. However, it is unclear whether medical experts will testify to different ACO-oriented standards of care.

E. *Managed Care Medical Malpractice Litigation in Florida*

To make more detailed predictions concerning the fate of ACOs in Florida, it is useful to examine how Florida courts have handled managed care medical malpractice litigation. The outcomes of managed care medical malpractice litigation can provide helpful insight into the future of ACO malpractice liability in Florida. These outcomes are particularly useful to analyze in the context of HMOs, a type of MCO.¹⁶⁰ Some HMO cases have resulted in very large punitive damage verdicts.¹⁶¹ A 2011 Florida case, for example, resulted in a “jury award [of] nearly \$80 million against Humana for terminating coverage for a special therapy program for a child with cerebral palsy, although the verdict was subsequently set aside for improper jury instructions and evidentiary errors.”¹⁶² Because awarding punitive damages is rare in medical malpractice cases, the fact that Florida case law has supported doing so, especially at such a staggering monetary amount, is significant: If Florida courts have been willing to award punitive damages in medical malpractice lawsuits against MCOs, and HMOs in particular, could this be a

whom or on whose behalf the testimony is offered,” striking the line that had previously followed, which allowed an expert witness to “specialize in a *similar* specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients” S.B. 1792, 108th Reg. Sess. § 7 (Fla. 2013) (emphasis added).

159. See *SB 1792: Medical Negligence Actions: Bill History*, FLA. SENATE, <http://www.flsenate.gov/Session/Bill/2013/1792> (last visited Feb. 9, 2015); see also S.B. 1792, 108th Reg. Sess. § 7 (Fla. 2013).

160. 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 (2003). ACOs are considered today’s “updated versions of HMOs.” Christensen et al., *supra* note 15.

161. See Agrawal & Hall, *supra* note 160, at 240 (explaining that “very large punitive damage verdicts, approaching \$100 million” have been issued by juries) (citing *Fox v. Health Net*, No. 219692, 1993 WL 794305 (Ca. Super. Ct. Dec. 23, 1993)).

162. *Id.* at 240 n.16 (citing *Humana Health Ins. Co. of Fla. v. Chipps*, 802 So. 2d 492, 495 (Fla. Dist. Ct. App. 2001)).

sign of what is to come in similar litigation involving ACOs?¹⁶³

In keeping with a strictly Florida law-based evaluation of ACO medical malpractice liability, it helps to narrow the scope to MCO cases involving vicarious liability because ERISA does not preempt lawsuits brought under a vicarious liability theory.¹⁶⁴ Plaintiffs' lawyers could argue that ACOs should be held vicariously liable for the actions of individual ACO providers, suppliers, and participants because ACOs have such a strong interest in patient outcomes, and those entities help facilitate those outcomes.¹⁶⁵ In the past, courts have held HMOs vicariously liable for similar reasons.¹⁶⁶

In 2000, the United States Supreme Court held in *Pegram v. Herdich* that there is no ERISA violation when an HMO physician simultaneously makes a treatment and coverage decision.¹⁶⁷ State court remedies are available "only if [the claim against the HMO] is not subject to preemption by ERISA"¹⁶⁸—and ACOs are not protected under ERISA.¹⁶⁹ Therefore, analysts and health lawyers should turn to Florida medical malpractice cases in which MCOs have been ineligible for ERISA protections to best prepare for future ACO medical malpractice litigation.

In *Villazon v. Prudential Health Care Plan, Inc.*,¹⁷⁰ the Florida Supreme Court recognized claims of vicarious liability for alleged medical malpractice of an HMO regarding the treatment decisions of the HMO's member physicians.¹⁷¹ This case could provide guidance to Florida courts dealing with ACO medical malpractice cases because, in *Villazon*, the Florida Supreme Court found that HMO vicarious liability

163. See Fine, *supra* note 13, at 657 (noting that "punitive damages are relatively rare in malpractice cases").

164. See Agrawal & Hall, *supra* note 160, at 245 ("Considering the variety of legal theories under which health plans might be held vicariously liable as a matter of course, and that ERISA does not preempt vicarious theories, we expected to hear in our interviews with lawyers and health plan managers that vicarious liability was a major concern.")

165. See Carmel M. Cosgrave et al., *ACOs in Public and Private Markets: An Overview*, SMITH AMUNDSEN 12–13, http://www.salawus.com/media/publication/25_ACO%20Guidebook%20-%20August%202013.pdf (last visited May 4, 2015).

166. See, e.g., *Petrovich v. Share Health Plan of Ill., Inc.*, 719 N.E.2d 756, 765–66 (Ill. 1999) (holding that HMOs can be held vicariously liable for medical malpractice by their physicians because "(1) [the] HMO held itself out as the provider of health care, without informing the patient that the care is given by independent contractors, and (2) [the] patient justifiably relied upon the conduct of the HMO by looking to the HMO to provide health care services, rather than to a specific physician").

167. See *Pegram v. Herdich*, 530 U.S. 211, 214 (2000).

168. See Agrawal & Hall, *supra* note 160, at 254 n.63 (citing *Miller v. HealthAmerica Pa., Inc.*, 50 Pa. D. & C. 4th 1, 26 (Pa. Ct. Com. Pl. 2000)).

169. See Harvey & Cohen, *supra* note 7, at 141.

170. *Villazon v. Prudential Health Care Plan, Inc.*, 843 So. 2d 842 (Fla. 2003).

171. See *id.* at 851.

claims are not preempted by ERISA, and ACOs similarly do not receive ERISA protection.¹⁷² Thus, the medical malpractice case law that has found HMOs ineligible for ERISA protections and able to maintain vicarious liability theories provides a helpful forecast for future ACO medical malpractice cases.

In *Villazon*, a deceased patient's husband filed a wrongful death action against an HMO, claiming that the HMO was vicariously liable for his wife's treating physicians' alleged medical malpractice.¹⁷³ The HMO filed for summary judgment, and the Supreme Court of Florida quashed the motion in part and remanded.¹⁷⁴ The Supreme Court of Florida held that ERISA did not preempt the plaintiff's claim of the HMO's vicarious liability.¹⁷⁵ The court found that genuine issues of material fact existed regarding whether the patient's treating physicians were agents of the HMO, which would subject the HMO to vicarious liability.¹⁷⁶ After concluding that the plaintiff's complaint for vicarious liability, "based upon allegations of negligent failure to provide adequate medical treatment for his wife's cancer," was not preempted by ERISA, the Supreme Court of Florida turned to the state law issue regarding vicarious liability.¹⁷⁷ Applicable state law directs the court to look at contractual provisions, including those between the HMO and the physicians, and also to look at the totality of the circumstances to find whether a principal-agent relationship exists, thereby affecting whether the HMO could be held vicariously liable for the alleged medical negligence of its member physician.¹⁷⁸ Because the issue of whether a principal-agent relationship existed had not been fully addressed, the court remanded.¹⁷⁹

VIII. PERHAPS ACO PROVIDERS DESERVE MORE OF THE BENEFIT OF THE DOUBT

In predicting the outcome of ACO performance, many have looked to what could possibly motivate and incentivize some physicians' behavior: "Fee-for-service health care rewards the overprovision of care; capitation (a set monthly fee per patient) rewards underprovision; and

172. See Harvey & Cohen, *supra* note 7, at 141 ("Unlike MCOs, however, ACOs will generally not have the benefit of ERISA, which does not cover them; nor are they slated to get comparable federal liability protections.").

173. See *Villazon*, 842 So. 2d at 844.

174. See *id.* at 844, 851.

175. See *id.* at 851.

176. See *id.* at 852.

177. *Id.* at 851-52.

178. See *id.* at 855.

179. *Id.* at 856.

salaries reward just showing up.”¹⁸⁰

Although many analysts have cited potential problems with payment incentive systems and doctor decisionmaking, perhaps these critics are too cynical and it is only a “minority of physicians (and hospital administrators) who are motivated mostly by money.”¹⁸¹ Additionally, despite their dark predictions regarding the medical malpractice liability of ACOs compared to that of MCOs, critics proclaim that “ACOs have significant advantages over MCOs for achieving cost containment without negatively affecting patient care,” citing reasons including that “mandatory quality and outcomes standards are common to shared-risk contracts and act as an internal quality check for . . . cost containment efforts.”¹⁸² Further, ACOs can implement “lessons learned from MCOs’ experience,” as well as capitalize on technological improvements in patient-related analytics.¹⁸³

There is one key difference between MCOs and ACOs that could very differently affect the behavior of provider members: While MCO providers faced losing their livelihoods if they did not properly adhere to MCO cost-containment goals, ACO providers only face losing a potential bonus.¹⁸⁴ Thus, the stakes are not as high for ACO providers, which could lessen their potential medical malpractice liability compared to that of MCOs of the 1990s. Furthermore, not all experts agree that ACOs will experience more institutional malpractice claims than MCOs: One expert predicts that ACOs are actually less likely than MCOs to invite cost-containment-effort-related institutional malpractice claims.¹⁸⁵ Therefore, just because a large number of medical malpractice lawsuits could arise does not mean that they will.

Moreover, even if more malpractice claims do arise, ACOs will not be left defenseless. Proposed solutions to the perceived potential medical malpractice liability concerns among ACOs are discussed in the following Part.

180. Steffie Woolhandler & David Himmelstein, *Doctors’ Pay, a Key to Health Care Reform: End Insurance’s Bad Incentives*, N.Y. TIMES (June 18, 2009), http://roomfordebate.blogs.nytimes.com/2009/06/18/better-medical-care-for-less/?_r=0 (opining that there is no ideal way to provide payments for physicians and that the few physicians that are motivated financially “will find a way to game an incentive system rather than do the hard work of providing excellent care”).

181. *Id.* (emphasis added).

182. Harvey & Cohen, *supra* note 7, at 141.

183. *See id.*

184. *See* 42 U.S.C. § 1395jjj (2010); *see also* Fine, *supra* note 13, at 673 (“Physicians who do not ration care or control costs in line with MCOs’ policies, or who advocate too strongly for patient care, fear and often face termination from the plan.”).

185. *See* Smith, *supra* note 10, at 165.

IX. PROPOSED SOLUTIONS

As experts and analysts have made predictions about future ACO litigation and risks of liability associated therewith, many have also proposed solutions.¹⁸⁶ The solutions included in this Part are relevant to ACOs in Florida and to ACOs generally. Because of Florida's aging population, chronic disease incidence, and projected increase in future health care spending, Florida ACOs will likely face substantial medical malpractice litigation in the future.¹⁸⁷ Therefore, the following proposed solutions are particularly pertinent to Florida ACOs.

A. *Enacting State ACO Legislation*

First and foremost, the Florida legislature should draft and enact ACO-related statutes because the state currently has none. New York, in 2011, enacted state-specific ACO legislation that Florida could look to for guidance.¹⁸⁸ The New York legislature expressly outlined its findings and purposes for enacting such legislation, including “that the formation and operation of accountable care organizations under [the New York legislation] . . . can be consistent with the purposes of federal and state anti-trust, anti-referral, and other statutes, including reducing over-utilization and expenditures.”¹⁸⁹ Further, the New York legislature included in its findings “that the development of accountable care organizations under this article will reduce health care costs, promote effective allocation of health care resources, and enhance the quality and accessibility of health care,” and “that this article is necessary to promote the formation of accountable care organizations and protect the public interest and the interests of patients and health care providers.”¹⁹⁰

186. See, e.g., Hermer, *supra* note 9, at 293 (advocating for the recognition of enterprise liability for ACOs).

187. See Ctrs. for Disease Control, *Florida: Burden of Chronic Diseases*, CDC.GOV 1, 1–2 (2008), <http://www.cdc.gov/chronicdisease/states/pdf/florida.pdf> (reporting that in 2005, 27% of deaths in Florida were caused by heart disease, and that in 2007, 62% of adults in Florida were overweight or obese, 28% reported having high blood pressure (hypertension), and 37% reported having high cholesterol, putting them at greater risk for developing heart disease and stroke); see also Martie Gillen & Jeffrey W. Dwyer, *The Future of Aging Is Florida*, U. FLA. IFAS EXTENSION: EDIS (2013), <http://edis.ifas.ufl.edu/fy624> (“Florida is perhaps the ‘oldest’ state in the U.S. because of interstate migration and the aging of baby boomers who often choose Florida as their post-retirement home. The oldest old (85+) population in the state is expected to more than double between the years 1995 and 2020. In 2010, three of the top five counties in the United States having the highest percentages of the population in the age group of 65 years and over were in Florida This increase in the number and diversity of older adults has monumental implications for health care spending The cost of providing health care for an older American is three to five times greater than the cost for someone younger than 65.”).

188. See N.Y. PUB. HEALTH LAW §§ 2999-n to 2999-r (McKinney 2012).

189. PUB. HEALTH LAW § 2999-n.

190. *Id.*

The New York law contains its own definition of an ACO (beyond the definition created by CMS) and specifically explains certification procedure and how other state laws will affect New York ACOs.¹⁹¹ Moreover, the law mandates that “[t]he commissioner [of health] shall make regulations establishing criteria for certificates of authority, quality standards for ACOs, reporting requirements and other matters deemed to be appropriate and necessary in the operation and evaluation of ACOs under this article.”¹⁹² Throughout the process, the commissioner must consult with “the superintendent of financial services, health care providers, third-party health care payers, advocates representing patients, and other appropriate parties.”¹⁹³ Finally, the law calls for the commissioner to “specifically delineate safe harbors that exempt ACOs” from the application of statutes involving “the general business law relating to arrangements and agreements in restraint of trade,” “the education law relating to fee-splitting arrangements,” and the law relating to “health care practitioner referrals.”¹⁹⁴

Although New York’s ACO legislation¹⁹⁵ lacks language about medical malpractice specifically, including language related to the applicable standard of care, the fact that it clearly sets out state-specific requirements and expectations for ACO development and operation at least allows for parties to point to concrete statutory language regarding the role of ACOs in the state. Florida should follow suit.

B. *Establishing Guidelines as Safe Harbors*

If Congress establishes safe harbors, ACOs will experience more protection from medical malpractice liability through the use of “an approach that would avoid the overdeterrence of cost-containment efforts associated with current liability standards while holding ACOs accountable for medical decisions not based on recognized standards of quality.”¹⁹⁶ Experts in the field of accountable care support the establishment of safe harbors to protect ACOs, asserting that “ACOs that meet those safe harbor requirements would receive protection from state

191. See PUB. HEALTH LAW § 2999-p (“An accountable care organization: (a) is an organization of clinically integrated health care providers that work together to provide, manage, and coordinate health care (including primary care) for a defined population; with a mechanism for shared governance; the ability to negotiate, receive, and distribute payments; and accountability for the quality, cost, and delivery of health care to the ACO’s patients; in accordance with this article; and (b) has been issued a certificate of authority by the commissioner under this article.”).

192. PUB. HEALTH LAW § 2999-q(1).

193. *Id.*

194. PUB. HEALTH LAW § 2999-r(2)(a) to (c).

195. See PUB. HEALTH LAW §§ 2999-n to 2999-r.

196. Harvey & Cohen, *supra* note 7, at 142.

tort law claims.”¹⁹⁷

One such safe harbor could establish clinical practice guidelines and standards regarding resource allocation, payment arrangements, and assumption of financial risk.¹⁹⁸ “[U]sing [clinical practice guidelines] as a safe harbor for medical practice is attractive . . . because it would replace the current uncertainty with what appear to be gold-standard recommendations developed by experts.”¹⁹⁹ Although putting clinical guidelines into practice might be easier said than done,²⁰⁰ such standards would at least be a start in “encourag[ing] improved regularity in physician practice”²⁰¹ across ACOs. “Guidelines are meant to constitute very strong evidence, even conclusive evidence, that guideline-compliant care is not *negligent*.”²⁰²

Regulations could include established standards regarding ACOs’ resource capacity to protect ACOs from making poor resource allocation choices.²⁰³ For example, “federal and state regulators could establish standards intended to ensure that ACOs have a sufficient number of specialists among its physicians,” and if “an ACO lacks the capacity to itself provide the full range of medical care, regulators should monitor whether such ACOs are denying or delaying referring patients to outside specialists and other providers who can meet the patients’ needs.”²⁰⁴ Florida regulators and Florida ACOs should work to align their established standards to reduce the risk of future malpractice litigation.

Concerns also exist regarding which types of patients ACOs will focus on to expend their allotted resources.²⁰⁵ Multiple studies have found that there are health care disparities related to patients’ race and gender, for example.²⁰⁶ With financial incentives to reduce the cost of treatment thrown into the mix, there is a chance that ACOs could exacerbate such health care disparities.²⁰⁷ Regardless of whether these disparities are caused by conscious or unconscious biases on the part of the

197. *Id.*

198. See Mantel, *supra* note 10, at 1439.

199. Hermer, *supra* note 9, at 281.

200. See *id.* at 284 (“Physicians must not only be aware of [guidelines], but also must put them into practice. At least one recent study has found that while a large majority of physicians are aware of current guidelines that are relevant to their specialty, far fewer of them actually apply those guidelines.”).

201. *Id.* at 282.

202. RANDALL R. BOVBERG & ROBERT A. BERENSON, URBAN INST., THE VALUE OF CLINICAL PRACTICE GUIDELINES AS MALPRACTICE “SAFE HARBORS” 4 (2012), available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf72667.

203. See Mantel, *supra* note 10, at 1439.

204. *Id.*

205. See *id.* at 1440.

206. See *id.*

207. See *id.*

treating physicians, regulatory measures could help solve the problem: “For example, the set of quality measures used to evaluate ACOs’ performance could include measures that evaluate the care ACOs provide to vulnerable patient populations.”²⁰⁸ Regulations could include that ACOs must “monitor and address disparities in the provision of care to patients, and educate their professionals on how gender, race, cultural and other factors may influence their clinical judgment.”²⁰⁹ Controlling for disparities would force Florida ACOs to provide patients with more equal, standardized care and work to ensure accountability, both to themselves and to the patient populations they treat.

C. *Creation of Captive Insurance Companies*

Another potential mitigation tool for handling ACOs’ medical malpractice liability is the creation of captive insurance companies.²¹⁰ A captive insurance company is one that is owned and controlled by its insureds.²¹¹ Benefits of captive insurance companies include “align[ing] the insurance protection across the system of care” so that the insurance plan “can be designed with criteria in place to promote risk management initiatives, evidence based care and high patient satisfaction.”²¹² Captive insurance companies “can also promote collaboration in the case of defending allegations of medical malpractice through . . . joint investigation and defense strategies . . . and [they can] eliminate the ‘finger pointing’ that often can ensue” with multiple insurance carriers.²¹³ Additionally, the creation of a captive insurance company can help an ACO “gain financial control and decision making power related to helping reduce medical malpractice claims”²¹⁴

D. *Detailed Documentation and Open Communication*

Further steps that ACOs should take to help mitigate their medical

208. *Id.* at 1441.

209. *Id.*

210. See *Accountable Care Organizations: The Important Role of Healthcare Risk, Quality and Safety Management*, WHITE PAPER 1, 2 (2011), http://www.claritygrp.com/media/1342/ACO_Whitepaper.pdf; see also Luke Sato et al., *Managing Risk and Patient Safety Across an ACO*, CRICO (Oct. 19, 2012), <https://www.rm.f.harvard.edu/Clinician-Resources/Article/2012/ACO-Managing-Risk-and-Patient-Safety-Across-an-ACO#> (“Captive insurance companies can drive initiatives by using carefully designed premium initiatives and risk-management grants that promote patient safety and risk reduction efforts,” and “[t]he captive can use this opportunity to continue to systematically support the development and implementation of activities to decrease patient harm and mitigate costs.”).

211. See *Accountable Care Organizations: The Important Role of Healthcare Risk, Quality and Safety Management*, *supra* note 210, at 2.

212. *Id.*

213. *Id.*

214. *Id.* at 2–3.

malpractice liability include diligent documentation and communication. In addition to creating and utilizing strong risk management programs, ACOs should “[d]ocument the data supporting the ‘best practices’ adopted by the organization” and “document whether there was a reason to deviate from those practices” during treatment.²¹⁵ ACO providers should also openly communicate with their patients that experience negative outcomes by apologizing when appropriate.²¹⁶ Finally, “sometimes it is better to absorb the cost of taking corrective action (for example, providing additional care without charge), than the risk of litigation.”²¹⁷

Regarding patients’ lengthy electronic health records, ACOs must ensure that their affiliated providers enter accurate information into the documentation.²¹⁸ Providers should carefully and frequently edit patients’ charts, and “[a]ny inaccuracies should be immediately corrected without editorialization or other comments that could draw attention to the error that persisted before the correction.”²¹⁹ Furthermore, although copying and pasting in patients’ records may be tempting, providers should resist the urge to do so and take care to “ensure that the volume of notes they create does not obscure key pieces of necessary information.”²²⁰ Overall, providers should use sound judgment in protecting themselves and their ACOs from medical malpractice liability by carefully documenting procedures and by keeping communication lines open with patients.

E. *Enterprise Liability*

Another potential way to address Florida ACOs’ potential medical malpractice liability is through enterprise liability, which “would make a health care entity . . . financially liable for acts of negligence, rather than or possibly in addition to the individual providers staffing it or otherwise providing services under its auspices.”²²¹ While Florida does not currently allow for the use of enterprise liability as a theory of recovery, it has not eliminated the possibility.²²²

One scholar has advocated for the adoption of enterprise liability for ACOs.²²³ Many health law scholars supported the use of enterprise

215. Siegel, *supra* note 16, at 2.

216. *See id.*

217. *Id.*

218. *See* DiGiacinto et al., *supra* note 95, at 2, 4.

219. *Id.* at 4.

220. *Id.*

221. Hermer, *supra* note 9, at 273.

222. *See* SAWAYA, *supra* note 138, § 7:4 (“The theories the courts have developed to apply to cases where the plaintiff is unable to identify which defendant caused his injuries [include] . . . enterprise liability.”).

223. *See* Hermer, *supra* note 9, at 293.

liability in the 1990s for MCOs.²²⁴ Consequently, ACOs could be even better candidates for the implementation of enterprise liability given that the “success of an ACO depends on the coordinated efforts of multiple different healthcare providers”:

[P]erhaps even more so than hospitals or even health maintenance organizations . . . ACOs will need to have the capacity to exercise a certain amount of control over participating health care providers in order to more reliably meet quality and cost targets. Given the need for such control, it makes sense that the enterprise should bear the financial risk of negligent medical errors, rather than the individual practitioners acting as a part of it. Physicians would likely continue to share in the costs of suit by, for example, reimbursing the ACO for what they otherwise would have owed as a premium to their liability insurer. Physicians would not, however, be named targets; rather, the ACO would take that place.²²⁵

Therefore, because enterprise liability, “[i]f done well, . . . has . . . potential . . . to enhance patient safety and quality of care, while at the same time facilitating compensation for negligently injured patients,”²²⁶ Florida courts should consider recognizing enterprise liability for Florida ACOs.

X. CONCLUSION

In sum, while only time will tell what Florida-specific ACO litigation will look like, one thing is certain—ACO medical malpractice litigation in Florida is inevitable. Regardless of the degree of risk that ACOs will face, these entities will likely be able to shield themselves from at least some liability by implementation of the solutions proposed in this note. Florida ACOs should take steps *now* to protect themselves in the future. Currently, it is impossible to determine if ACOs will truly be able to meet their goal of accountability, both to themselves in lowering costs and to their patients in providing excellent care,²²⁷ should substantial medical malpractice litigation arise. If ACOs manage to strike the balance between accountability to their patients and accountability for their costs, ACOs and their patients should face each other in court far less frequently. In order for this to occur, however, ACOs must chart a new path, separate from that of MCOs in the past. ACOs must be genuine alternatives to MCOs, rather than MCOs’ mere successors. Equipped with the proposed solutions discussed above, Florida ACOs can work to make this alternative image a reality.

224. *See id.*

225. *Id.* at 295–96.

226. *Id.* at 302.

227. *See* Ctrs. for Medicare & Medicaid Servs., *supra* note 6.