

# Be Prepared in the Post-PPACA Liability and Healthcare Environment: Assure, Do Not Assume

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**T**he economic and liability lines in healthcare have crossed—significant incentives now exist for physician practices to double-down on best practices in safety and risk management. Now is the time to put these strategies into your business plan; your long-term successes could be dependent upon doing so. Some of the strategies will be new, while others involve traditional strategies that have taken on more importance since the June 28, 2012, Supreme Court of the United States ruling on the Patient Protection and Affordable Care Act (PPACA).

The Act largely removes the uncertainty felt by physicians and hospitals as many had tried to simultaneously manage budgets and patient care and put plans into place to comply with the PPACA requirements, or anticipating the resulting changes in healthcare delivery and reimbursement. Now, given that the Act was upheld, these trends, particularly those focused on quality and safety, will accelerate.

Much of the quality of care changes to date have been spearheaded by hospitals and health systems with physician collaboration (e.g., implementation of new electronic medical record programs and reducing medical errors, which met with some successes). For example, the Centers for Disease Control and Prevention has reported that the overall rate of blood-borne infections at hospitals was down by 32% in 2010 as compared with 2009; modest reductions were identified with catheter-associated urinary tract infections and surgical site infections.<sup>1</sup> Recently, Quinn et al. released results of a study in June 2012 that associated the use of electronic health records with a reduced number of medical malpractice claims.<sup>2</sup>

This focus on quality, outcomes, and safety will continue and expand. Whether it is employers, government programs, or commercial insurers, there will be a focus

on quality and safety metrics, and reimbursement will incentivize the same. One would think this should cause a reduction in liability exposure, and perhaps over time it will. However, because many of the Act's requirements result in changes discussed below, without a risk management focus, the liability exposure post-PPACA could be dramatic. These issues are discussed in greater detail below, beginning with a review of the ever-fascinating and -evolving litigation environment.

## THE EVOLVING LITIGATION ENVIRONMENT

### Frequency and Severity

Frequency and severity of claims are the two primary factors used to evaluate liability risk and exposure. "Frequency" means looking at the number of cases filed in a given period. For many years, it has been at an all-time, historic low. Now, in some venues, frequency is starting to creep upwards.<sup>3</sup>

More significant is the continuation of, and potential increase in, severity. "Severity" looks at the monetary value of settlement and damage awards in cases—how high are they? According to data released in 2011, severity continues to rise. Between 2002 and 2008, it rose 6.3% per year,<sup>3</sup> particularly in the area of what is called the "super losses" (multimillion-dollar awards). In fact, it has been reported that more than half of the largest healthcare claims ever recorded were paid in the last five years.<sup>4</sup> Further, just in the last two years, six states witnessed their largest medical malpractice jury award ever.<sup>4</sup> More and more news media are picking up coverage of damage awards in these verdict ranges, often noting new, record-high verdicts. The numbers are alarming.

For example, in May 2012, the *Philadelphia Business Journal* reported a \$78.5 million verdict in an obstetrical case.<sup>5</sup> In September 2011, a physician was found negligent and the plaintiff awarded \$23 million—among the highest verdicts ever in the Pennsylvania county.<sup>6</sup> The state of Maryland witnessed one of its largest medical malpractice

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verdicts in a case decided by a Baltimore jury in June 2012—\$55 million.<sup>7</sup> In 2011, a Michigan jury awarded \$144 million in a medical malpractice case.<sup>8</sup>

With this visibility, some say more patients will pursue suits to obtain similar results; and plaintiff attorneys use the large verdicts to impact settlement negotiations. This is difficult to quantify, but clearly there is a ripple effect.

In addition, plaintiff lawyers are accelerating “consolidation.” That is, fewer smaller plaintiffs’ firms are trying significant cases; instead, they refer (for a fee) cases to larger law firms with significant resources and experience. These larger plaintiff law firms have a reputation in their communities for being *the* plaintiffs’ law firm. They also have new resources that include not only healthcare providers as part of their litigation team, but also physicians, some of whom have graduated from law school as well.

Further, knowing how expensive medical professional liability cases are to litigate, plaintiff attorneys are looking to take on cases with the greatest potential damage value, particularly those with the “plus factors”—cases with an aggravating circumstance that may impact the value of an award in the eyes of a plaintiff attorney, patient/plaintiff, and/or ultimately the jury (also patients). For example, in one case noted above, the hospital-defendant was accused of not having had its medical equipment serviced for more than 10 years (where yearly servicing was recommended to properly maintain the equipment). While this alone does not make a medical malpractice case, it does impact claims and did impact the severity of the Pennsylvania award (\$78.5 million).

### *The Supreme Court decision upholding the PPACA is a factor in your liability equation.*

In that plaintiff lawyers are also taking fewer cases, they need to recoup their costs and obtain their profit through the cases they do have, which means the value of those cases increases. It may become more difficult to settle claims pre-suit, or at all, if demands continue to rise to an unreasonably high level. Defendants in medical malpractice cases may need to stand their ground and therefore will need to have the appropriate trial preparation and resources necessary to help ensure there is not an adverse verdict in that “super losses” category at trial.

### **The Impact of National Healthcare Reform on Frequency and Severity**

The Supreme Court of the United States’ decision upholding the PPACA is a factor in your liability equation. Frequency may take a further upswing, combined with the potential for increased severity in cases where a claim for “economic decision making” (i.e., that the doctor decided

on a certain care plan in an effort to save on costs, at the expense of the patient’s health) could enter the picture. This does not have to be, but without attention could be, the result. Consider the following potential implications.

- **Newly insured patients:** Increase in the number of insured patients by approximately 32 million. Among the 32 million new patients may be:
  - Insured patients as a result of the PPACA’s mandatory coverage provisions;
  - Insured patients eligible for Medicaid; and
  - Insured patients through state insurance exchanges.
- **New coverage and expanded coverage:** More expansive patient insurance coverage, which means more care will need to be provided to more individuals. The change in coverage will include:
  - More basic care for newly insured patients, that includes drug coverage, hospital care, maternity care, and other minimum-quality coverage parameters;
  - Coverage for existing and newly insured patients for preexisting conditions; and
  - More preventive services mandated coupled with no copays required.
- **Who these new patients might be:** Consider the following:
  - Patients without a true physician-patient relationship;
  - Patients seen by a physician for the first time, while in mid-disease;
  - Patients who have not had ongoing, preventive care; and
  - Patients not accustomed to follow-up or compliance with care plans or instructions.
- **New reimbursement models:** Focused on outcomes and quality; away from fee for services; in an effort to achieve enhanced quality, more accessible care, and a reduction in healthcare costs. The last is part of the government’s plan to bend the cost curve over time. Some models include incentives and/or “penalties.” These changes will be incremental, but the trend lines are clear. Models include:
  - Bundled payments;
  - Value-based payment modifier under the physician fee schedule (a differential payment to physician[s] based on quality of care provided compared with cost). The modifier is to be introduced as budget-neutral initiative, which means some providers will be increasing their reimbursement, while others will receive the delta; and
  - Shared-savings program for Accountable Care Organizations (ACOs) and other entities, embraced by employers and commercial insurers across the nation.
- **New delivery modules:** A change in the way healthcare is delivered because of both specific mandates in the Act and also in response to the Act. This includes both where care will be provided and who will provide the care:

- New structures like ACOs or Patient-Centered Medical Homes and associated “neighborhoods”;
  - Independence at Home medical practices;
  - Community-based care-transition programs;
  - An increased reliance on mid-level providers; and
  - A different type of collaboration between primary care and specialists
- **New data requirements:** Increase in focus on data collection, analysis, and transparency. While these are current trends, implementation of the PPACA will likely result in an acceleration of them. For example:
- The publication of patient safety ratings related to certain quality data points, including making certain physician data publicly available (physician compare Web sites);
  - Public reporting of performance information, including physician performance Web sites that are physician-specific;
  - Significant public reporting requirements of ACOs, with associated penalties for failure to report; and
  - Improvements to the Physician Quality Reporting System.

One can envision a scenario in which there will be more patients in the healthcare system, many mid-disease, with more comprehensive insurance, requiring more screening and testing; with care provided by new providers, including mid-level providers; all of which combined could result in an acceleration of more claims being filed. This is why we say without increased focus on safety and risk mitigation systems, the result could lead to an increase in the cluster of circumstances that have traditionally caused claims and some new ones:

- Claims about test tracking, patient notification of same, and patient care involving abnormal results;
- Claims about patient referrals and consultations/patient hand-offs;
- Claims about patient discharge from the hospital and medication reconciliation;
- Claims involving more complicated/chronic conditions and needed follow-up;
- Claims involving “comingling” of responsibility; and
- Claims involving the use of and supervisory responsibilities for mid-level providers.

As mentioned above, severity post-PPACA may also well be impacted by plaintiff claims that assert that decisions on care were based on economics and not on what might have been the appropriate care for the particular patient. In other words, a decision to not order a test or to not provide a referral could be alleged to be due to the fact that the same would result in an economic benefit through reimbursement for the doctor. These are the type of allegations seen in the past with managed care, a scenario which will hopefully not reoccur.

Delegates of the American Medical Association approved a 2012 report produced by The American Medical Association Council on Ethical and Judicial Affairs, which addresses physician stewardship, and particularly the physicians’ role to do what is best for patient care, regardless of the cost involved, but that is difficult in today’s environment.<sup>9</sup> The report provides guidance to physicians on how they can manage costs while not compromising patient health. A doctor’s obligation is to do what is medically right for the patient, and not to proceed with a cheaper method of care if it is not the right treatment for the patient. This will become more difficult to achieve in the new environment.

## BE POISED TO SUCCEED IN THE POST-PPACA ENVIRONMENT: ASSURE, NOT ASSUME

Align your practice infrastructure and patient care with the new environment, focusing on core elements that relate to managing the many issues noted above. Specifically, focus on impacting quality and safety, looking to obtain certain outcomes in your specialty and the patient experience. This will both blunt that potential liability implication and prepare you for the post-PPACA environment. To begin, you could focus on:

1. Strengthen care collaboration, both externally and internally.
2. Know how your patients feel about their experience with you and your practice.
3. Determine what metrics apply to you specifically.

Let’s briefly discuss what this pragmatically could look like.

### Strengthen care collaboration, both externally and internally.

A large focus of the PPACA and its associated regulations is on care collaboration, including transitions of care from the practice to other practices (external) and collaborative care among your team (internal). External collaboration examples include:

- Transitioning care from acute care to post-acute care or home;
- Transitioning care from a primary provider to a specialist (and vice versa); and
- Collaborating on patient home-care needs (telemedicine, telemonitoring, visiting nurses).

The process is more than a “hand-off” in many cases. In the traditional sense of that concept, one clinician “handed-off” care from himself or herself to another, and the new provider is considered to be in control of the patient’s care. However, in the new collaborative environment, a “collaborative hand-off” needs to occur, which means joint care and treatment of patients with effective communication. Key is having an infrastructure, processes,

and procedures in place, and following those processes and procedures. The new care delivery models are designed to enhance collaboration.

Internal collaboration examples include both clinical relationships and processes/procedures that are integral to safer care:

- Supervisory physician collaboration with mid-level providers;
- Test tracking and patient notification; and
- Mid-level providers collaborating with one another.

### Know how your patients feel about their experience with you and your practice.

“Patient experience,” historically referenced as “patient satisfaction,” has, for the first time, taken on a direct link to physician reimbursement (in addition to its well-known and -documented role in professional liability risk reduction).<sup>10</sup> Patient experience rating is one of the four metrics used by Medicare as part of its shared-savings program applicable to the ACOs. Patient /caregiver experience data are collected from patients in the following areas:

- Timely patient care, appointments, and information;
- How well a physician communicates with patients;
- Whether staff members are helpful, courteous, and respectful;
- Overall patient rating of physician;
- Health promotion and education;
- Shared decision-making; and
- Patient health status and functionality.

Physician practice evaluations of patient experience (satisfaction) is not new, but the link to reimbursement is, and it is accelerating.<sup>11</sup> Already, patient experience is having a direct impact on reimbursement. In April 2012, the value-based purchasing program of the PPACA completed its first performance period. The fee arrangement includes a 1% reduction in reimbursement to 3000 hospitals, with an opportunity to either earn it back or earn more depending on certain performance parameters. Thirty percent of the bonus benchmarks are based on patient satisfaction scores. The Agency for Healthcare Research and Quality created a publicly available assessment tool for physicians to evaluate these areas (Consumer Assessment of Healthcare Providers and Systems, [CAHPS]). It is time to commit to that five-star culture.

### Determine what metrics apply to you specifically.

A specialty-by-specialty review is beyond the scope of this article, but the PPACA is a good place to start, to understand initiatives and changes that will relate to you specifically. In addition, more metrics and data points are being determined by the federal government, and so this is an area where prediction plus monitoring is important.

Further, it is not enough to understand your specific profile, but also how you compare with your peers, as reimbursement methodologies will be largely done on a comparative basis. Key is finding out now “what you don’t know” instead of after you have submitted data (or data are submitted on you) for reimbursement.

### How to Do It

Assemble a committee, which may appropriately be your physician practice Quality Assurance (QA) Committee. Such committees are often responsible for quality assurance initiatives, reviewing quality assurance issues, promoting best practices, tracking and trending data, prioritizing risk management activities, evaluating patient and physician concerns, and developing risk management strategies. It can be a fit. Of course one must always be mindful to structure the QA committee in a way that affords the greatest protections of confidentiality (attorney-client privilege and/or peer-review protections), particularly when the committee will be responsible metrics, quality, and patient experience data, among other areas.

For the post-PPACA initiative, the QA committee or other ad hoc committee should oversee the efforts to understand the areas above, to analyze the information obtained, and to prioritize next steps. It should be responsible for ongoing efforts to implement needed changes and to assure, not assume, that the metrics determined are being met (or exceeded), strategies to reduce clinical and liability risk are being used and used appropriately, infrastructure and processes are as efficient as possible, and the patient experience is being monitored. It is a tall order, and will require collaboration within your practice and among your peers.

## CONCLUSION

The healthcare industry has changed, and with the recent decision from the Supreme Court of the United States on the PPACA, change in the areas of safety, collaboration, and measuring is going to accelerate. And all of these will impact how physicians are reimbursed for patient care. One would think that such incentivizing should lead to reduced number of adverse clinical outcomes that could lead to claims, and therefore the number of claims.

### *Those that are prepared sooner will achieve greater benefits.*

However, the changed focus is occurring in combination with an anticipated dramatic increase in the number of patients, and those patients will likely include patients who have not had ongoing medical care, do not have a true physician-patient relationship, and who are traditionally less compliant with healthcare plans and care. It could

result, therefore, without appropriate safety and risk management measures and preparedness, in greater liability exposure in some traditional and new areas.

Keys to success in the post-PPACA environment include achieving certain benchmarks or metrics, achieving efficiencies in care transition and collaboration, incorporating best practices in clinical and risk management, scoring well on patient experience surveys, and enhancing the patient experience overall. Those that are prepared sooner will achieve greater benefits; the delta generally will be important, and the beginning is when one should be able to impact one's reimbursement the most. ■■

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