



GUIDELINES AND STANDARDS AND RULES, OH MY! STANDARD OF CARE UNDER THE ACA

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With the implementation of the Affordable Care Act (“ACA”) and the changes it has and will continue to make in the medical field, hospitals, doctors, nurses, and risk managers are worried about how the ACA will affect the standard of care in malpractice lawsuits. While the ACA does not specifically address medical malpractice tort reform, the act will significantly affect medical malpractice cases across the country by potentially creating a de facto federal standard of care for many, if not all, malpractice claims.

THE ACA AND MEDICARE PAYMENT PROVISIONS

The ACA expands Medicare and Medicaid’s current uses of Quality Measures by developing additional measures and linking the use of those measures with medical providers’ reimbursements. While the ACA did not create the idea of creating Quality Measures, in linking Quality Measures with physician reimbursement, it, in effect, creates a standard of care.

1. QUALITY MEASURES

Most physicians who treat Medicare and Medicaid patients are familiar with the Physician Quality Reporting System (“PQRS”). The PQRS uses incentive pay-

ments, and will begin to use payment adjustments in 2015, to encourage eligible health care professionals (“Providers”) to report on specific “Quality Measures.” A Quality Measure is a Centers for Medicare and Medicaid (“CMS”) created best practices list. It covers everything from how to treat individual conditions to the prevention of transmission of hospital acquired diseases.

For example, 2014 PQRS Quality Measure 65, titled “Appropriate Treatment for Children with Upper Respiratory Infection (“URI”)” provides incentives and will adjust payments for the treatment of that condition based on the percentage of children three months to 18 years of age diagnosed with URI but not dispensed an antibiotic prescription on or three days after the episode.¹ This Quality Measure is designed to steer Providers to prescribe antibiotics within three days to children diagnosed with URIs.

2. VALUE BASED PAYMENT MODIFIER

The Value Based Payment Modifier (“VBM”) creates differential payment to individual Providers or groups of Providers under the Medicare Physician Fee Schedule based on the quality of care and cost during a performance period. Each Provider group receives two composite scores (quality and

cost), based on how far the Provider is from the national mean.²

Beginning in 2015, the VBM will affect Medicare payments to Providers in groups of 100 or more Providers based on 2013 performance on quality and cost measures. In 2016, the VBM will apply to physicians in groups of 10 or more Providers based on 2014 performance. In 2017, the VBM will apply to all Providers based on 2015 performance.³

The ACA uses Quality Measures to determine the quality of care score of the VBM formula. In registering for the VBM, Providers must select at least one Quality Measure area for evaluation. In addition, CMS will also evaluate group Providers on three outcome Quality Measures under the administrative claims option. “These include: 1) an all cause readmission measure; 2) an acute preventive quality indicator composite; and 3) a chronic preventive quality indicator composite.”⁴

In addition to the Quality Measure composite score, the VBM creates a cost composite score based on: 1) a total per capita cost measure; and 2) total per capita cost measures for beneficiaries with four chronic conditions (chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes). The payment

adjustments are determined by a combination of the Quality Score and the Cost score. For example, a high-quality, low cost score would result in a 2% increase in Medicare reimbursements while a low quality, high cost score would result in a 1% reduction in Medicare reimbursements.⁵

3. QUALITY MEASURES, VBM AND CHANGING STANDARD OF CARE

The current standard of care in malpractice cases is how a similarly qualified practitioner would have performed under the same or similar circumstances. Most states require practitioners to adhere to a national standard. However, in 21 states the standard of care requires the practitioner to have a reasonable caliber of skill and knowledge possessed by practitioners in the locality where he or she practices. Therefore, depending on where a doctor or other medical provider practices, he or she may be held to a national standard or a local standard.

The ACA's changes to the standard of care will affect Providers in both national and local standard states. As Providers increase compliance with the Quality Measures to receive payment increases through the VBM, the Quality Measures will become the standard practice. Rather than a direct assault on the Standard of Care through direct legislation, the ACA more subtly alters the Standard of Care through the use of the Federal government's spending powers.

Additionally, as more Providers are pulled into the PQRS and VBM systems, it will become increasingly difficult for Providers in locality standard states to argue their locality has a different standard of care than the national standard. Providers in locality standard states will be following the same Quality Measures that are followed across the country. Concern over this fundamental alteration of the standard of care has led to several attempts to curb the PQRS and VBM's impact.

ATTEMPTS TO CURB THE ACA'S ALTERATIONS OF THE STANDARD OF CARE

Georgia recently adopted a law based on model legislation drafted by the American Medical Association ("AMA"), al-

though similar legislation has been proposed on the federal level. Georgia House Bill 499 states payment standards like the VBM cannot establish a standard of care without competent expert testimony establishing the appropriate standard of care. The proposed federal law, H.R. 1473, contains similar language, but has not been passed into law.

The Georgia statute and Federal proposal are limited in their scope and are unlikely to significantly stem the changes in the Standard of Care. In any medical malpractice case, the standard of care can only be established through expert testimony. These laws only require that any party wishing to use the Quality Measures or VBM to establish the standard of care do so through expert testimony.

Neither the Georgia law nor Federal proposal will curb the underlying risk of Quality Measures becoming a de facto standard of care. As more Providers participate in the VBM, they will not be able to argue they are unfamiliar with the Quality Measures or that the Quality Measures are not used in their locality. These laws only eliminate the possibility of Quality Measures being able to be introduced as Standard of Care without expert testimony.

WHAT ARE RISK MANAGERS, PRACTITIONERS, AND DEFENSE COUNSEL TO DO?

Those concerned about the Quality Measures changing the standards of care in their field can be comforted in three arguments: 1) the Quality Measures are written with the understanding that they will not apply in every case; 2) Quality Measures can actually bolster a defense in a medical malpractice suit; 3) physicians treat individuals.

First, as more Quality Measures are created, it is likely that a Provider will often prescribe treatment that does not comply with the Quality Measures. In fact, some level of noncompliance seems to be presumed. The Quality Measures only look at percentages of compliance and do not require that the Quality Measure be met in every individual case.

Secondly, the use of Quality Measures as a standard of care can, in some instances, be used to bolster a physician's defense.

There will be cases where defendant providers complied with the Quality Measures and yet the patient had a bad outcome. Providers who met the Quality Measure can argue that their compliance with the Quality Measure means they met the standard of care. Concerns about physicians making this argument led to Georgia's standard of care law to include language indicating compliance with the Quality Measures does not, by itself, prove compliance with the Standard of Care. Providers in states other than Georgia could argue that compliance with a Quality Measure is evidence of compliance with Standard of Care.

Finally, when faced with a Plaintiff alleging failure to comply with a Quality Measure was a violation of the Standard of Care, providers should be sure to point out that each patient is treated as an individual and that each patient's treatment is tailored to that patient's needs. Providers treat patients based on the provider's training and experience. If a provider does not follow a Quality Measure, he or she will need to ensure that her deviation from the Quality Measure is based on their training and experience and the individual patient's conditions.



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¹ Centers for Medicare and Medicaid, *2014 Physicians Quality Reporting System (PQRS) Measures List* (January 23, 2014).

² American Osteopathic Association, *Physician Value-Based Payment Modifier, How Will the VBM Affect Your Practice*, <http://www.osteopathic.org/inside-aoa/advocacy/regulatory-issues/Documents/value-based-modifier-policies-faq.pdf> (last visited July 3, 2014).

³ Providers that refuse to participate could face penalties up to a 2.5% reduction in Medicare reimbursement. *Id.*

⁴ Heart Rhythm Society, *Physician Value-Based Payment Modifier: Transforming Medicare From a Passive Payer to an Active Purchaser of Higher Quality, More Efficient Healthcare*, http://www.hrsonline.org/content/download/11418/513930/file/VBM_Analysis_2013.pdf (last visited on July 3, 2014).

⁵ *Id.*