ACOS IN PUBLIC AND PRIVATE MARKETS

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OVERVIEW OF ACOs

In order to better serve patients, incentivize healthcare providers to provide high-quality care, and reduce government spending on Medicare, the Affordable Care Act (ACA) created the Medicare Shared Savings Program (“Shared Savings Program”). In order to achieve this, the Shared Savings Program depends on Accountable Care Organizations (ACOs), or a group of physicians, hospitals, and healthcare providers-suppliers that voluntarily merge their practice areas in such a way that provides efficient coordinated care to Medicare Fee-For-Service patients.² ACOs can also enter into private agreements with insurers or be employer-sponsored without participating in the Shared Savings Program. Prior to its incorporation into the ACA, the term ACO was first used by Drs. Elliot Fisher and Glenn Hackbarth at a 2006 MedPAC meeting to more efficiently integrate patient care.²

When an ACO successfully meets the quality performance standards at a low cost, as determined by the Secretary of the Department of Human & Health Services (“Secretary” and HHS), the ACO “shares in the savings” it provides the Medicare program.³ ACOs are afforded a wide breadth of flexibility in establishing clinical integration and coordination of healthcare efforts. Additionally, the Shared Savings Program aims to encourage “investment in infrastructure and redesigned care processes,”⁴ which can cost between $1.7 million to $12 million to implement.⁵ The benefits of investing in ACO infrastructures will soon be seen; Centers for Medicare & Medicaid Services (CMS) estimates that the program will generate $470 million in net savings to the federal government from 2012 to 2015.⁶

Providers can only benefit from the Shared Savings Program if they are a part of an ACO that participates in the program. Further, CMS analyzes whether the ACO has met the program’s goals in providing cost-efficient care as a whole rather than whether each individual provider has met the goals—it is essentially an all-or-nothing agreement.

Ideally, coordinated care requires healthcare providers working together as a team to ensure that Medicare patients receive the necessary treatment through the ACO without requiring the patient to seek out his or her own doctors to satisfy their healthcare needs. Through this coordinated care, hospital admissions, particularly for chronic illnesses, will be reduced, resulting in a healthier population and reduced costs to providers and Medicare.

³ § 3022(a)(1)(B).
CMS-CERTIFIED ACOs

Eligibility Requirements

Qualified healthcare providers and suppliers “may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an ACO.”\(^7\) A group of providers and suppliers that has established a method of self-governance is eligible to participate as an ACO in the Shared Savings Program if it falls in one of the following categories:\(^8\)

A. ACO professionals in group practice arrangements;
B. Networks of individual practices of ACO professions;
C. Partnerships or joint ventures arrangements between hospitals and ACO professionals;
D. Hospitals employing ACO professionals; or
E. Other Medicare providers and suppliers as determined by the Secretary.

Application Process

In order to become an ACO under the Shared Savings Program, the prospective group of providers and suppliers must apply through CMS under one of the following programs:\(^9\)

- **Medicare Shared Savings Program** – Helps fee-for-service providers become an ACO.
- **Advance Payment ACO Model** – supplemental incentive program for certain participants in the Shared Savings Program. There are currently 35 ACOs in this category. These ACOs are given upfront payments each month so they may invest in their care coordination infrastructure. This program is directed toward physician based and rural providers.\(^10\)
- **Pioneer ACO Model** – was available for early adopters of coordinated care. CMS is no longer accepting applications for this program.

In the application, the prospective ACO must provide a statement as to how it plans to deliver quality, coordinated care and lower the costs for its Medicare beneficiaries.\(^11\) If the application is approved, the ACO must agree to participate in the Shared Savings Program for at least three years, but that does not mean the ACO will automatically be accepted into the program.\(^12\) All ACO participants and their ACO providers/supplier must agree in writing to participate in and comply with the Shared Savings Program’s regulations.\(^13\) Further, the applying ACO must provide a list of all participating participants, providers, and suppliers before the

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\(^7\) § 3022(a)(1)(A).
\(^8\) § 3022(b)(1)(A)-(E).
\(^9\) Accountable Care Organizations (ACO) - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?
\(^10\) Advance Payment ACO Model - http://innovation.cms.gov/initiatives/Advance-Payment-ACO-Model/
\(^12\) Id.
application is submitted. The applicant should also provide an example of an agreement it has made with participants and/or provider/suppliers.

ACO participants are identified by taxpayer identification numbers (TINs) and individual providers and suppliers do their Medicare billing through the ACO participants’ TINs. “ACO participant means an individual or a group of ACO providers/suppliers that is identified by a Medicare-enrolled TIN that alone or together with one or more other ACO participants comprises the ACO.” An ACO provider/supplier is one that is enrolled in Medicare and bills services provided to Medicare fee-for-service patients through the ACO participant’s TIN. ACO participants can have multiple providers/suppliers underneath it.

**Initial Requirements to Participate in the Shared Savings Program**

In order to participate in the Shared Savings Program, the ACO must meet the following requirements:

A. The ACO must be willing to be held accountable for the overall quality and cost of healthcare of the Fee-for-service beneficiaries assigned to it.

B. The ACO must agree to participate in the program for no-less than a three-year period.

C. The ACO must have a formal legal structure in place that allows it to receive and distribute shared savings to participating providers and suppliers.

D. The ACO must include enough primary care physicians to service the amount of Medicare fee-for-service beneficiaries assigned to the ACO, which at minimum, must be 5,000 beneficiaries.

E. The ACO must provide the Secretary with information regarding: the participating ACO professionals in order to determine the assignment of Medicare beneficiaries; quality care reporting; and the determination of shared savings payments.

F. The ACO must have an internal management and leadership structure that includes clinical and administrative systems.

G. The ACO must promote patient engagement and evidence-based medicine, report quality care and cost measurements, and coordinate care through whatever electronic health record technology is available.

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14 *Id.* at 2.
15 *Id.*
16 *Id.* at 1.
17 *Id.*
18 *Id.*
19 § 3022(b)(2)(A).
20 § 3022(b)(2)(B).
21 § 3022(b)(2)(C). Further, the ACO’s governing body must have a fiduciary duty unique to the ACO and is responsible for “its oversight and strategic direction, [and] holding the ACO management accountable for the ACO’s activities.” *Additional Guidance for Medicare Shared Savings Program* - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/Memo_Additional_Guidance_on_ACO_Participants.pdf – p. 2
22 § 3022(b)(2)(D).
23 § 3022(b)(2)(E).
24 § 3022(b)(2)(F).
The ACO must show the Secretary that it meets “patient-centeredness criteria.”

Reporting Requirements

ACOs are required to report to the Secretary to evaluate whether the ACO is meeting the prescribed quality care standards. The quality of care is measured through the Quality Performance Standards. There are thirty-three required quality measures that ACOs are required to satisfy in order to benefit from the Shared Savings Program. These quality measures fall under four categories:

1. Patient/caregiver experience (7 measures)
2. Care coordination/patient safety (6 measures)
3. Preventative Health (8 measures)
4. At-risk population (12 measures under five sub-categories)

Through powers vested in it by the ACA, CMS also uses Physician Quality Reporting System requirements through the Shared Savings Program to determine incentive payments for ACOs who report positive quality measures through the ACO Group Practice Reporting Option (GPRO) web portal. Physician Quality Reporting System incentive payments under the Shared Savings Program are dispersed for each calendar year to ACOs that complete the GPRO within the reporting period.

ACOs must update the list of its participating ACO participants and ACO providers/suppliers. This participant list is used to determine whether an ACO satisfies the 5,000 beneficiary requirement, establish the historical benchmark, coordinate Physician Quality Reporting, and screening TINs. When ACO participants change, ACOs must submit monthly reports to CMS.

Payments of Savings

Healthcare providers and suppliers in an ACO will continue to be compensated under the original Medicare fee-for-service program under parts A and B. However, an ACO is only eligible to receive shared savings if the “estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable

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25 § 3022(b)(2)(G). This is particularly important because in order to successfully achieve better outcomes and coordinated care, all providers involved in a patient’s treatment need easy and consistent patient files through that technology.
26 § 3022(b)(2)(H).
27 § 3022(b)(3)(B).
30 Id. at 1-2.
32 Id.
benchmark.”33 The Secretary establishes adjustable benchmarks for each ACO using recent per-
beneficiary expenditures from the previous three years.34 Traditionally Medicare pays providers
on a volume-based purchasing agreement; however through ACOs, Medicare will focus on
value-based purchasing.35

CMS offers two payment models for ACOs to follow. Under the one-sided model (upside
model), providers can participate in ACOs without any financial risks during the agreement
period.36 The two-sided model (downside model) requires providers to assume some financial
risks (if the ACO exceeds the allocated costs, it must pay back a portion of excess spending), but
they share in any savings, even if below their benchmark. ACOs on the one-sided track may
receive a maximum sharing rate of 50% while those on the two-sided track may receive 60%.37
For both models, benchmarks are reset at the start of each agreement period.38 Upon receipt of
their savings, ACOs are then in charge of dispersing savings payments to their participants,
providers, and suppliers.

Under the Shared Savings Program, ACOs can still receive some savings payments if
their savings occur through normal care and ACO activities; however, a minimal savings rate
(“MSR”) is established in order to assure that ACOs are purposefully achieving performance
goals.39 A higher MSR yields less savings paid to ACOs while a lower MSR yields more savings
to be paid.40 Although a higher MSR ensures that quality care will be achieved, it can easily
discourage smaller, potentially successful ACOs from participating in the program.41 On the
other hand, lower MSRs encourage more ACOs to participate, but have fewer assurances that
quality care is being achieved.42 CMS hopes to establish balanced MSRs that protect the interests
of both ACOs and Medicare Trust Funds.43

Assignment of Beneficiaries

First, a Medicare beneficiary is assigned to the ACO where they receive a “plurality” of
their primary care services from primary care physicians.44 If the beneficiary has not received
any services from a primary care physician in or outside the ACO, the beneficiary is assigned to
the ACO where they receive a plurality of primary care services from specialists or non-
physician practitioners.45

33 § 3022(d)(1)(B)(i).
34 § 3022(d)(1)(B)(ii).
36 Id.
37 Id.
38 Id. at 67,909-10.
39 Id. at 67,927.
40 Id.
41 Id.
42 Id.
43 Id.
44 FAQs – Medicare Shared Savings Program - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-
Payment/sharedsavingsprogram/downloads/MSSP_FAQs.pdf – P. 3
45 Id.
COMMERCIAL MARKET ACOs

Although ACOs are largely contemplated in the Medicare Shared Savings Program context, private insurance carriers and payers have also constructed ACO-type arrangements outside of the Shared Savings Program. The basic principles behind CMS certified ACOs, coordinated healthcare at a low cost, apply in the commercial context.

What do Commercial Market ACOs Look Like?

Like CMS secondary payer arrangement with ACOs, commercial ACOs are value-based agreements, but with private primary payers. There are a number of advantages of commercial payer ACO agreements. For example, according to Dr. Lee Sacks, Advocate Health Care’s Chief Medical Officer, "By innovatively collaborating with health insurance companies, like BCBSIL, we [Advocate Health Care] will be able to afford the infrastructure, investments and incentives for physicians to better coordinate care across the continuum. This will allow for elimination of waste and inefficiency found in more traditional approaches to care delivery. Moving from the traditional fee-for-service approach to a fee-for-value one translates into better care for our patients." Nonetheless, these ACOs are still subject to federal regulations and need to ensure technology systems are compatible in order to deliver the most efficient and coordinated care.

Recently, Advocate Health Care and Blue Cross Blue Shield of Illinois (BCBSIL) teamed up to form the largest commercial market ACO (AdvocateCare) in Illinois. The venture has been successful thus far; according to the vice-president of AdvocateCare, during the first six months of 2011, Advocate’s hospital admissions fell 10.6 percent compared to 2010 and emergency room visits were down 5.4 percent. AdvocateCare’s agreement with BCBSIL includes “a payment system that incentivizes Advocate to contain costs but doesn’t put it at risk of catastrophic loss.”

Premier White Paper on Commercial ACO Agreements

In its study of 22 ACO it helped create under the Partnership for Care Transformation (PACT) program, the Premier healthcare alliance found that fourteen of the twenty-two ACOs participated in the Shared Savings Program. Thirteen of the fourteen chose track one, which is considered the less risky savings structure because it does not impose penalties on ACOs that do not meet savings goals.

47 Id.
49 Id.
50 Id.
52 Id.
In the commercial market, it is more common for a value-based agreement to feature a downside model, where ACO members pay a penalty if they do not meet their cost-savings goals; eleven out of twenty PACT ACOs had downside arrangements in commercial plans.\textsuperscript{53} Premier postulates that the prevalence of downside agreements in commercial markets is likely due to the fact that commercial payers have bottom lines to meet as opposed to public payers.\textsuperscript{54} Despite the downside risks associated with the ACO commercial market, the payouts are much larger—50 to 80 percent of savings go back to members compared to the 25 to 60 percent in the Medicare and Medicaid markets.\textsuperscript{55} Some PACT members reported receiving 100 percent of the achieved savings.\textsuperscript{56} Although risk-free value-based agreements are uncommon, the most popular way to create this relationship with a commercial payer “at a lower risk level is to implement care management agreements…”\textsuperscript{57} Further, “moving toward risk-based arrangements with [commercial] payors allows a provider organization to incrementally build the financial and clinical infrastructure necessary to support accountable care.”\textsuperscript{58}

The commercial market is not the only non-governmental sector turning toward value-based healthcare agreements; employers are also getting in on the action. Employers with self-funded employee healthcare plans are experimenting with joining or starting their own ACOs.\textsuperscript{59}

Below is a breakdown of the market split for types of payer agreements Premier observed in its survey.\textsuperscript{60}

\[\text{Number of executed agreements, by payor}\]

\[\text{Diagram showing the number of executed agreements by payor.}\]

\begin{itemize}
\item \textit{Medicaid}
\item \textit{Medicare Advantage}
\item \textit{Commercial}
\item \textit{Self-insured Employers}
\item \textit{Provider-owned Plan}
\item \textit{Medicare}
\end{itemize}
FTC AND DOJ TAKE ON ACOs

Final Policy Statement Overview

On October 28, 2011, the Federal Trade Commission (“FTC”) and Department of Justice (“DOJ”) issued the “Final Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program” (“Final Policy Statement”). The entire Final Policy Statement applies to all ACOs (in effect or seeking approval) that participate in the Shared Savings Program.

There will not be mandatory antitrust review of ACO operations, but the FTC and DOJ will protect market competition by monitoring data provided by CMS. Newly formed ACOs can request an expedited 90-day review in order to obtain antitrust guidance.

The FTC and DOJ understand that ACOs want to innovate healthcare management in the Medicare and commercial markets; however, the agencies fear that the consolidation of multiple practices “could reduce competition, since competitors are now joining forces in forming ACOs, and harm consumers through higher prices or lower quality of care.” Generally, “antitrust laws treat naked price-fixing and market-allocation agreements among competitors as per se illegal.” When evaluating antitrust issues in ACOs, the agencies use the “rule of reason” which examines whether an ACO will have anticompetitive effects on the market and whether those effects are outweighed by the potential procompetitive effects of the ACO. The Final Policy Statement focuses on ACOs participating in the Shared Savings Program and not private market ACOs.

Antitrust Safety Zones

When examining the antitrust issues facing ACOs the agencies determine whether or not the ACO lies within the “antitrust safety zone.” ACOs that have been approved by CMS are likely to fall into the safety zone because they are unlikely to raise competitive concerns—absent extraordinary circumstances, the FTC and DOJ will not contest an ACO that is in the safety zone. The agencies suggest that ACOs look at their primary service area (“PSA”) to determine whether they fall within the safety zone—the PSA is useful in examining any competitive effects an ACO might have. To be in the safety zone, independent ACO participants that provide the same service (physician specialties, major diagnostic categories for inpatient facilities, and outpatient categories) cannot take up more than 30%
of each participant’s PSA.70 “The PSA for each participant is defined as ‘the lowest number of postal zip codes from which [the ACO participant] draws at least 75 percent of its [patient],’ separately for all physician, inpatient, or outpatient services.”71 PSA availability varies depending on whether the ACO participant is exclusive or non-exclusive to the ACO.72 Hospitals or ambulatory surgery centers must be non-exclusive to the ACO in order to fall within the safety zone.73

ACOs that have more than a 30% PSA share are still within the safety zone if they are in a rural area.74 There is also a “dominant participant limitation” when determining whether an ACO falls within the safety zone. Under this limitation, if an ACO has a participant that has a 50% or more PSA in a practice area unique to it, that participant must be non-exclusive to the ACO and cannot require private payers to only contract with the ACO.75

“ACOs that fall outside the safety zone may be procompetitive and lawful. An ACO that does not impede the functioning of a competitive market will not raise competitive concerns.”76 In order to avoid antitrust issues, the FTC and DOJ suggest that ACO participants not engage in price-fixing or sharing of sensitive information that could lead to a decrease in competition in the market.77 Generally, ACOs should avoid and protect itself from “conduct that may facilitate collusion among ACO participants in the sale of competing services outside the ACO.”78

An ACO with high market power, as evidenced through a high PSA, should avoid the following conduct:79

1. Preventing or discouraging private payers from directing or incentivizing patients to choose certain providers” who may not participate in the ACO.
2. Tying sales of the ACO’s services to the private payer’s purchase of other services from providers outside the ACO (and vice versa).
3. Making exclusive contracts with ACO physicians, hospitals, and other providers so that they cannot contract with private payers outside the ACO.
4. Restricting a private payers’ ability to provide enrollees with information on the quality and efficiency of the ACO participants if the information is similar to that used by the Shared Savings Program.

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70 Id. at 67,028.
71 Id.
72 Id.
73 Id. at 67,029.
74 Id.
75 Id.
76 Id.
77 Id.
78 Id.
79 Id.
BENEFITS OF ACOs

For Patients

Due to the comprehensive coordinated care systems, patients will no longer be required to coordinate their own care, rather this is left to the treating physicians. There are no HMO restrictions; fee-for-service Medicare patients can still choose their providers and even go outside of the network, unlike HMOs. The end goal is to reduce acute care admissions and keep people healthy through quality service. Fee-for-service Medicare patients who see ACO providers maintain their Medicare rights, including the right to include Medicare-covered doctors.  

Patients can expect to see better health results and more physician involvement in the coordination of their care. Particularly, ACOs should reduce hospital admissions and acute care visits, especially for those with chronic illnesses. Additionally, the structure of an ACO requires that all parties involved (hospitals, providers, insurers, suppliers) communicate and share information about a patient’s health history and future.

For Hospitals

Hospitals can expect to see the following benefits:

- Better and demonstrable clinical outcomes.
- Enhanced reputation for quality.
- Physician loyalty.
- Decreased costs of doing business.
- Increased efficiency.
- Improved affinity with the healthcare community.
- Patient satisfaction.

For Physicians

Physicians can expect to see the following benefits:

- Improved office workflow efficiencies.
- Ease of access to key clinical information.
- Increased care coordination and enhanced communication with all members of the patient’s care team.

80 General ACO Information - http://innovation.cms.gov/initiatives/ACO.
81 ACO Basics - http://www.medicity.com/aco-basics.html
82 Id.
83 Id.
• Ability to manage difficult cases that require multiple visits and involve multiple providers.
• Improved application of evidence-based medicine through disease management protocols and clinical decision support.
• ‘Hassle-free’ clinical practice and enormous increase in physician and staff job satisfaction.

CHALLENGES FACING ACOs

If an ACO does not comply with the eligibility requirements of the Shared Savings Program, avoids at-risk patients, or fails to meet the quality performance standards, CMS may terminate the agreement with the ACO; however, this list is not exhaustive. There is no administrative or judicial review of the quality performance standards the Secretary establishes; the assessment of quality care; the assignment of beneficiaries; the determination of whether an ACO is eligible to receive shared savings; the percent of shared savings the Secretary specifies; and the termination of the ACO. Establishing an ACO is no easy feat. All participants, hospitals, providers, physicians, and suppliers must put in considerable effort to ensure that better health outcomes are reached, technology is integrated, and they are abiding by all state and federal regulations.

Liability Issues

The inherent nature of ACOs is to provide care at low costs. This seemingly beneficial aspect brings concerns as to the level of quality of that care and whether physicians will be free to make necessary medical care decisions without considering the cost of the care. It is possible that medical malpractice suits or suits challenging the admissions and cost-cutting policies of the ACO may be seen in the near future. A recent American Medical Association (AMA) article outlined various challenges that ACOs might face in the future. The authors, a Harvard professor and Massachusetts radiologist, give various suggestions as to how ACOs can shield themselves from liability. First, the ACO could become its own health insurer and gain ERISA protection as to avoid state law medical malpractice claims. Second, the ACO could purchase managed care insurance. Lastly, the ACO could “base their policies on recognized standards of care.” To that point the AMA has outlined various standards by which ACOs should abide.

84 § 3022(d)(3)-(4).
86 § 3022(g)(1)-(6).
88 Terry Baynes, Accountable care could mean more lawsuits: AMA article, REUTERS LEGAL (Jul. 29, 2013 at 09:59 PM).
89 Id.

4. Below are the AMA standards for ACOs:
   1. “The guiding principle that the goal of an ACO is to increase access to care, improve the quality of care and ensure the efficient delivery of care;
   2. ACOs must be physician led (to ensure that medical decisions are based on patients’ versus commercial interests) and encourage an environment of collaboration among physicians;
   3. Physician and patient participation should be voluntary;
It is thought that ACO participants and providers/suppliers who usually contract with the ACO could be classified as independent contractors. Providers are not employed by the ACO; rather they independently pool their resources and skills together to meet patient needs. Unfortunately, the ACA does not specifically address liability issues facing ACOs and their affiliates. Scholars speculate that “…courts will [likely] find that ACOs play a central role in providing quality healthcare to ACO beneficiaries” and therefore, an ACO could be held directly liable for a participant’s malpractice because they are so central to the patient’s healthcare.

Apparent Authority

Additionally, it could be argued that because of its significant interest in patient outcomes, an ACO can be held vicariously liable for the actions of ACO participants and providers/suppliers. As outlined in Petrovich v. Share Health Plan of Illinois, Inc., HMOs can be held vicariously liable for the actions of physician-independent contractors under the doctrine of apparent authority. In Petrovich, the court relied on Gilbert v. Sycamore Municipal Hospital’s holding that under the apparent authority doctrine; hospitals could be held vicariously liable for medical malpractice conducted by its physicians as independent contractors. The Petrovich court continued to apply this doctrine to HMOs because they promulgate themselves as

4. The ACO’s savings and revenues should be retained for patient care services and distributed to the ACO participants;
5. Waivers and safe harbors should be created to give flexibility to the patient referral and antitrust laws necessary to allow physicians to form or participate in ACOs without being employed by the hospitals or ACOs;
6. Additional resources should be provided to encourage ACO development in the form of financing up-front costs of creating an ACO;
7. ACO spending benchmarking should be adjusted for difference in geographic practice costs and risk adjusted for individual patient risk factors, and ACOs spending less than the national average per Medicare beneficiary should be provided an additional bonus payment so that organizations that have already achieved significant efficiencies are incented to participate;
8. the quality performance standards established by the Secretary must be consistent with the AMA’s principles for quality reporting;
9. An ACO must be afforded due process before it is terminated from Medicare for failing to meet quality performance standards;
10. The ACO should be allowed to use different payment models, and any capitation payments must be risk-adjusted;
11. The Consumer Assessment of Healthcare Providers and Systems Patient Satisfaction Survey should be used to determine whether an ACO meets the required patient centeredness criteria;
12. Medicare must ensure that electronic health record systems are interoperable; and
13. If an ACO bears risk, it must abide by financial solvency standards for risk-bearing organizations.”

91 Christopher Smith, Between the Scylla and Charybdis: Physicians and the Clash of Liability Standards and Cost Cutting Goals Within Accountable Care Organizations, 20 ANNALS HEALTH L. 165, 195 (Summer 2011).
92 Id. at 197.
93 Id.
94 188 Ill. 2d 17, 32 (Ill. 1999).
95 Id.
facilitators of quality healthcare at a low cost. Similarly, the purpose of ACOs is to encourage and promote quality, coordinated healthcare while keeping costs low. As a result, courts may find it contradictory to treat the liability of ACOs differently than that of HMOs.

Along similar lines, on April 9, 2013, a Nevada state court jury awarded several patients who were negligently infected with Hepatitis C a total of $524 million in damages at the expense of United HealthCare, an HMO insurer. Plaintiffs argued that the health insurer’s emphasis on low healthcare expenses was at the cost of patient health and safety, thus forcing a Nevada clinic doctor to reuse materials used in performing blood work on the various plaintiffs.

It is important to note that although ACOs look like HMOs or MCOs, they are very different. ACOs place responsibility with healthcare providers whereas HMOs and MCOs are primarily insurer and cost driven. “[P]hysicians in [an] MCO face possible termination if they do not achieve cost cutting goals, whereas physicians and providers in the ACO context fail to receive a bonus if they do not cut costs and achieve certain quality standards.”

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96 Id. at 32-33.
98 Id.
99 Smith, supra note 84 at 193.