WHO'S MY PATIENT ANYWAY?

CONSOLIDATION IN THE HEALTHCARE INDUSTRY BLURS THE LINES IN THE PROVIDER/PATIENT RELATIONSHIP

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The Affordable Care Act ("ACA"), also known as Obamacare, has sent tremors down the spine of almost any industry executive for a whole host of reasons: increased costs, reduction of employee hours, and layers of new paperwork, just to name a few. One area of concern unique to the healthcare industry is the increased liability exposure that the ACA brings and encourages with healthcare providers. The ACA establishes incentives for healthcare providers to partner together as Accountable Care Organizations ("ACOs") in order to achieve the dual goals of containing costs and improving the quality of care. Though their moniker suggests new accountability for payment and reimbursement, the name of these new creatures begs the question of who will be accountable

legally for the care provided.

ACOs are new legal entities comprised of any combination of hospitals, primary care physicians, and specialists. The ACA provides rules for the ACOs to monitor costs and the quality of care provided to patients. If goals are met on those two fronts, the ACO is eligible for increased compensation tied to savings and increased care quality. The main guidelines for these ACOs govern both their structure and reporting. The structure must allow for distributing any shared savings and the entity must meet reporting requirements for clinical outcomes among other utilization. While this new model applies currently to Medicare patients, it is expected that these same structures will be adopted in the private market for non-Medicare patients.

As ACOs form and expand in size, an increased number of nurses, doctors, and specialists come into contact with patients. The ACA incentives envision patients receiving multiple opinions and diagnoses, and doctors can expand their patient network by bringing nurse practitioners and physician assistants on board. However, these additions bring added risk to ACOs and its members or employees in the form of vicarious liability. Vicarious liability occurs when employees of a business come in contact with a client or patient.

As ACOs form and come into practice, issues impacting vicarious liability analysis are emerging in two primary areas. First, as hospitals take a more active role in care to take advantage of the ACAs incentives, they are employing the physicians and other care providers that treat patients in the hospital, or "inpatient" care. This is seen in recent data that shows the number of physicians that have an ownership stake in their practices shrank from a highpoint of 57 percent in 2000 to a projected 30 percent for this past year. *How Has the Rise of Physician Employment Changed Hospitals' Recruitment Strategies?*, Becker's Hosp. Rev (Nov. 29, 2012). While these employed physicians, known as "hospitalists," have been mainly primary care doctors, this trend is expected to expand into specialists such as cardiologists, surgeons, and anesthesiologists. As these physicians move in house, hospitals will be seen as the provider of care and be looked to for any problems associated with that care.

Another emerging area impacting vicarious liability is the increased use of non-physician providers. This is primarily seen in the use of nurse practitioners, nurse anesthetists, and physician assistants. As the ACA expands those having access to treatment, the use of these non-physician providers is expected to increase dramatically in order to keep up with increased demand for services. In some states, these lower level providers can treat, diagnose, and even proscribe medications on their own. *Nurse Practitioners and Primary Care*, Health Affairs: Health Policy Briefs (Oct. 25, 2012). However, most all states require these lower level personnel to practice under the supervision of a physician. Therefore, as these non-physicians increase in number and in scope of practice, the ACOs employing them will see their exposure expand just as dramatically as this care is provided.

These issues surrounding vicarious liability for ACOs, whether physician-owned practices or hospitals, are also impacted by the new marketplace created by the ACA. Because of the payment incentives created by the ACA, expect to see increased competition among ACOs for these healthcare dollars. As in any industry, this will come in the form of marketing of services and attempts to expand those services. As hospitals and physician-based ACOs market their services, they will undoubtedly hold themselves out as having the best "trauma team," "heart center," or "stroke unit," just to name a few. In all venues, these efforts to hold themselves out as providing these services as an ACO, as opposed to an individual physician, will mean that the ACO can expect to be vicariously liable for the treatment in these marketed areas. While hospitals have been held responsible for many years for treatment in the areas of emergency medicine and neonatal intensive care units, expect the marketing of additional services to expand the exposure of these hospitals and other ACOs into these other areas of practice.

This can be troublesome when it comes to medical malpractice insurance, as a general policy form may not have any endorsements that address vicarious liability coverage. Should a lawsuit be brought by a patient against a practice, the doctor(s) who owns the practice can be named, even if they never had any contact with the patient. Additionally, if the main provider of treatment was a contractor rather than an employee, this contractor may have malpractice insurance of his or her own, resulting in a dispute between multiple carriers over which is responsible for coverage in the suit. In some cases, this can result in the carriers denying coverage due to unclear language in the policies. Because of all the possible loopholes, it is important that physicians and ACOs carefully review their insurance policy to ensure that their carrier will insure any employees or contractors in their practice.

Malpractice carriers handle vicarious liability in different ways. Some include coverage for lab technicians, office assistants, and others known as "allieds" in the general policy form while requiring non-physician providers, more closely aligned with treatment, to be specifically named. Because these provisions differ from policy to policy, it is important that they be discussed before a policy is issued. Indeed, ACOs should seek out legal counsel in order to ensure that no coverage is overlooked. The cost of retaining an attorney may be considerable, but paying this amount up front is preferable to the worst case scenario of the carrier denying coverage of a claim based on ambiguous language in the policy's wording.

The ACA attempts to change the way medical care is delivered in the United States. By altering the payment structure and creating new incentives, it is already changing the landscape for how healthcare providers work, partner in their provision of care, and structure their medical practices. This new framework is being built upon decades of rules, scattered among the states, governing when legal entities are vicariously liable for the acts of their agents. It remains to be seen how state legislatures and courts will handle this expanded exposure and liability. Those of us providing counsel to these new and existing healthcare providers must keep abreast of these changes in order to help our clients navigate the new landscape the ACA is creating. And to help them answer the question: Who's my patient, anyway?

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