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## A Promise Realized? A Critical Review of Accountable Care Organizations Since the Enactment of the Affordable Care Act

Jean Phillip Shami

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# A Promise Realized? A Critical Review of Accountable Care Organizations Since the Enactment of the Affordable Care Act

JEAN PHILLIP SHAMI\*

*As the six-year anniversary of the passage of the Affordable Care Act (“ACA”) comes to a close, a critical review of one of the key inventions of the ACA—Accountable Care Organizations (“ACOs”)—is timely as part of the greater narrative around affordable, quality health care in America. This Comment begins with a discussion of the statutory creation, philosophy and vision, and organizational structure of ACOs in the context of the passage of the ACA in 2010. Then, it will critically review ACOs from three perspectives based on the ACO model’s mission to provide better care for more people at a lower cost. The first critical perspective will address the concept of “bending the cost curve” to understand whether ACOs have effectively reduced costs, both statutorily and practically. The second critical perspective will consider the “quality of care” framework used to “grade” ACOs, questioning whether this grading system is effective—or even sufficient—to improve the quality of health care. The third critical perspective will evaluate whether*

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*ACOs have enabled greater access to care for all Americans—an aspiration for a renewed American health care system—or simply intensified the marginalization of access to health care in this country. It is undeniable that the ACO model of care could greatly impact health outcomes in the United States by restructuring the delivery system of patient care.*

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## INTRODUCTION

Perhaps the most meaningful contribution of the ACO model is that it gives providers a reason to change the culture of medicine. It asks providers across specialties to work together and coordinate care in a way that was not rewarded under fee-for-service. It asks organizations to stitch the separate pieces of the patient’s care trajectory together through teamwork. In the long run, this may be the most intangible but substantive legacy that the ACO model provides. Under a single, collective contract at the organizational level, providers are quite literally in it together. If providers can break down silos, [offer] better care coordination, and manage population health with a collective vision towards keeping patients healthy, the ACO paradigm would be able to claim a profound achievement. Such changes, however, will take time and they are not guaranteed.<sup>1</sup>

On March 23, 2010, as President Obama signed into law the Patient Protection and Affordable Care Act (“ACA”),<sup>2</sup> politicians and the public reacted both positively and negatively. Proponents rejoiced as they believed the ACA was a step forward towards universal health care coverage in the United States.<sup>3</sup> Opponents, however,

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<sup>1</sup> Zirui Song, *Accountable Care Organizations: Early Results and Future Challenges*, 21 J. CLINICAL OUTCOMES MGMT. 364, 364–71 (Aug. 2014).

<sup>2</sup> Patient Protection and Affordable Care Act (PPACA) of 2010, Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of 42 U.S.C.).

<sup>3</sup> Donald M. Berwick, *Launching Accountable Care Organizations—The Proposed Rule for the Medicare Shared Savings Program*, NEW ENG. J. MED. 1,

maintained a high cry that the ACA violated individual liberties, portraying the ACA as the manifestation of “a larger and larger government, more and more intrusive in your life . . . that potentially causes you to lose the insurance that you like . . . .”<sup>4</sup> Amidst these political and societal tensions, the United States health care industry experienced monumental shifts in health care coverage, organizational and funding structures, and a fundamental understanding of the meaning of “health” in the United States.<sup>5</sup> As policymakers and health care providers alike seek to achieve the “Triple Aim”<sup>6</sup>—composed of “[i]mproving the patient experience of care . . . ; [i]mproving the health of populations; and [r]educing the per capita cost of health care”<sup>7</sup>—through the implementation of the various provisions of the ACA, one major organizational structure has garnered special attention: the Accountable Care Organization (“ACO”) models of care.

Defined 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,”<sup>8</sup> the ACO models

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4 (Mar. 31, 2011), <http://www.nejm.org/doi/pdf/10.1056/NEJMp1103602> (“Whatever form ACOs eventually take, one thing is certain: the era of fragmented care delivery should draw to a close. Too many Medicare beneficiaries—like many other patients—have suffered at the hands of wasteful, ineffective, and poorly coordinated systems of care, with consequent costs that are proving unsustainable.”).

<sup>4</sup> Mitt Romney, *Mitt Romney: I Will Repeal Obamacare*, P2012.ORG (June 28, 2012), <http://www.p2012.org/issues/hc062812oppose.html>; see also Robert B. Leflar, *Reform of the United States Health Care System: An Overview*, 10 U. TOKYO J.L. & POL. 44, 49 (2013) (Opponents of the ACA argued that the law “infringed on personal liberty and was beyond Congress’s power.”).

<sup>5</sup> See generally PPACA, 124 Stat. 119 (codified as amended in scattered sections of 42 U.S.C.).

<sup>6</sup> Inst. for Healthcare Improvement, *The IHI Triple Aim Initiative*, INST. HEALTHCARE IMPROVEMENT, <http://www.ihl.org/engage/initiatives/tripleaim/Pages/default.aspx> (last visited Jan. 16, 2016) [hereinafter IHI Triple Aim] (describing a framework “to optimiz[e] health system performance” through the “Triple Aim.”).

<sup>7</sup> IHI Triple Aim, *supra* note 6. See also Berwick, *supra* note 3, at 1 (“[The ACO’s] purpose is to foster change in patient care so as to accelerate progress toward a three-part aim: better care for individuals, better health for populations, and slower growth in costs through improvements in care.”).

<sup>8</sup> Center for Medicare & Medicaid Services, *Accountable Care Organizations (ACOs): General Information*, CTRS. MEDICARE & MEDICAID SERVS. (Jan.

has been (skeptically)<sup>9</sup> characterized as an organizational model likely to result in major cost savings for the Medicare program—and the American health care system as a whole.<sup>10</sup> While many studies generally paint a positive picture of the impact ACOs have had since their inception under the ACA,<sup>11</sup> several questions remain unanswered.

This Comment hopes to shed light on the current state of the ACO model of care, while pointing to the remaining unanswered questions. In so doing, this Comment posits that, with respect to ACOs, the “Triple Aim”<sup>12</sup> has been undone by the disproportionate emphasis on “restraining costs.”<sup>13</sup> This financial focus overshadows the two remaining priorities of American health reform: improving quality of care and facilitating access to care through the ACO

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11, 2016), <https://innovation.cms.gov/initiatives/aco/> [hereinafter *ACOs: General Information*].

<sup>9</sup> See Eleanor D. Kinney, *The Affordable Care Act and the Medicare Program: The Engines of True Health Reform*, 13 YALE J. HEALTH POL’Y, L., & ETHICS 253, 295 (2013) (“Although the provider community was initially skeptical of ACOs, . . . they have responded to the initiative relatively enthusiastically.”) (footnote omitted).

<sup>10</sup> See Berwick, *supra* note 3, at 4 (“CMS believes that with enhanced cooperation among beneficiaries, hospitals, physicians, and other health care providers, ACOs will be an important new tool for giving Medicare beneficiaries the affordable, high-quality care they want, need, and deserve.”); Jenny Gold, *Accountable Care Organizations, Explained*, KAISER HEALTH NEWS (Sept. 14, 2015), <http://khn.org/news/aco-accountable-care-organization-faq/> (“While ACOs are touted as a way to help fix an inefficient payment system that rewards more, not better, care, some economists warn they could lead to greater consolidation in the health care industry . . . .”); Thomas L. Greaney, *Regulators as Market-Makers: Accountable Care Organizations and Competition Policy*, 46 ARIZ. ST. L.J. 1, 1 (2014) (“The ACO strategy entails regulatory interventions that at once aim to reshape the health care delivery system, improve outcomes, promote adoption of evidence-based medicine and supportive technology, and create a platform for controlling costs under payment system reform.”). While multiple ACO models exist, this Comment will refer to them collectively as the “ACO model of care.”

<sup>11</sup> Interestingly, the ACO model of care did not originate from the ACA. See Paul R. DeMuro, *Accountable Care*, 24 HEALTH L. 1, 11 (2012) (“ACOs are not uniquely a convention of the Medicare program and have existed in some form for a number of years. In fact, many provider/health plan ‘partnerships’ are in the form of . . . [commercial] ACOs.”).

<sup>12</sup> IHI Triple Aim, *supra* note 6.

<sup>13</sup> Leflar, *supra* note 4, at 49.

model of care.<sup>14</sup> This Comment advocates for a rebalancing of priorities to achieve the original tri-mission of expanded access, improved quality, and reduced costs within the new, post-ACA American health care system.

Part I begins with an overview of the statutory definition, philosophy and values, and various organizational structures currently in place for ACOs. Following this foundational description of the ACO model of care, this Comment will consider three perspectives in the overall discussion of ACOs, all of which are within the framework of the “Triple Aim.”<sup>15</sup> Part II considers the first of these perspectives—reducing overall costs within the American health system—by exploring the idea of “bending the cost curve,” and the general ability of the ACO model to reduce costs under the current Medicare system and beyond. Part III critically reviews the grading methodology used to achieve the second perspective in the triangle—quality of care provided—and asks whether this methodology is accurately structured to achieve true improvements in quality of care. Part IV considers the third perspective of the “Triple Aim”<sup>16</sup>—expanding access to care—and evaluates whether ACOs have met that goal. This Comment concludes with final thoughts on the general success of, as well as the future trajectory, of the ACO model of care.

#### I. ACCOUNTABLE CARE ORGANIZATIONS: PHILOSOPHY, STATUTE, AND ORGANIZATION

Though the ACO model of care has become a popularized product of the ACA,<sup>17</sup> the concept of the ACO generally existed in one form or another prior to the passage of the ACA.<sup>18</sup> However, because of the passage of the ACA, the ACO model has become one of the more lucrative, incentive-based programs for health care providers.<sup>19</sup> For policymakers, the concept of the ACO fits nicely in the

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<sup>14</sup> *Id.*

<sup>15</sup> IHI Triple Aim, *supra* note 6.

<sup>16</sup> IHI Triple Aim, *supra* note 6.

<sup>17</sup> *See, e.g.,* Gold, *supra* note 10 (“ACOs have become one of the most talked about new ideas in . . . [the ACA].”).

<sup>18</sup> DeMuro, *supra* note 11, at 1, 11.

<sup>19</sup> Part II provides a detailed discussion of the payment methods used to reward ACOs for savings generated. *See generally infra* Part II.

shifting framework, goals, and values of the new post-ACA American health care system.<sup>20</sup>

Defined as “a group of primary care doctors, specialists, hospitals, and other health care providers, who come together with a common goal of delivering high-quality coordinated care to their Medicare patients,”<sup>21</sup> the ACO model of care aims to balance the “Triple Aim”<sup>22</sup> by implementing a “carrot-and-stick approach” to care.<sup>23</sup> Essentially, the ACO model creates a multi-team system of care in which overall reductions in cost and general improvements in quality care are rewarded.<sup>24</sup> At least 744 ACOs have been created since 2011, both privately and through public programs created through Medicare.<sup>25</sup> While strategies of implementation vary among ACOs,

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<sup>20</sup> Greaney, *supra* note 10, at 4 (“The MSSP attempts to tackle this policy quandary [of changing the payment and delivery system of the health care system] by addressing both problems simultaneously, offering financial rewards to providers that organize and reorient their practices to deliver seamless, high quality care.”).

<sup>21</sup> Robert Tagalicod, *Accountable Care Organizations: The Future of Coordinated Care*, CTRS. MEDICARE & MEDICAID SERVS. (Aug. 23, 2013, 2:33 PM), [https://www.cms.gov/eHealth/ListServ\\_AccountableCareOrgs.html](https://www.cms.gov/eHealth/ListServ_AccountableCareOrgs.html); Kinney, *supra* note 9, at 294 (“CMS defines ACOs as ‘groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.’”); *see also* Song, *supra* note 1, at 364 (“Three key characteristics are embedded in this definition. First is *joint accountability*. . . . *Second*, an ACO takes on accountability for *both spending and quality*. . . . *Third*, an ACO is responsible for the care of a *population* of people.”).

<sup>22</sup> IHI Triple Aim, *supra* note 6.

<sup>23</sup> Gold, *supra* note 10 (“The law takes a carrot-and-stick approach by encouraging the formation of . . . [ACOs] in the Medicare program. Providers make more if they keep their patients healthy.”).

<sup>24</sup> Berwick, *supra* note 3, at 1 (“Under the law, an ACO will assume responsibility for the care of a clearly defined population of Medicare beneficiaries attributed to it on the basis of their patterns of use of primary care. If an ACO succeeds in both delivering high-quality care and reducing the cost of that care to a level below what would otherwise have been expected, it will share in the Medicare savings it achieves.”); Song, *supra* note 1, at 368 (“ACOs serve as a vehicle for payment reform and organizational reform among providers. They bring physicians across specialties and hospitals together under the same contractual roof, allowing the organization to determine how it allocates its resources under the spending target.”).

<sup>25</sup> Gold, *supra* note 10 (“About 6 million Medicare beneficiaries are now in an ACO, and, combined with the private sector, at least 744 organizations have become ACOs since 2011. An estimated 23.5 million Americans are now being



the ACA provides a general statutory framework to guide the formation, goals, values, and organizational functioning of ACOs in the United States.<sup>26</sup>

*A. Statutory Definition of ACOs Under the Affordable Care Act*

Buried in the long list of reforms and policy strategies within the ACA, Title III<sup>27</sup>—titled “Improving the Quality and Efficiency of Health Care”—is the formulaic attempt to balance the “Triple Aim” for beneficiaries participating in the Medicare program.<sup>28</sup> This title aims to 1) improve quality of care and 2) more efficiently deliver care by reforming the payment structures, quality standards, delivery methods, and organizational models through which Medicare beneficiaries receive care.<sup>29</sup> Of the seven subtitles under Title III, subtitle A forms the statutory basis for generally achieving the “Triple Aim”: Part I influences the current cost structures; Part II addresses the quality of care provided; and Part III targets the efficiency of care.<sup>30</sup> Specifically, Part III outlines in detail the ACO model of care through the Medicare Shared Savings Program.<sup>31</sup>

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served by an ACO.”); Terry L. Corbett, *Healthcare Corporate Structure and the ACA: A Need for Mission Primacy Through a New Organizational Paradigm?*, 12 IND. HEALTH L. REV. 103, 162 (2015) (“[T]he ACA does not prohibit the development of ‘private’ ACOs, which are free to organize and operate independent of the Medicare Program. In theory, at least for now, such ACOs could operate entirely as for-profit enterprises relying solely on reimbursement from non-governmental, third-party payors . . .”). See generally Valerie A. Lewis et al., *Accountable Care Organizations in the United States: Market and Demographic Factors Associated with Formation*, 48 HEALTH SERVS. RES. 1840, 1849–53 (2013) (providing visual and descriptive results of the number of ACOs across various geographical regions); David Muhlestein, *Growth And Dispersion Of Accountable Care Organizations In 2015*, HEALTH AFF. BLOG (Mar. 31, 2015), <http://healthaffairs.org/blog/2015/03/31/growth-and-dispersion-of-accountable-care-organizations-in-2015-2/> (Section titled “ACO Growth,” which describes the increase in the number of ACOs since 2011 when ACO contracts began).

<sup>26</sup> See *infra* Part I, section A, subsection 3; Part. I, section C.

<sup>27</sup> PPACA, tit. III, 124 Stat. at 353–538.

<sup>28</sup> See generally *id.*

<sup>29</sup> See *id.*

<sup>30</sup> PPACA, tit. III, subtit. A, pt. I–III, 124 Stat. at 353–415.

<sup>31</sup> *Id.* at pt. III, 124 Stat. at 389–415.

1. SUBTITLE A, PART III: ENCOURAGING DEVELOPMENT OF  
NEW PATIENT CARE MODELS

Subtitle A, Part III<sup>32</sup> is “designed to make the delivery of, and payment for, health care services to Medicare fee-for-service beneficiaries more integrated and efficient and therefore, less costly.”<sup>33</sup> This part of Subtitle A establishes the Center for Medicare and Medicaid Innovation (“CMI”) within the Centers for Medicare and Medicaid Services (“CMS”), as well as several incentive programs for health care providers of varying size and experience to participate in the twin goals of Title III: improving quality and efficiency.<sup>34</sup> In effect, Part III creates a national laboratory for creating, testing, and refining models of care consistent with the “Triple Aim.”<sup>35</sup>

2. SECTION 3021: ESTABLISHMENT OF CENTER FOR MEDICARE  
AND MEDICAID INNOVATION WITHIN CENTER FOR  
MEDICARE AND MEDICAID SERVICES

Section 3021 outlines the mission and objectives of the CMI, the research arm used to identify and test models that best reduce the cost of care while improving quality.<sup>36</sup> The CMI “test[s] innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care furnished to individuals.”<sup>37</sup> Based on the research results produced from “consult[ing] representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management,”<sup>38</sup> the Secretary of the Department of Health and Human Services (“Secretary”) will “give preference to models that . . .

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<sup>32</sup> PPACA, tit. III, subtit. A, pt. III, secs. 3021–27, 124 Stat. at 389–415.

<sup>33</sup> Kinney, *supra* note 9, at 292.

<sup>34</sup> See PPACA, tit. III, subtit. A, pt. III, sec. 3021, 124 Stat. at 389–95.

<sup>35</sup> See Centers for Medicare & Medicaid Services, *Innovation Center*, CTRS. MEDICARE & MEDICAID SERVS., <https://innovation.cms.gov> (last visited Jan. 29, 2016).

<sup>36</sup> 42 U.S.C. § 1315a (2012); David Blumenthal et al., *The Affordable Care Act at 5 Years*, 372 NEW ENG. J. MED. 2451, 2455 (2015) (“Funded at \$1 billion per year for 10 years, CMMI has the authority to undertake a wide variety of experiments for the purpose of improving quality and reducing cost within the Medicare and Medicaid Programs.”).

<sup>37</sup> 42 U.S.C. § 1315a(a)(1).

<sup>38</sup> *Id.* at (a)(3).

improve the coordination, quality, and efficiency of health care services furnished to applicable individuals.”<sup>39</sup> The Secretary selects models based on “evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.”<sup>40</sup> Successful models may be expanded on a national scale in order to further the twin goals of improving quality and efficiency of care.<sup>41</sup>

### 3. SECTION 3022: MEDICARE SHARED SAVINGS PROGRAM

As a separate initiative, Section 3022 creates the Medicare Shared Savings Program (“MSSP”), the program through which the ACO initiative exists.<sup>42</sup> The MSSP aims to “promote[] accountability for a patient population and coordinate[] items and services . . . , and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.”<sup>43</sup> To do so, the MSSP sets a broad model of participation such that:

(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 . . . .<sup>44</sup>

Under this provision, groups of health care providers who meet the eligibility requirements may receive payment for shared savings earned for meeting defined performance standards by coordinating

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<sup>39</sup> *Id.* at (a)(1).

<sup>40</sup> *Id.* at (b)(2)(A).

<sup>41</sup> Blumenthal et al., *supra* note 36, at 2455 (“This new capability to spread proven programs quickly could markedly enhance the nimbleness of federal policymaking.”).

<sup>42</sup> 42 U.S.C. § 1395jjj.

<sup>43</sup> 42 U.S.C. § 1395jjj(a)(1).

<sup>44</sup> 42 U.S.C. § 1395jjj(a)(1)(A)–(B); Frank Pasquale, *Accountable Care Organizations in the Affordable Care Act*, 42 SETON HALL L. REV. 1371, 1372 (2012) (“The MSSP is an incentive program, not a mandate: the private sector must choose to participate if it is to be effective.”).

the overall care of Medicare beneficiaries assigned to the ACO by the Secretary.<sup>45</sup> Eligibility is determined based on whether the group of providers “have established a mechanism for shared governance,”<sup>46</sup> though Section 3022 does not require any particular structure of governance.<sup>47</sup>

However, all participating ACOs must meet the following eight general requirements that help define and guide the operation of an ACO: 1) a willingness “to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned” to the ACO; 2) a formal contract of no less than three years entered with the Secretary; 3) a formal legal structure that allows “the organization to receive and distribute payments for shared savings”; 4) a minimum number of Medicare fee-for-service beneficiaries that the ACO serves (at least 5,000), as well as primary care physicians; 5) the provision of necessary information to the Secretary to aid in the assigning of Medicare fee-for-service beneficiaries, as well as “the implementation of quality and other reporting requirements”; 6) a leadership and management structure “that includes clinical and administrative systems”; 7) a process “to promote evidence-based medicine and patient engagement, report on quality and

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<sup>45</sup> See 42 U.S.C. § 1395jjj(a)(1)(A)–(B); *id.* at (c) (“The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided . . . by an ACO professional.”).

<sup>46</sup> 42 U.S.C. § 1395jjj(b)(1)(A)–(E); Louise Walling, *Joining an ACO? Questions to ask before you sign*, 4 TEX. MED. LIABILITY TR. 1, 2 (2013).

<sup>47</sup> Centers for Medicare & Medicaid Services, *Shared Savings Program*, CTRS. MEDICARE & MEDICAID SERVS. (Dec. 20, 2015, 11:50 AM), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/> (last visited Jan. 13, 2016) [hereinafter *Shared Savings Program*] (“Participation in an ACO is purely voluntary.”); Corbett, *supra* note 25, at 160 (“By design, the ACA has not specified any particular legal or organizational form through which these multiple stakeholders are to accomplish the requisite ‘shared governance’ of the ACO.”). Section 3022 does articulate a select group of providers that will be eligible to participate; however, it also includes a catch-all provision that states that “[s]uch other groups of providers of services and suppliers as the Secretary determines appropriate” may participate, leaving the “shared governance” structure broad. See 42 U.S.C. § 1395jjj(b)(1)(A)–(E).

cost measures, and coordinate care”; and 8) an ability to “demonstrate to the Secretary that . . . [the ACO] meets patient-centeredness criteria specified by the Secretary.”<sup>48</sup>

These general requirements are coupled with quality and reporting requirements, established to determine the overall reduction of costs and improvement in quality and efficiency of care that an ACO provides in a given year.<sup>49</sup> These quality and reporting requirements are established by the Secretary in conjunction with quality performance standards designed “to assess the quality of care furnished by . . . ACO[s],”<sup>50</sup> with quality standards improving over time “by specifying higher standards, new measures, or both . . . .”<sup>51</sup> This information is collected by the ACO during a given year and then submitted to the Secretary in order “to evaluate the quality of care furnished by the ACO.”<sup>52</sup> The information collected can range from “clinical processes and outcomes” to “patient and . . . caregiver experience of care,” as well as “utilization.”<sup>53</sup>

In exchange for meeting these quality and cost-saving requirements, participating ACOs are eligible to receive a payment of “shared savings.”<sup>54</sup> Such “shared savings” are calculated as “a percent . . . of the difference between . . . [the] estimated average per

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<sup>48</sup> See 42 U.S.C. § 1395jjj(b)(2)(A)–(H); Corbett, *supra* note 25, at 160 n.296; The Dartmouth Institute for Health Policy & Clinical Practice, *What is an ACO*, DARTMOUTH INST. HEALTH POL’Y & CLINICAL PRAC., <http://tdi.dartmouth.edu/research/evaluating/health-system-focus/accountable-care-organizations/about-us> (last visited Jan. 13, 2016) [hereinafter *Dartmouth Institute*] (Articulating that all ACOs must be capable of: 1) “Providing or managing the continuum of care for patients as a real or virtually integrated delivery system”; 2) “Supporting comprehensive performance measurement and expenditure projections”; 3) “Internally distributing shared savings and prospectively planning budgets and resource needs.”); DeMuro, *supra* note 11, at 3–5 (listing the foundational elements of an accountable care organization, including: “Patient-Centered Medical Homes”; “Cross-Collaborative Team Approach to Care”; “Strong Foundation of High-Performing Primary Care”; “Ability to Measure Quality”; “Evidence-Based Medicine”; “Transparency”; “Health Information Technology”; “Culture of Accountability”; “Integrating Independent Physicians”; and “Telemedicine and E-Health.”).

<sup>49</sup> See 42 U.S.C. § 1395jjj(b)(3)(A)–(D).

<sup>50</sup> *Id.* at (b)(3)(A).

<sup>51</sup> *Id.* at (b)(3)(C).

<sup>52</sup> *Id.* at (b)(3)(B).

<sup>53</sup> See *id.* at (b)(3)(A)(i)–(iii).

<sup>54</sup> *Id.* at (d)(1)(A).

capita Medicare expenditures in a year”<sup>55</sup> and a benchmark set by the Secretary,<sup>56</sup> with limits to the total amount of shared savings an ACO is able to receive.<sup>57</sup> This benchmark is set “using the most recent available [three] years of per-beneficiary expenditures for . . . services for Medicare fee-for-service beneficiaries assigned to the ACO” and is adjusted both annually and to the characteristics of each beneficiary.<sup>58</sup> A provider or supplier’s original payments under the Medicare fee-for-service program remain unaltered;<sup>59</sup> rather, the shared savings incentive is an additional payment that may be earned by participating ACOs that meet the quality performance standards and general ACO requirements.<sup>60</sup> However, the Secretary maintains the discretion to terminate contracts with ACOs that do not meet the quality performance standards,<sup>61</sup> as well as impose sanctions on ACOs that attempt to reduce costs by avoiding at-risk patients.<sup>62</sup>

Alternatively, the Secretary may choose to use a payment model other than the shared savings model for making payments to participating ACOs.<sup>63</sup> The first of these alternatives is a partial capitation model in which the participating ACO “is at financial risk for some, but not all, of the items and services covered.”<sup>64</sup> This payment model is typically limited to advanced health systems best able to bear the risk.<sup>65</sup> The second alternative allows for the Secretary to implement a payment model “that the Secretary determines will improve the quality and efficiency of items and services furnished” by the participating ACO.<sup>66</sup> In both these alternatives, the payment model

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<sup>55</sup> *Id.* at (d)(2).

<sup>56</sup> *Id.* at (d)(1)(B)(ii).

<sup>57</sup> *Id.* at (d)(2).

<sup>58</sup> *Id.* at (d)(1)(B)(ii).

<sup>59</sup> *Id.* at (d)(1)(A) (original payments by Medicare are “made to providers of services and suppliers participating in an ACO, under the original Medicare fee-for-service program.”).

<sup>60</sup> *Id.*

<sup>61</sup> *Id.* at (d)(4).

<sup>62</sup> *Id.* at (d)(3).

<sup>63</sup> *Id.* at (i)(1).

<sup>64</sup> *Id.* at (i)(2)(A).

<sup>65</sup> *Id.* at (i)(2)(A) (this payment model is limited to “ACOs that are highly integrated systems of care and . . . [are] capable of bearing risk.”).

<sup>66</sup> *Id.* at (i)(3)(A).

must not be designed to cause more spending towards the participating ACO than would have been spent for the ACO under a normal payment model.<sup>67</sup>

### B. *Philosophy and Vision for ACOs*

The ACA and the rapid move to the ACO model of care reflects a national desire to increase health coverage for all Americans while reducing the cost of care in the United States.<sup>68</sup> These national aims are encapsulated in the “Triple Aim”<sup>69</sup>—increasing access to care, reducing cost of care, and improving quality of care<sup>70</sup>—which mirror the goal of the ACO model of care<sup>71</sup>—“to be accountable for the overall cost and quality for a full spectrum of care for a defined population.”<sup>72</sup> ACOs are driven by three philosophical principles that align with the “Triple Aim”: 1) “Local Accountability” by assigning the patient to the ACO where they receive the greatest number of services, but without requiring the patient to only go to the assigned ACO; 2) “Shared Savings” that ACOs may earn when quality stand-

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<sup>67</sup> *Id.* at (i)(2)(B), (i)(3)(B).

<sup>68</sup> Leflar, *supra* note 4, at 49.

<sup>69</sup> IHI Triple Aim, *supra* note 6.

<sup>70</sup> Berwick, *supra* note 3, at 1; Leflar, *supra* note 4, at 49 (quotations removed).

<sup>71</sup> Ellen Josephine Angelo, *Accountable care organizations: Are they the right answer?*, 42 NURSING MGMT. 20, 22 (2011) (“The goal of the ACO is to pay providers . . . utilizing a methodology that encourages the team to collaboratively work together and share accountability based on efficiency and high quality exceeding national benchmarks.”).

<sup>72</sup> *Dartmouth Institute*, *supra* note 48. See also Angelo, *supra* note 71; Berwick, *supra* note 3, at 1; Greaney, *supra* note 10, at 5–6 (“[T]he core concept [of an ACO] envisions a local entity and a related set of providers, including primary care physicians, specialists, and hospitals that can be held accountable for the cost and quality of the entire continuum of care delivered to a defined population . . . .”); Peter Wehrwein, *An Accounting of ACOs: Where they are, what they are, and how many there are*, MANAGED CARE MAG. ONLINE (Nov. 2014), <http://www.managedcaremag.com/linkout/2014/11/26> (defining ACOs as “a provider-led organization that takes on the financial risk for the health care of a defined population.”).

ards are met and costs are reduced; and 3) “Performance Measurement[s]” which ACOs must collect to monitor overall performance.<sup>73</sup>

An ACO “itself has a fiduciary obligation to the patients it serves comparable to that historically attributed only to physicians,” extending this “well-established [duty] in the profession of medicine ‘to all major participants in the health care industry’ . . . involved in the direct delivery of health care services to patients.”<sup>74</sup> This standard in turn shifts the control element from insurers to providers of care because beneficiaries are assigned to ACOs based on usage rather than on plan selection.<sup>75</sup> Along with this fiduciary obligation, ACOs are held to a level of accountability through the measures and quality reporting requirements, as well as the requirement to control costs.<sup>76</sup> Similarly, the ACO model of care is intended to shift the payment model from one of fee-for-service to one based on delivering the highest quality care at the lowest price possible.<sup>77</sup> By setting a fiduciary obligation and an accountability measure on participating ACOs, along with a restructured payment model, the intention is for the ACO to fix the fragmented American health system that currently lacks coordination and communication.<sup>78</sup>

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<sup>73</sup> *Dartmouth Institute*, *supra* note 48. See also Pasquale, *supra* note 44, at 1374 (Describing “the ‘three key attributes’ of ACOS [as]: ‘organized care, performance measurement, and payment reform.’”).

<sup>74</sup> Corbett, *supra* note 25, at 177.

<sup>75</sup> Greaney, *supra* note 10, at 7–8 (Noting the distinction between Health Management Organizations (“HMOs”) and ACOs, including that beneficiaries are assigned to a specific ACO whereas beneficiaries are not assigned to HMOs).

<sup>76</sup> DeMuro, *supra* note 11, at 1 (the ACO “understand[s] that care will be measured and reported and that quality must improve, all while costs are controlled, or at least monitored.”) (internal quotation marks omitted).

<sup>77</sup> Michealle Gady & Marc Steinberg, *Making the Most of Accountable Care Organizations (ACOs): What Advocates Need to Know*, FAMILIES USA 1, 2 (February 2012), [http://familiesusa.org/sites/default/files/product\\_documents/ACO-Basics.pdf](http://familiesusa.org/sites/default/files/product_documents/ACO-Basics.pdf) (“One of the goals of ACOs is to move the health care system away from a fee-for-service system, in which providers are paid for each service a patient receives, to one focused on delivering the best care at the best price.”). This is discussed in further detail in Part III. See *infra* Part III, section A.

<sup>78</sup> Gady & Steinberg, *supra* note 77, at 2 (“ACOs aim to fix the fragmentation in our health care system by addressing simultaneously both the way care is delivered . . . and the way that it is paid for . . . . The ACO should help bridge the gap in communication that has often existed between providers . . . [and] health care



### C. Organizational Structures of ACOs

While several models of ACOs have been promulgated and tested since the passage of the ACA,<sup>79</sup> three major models have arisen through CMS. They vary based on their contractual structure, organizational development, and payment method.<sup>80</sup> These three major models include the Medicare Shared Savings Program, the Pioneer ACO Model, and the Advanced Payment ACO Model.

#### 1. MEDICARE SHARED SAVINGS PROGRAM

Of the major ACO models created and tested, MSSP is currently one of the largest initiatives serving fee-for-service Medicare beneficiaries.<sup>81</sup> Under this “new approach to the delivery of health care,”<sup>82</sup> participating organizations must meet quality performance standards set forth by the Secretary while generating savings in order to qualify for the percentage of the “shared savings” from the Medicare program.<sup>83</sup> Shared savings are determined by calculating the difference between the dollar amount spent per patient in a given

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providers.”); Gold, *supra* note 10 (“ACOs are touted as a way to help fix an inefficient payment system that rewards more, not better, care . . . .”); Greaney, *supra* note 10, at 1 (“The ACO strategy entails regulatory interventions that at once aim to reshape the health care delivery system, improve outcomes, promote adoption of evidence-based medicine and supportive technology, and create a platform for controlling costs under payment system reform.”). See Berwick, *supra* note 3, at 1 (“A common criticism of U.S. health care is the fragmented nature of its payment and delivery systems [in which] . . . no single group of participants . . . takes full responsibility for guiding the health of a patient or community . . . . Fragmentation leads to waste and duplication—and unnecessarily high costs.”).

<sup>79</sup> See *ACOs: General Information*, *supra* note 8 (“ACO Programs at CMS”).

<sup>80</sup> See *id.*

<sup>81</sup> Association of State and Territorial Health Officials, *Accountable Care Organizations and Public Health*, ASS’N ST. & TERRITORIAL HEALTH OFFICIALS 1, 2 (2013), [http://www.astho.org/programs/access/primary-care/\\_materials/aco-and-public-health-fact-sheet/](http://www.astho.org/programs/access/primary-care/_materials/aco-and-public-health-fact-sheet/) [hereinafter *ASTHO*] (“One of the largest ACO initiatives . . . [a]s of September 2012, MSSP selected 116 organizations . . . to participate in the program.”). See *Shared Savings Program*, *supra* note 47.

<sup>82</sup> *Shared Savings Program*, *supra* note 47.

<sup>83</sup> *ASTHO*, *supra* note 81, at 2; *Shared Savings Program*, *supra* note 47 (“[T]he Shared Savings Program aims to improve [Medicare fee-for-service] beneficiary outcomes and increase value of care . . . [by] reward[ing] ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first.”).

year and the national benchmark set by the government, which represents the amount of health care dollars allocated per patient per year.<sup>84</sup> If the amount calculated is less than the national benchmark, the ACO experiences a “shared savings,” of which the Medicare program will pay back a percentage to the participating ACO.<sup>85</sup> However, ACOs in the MSSP do not face shared risk for exceeding the national benchmark due to the contractual relationship created—the so called “one-sided ACO contract.”<sup>86</sup> Reducing the cost of care alone is insufficient; rather, the quality of care the ACO coordinates and provides must improve, based on thirty-three quality measures across four domains.<sup>87</sup> As the quality of care improves and the health

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<sup>84</sup> Walling, *supra* note 46, at 1–2. This national benchmark that the ACO assumes as its spending target “usually takes into account its historical cost trends and the burden of morbidity among its patients.” Song, *supra* note 1, at 364.

<sup>85</sup> Walling, *supra* note 46, at 2; Song, *supra* note 1, at 364–65. (manuscript at 2) (“If spending for [the ACO’s]. . . patient population ends up below the target by at least a minimum amount, the organization receives a share of the savings. If the spending exceeds the target. . . the organization may not be reimbursed a portion of the difference.”). The percentage earnable under a one-sided contract is 50 percent of the savings generated. See Centers for Medicare & Medicaid Services, *Guide to Quality Performance Scoring Methods for Accountable Care Organizations*, CTRS. MEDICARE & MEDICAID SERVS. 1, 4 (2012), <https://www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/downloads/2012-11-aco-quality-scoring-supplement.pdf> [hereinafter *Guide to Quality Performance*].

<sup>86</sup> Song, *supra* note 1, at 365 (“In a so-called one-sided ACO contract—the majority of those in the . . . [MSSP]—organizations face only shared savings but do not face shared risk.”); McClellan et al., *A National Strategy To Put Accountable Care Into Practice*, 29 HEALTH AFF. 982, 984 (2010) (“[A] ‘one-sided’ shared-savings model . . . would entail no performance risk to providers even if they experience higher costs or if they do not achieve quality performance goals.”).

<sup>87</sup> Centers for Medicare & Medicaid Services, *The Affordable Care Act: Helping Providers Help Patients*, CTRS. MEDICARE & MEDICAID SERVS. 1, 2, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/downloads/ACO-Menu-Of-Options.pdf> (last visited Jan. 13, 2016) [hereinafter *A Menu of Options*] (“These [four] domains include patient, experience, care coordination and patient safety, preventive health[,] and at-risk populations.”). See generally Centers for Medicare & Medicaid Services, *Quality Measures and Performance Standards*, CTRS. MEDICARE & MEDICAID SERVS. (Mar. 2, 2015), [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality\\_Measures\\_Standards.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html) (providing information and resources on the thirty-three current quality measures). Quality measures and domains are discussed in detail in Part III. See *infra* Part III, section A.

expenditures decrease, the ACO will experience a greater amount of shared savings.<sup>88</sup>

## 2. PIONEER ACO MODEL

The second of the ACO models is a more advanced model “designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings.”<sup>89</sup> Unlike other ACO initiatives, Pioneer ACOs allow “provider groups to move more rapidly from a shared savings payment model to a population-based payment model . . . [that is] flexible to accommodate [to] the specific organizational and market conditions in which [the] Pioneer ACOs work.”<sup>90</sup> Similar to other ACO models, Pioneer ACOs work to improve quality of care and health outcomes provided to Medicare beneficiaries, while reducing the cost of care for all paying actors.<sup>91</sup> Unlike the MSSP ACOs, Pioneer ACOs enter a “two-sided contract” in which the participating ACO faces “both

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<sup>88</sup> *A Menu of Options*, *supra* note 87, at 2 (“The higher the quality of care providers deliver, the more shared savings their Accountable Care Organization may earn, provided they also lower growth in health care expenditures.”).

<sup>89</sup> Centers for Medicare & Medicaid Services, Pioneer ACO Model, CTRS. MEDICARE & MEDICAID SERVS. (Dec. 07, 2015), <https://innovation.cms.gov/initiatives/Pioneer-ACO-Model/index.html> [hereinafter Pioneer ACO Model] (last visited Sept. 26, 2016); *ASTHO*, *supra* note 81, at 2 (“The Pioneer Model was designed for organizations with previous experience operating in ACO-like arrangements with coordinated, patient-centered care.”); *A Menu of Options*, *supra* note 87, at 2 (“The Pioneer model is an initiative complementary to the [MSSP] . . . designed for organizations with experience providing integrated care across settings.”); Kinney, *supra* note 9, at 294 (“The Pioneer ACO Model was designed specifically for organizations with ‘experience offering coordinated, patient-centered care, and operating in ACO-like arrangements.’”).

<sup>90</sup> *Pioneer ACO Model*, *supra* note 89; *A Menu of Options*, *supra* note 87, at 2 (“The Pioneer Model tests a rapid transition to a population-based model of care, and engages other payers in moving toward outcomes-based contracts.”); *ASTHO*, *supra* note 81, at 2 (The Pioneer ACO Model “will allow these provider groups to move more rapidly from a shared savings payment model to a population-based payment model.”).

<sup>91</sup> *Pioneer ACO Model*, *supra* note 89 (The Pioneer ACO Model aligns “provider incentives, which will improve quality and health outcomes for patients across the ACO, and achieve cost savings for Medicare, employers[,] and patients.”).

shared savings and shared risk,” but enjoys potentially higher returns for meeting quality measures and cost reductions.<sup>92</sup> Savings received or losses owed in a given year are based on whether the ACO’s expenditures are “outside a minimum corridor set by the ACO’s minimum savings rate (MSR) and minimum loss rate (MLR).”<sup>93</sup> While the program began with thirty-two Pioneer ACOs,<sup>94</sup> the program currently has nine participating ACOs.<sup>95</sup>

### 3. ADVANCED PAYMENT ACO MODEL

The Advanced Payment ACO Model arose out of stakeholder concerns regarding their lack of available capital to invest in infrastructure and staff needed to provide the high-quality care demanded of participating ACOs.<sup>96</sup> Under the Advanced Payment ACO Model, participating ACOs—typically smaller ACOs formed by physician-owned and rural providers<sup>97</sup>—receive an upfront,

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<sup>92</sup> McClellan et al., *supra* note 86, at 984 (“Also possible are ‘two-sided’ or ‘symmetric’ payment models that would give providers an opportunity to receive proportionately larger bonus payments in exchange for accountability for costs that greatly exceed preset goals.”); Song, *supra* note 1, at 365. The percentage earnable under a two-sided contract is sixty percent of the savings generated. See *Guide to Quality Performance*, *supra* note 85, at 4.

<sup>93</sup> *Pioneer ACO Model*, *supra* note 89 (“If savings/loss is within this corridor, no payment is made to the ACO or owed to CMS. If the Gross Savings/Losses percentage is outside this corridor, then the ACO splits the overall savings/loss with CMS.”).

<sup>94</sup> *ASTHO*, *supra* note 81, at 2 (As of 2013, “[t]hirty-two ACOs [were] . . . participating in the Pioneer ACO Model.”); Kinney, *supra* note 9, at 294 (As of 2013, “[t]here [were] thirty-two organizations participating in the Pioneer ACO Model.”).

<sup>95</sup> See *Pioneer ACO Model*, *supra* note 89. This decrease in the number of participating ACOs is likely due to the high standards required to share in savings generated. See, e.g., Peter Wehrwein, *Pioneer ACOs: Some Unhitch Wagons While Others Roll Over Rocky Terrain*, *MANAGED CARE MAG. ONLINE* (Oct. 2014), <http://www.managedcaremag.com/linkout/2014/10/43>. See also *infra* Part II, section A, subsection 1; note 138, 151–52.

<sup>96</sup> Centers for Medicare & Medicaid Services, *Advance Payment ACO Model*, CTRS. MEDICARE & MEDICAID SERVS. (Jan. 11, 2016), <https://innovation.cms.gov/initiatives/Advance-Payment-ACO-Model/index.html> (last visited Sept. 26, 2016) [hereinafter *Advance Payment ACO Model*] (“In developing the Advance Payment ACO Model, CMS is responding to input from stakeholders . . . [who] expressed a concern about their lack of ready access to the capital needed to invest in infrastructure and staff for care coordination.”).

<sup>97</sup> Kinney, *supra* note 9, at 294.

monthly payment in “advance [of] the shared savings they are expected to earn” to support start-up costs and infrastructure-building.<sup>98</sup> In return, CMS recovers the advance payments through the shared savings experienced by the ACO.<sup>99</sup> ACOs participating in this model of care receive three types of payments, which “acknowledge that new ACOs will have both fixed and variable start-up costs”<sup>100</sup>: 1) an upfront, fixed payment received by each ACO; 2) an upfront, variable payment that is based on the number of historically-assigned beneficiaries to the ACO; and 3) a monthly payment that varies based on the size of the ACO and the number of historically-assigned beneficiaries to the ACO.<sup>101</sup> Through this payment structure, the Advanced Payment ACO Model allows “physician-based and rural providers [participating in MSSP] . . . [to] come together voluntarily to give coordinated high quality care to the Medicare patients they serve.”<sup>102</sup> There are currently thirty-five participants under this ACO model.<sup>103</sup>

## II. PERSPECTIVE #1: “BENDING THE COST CURVE” THROUGH ACOs

The first perspective considers whether the ACO model are able to truly have a cost-cutting impact on the general rise in health care costs experienced in America over the past several decades. As a

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<sup>98</sup> *Advance Payment ACO Model*, *supra* note 96 (“Through the Advance Payment ACO Model, selected participants will receive upfront and monthly payments, which they can use to make important investments in their care coordination infrastructure . . . [S]elected organizations will receive an advance on the shared savings they are expected to earn.”); Kinney, *supra* note 9, at 294 (“The Advanced Payment ACO Model provides additional support to physician-owned and rural providers who would benefit from additional start-up resources to build the necessary infrastructure, such as new staff or information technology systems.”).

<sup>99</sup> *A Menu of Options*, *supra* note 87, at 2 (“The advance payments would be recovered from shared savings achieved by the Accountable Care Organization.”).

<sup>100</sup> *Advance Payment ACO Model*, *supra* note 96 (“Advance payments are structured . . . to acknowledge that new ACOs will have both fixed and variable start-up costs.”).

<sup>101</sup> *Advance Payment ACO Model*, *supra* note 96 (“Initiative Details”).

<sup>102</sup> *Advance Payment ACO Model*, *supra* note 96. See *ASTHO*, *supra* note 81, at 2 (“The Advance Payment ACO Model will provide additional support to physician-owned and rural providers participating in the Shared Savings Program . . .”).

<sup>103</sup> *Advance Payment ACO Model*, *supra* note 96.

cost-generating enterprise, “ACOs can be seen as an attempt to mitigate market and regulatory failures that pervade the financing and delivery of health care services.”<sup>104</sup> This section will consider whether, in reality, ACOs are able to have such a pervasive effect on the overall costs of health care in the United States, or whether this model of care can only have a small effect on spending. Once “bending the cost curve” is defined, the cost-cutting effects of ACOs will be considered, ending with a survey of suggested approaches to further reduce costs through the ACO model of care.

A. *What Does It Mean to “Bend the Cost Curve?”*

Understanding the theory of “bending the cost curve” in the context of the ACO begins with a consideration of the overall growth in spending within the American health care system since the creation of the Medicare and Medicaid programs in the late 1960s. Immediately following its passage, the Medicare program began allocating millions of federal dollars into the American health care system, resulting in the health care system’s rapid growth as a sizeable portion of the national gross domestic product (“GDP”).<sup>105</sup> Since 1960, “health spending [in the United States] has grown nearly five times as much as GDP . . . [yet the United States does] not achieve longer life or overall better health statistics than other industrialized countries with modern health care systems.”<sup>106</sup> However, this increase in

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<sup>104</sup> Greaney, *supra* note 10, at 4.

<sup>105</sup> Barry R. Furrow, *Cost Control and the Affordable Care Act: CRAMPing\* Our Health Care Appetite*, 13 NEV. L.J. 822, 823 (2013) (“Medicare was implemented in 1966; as a result, the federal government immediately began to pour millions of federal dollars into health care expenditures, which have rapidly grown to ever-higher percentages of our gross domestic product . . .”). *See also* John Lechleiter, *To Bend The Cost Curve Downward, Stop Focusing On Minor Cost Cuts*, FORBES (Aug. 15, 2014, 8:00 AM), <http://www.forbes.com/sites/johnlechleiter/2014/08/15/to-bend-the-healthcare-cost-curve-downward-stop-focusing-on-minor-cost-cuts/print/> (“Health spending is by far the biggest single factor driving growth in the federal budget—fueled, in large part, by the aging of the Baby Boom generation, as 10,000 Americans turn 65 every day for another 16 years.”).

<sup>106</sup> Furrow, *supra* note 105, at 823 (“Yet for all this spending, we do not achieve longer life or overall better health statistics than other industrialized countries with modern health care systems.”).

spending has decreased slightly since the 2008 recession,<sup>107</sup> creating uncertainty as to the underlying cause of this reduction.<sup>108</sup>

The concept of “bending the cost curve” developed against this backdrop, focusing policymakers’ and academics’ analysis around the question: “Does this health reform proposal bend the cost curve?”<sup>109</sup> This question simply translates into whether a proposed

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<sup>107</sup> Furrow, *supra* note 105, at 824 (“The recession of 2008 has reduced this differential [between health care costs and general inflation]; health spending and GDP grew at similar rates in 2010, with health spending as a share of GDP steady at 17.9%. National health expenditures growth has ranged from as high as 11.0% in 1990 to 3.9% in 2010.”). See also Sophie Novack, *The Health Cost Curve Is Bending. Is Obamacare to Blame?*, NAT’L J. (Jan. 2, 2014), <http://www.nationaljournal.com/health-care/2014/01/02/health-cost-curve-is-bending-is-obamacare-blame> (“Federal actuaries estimate that real spending on health care increased only 0.8 percent per person in 2012, slightly less than real gross domestic product per capita. Comparatively, since 1960, spending has increased an average of 2.3 percentage points more than GDP growth.”); Ezra Klein, *The cost curve is bending. Does Obamacare deserve the credit?*, THE WASH. POST: WONKBLOG (May 31, 2013), <https://www.washingtonpost.com/news/wonk/wp/2013/05/31/the-cost-curve-is-bending-does-obamacare-deserve-the-credit/> (“National health spending grew by 3.9 percent each year from 2009 to 2011, the lowest rate of growth since the federal government began keeping such statistics in 1960 . . .” (internal quotation marks omitted)). See generally Charles Roehrig, *What Is Behind The Post-Recession Bend In The Health Care Cost Curve?*, HEALTH AFF. BLOG (Mar. 23, 2015), <http://healthaffairs.org/blog/2015/03/23/what-is-behind-the-post-recession-bend-in-the-health-care-cost-curve/print/> (Exhibit 2 titled “Shares Of NHE [National Health Expenditures]: Middle Of Post-Recession Period (2011)” exhibiting the break down in health care spending for 2011).

<sup>108</sup> See Furrow, *supra* note 105, at 824 (“Slowing in health care spending may be due to several factors.”); Klein, *supra* note 107 (“The curve is bending, but we don’t really know why, and we don’t know if it’ll stay bent.”); Novack, *supra* note 107 (“The recent slowdown is promising, but analysts remain split over what accounts for the change—and, consequently, how long it will be sustained. The more pessimistic view is that the lower cost growth is a result of the recession and will inflate again as the economy recovers. The optimistic explanation is that measures to control costs might finally be working—including related provisions in the Affordable Care Act.”); Roehrig, *supra* note 107 (“I now turn to . . . the record low growth in NHE that began in 2009 . . . and continued through 2013 . . . There has been extensive discussion about whether these low rates are the result of temporary cyclical factors, such as the recession, or more permanent structural factors.”).

<sup>109</sup> Chris Frates, *CBO: Bend the cost curve, what does that even mean?*, POLITICO.COM: LIVE PULSE (Oct. 30, 2009), [http://www.politico.com/livepulse/1009/CBO\\_Bend\\_the\\_cost\\_curve\\_what\\_does\\_that\\_even\\_mean.html](http://www.politico.com/livepulse/1009/CBO_Bend_the_cost_curve_what_does_that_even_mean.html) (“It’s a question that is endlessly asked in Washington, ‘Does this health reform proposal

health reform will lower health care costs over time.<sup>110</sup> While this has become a catch-phrase to describe what politicians and policy-makers hope the reforms under the ACA—such as the ACO model of care—will do, some find it difficult to project whether a proposed reform will actually “bend” health care costs.<sup>111</sup> Regardless of the measurability of the “bend” of the cost curve, the success of reforms like the ACO model of care are critically necessary—their success could dictate whether “coverage will be affordable and the federal budget will be close to balanced” or whether “it will be very difficult for the federal government . . . to keep the spending commitments made in the health reform act.”<sup>112</sup>

# 1. RE-VALUING VALUE-BASED PAYMENTS TO “BEND THE COST CURVE”

“Bending the cost curve” has become synonymous with restraining costs under the “Triple Aim” and is a major metric in the debate over the effectiveness of ACOs in containing health care costs. The key strategy to accomplishing this “bend”—which drives the mission of ACOs—is the transition from a fee-for-service payment system to a value-based payment system.<sup>113</sup> Under the fee-for-service

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bend the cost curve?’ Really, it’s just a highfalutin way of asking, ‘Does this lower costs over time?’”); Timothy C. Gutwald, *Bending the Health Care Cost Curve: Incentivizing Quality and Efficiency*, 90 MICH. B.J. 20, 20 (2011) (“If health care spending trends continued, the Congressional Budget Office estimated that by 2025, one quarter of our gross domestic product would be devoted to health care. Armed with this data, politicians and policymakers began to talk about ‘bending the cost curve.’”).

<sup>110</sup> Frates, *supra* note 109.

<sup>111</sup> *Id.* (quoting Doug Elmendorf, Director of the Congressional Budget Office as he expounded on how “it’s hard to know whether a proposal . . . will continue [to lower costs] . . . indefinitely or, to put it another way, that the curve will stay bent.”). Elmendorf concludes that a more productive analysis is considering “whether proposals would ‘lower’ or ‘raise’ the curve . . . than to discuss those proposals’ effects on the shape of the curve.” *See id.*

<sup>112</sup> David Cutler, *How Health Care Reform Must Bend The Cost Curve*, 29 HEALTH AFF. 1131, 1131 (2010) (“[W]hether reform is successful over the long haul will be determined almost exclusively by its impact on health care spending beyond the first decade.”).

<sup>113</sup> Corbett, *supra* note 25, at 149 (“Various provisions . . . [of the ACA] are designed to ‘shift the payment system from traditional fee-for-service (FFS) to budgeted . . . or value-based (e.g., pay-for-performance) payment models.’”). *See also* Furrow, *supra* note 105, at 861 (“As U.S. healthcare begins to move from an



payment system, physicians and health care providers are paid for the *quantity* of services provided rather than for the *quality* of the services provided.<sup>114</sup> The incentives from a fee-for-service payment system are straight forward: “[T]he present [fee-for-service] system encourages health care providers to offer more and more costly treatments, not just those that are effective or cost-effective.”<sup>115</sup> This “do more to make more”<sup>116</sup> payment system results in inefficient, ineffective, and unsafe treatment procedures, tests, and diagnoses, further contributing to the rise in health care spending.<sup>117</sup>

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activity-based business model that incentivizes utilization of services to a value-based model that incentivizes population health management across the continuum of care, thousands of healthcare ‘science projects’ are taking place in communities nationwide.”); Novack, *supra* note 107 (“Provider-payment reform focuses on moving away from the current fee-for-service model toward more value-based rewards, with incentives that encourage efficient and quality care, rather than quantity.”).

<sup>114</sup> Greaney, *supra* note 10, at 15 (“Since its inception, traditional Medicare has reimbursed providers using methodologies that reward volume . . . [by paying] on a fee-for-service basis, i.e. issuing a separate payment for each service provided.”).

<sup>115</sup> Gutwald, *supra* note 109, at 21. *See also* Jeff Goldsmith, *Accountable Care Organizations: The Case For Flexible Partnerships Between Health Plans and Providers*, 30 HEALTH AFF. 32, 32 (2011) (“As is well known, this approach [fee-for-service] offers providers powerful financial incentives to increase the volume of services they deliver.”); Greaney, *supra* note 10, at 5 (“Most notably, the longstanding reliance on fee-for-service methods of payment has spawned an ethos of provider payment that rewards volume and disincentivizes cost-benefit tradeoffs.”); *id.* at 15 (“As a result of fee-for-service payment, physicians have strong incentives to increase the volume of services provided in hospitals . . .”). However, “[t]his is not to say that physicians or hospitals try to keep people sick or knowingly provide unnecessary care . . . . However, the fee-for-service system offers little motivation to improve quality or efficiency or provide services that have a low profit margin.” *See* Gutwald, *supra* note 109, at 21.

<sup>116</sup> Goldsmith, *supra* note 115, at 35.

<sup>117</sup> DeMuro, *supra* note 11, at 16 (“The unsustainable rate of increase in healthcare spending in the United States is thought by many to stem from our historic reliance on fee-for-service as the method of paying for the delivery of healthcare.”); Furrow, *supra* note 105, at 829 (“The modes of reimbursement—fee-for-service payment to physicians and ‘usual, customary, and reasonable’ charges—created a national crisis by 1970.”); Jessica L. Mantel, *Accountable Care Organizations: Can We Have Our Cake and Eat it Too?*, 42 SETON HALL L. REV. 1393, 1396 (2012) (“Unfortunately, the health care system as currently organized has limited capacity to reduce waste or improve the management of

To counter the lucrative fee-for-service payment system, the ACA shifts the payment method to a value-based purchasing system, also known as “pay-for-performance.”<sup>118</sup> This system posits using “outcome measures tied to pay to begin the process of moving from payment per procedure to true outcome-driven health care.”<sup>119</sup> By “linking existing measures of inpatient quality to payment, and expanding performance-based measurement and payment systems,” the value-based payment system aims to bring the focus of care on *quality* rather than on *quantity*.<sup>120</sup> Because many of the quality measures used under the volume-based purchasing system are believed to lower health care costs,<sup>121</sup> this payment method incentivizes “efficient and quality care, rather than quantity”<sup>122</sup> with the intention of “bending the cost curve.” The value-based purchasing payment method hopes to balance the “Triple Aim” by reducing costs while increasing quality and efficiency of care.

B. *Are ACOs Under Medicare Successfully Bending the Cost Curve?*

At a high level overview of spending in the American health care system, costs have gone down annually since 2008. Between the 2005–2007 period and the 2009–2013 period, the growth rate in national health spending dropped 2.6 percentage points from 6.5% to 3.9%.<sup>123</sup> This is the “lowest rate of growth since the federal government began keeping such statistics in 1960,” and could mean \$770 billion in savings for the government if maintained over the next decade.<sup>124</sup>

The Medicare program similarly experienced a drop in spending and experienced a fall in the growth rate in spending on health care

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chronic care patients. In particular, incentives inherent in our fee-for-service payment system result in a fragmented delivery system and promote both a higher volume and intensity of care.”).

<sup>118</sup> See *supra* note 113.

<sup>119</sup> Furrow, *supra* note 105, at 860.

<sup>120</sup> See Cutler, *supra* note 112, at 1134.

<sup>121</sup> See *id.* (“Many of the quality measures being considered are associated with lower costs—for example, improvements in patient safety.”).

<sup>122</sup> See Novack, *supra* note 107.

<sup>123</sup> Roehrig, *supra* note 107.

<sup>124</sup> Klein, *supra* note 107.

services (excluding dental services) in comparison to overall spending.<sup>125</sup> This reduction occurred while Medicare beneficiary enrollment grew nearly a percentage point faster during the 2009–2013 period than the 2005–2007 period.<sup>126</sup> While the reason for these savings remains somewhat unexplained, two major theories have arisen: 1) These savings are the short-lived effects of the 2008 recession and will likely end as the economy continues to regain momentum, or 2) the effects of the major reforms under the ACA are working.<sup>127</sup>

This then begs the question: are ACOs actually contributing to “bending the cost curve?” The official position of the CMS is “yes,” and that the “bend” is occurring across the various ACO programs offered.<sup>128</sup> Based on yearly performance results, “Medicare [ACOs] . . . continue to improve the quality of care for Medicare beneficiaries, while generating financial savings.”<sup>129</sup> Quantitatively, this meant that “the 20 . . . Pioneer ACO Model[s] and [the] 333 . . . [MSSP] ACOs generated more than \$411 million in total savings in 2014”<sup>130</sup> while generating over \$417 million in savings for Medicare in 2013.<sup>131</sup> Of these savings, 97 of the participating ACOs qualified

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<sup>125</sup> Roehrig, *supra* note 107.

<sup>126</sup> *Id.*

<sup>127</sup> See Klein, *supra* note 107; Novack, *supra* note 107.

<sup>128</sup> See generally Centers for Medicare & Medicaid Services, *Medicare ACOs continue to succeed in improving care, lowering cost growth*, CTRS. MEDICARE & MEDICAID SERVS. (Nov. 10, 2014), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-11-10.html> [hereinafter *Medicare ACOs Fact Sheet 2014*]; Centers for Medicare & Medicaid Services, *Medicare ACOs Provide Improved Care While Slowing Cost Growth in 2014*, CTRS. MEDICARE & MEDICAID SERVS. (Aug. 25, 2015), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-25.html> [hereinafter *Medicare ACOs Fact Sheet 2015*]. See also, John Okray, *Accountable Care Organizations Start to Pay Dividends*, 61 FED. LAW. 14 (2014) (showing the findings reported by CMS in their September 2014 announcement with regards to participating ACOs).

<sup>129</sup> *Medicare ACOs Fact Sheet 2015*, *supra* note 128. See also *Medicare ACOs Fact Sheet 2014*, *supra* note 128 (showing that the financial and quality results for Performance Year 2 (2013) resulted in similar financial savings and achieving quality measures).

<sup>130</sup> *Medicare ACOs Fact Sheet 2015*, *supra* note 128.

<sup>131</sup> *Medicare ACOs Fact Sheet 2014*, *supra* note 128 (“ACOs in the Pioneer ACO Model and [MSSP] . . . also generated over \$417 million in savings for Medicare.”).

for shared savings payments totaling \$422 million.<sup>132</sup> Quality standards are consistently being met for the majority of ACOs surveyed.<sup>133</sup>

While such enormous savings are positive on their face, they may be somewhat deceiving as they do not reflect the *number* of ACOs generating savings in a given year—or, alternatively, not generating savings at all. This may simply be a reflection of savings generated by *some* ACOs, rather than a testament to the program as a whole “bending the cost curve.”<sup>134</sup> It would seem that a comprehensive evaluation would consider both the *dollar amount* saved by the various ACO programs, as well as the *number* of ACOs actually generating savings. Such a holistic analysis can be conducted with the detailed information collected on the Pioneer ACO Model since its inception.<sup>135</sup> During the three years of reported data on participating Pioneer ACOs, all were able to meet the quality standards set for that year.<sup>136</sup> “However, the first-year experience for many of the Pioneer ACOs illustrates a disconnect between the quality measures and cost savings,”<sup>137</sup> though this disconnect seems to be lessening each year.<sup>138</sup>

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<sup>132</sup> *Medicare ACOs Fact Sheet 2015*, *supra* note 128 (“At the same time, 97 ACOs qualified for shared savings payments of more than \$422 million by meeting quality standards and their savings threshold.”).

<sup>133</sup> *See Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 1 (2012)”); *Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 2 (2013)”); *Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 3 (2014)”); *Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 4 (2015)”).

<sup>134</sup> *See supra* note 133.

<sup>135</sup> *See id.*

<sup>136</sup> *See id.*

<sup>137</sup> Ken Perez, *Emerging Opportunities for ACO Cost Reduction*, HEALTHCARE FIN. MGMT. 116, 116 (2014). *See also supra* Table 1.

<sup>138</sup> *See supra* Table 1. One explanation for this seeming “lessening effect” is that the number of participating Pioneer ACOs has decreased each year since the first year of the program (2012). *See also Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 1 (2012)”); *Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 2 (2013)”); *Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 3 (2014)”); *Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 4 (2015)”).

From this, one may also make the conjecture that the remaining Pioneer ACOs in the program are the high-

**Table 1** Number and Percentage of Pioneer ACOs Owing Losses/Receiving \$0 in Shared Savings

Year	Number of Pioneer ACOs Owing Losses	Percentage of Pioneer ACOs Owing Losses	Number of Pioneer ACOs Owing Losses/Receiving \$0 in Shared Savings	Percentage of Pioneer ACOs Owing Losses/Receiving \$0 in Shared Savings
<b>Year 1 (2012)</b>	1 out of 32	3.13%	19 out of 32 (+18)	59.38%
<b>Year 2 (2013)</b>	6 out of 23	26.09%	12 out of 23 (+6)	52.17%
<b>Year 3 (2014)</b>	3 out of 20	15.00%	9 out of 20 (+6)	45.00%
<b>Year 4 (2015)</b>	1 out of 12	8.33%	6 out of 12 (+5)	50.00%

*Source:* Author's calculation based on data provided at <https://innovation.cms.gov/initiatives/Pioneer-ACO-Model/index.html>.

Table 1 presents two sets of data relevant to understanding the number of Pioneer ACOs generating a loss or zero savings for the Medicare program over the four years of available data.<sup>139</sup> The second and third columns reflect the number and percentage, respectively, of participating Pioneer ACOs which incurred a loss—and subsequently owed money—for Medicare.<sup>140</sup> The third and fourth

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performing ACOs that were able to meet both the quality standards and the cost-reducing requirements. *Id.* While not necessarily a novel revelation, it does beg the question of whether the Pioneer ACO program is simply “weeding out” the ineffective participants, leaving a small pool of effective ACOs to dominate the market in the future. Such an inference would bolster the fear of ACOs monopolizing the health care industry. *See infra* note 163.

<sup>139</sup> *See supra* Table 1. *See also Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 1 (2012)”); *Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 2 (2013)”); *Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 3 (2014)”); *Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 4 (2015)”); *See generally Pioneer ACO Model*, *supra* note 89.

<sup>140</sup> *See supra* note 139.

columns reflect the number and percentage, respectively, of participating Pioneer ACOs which either incurred a loss or received no shared savings but did not owe money to Medicare.<sup>141</sup> In essence, all participating Pioneer ACOs are meeting the quality standards; however, the same is not true for the savings thresholds set for each participating ACO.<sup>142</sup>

Although the intention “is that by meeting the thirty-three quality-performance standards, the needed cost savings will naturally follow,”<sup>143</sup> Table 1 suggests that cost savings do not always follow simply from meeting the quality standards.<sup>144</sup> However, as Table 1 also reflects, the gap between quality standards and cost savings has progressively decreased each year since the beginning of the program.<sup>145</sup> Whether this is due to the fact that fewer ACOs are participating in the Pioneer Model program, or whether it is due to actual improvements in strategies for cost savings, is beyond the scope of this Comment. However, such a discrepancy should be clarified in the CMS analysis and presentation of data as it may be creating a false perception of success in the Pioneer ACO program.<sup>146</sup>

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<sup>141</sup> See *id.* The reason some Pioneer ACOs owe no money to Medicare but do not receive a portion of shared savings is due to their contractual relationship with CMS—the “one-sided contract.” See Part I, section C, subsections 1–2.

<sup>142</sup> See *supra* Table 1. See also *Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 1 (2012)”); *Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 2 (2013)”); *Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 3 (2014)”); *Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 4 (2015)”).

<sup>143</sup> Perez, *supra* note 137, at 116.

<sup>144</sup> See *supra* note 139.

<sup>145</sup> See *id.*

<sup>146</sup> See generally Perez, *supra* note 137, at 116; *Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 1 (2012)”); *Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 2 (2013)”); *Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 3 (2014)”); *Pioneer ACO Model*, *supra* note 89 (under “Initiative Details,” select “Performance Year 4 (2015)”); *Medicare ACOs Fact Sheet 2015*, *supra* note 128; *Medicare ACOs Fact Sheet 2014*, *supra* note 128; *Pioneer ACO Model*, *supra* note 89; *supra* Table 1.

### C. *Can More Be Done to Bend the Cost Curve?*

While the ACO model has resulted in general savings since its inception, some argue that the model focuses on low-impact cost-saving measures.<sup>147</sup> With such mixed opinions about the success—or failure—of the ACO model, can more be done to effectively “bend the cost curve” in a more meaningful way? Several proposals have been made in the literature,<sup>148</sup> which may be beneficial for the CMI and the CMS to review and possibly incorporate. Though the list of proposals here is not exhaustive, it presents a snapshot of proposals introduced by both conservative and liberal advocates that could potentially result in savings to further “bend the cost curve.”

#### 1. IDENTIFYING EXTERNAL INFLUENCES ON THE FINANCIAL BENCHMARKS

One major set of reforms calls for refining the financial benchmarks ACOs must meet.<sup>149</sup> While much of the current literature focuses on reforming the payment method for health services provided,<sup>150</sup> it would be beneficial to consider external influences that may hinder effective cost savings. One measure is to recognize and

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<sup>147</sup> See Lechleiter, *supra* note 105 (arguing that “[i]f we simply take projections of future costs as a given and settle for trimming costs off that trend line, we will lose opportunities to truly bend the cost curve, and more importantly, to achieve levels of health and well-being that are unattainable with current technology and financial resources.”).

<sup>148</sup> See, e.g., *infra* notes 150, 162–63, 166, 170.

<sup>149</sup> See generally Ezekiel Emanuel et al., *A Systemic Approach to Containing Health Care Spending*, 367 NEW ENG. J. MED. 949 (2012); Hamilton Moses III et al., *The Anatomy of Health Care in the United States*, 310 J. AM. MED. ASS’N 1947 (2013); Lechleiter, *supra* note 105; James J. Mongan et al., *Options for Slowing the Growth of Health Care Costs*, 358 NEW ENG. J. MED. 1509 (2008); Wehrwein, *supra* note 95.

<sup>150</sup> See, e.g., *supra* note 149. See also Muhlestein, *supra* note 25 (“Much of the policy conversation around accountable care has focused on payment models. While it is certain that payment models do incent[ivize] behavior, adopting a payment model does not guarantee that a provider will be able to transform the practice of care in a way that improves outcomes and lowers costs . . . . A myopic policy focus on payment ignores the core objective of accountable care . . . .”).

adjust for regional variations in costs and prices, which have negatively impacted some participating ACOs.<sup>151</sup> Such a proposal calls for the financial benchmarks to take into account the regional variances in the area-wage index, one factor used to calculate Medicare payments.<sup>152</sup>

Similarly, it is critical to recognize that the ACO model's ability to "bend the cost curve" is limited by the continuing rise in the price of health care goods and services in the United States.<sup>153</sup> Although the ACO model works to reduce *costs* for the patient and Medicare, this model cannot control for the general *price* of goods and services used in the provision of care. The reality of health care in the United States is that some costs can only be controlled when external factors—such as the general price of health care goods and services—are controlled.<sup>154</sup> Recognizing that a portion of costs generated by

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<sup>151</sup> See Wehrwein, *supra* note 95 (Some Pioneer ACOs "stood to get penalized even though [they] launched . . . management programs, reined in hospital readmissions, and reduced its high rate[s]. The Pioneer financial benchmarks were the problem . . ."). See also Emanuel et al., *supra* note 149, at 951 ("Prices for the same services vary substantially within the same geographic area.").

<sup>152</sup> Wehrwein, *supra* note 95 ("First, the benchmarks haven't taken into account regional variances in the area-wage index, one of the factors used to calculate Medicare inpatient hospital payment."). The area-wage index is a standardized amount adjusted "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." Centers for Medicare & Medicaid Services, *Wage Index*, CTRS. MEDICARE & MEDICAID SERVS. (Aug. 4, 2014), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html> (internal quotation marks removed).

<sup>153</sup> See Moses III et al., *supra* note 149, at 1949 ("Since 2000, increase in price has continued but has moderated from historical norms . . ."). While many have argued that the greatest impact on spending in the American health care system has resulted from an ever aging population, along with a higher demand for health services, data seems to contradict this belief. See *id.* ("[D]ata contradict[s] [the] commonly held belief that aging of the population and increased demand for services have driven spending historically."). See also *id.* at 1951 (Figure 5 provides a graphical representation of how medical price growth, while modestly decreasing over time, still remains the greatest portion of health care spending in the United States).

<sup>154</sup> While this may be an unfavorable—or politically unfeasible—recommendation within the American philosophical framework of individualism and capitalism, the data continues to indicate that it is one that must be recognized if effective reforms are to be made. See *id.* at 1949 ("Between 2000 and 2011, increase



ACOs does not necessarily come from excessive or ineffective care, but rather from the general price of health goods and services in America, could help shape meaningful policies that truly “bend the cost curve” and improve the impact of ACOs on the health care system.<sup>155</sup>

## 2. TRANSPARENCY AND PATIENT CHOICE

Another major line of proposals aims to improve transparency and patient choice within the ACO program. As the price of care within the American health system continues to consume health spending,<sup>156</sup> one proposal aims to use transparency as a price control strategy.<sup>157</sup> Typically, “consumers almost never receive price information before treatment,”<sup>158</sup> leaving them powerless to make informed decisions about their care.<sup>159</sup> This results in price variations within a geographical area and between patients receiving the same plan of care.<sup>160</sup> By requiring health care providers, such as ACOs, to make “available information about the cost and quality of health

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in price (particularly of drugs, medical devices, and hospital care), not intensity of service or demographic change, produced most of the increase in health’s share of GDP.”). *See also supra* note 152.

<sup>155</sup> *See supra* note 153. *See also* Barry G. Saver et al., *Care that Matters: Quality Measurement and Health Care*, 12 PUB. LIBR. MED. 1, 6 (2015) (“[T]here should be acknowledgement that improved health is often the result of actions by multiple parties at multiple levels, not individual providers. In many cases, patient action (or inaction) is critical and individual providers have limited influence.”).

<sup>156</sup> *See* Moses III et al., *supra* note 149, at 1949.

<sup>157</sup> *See* Emanuel et al., *supra* note 149, at 951–52. *But see* Mongan et al., *supra* note 149, at 1511–12 (“Although the impact of this approach is unknown, we believe that cost savings are likely to be limited . . .”). Transparency is defined as “making available information about the cost and quality of health care services so that patients can become informed consumers.” *See id.* at 1511.

<sup>158</sup> Emanuel et al., *supra* note 149, at 951. One reason for this secrecy is because of anticompetitive clauses, such as “gag clauses,” that providers incorporate in contracts with insurers to “prohibit insurers from releasing price information to their members.” *See id.* at 952.

<sup>159</sup> *See id.* at 951.

<sup>160</sup> *See id.* This variation in price among geographical areas represents a greater market break down best explained by the Lemon Theory and asymmetrical information between the seller—the health care provider—and the buyer—the patient. *See generally* George A. Akerlof, *The Market for “Lemons”: Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488 (1970).

care services” provided,<sup>161</sup> patients are better able to evaluate where to receive care from.<sup>162</sup> This in turn “may lead high-cost providers to lower prices” in order to remain competitive within the market.<sup>163</sup>

In line with strengthening patient choice, some have proposed transitioning from a system of attribution<sup>164</sup> to a model of self-enrollment in which the beneficiary chooses which ACO to associate with.<sup>165</sup> By giving the beneficiary the choice, the beneficiary is then able to clearly decide which ACO he or she prefers. Rather than leaving an ACO “[un]able to identify the patients for whom [it is] responsible [for] until after the contract year ends,”<sup>166</sup> this model ensures that the ACO is clear as to who falls within its assigned population.<sup>167</sup> One concern with giving the choice to the beneficiary is

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<sup>161</sup> Mongan et al., *supra* note 149, at 1511.

<sup>162</sup> See Emanuel et al., *supra* note 149, at 951 (“Price transparency would allow consumers to plan ahead and choose lower-cost providers . . .”); Mongan et al., *supra* note 149, at 1511.

<sup>163</sup> See Emanuel et al., *supra* note 149, at 951. One concern associated with the price transparency is the potential for collusion; however, “this risk could be addressed through aggressive enforcement of antitrust laws.” See *id.* The Department of Justice and the Federal Trade Commission released a joint statement regarding ACOs and antitrust law and enforcement. See Greaney, *supra* note 10, at 22–27.

<sup>164</sup> Under the current system, ACOs are informed by CMS of tentative assignments on a quarterly basis and receive final assignments at the end of each performance year based on data from the previous year. See Valerie A. Lewis et al., *Attributing Patients To Accountable Care Organizations: Performance Year Approach Aligns Stakeholders’ Interests*, 32 HEALTH AFF. 587, 588–89 (2013) (describing Medicare’s “hybrid approach” to attribution, which includes quarterly prospective assignments and a final year-end assignment); Nicholas Hodges, *Accountable Care Organizations: Realigning the Incentive Problems in the U.S. Health Care System*, 26 U. FLA. J. L. & PUB. POL’Y 99, 114, 114 n.99 (2015) (“Note that the literature often uses the word ‘attribution’ to mean the process of assigning beneficiaries to an ACO.”).

<sup>165</sup> See Paul B. Ginsburg & Alice M. Rivlin, *Challenges for Medicare at 50*, 373 NEW ENG. J. MED. 1993, 1995 (2015) (“Shifting from an attribution model to an enrollment model—in which beneficiaries choose to participate in an ACO and have incentives to do so . . . —is the most effective way of engaging beneficiaries.”). But see generally Valerie A. Lewis et al., *supra* note 164, at 588 (discussing research findings on two alternative methods of attribution to the current method through Medicare: “prospective attribution” and “performance year attribution”).

<sup>166</sup> Ginsburg & Rivlin, *supra* note 165, at 1994–95.

<sup>167</sup> See *supra* note 165. This proposal may not be as effective in areas where only one ACO is available to the beneficiary. However, on a global scale this

the potential for fraud or coercion in attempting to attract a beneficiary to a certain ACO; however, much of this behavior would likely be controlled under current fraud and abuse laws.<sup>168</sup>

As a result of improved price transparency and patient choice in ACO provider, beneficiaries are empowered to take control of their care. However, the effectiveness of both these proposals requires that patients be more informed consumers. One proposal is to improve the health literacy of participants in the American health care system.<sup>169</sup> Health literacy is defined as “the degree to which a person

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proposal will eliminate some of the confusion ACOs typically face regarding their assigned population and will allow ACOs to better track costs. *See* Ginsburg & Rivlin, *supra* note 165, at 1994–95.

<sup>168</sup> *See generally* 42 U.S.C. § 1320a–7b (2012); 42 U.S.C. § 1395nn (2012). *But see* Benjamin Holland Able, *The Stark Physician Self-Referral Law and Accountable Care Organizations: Collision Course or Opportunity to Reconcile Federal Anti-Abuse and Cost-Saving Legislation?*, 26 J.L. & HEALTH 315 (2013); BARRY D. ALEXANDER ET AL., *THE FUNDAMENTALS OF HEALTH LAW* 180, 201 (6th ed. 2014) (“On November 2, 2011, the OIG [Office of Inspector General], in conjunction with CMS, issued an interim final rule with comment period establishing waivers of the Anti-Kickback Statute [and Stark Law] . . . to particular arrangements involving ACOs under the Medicare shared savings program. While not technically a safe harbor, the interim final rule establishes five waivers of application of the Stark law, the Anti-Kickback Statute, and the Civil Monetary Penalty provisions related to gainsharing and beneficiary inducements if certain conditions are met. According to the interim final rule, an arrangement need only fit one waiver to be protected.”); Greaney, *supra* note 10, at 14; Wasif Ali Khan, *Accountable Care Organizations: A Response to Critical Voices*, 14 DEPAUL J. HEALTH CARE L. 309, 326–27, 332–38 (2012); Pasquale, *supra* note 44, at 1376–77.

<sup>169</sup> *See generally* Brietta Clark, *Using Law to Fight a Silent Epidemic: The Role of Health Literacy in Health Care Access, Quality, & Cost*, 20 ANNALS HEALTH L. 253 (2011) (providing a thorough description of the health literacy strategy and its ability to induce cost savings in the American health care system). A number of governmental agencies have researched and pursued health literacy as a strategy for health promotion in the United States. *See, e.g.*, COMM. ON HEALTH LITERACY, INST. OF MED., *HEALTH LITERACY: A PRESCRIPTION TO END CONFUSION* (Lynn Nielsen-Bohlman et al. eds., 2004); Off. Disease Prevention & Health Promotion, *Health Literacy and Communication*, HEALTH.GOV (Jan. 14, 2016), <http://health.gov/communication/> [hereinafter *Health Literacy Website*]. This has manifested in health literacy being incorporated as a major objective of Healthy People 2020, a “science-based, 10-year national [initiative] . . . for improving the health of all Americans.” *See* Off. Disease Prevention & Health Promotion, *About Healthy People*, HEALTHYPEOPLE.GOV (Jan. 13, 2016), <http://>

has the capacity to obtain, communicate, process, and understand basic health information and services in order to make appropriate health decisions.”<sup>170</sup> Promoting health literacy among patients would likely result in a more informed consumer population while producing “significant cost savings for providers, insurers, and the government.”<sup>171</sup> By “empowering patients with better information and decision-making skills,”<sup>172</sup> patients are able to choose the ACO and range of care most suitable to their needs, preferences, and financial ability.

### III. PERSPECTIVE #2: QUALITY OF CARE AND THE METHODOLOGY OF GRADING ACOS

The second perspective considers the quality performance measures ACOs must meet in conjunction with the cost-saving measures in order to receive a portion of the shared savings. Underlying these measures is what “high-quality care” means: “It is care that assists healthy people to stay healthy, cures acute illnesses, and allows chronically ill people to live as long and fulfilling a life as possible.”<sup>173</sup> This section will begin with a description of the quality

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[www.healthypeople.gov/2020/About-Healthy-People](http://www.healthypeople.gov/2020/About-Healthy-People) [hereinafter *Healthy People Website*]. See also Off. Disease Prevention & Health Promotion, *Health Communication and Health Information Technology*, HEALTHYPEOPLE.GOV (Jan. 13, 2016), <http://www.healthypeople.gov/2020/topics-objectives/topic/health-communication-and-health-information-technology/objectives> (Health literacy falls under the major topic of “Health Communication and Health Information Technology” and is coded as “HC/HIT-1 Improve the health literacy of the population”).

<sup>170</sup> *Health Literacy Website*, *supra* note 169 (select “About” on left column). See also Clark, *supra* note 169, at 258–59 (providing various definitions for “health literacy”).

<sup>171</sup> Clark, *supra* note 169, at 272.

<sup>172</sup> *Id.* at 274. Clark proposes several ways to improve health literacy among Americans, including providing various forms and comprehension levels of information, patient coaching and patient-centered materials, and encouraging patient questions and dialogue. See Clark, *supra* note 169, at 278–83.

<sup>173</sup> THOMAS S. BODENHEIMER & KEVIN GRUMBACH, UNDERSTANDING HEALTH POLICY: A CLINICAL APPROACH, 111, 111 (5th ed. 2009). Bodenheimer and Grumbach build further on this definition by explaining the various components of “high-quality care,” including “access to care,” “adequate scientific knowledge,” “competent health care providers,” “separation of financial and clinical decisions,” and “organization of health care institutions to maximize quality.” See generally *id.* at 111–16.

performance measures used by the CMS to evaluate ACOs. It will then consider whether these quality measures are effective in producing “quality care” for beneficiaries. It will end with a suggested general reengineering of the quality measures used to evaluate ACOs.

#### A. Grading the ACOs: The Four Domains of Review

In an effort to improve the quality of care provided by ACOs, the CMS incorporated quality performance measures to the evaluation scheme of ACOs.<sup>174</sup> ACOs must meet thirty-three quality performance measures set for a given year in order to share in any savings generated during that year.<sup>175</sup> Based on nationally recognized standards,<sup>176</sup> these thirty-three quality measures span four domains that chart the post-ACA path to “quality care.”<sup>177</sup> The four domains include: 1) patient/caregiver experience; 2) care coordination/patient safety; 3) preventive health; and 4) at-risk population, including diabetes, hypertension, ischemic vascular disease, heart failure, and coronary artery disease.<sup>178</sup>

ACOs are required to thoroughly report on all thirty-three quality measures at each reporting period during a performance year.<sup>179</sup>

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<sup>174</sup> See generally *Guide to Quality Performance*, *supra* note 85.

<sup>175</sup> See *id.* at 1. These thirty-three quality measures were developed by a consortium of non-profit health organizations and institutions known as “measure stewards” and include organizations like the Agency for Healthcare Research and Quality and the National Committee on Quality Assurance. See CTRS. MEDICARE & MEDICAID SERVS., ACCOUNTABLE CARE ORGANIZATIONS 2015 PROGRAM ANALYSIS QUALITY PERFORMANCE STANDARDS NARRATIVE MEASURE SPECIFICATIONS 1, 1–6 (2015) (providing a brief introduction on ACOs and the quality measures, as well as detailed information regarding the measure and measure steward associated with the measure).

<sup>176</sup> See generally PPACA, tit. III, subtit. A, pt. II, secs. 3013–14, 124 Stat. at 381–89; 42 C.F.R. § 425.500–.502 (2014); Barry G. Saver et al., *supra* note 155, at 3 (“[T]hese measures are typically derived from the Healthcare Effectiveness Data and Information Set (HEDIS), whose sponsor states they ‘were designed to assess measures for **comparison** among health care systems, not measures for **quality improvement**.’” (bold in original)).

<sup>177</sup> See *Guide to Quality Performance*, *supra* note 85, at 1.

<sup>178</sup> See *id.*

<sup>179</sup> See *id.* A “performance year” consists of a twelve-month period, beginning on January 1 of each year during the agreement period. See *id.* at 2. A “reporting period” also consists of a twelve-month period, beginning on January 1 of each year during the agreement period. See Centers for Medicare & Medicaid Services,

Reporting and data collection is done through a variety of methods, including web interface, patient surveys, claims data, and data from electronic health records.<sup>180</sup> This data is then evaluated and used to score ACOs across the measures and domains set for a performance year.<sup>181</sup> At the onset of the ACO program, payment was based on an ACO completely and accurately reporting on all thirty-three quality measures.<sup>182</sup> However, the CMS is transitioning away from this payment model to a “pay for performance” model<sup>183</sup> in which ACOs must meet performance benchmarks—rather than reporting benchmarks—to share in any savings realized.<sup>184</sup>

The CMS sets a “Minimal Attainment Level” for each measure, which is the minimum threshold an ACO must meet to earn points in a given domain.<sup>185</sup> The minimum attainment level was initially set at 30% or the 30th percentile under the pay-for-performance model, meaning the ACO being evaluated would need to perform

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*Guide to Quality Measurement for Accountable Care Organizations Starting in 2012: Agreement Period, Performance Year, and Reporting Period*, CTRS. MEDICARE & MEDICAID SERVS. 1, 3 (“All quality measures will have a [twelve]-month, calendar year reporting period, regardless of ACO start date.”). *See also id.* at 2 (providing a breakdown of the performance year and corresponding reporting period in table form).

<sup>180</sup> *See Guide to Quality Performance*, *supra* note 85, at 1.

<sup>181</sup> *See id.* at 2, 3.

<sup>182</sup> *See id.* at 2.

<sup>183</sup> The “pay-for-performance” model—using “outcome measures tied to pay . . . [used to move] from payment per procedure to true outcome-driven health care”—is a major cost-saving and quality improving measure implemented through various programs under the ACA. *See generally* Furrow, *supra* note 105, at 860–62.

<sup>184</sup> *See Guide to Quality Performance*, *supra* note 85, at 2. In Performance Year 1, ACOs were able to meet quality performance measures by reporting on all thirty-three measures. *See id.* In subsequent performance years, ACOs must meet performance benchmarks for a greater share of the measures until the program completely transitions to all measures being evaluated on performance as opposed to reporting. *See id.*

<sup>185</sup> *See Guide to Quality Performance*, *supra* note 85, at 2–3; Hodges, *supra* note 164, at 118; Centers for Medicare & Medicaid Services, *Medicare Shared Savings Program Quality Measure Benchmarks for the 2014 Reporting Year*, CTRS. MEDICARE & MEDICAID SERVS. 1, 4 (Feb. 2015), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-QM-Benchmarks-2015.pdf> [hereinafter *Quality Measure Benchmarks 2014*].

better than the bottom 30% of providers evaluated.<sup>186</sup> So long as the minimum attainment level is met or passed on at least one measure for each of the four domains, the ACO will earn points and likely be eligible for a share of the savings generated.<sup>187</sup> However, if the ACO fails to meet the minimum attainment level, it will receive no points for the given measure.<sup>188</sup> Failure to meet the minimum attainment level on at least 70% of the measures in each domain may result in warnings or termination, as well as the ACO no longer qualifying for shared savings.<sup>189</sup>

Each measure is scored on a scale from 0 to 2, except for one measure—the Electronic Health Records measure—which is measured on a scale from 0 to 4.<sup>190</sup> Points earned on this “sliding scale” are based on an ACO’s actual level of performance on a given measure.<sup>191</sup> Thus, the better an ACO performs on a given measure, the more points an ACO is able to earn.<sup>192</sup> The total points earned for each measure within a given domain are then summed and divided

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<sup>186</sup> See *Guide to Quality Performance*, *supra* note 85, at 2; Hodges, *supra* note 164, at 118 (“CMS has set a minimum attainment level at the 30th percentile of each performance benchmark.”). However, this percentage is set to increase over time in order to drive quality up. See *id.* (“CMS intends to gradually raise the minimum attainment level over time in order to drive quality improvements amongst ACOs.”).

<sup>187</sup> See *Guide to Quality Performance*, *supra* note 85, at 2–3. However, this requires that the ACO meet the cost saving criteria as well. See *id.* at 3.

<sup>188</sup> See *Guide to Quality Performance*, *supra* note 85, at 2.

<sup>189</sup> See *id.* at 4.

<sup>190</sup> See *Guide to Quality Performance*, *supra* note 85, at 3. The electronic health records measure is weighted more heavily than the other measures in order to promote the transition and use of electronic health records among ACOs. See *id.* at 3; *Quality Measure Benchmarks 2014*, *supra* note 185, at 4 (“The [Electronic Health Records] measure is double weighted and worth up to 4 points to provide incentive for greater levels of [Electronic Health Records] adoption.”).

<sup>191</sup> See *Guide to Quality Performance*, *supra* note 85, at 3. It is important to note that the thirty-three quality measures will be scored as twenty-three measures as a result of composite measures, which combine several measures such that the overall score is on an “all or nothing basis”—meaning each individual measure in a composite measure must be met in order to earn the total points for the composite measure. See *id.* at 2; *Quality Measure Benchmarks 2014*, *supra* note 185, at 1.

<sup>192</sup> See *Guide to Quality Performance*, *supra* note 85, at 3. For four of the quality measures, a reverse sliding scale is used such that a lower score signifies better performance and thus results in a higher score. See *Quality Measure Benchmarks 2014*, *supra* note 185, at 4.

by the total possible points in the domain, resulting in a percentage score for each domain.<sup>193</sup> A final overall quality score for the ACO is calculated by averaging the percentage score for each of the four domains, which is then used to determine the amount of shared savings the ACO is entitled to.<sup>194</sup>

B. *A+ or F? Reengineering the Quality Measures to Achieve  
"Quality Care"*

A brief review of the thirty-three measures and four domains reveal two major concerns, both of which may be resolved with one global strategy. First, as noted earlier, a disconnect exists between ACOs meeting the quality measures required of them and the subsequent cost savings that are supposed to be generated.<sup>195</sup> This could mean that the quality measures are not an effective cost-saving tool.<sup>196</sup> Second, the measures themselves appear disassociated and myopic, seemingly lacking any general direction towards more holistic, long-term improvements in health in the United States.<sup>197</sup> While the current measures are valuable in addressing major health concerns in the United States,<sup>198</sup> an improved framework of "high-quality care" is needed, one aimed at improving the long-term health status for the patient population the ACO serves rather than implementing temporary fixes.<sup>199</sup>

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<sup>193</sup> See *Guide to Quality Performance*, *supra* note 85, at 3; *Quality Measure Benchmarks 2014*, *supra* note 185, at 5.

<sup>194</sup> See *Quality Measure Benchmarks 2014*, *supra* note 185, at 5 ("[The] final overall quality score for each ACO . . . will be used to determine the amount of savings it shares or, if applicable, the amount of losses it owes."); *Guide to Quality Performance*, *supra* note 85, at 3. Each of the four domains are weighted equally at 25%. See *id.* at 3 (Table 1 reflects the domain weight for each domain); *Quality Measure Benchmarks 2014*, *supra* note 185, at 4 (Table 1 reflects the domain weight for each domain).

<sup>195</sup> See Part II, section B.

<sup>196</sup> See *id.*

<sup>197</sup> One article suggests that these quality measures "are often based on easily measured, intermediate endpoints . . . not on meaningful, patient-centered outcomes; their use interferes with individualized approaches to clinical complexity and may lead to gaming, overtesting, and overtreatment." See Barry G. Saver et al., *supra* note 155, at 1.

<sup>198</sup> But see *id.* at 2 ("Some well-known quality measures do not perform as intended, or may even be associated with harm . . .").

<sup>199</sup> See Barry G. Saver et al., *supra* note 155, at 1–3.



Because a disconnect between quality attainment and cost reduction currently exists in the ACO model,<sup>200</sup> this shift to a long-term improvements model may, over time, result in more consistent reductions in cost. Not only should this model define the goal and strategy for achieving sustained, long-term improvements in health, but it should also dictate the domains and measures chosen for rating ACOs.<sup>201</sup> This model would shift the ACOs' focus from simply meeting a random assortment of "quality" measures to aligning their quality strategy towards a goal—namely *meaningful* long-term health improvement for their patient population.

Several frameworks currently exist centered on producing long-term improvements in the general health status of Americans.<sup>202</sup> Each defines the overlaying goal of the framework and details measures used to determine whether the goal of long-term health improvement is being met.<sup>203</sup> One such framework is "Healthy People 2020,"<sup>204</sup> a national program whose mission and measures are updated every ten years in response to the shifting needs and current status of health in the United States.<sup>205</sup> Three other potential frameworks in the literature may be of value in determining the overall mission, framework, and measures to evaluate ACOs.

One potential framework is a public health-centered framework<sup>206</sup> that addresses current challenges in the provision of health through "a combination of technological advances, more effective clinical and administrative systems, and political commitment to invest in prevention and control" of patient health outcomes.<sup>207</sup> Under

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<sup>200</sup> See *supra* Part II, section B and accompanying notes.

<sup>201</sup> This process of creating quality measures by which to evaluate ACOs should be done in a transparent manner—rather than in the bureaucratic, stakeholder-influenced manner currently used. See Barry G. Saver et al., *supra* note 155, at 2, 3 ("Such measures should merit public trust, earn the support of clinicians, and promote the empowerment of patients. Their development should be open and transparent with careful attention to the best evidence of utility."); *supra* note 175–76.

<sup>202</sup> See, e.g., Barry G. Saver et al., *supra* note 155; *Healthy People Website*, *supra* note 169; Thomas R. Frieden, *The Future of Public Health*, 373 NEW ENG. J. MED. 1748 (2015).

<sup>203</sup> See *supra* note 202.

<sup>204</sup> *Healthy People Website*, *supra* note 169.

<sup>205</sup> *Id.*

<sup>206</sup> See Frieden, *supra* note 202, at 1749.

<sup>207</sup> *Id.*

this framework, domains and measures used to evaluate ACOs would have “five essential characteristics: consistency, patient-centeredness, team-based care, registry-based information systems, and continuous improvement in treatments and delivery.”<sup>208</sup> This framework provides a broader, more holistic approach to addressing quality standards through the ACO model of care.

A second framework provides a set of “patient-centered” principles<sup>209</sup> that could be used to develop measures that would result in “meaningful health outcomes.”<sup>210</sup> This framework dictates that a quality measure must:

1. address clinically meaningful, patient-centered outcomes;
2. be developed transparently and be supported by robust scientific evidence linking them to improved health outcomes in varied settings;
3. include estimates, expressed in common metrics, of anticipated benefits and harms to the population to which they are applied;
4. balance the time and resources required to acquire and report data against the anticipated benefits of the metric;
5. be assessed and reported at appropriate levels; they should not be applied at the provider level when numbers are too small or when interventions to improve them require the action(s) of a system.<sup>211</sup>

Measures created through this framework are intended to be evidence-based, ensuring that the measures themselves are effective and justified.<sup>212</sup>

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<sup>208</sup> *Id.*

<sup>209</sup> Barry G. Saver et al., *supra* note 155, at 3–6.

<sup>210</sup> *Id.* at 4.

<sup>211</sup> *Id.* (Box 1. Core Principles for Development and Application of Health Care Quality Measures).

<sup>212</sup> *See id.* at 3–6.

A final framework that could be used to develop a more holistic set of quality measures is the CMS Quality Strategy Goals and Foundational Principles.<sup>213</sup> These goals and principles guide CMS activities so as “to optimize health outcomes by improving quality and transforming the health care system.”<sup>214</sup> While the six strategy goals themselves are comprehensive in nature,<sup>215</sup> it is the four foundational principles guiding each of these goals that brings the Strategy Goals together to meet a greater mission.<sup>216</sup> Such a two-tiered structure that includes particular goals driven by underlying principles is one that would be beneficial in conjunction with the development of measures to evaluate ACOs on quality performance.

#### IV. PERSPECTIVE #3: ACOs AND ACCESS TO CARE

The final perspective considers whether ACOs have enhanced access to quality care. While critics argue that cost-saving measures are creating barriers to needed care,<sup>217</sup> a greater concern is whether populations most in need are gaining access to the comprehensive care of ACOs. One population—Medicaid beneficiaries—could benefit most from the ACO model of care. Efforts by CMS to improve Medicaid beneficiary access to ACOs have already begun to take effect, though greater action should be taken to incorporate this community into the ACO programs.

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<sup>213</sup> See generally CTRS. MEDICARE & MEDICAID SERVS., CMS QUALITY STRATEGY 2016 1 (2016) [hereinafter CMS QUALITY STRATEGY 2016].

<sup>214</sup> CMS QUALITY STRATEGY 2016, *supra* note 213, at 3.

<sup>215</sup> See *id.* at 5 (“The CMS Quality Strategy goals reflect the six priorities set out in the National Quality Strategy . . .”). These six goals include: 1) Make care safer by reducing harm caused in the delivery of care; 2) Strengthen person and family engagement as partners in their care; 3) Promote effective communication and coordination of care; 4) Promote effective prevention and treatment of chronic disease; 5) Work with communities to promote best practices of healthy living; and 6) Make care affordable. See *id.*

<sup>216</sup> These four foundational principles include: 1) Eliminate Racial and Ethnic Disparities; 2) Strengthen Infrastructure and Data Systems; 3) Enable Local Innovations; and 4) Foster Learning Organizations. See *id.* at 5–7.

<sup>217</sup> See *supra* notes 197–98. See also Barry G. Saver et al., *supra* note 155, at 4 (stating that an Institute of Medicine report in 2015 “highlight[ed] how ‘many measures focus on narrow or technical aspects of health care processes, rather than on overall health system performance and health outcomes’ and [found] that the proliferation of measures ‘. . . create[s] serious problems for public health and for health care.’”).

A. ACOs: The “Ivory Towers” of the U.S. Health Care Industry?

It is undeniable that the ACO model of care has had an immediate impact on the delivery of care—despite certain flaws in the model. However, the ACO model of care seems to create a metaphorical “ivory tower” of care by affording a luxury—quality care at a lower cost—to certain beneficiaries of the American health care system—namely Medicare beneficiaries and private payers.<sup>218</sup> When considering the long-term impact of this “ivory tower” on improving the health status of Americans, solely catering to these two groups is insufficient. Further, this “ivory tower” effectively blocks one major group of beneficiaries from accessing the comprehensive care offered by ACOs: Medicaid beneficiaries.<sup>219</sup>

Because the statutory formation of the ACO model of care only provides for Medicare beneficiaries,<sup>220</sup> the ACA left Medicaid beneficiaries relatively precluded from enjoying the comprehensive care that ACOs promised to provide.<sup>221</sup> However, such a strategy is

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<sup>218</sup> Lewis et al., *supra* note 25, at 1849 (“The coverage of ACOs varie[s] by type of payer—21 percent of local areas were served by at least one Medicare ACO, 13 percent were served by at least one private payer ACO, and 3 percent were served by at least one Medicaid ACO (confined almost entirely to states that launched Medicaid ACO projects: Oregon, Minnesota, and New Jersey).”); Stephen M. Shortell et al., *Accountable Care Organizations: The National Landscape*, 40 J. HEALTH POL., POL’Y & L. 647, 649 (2015) (“About half have a contract with a private payer, with 16 percent having a contract with both Medicare and a private payer. Thirty-six percent have a contract with Medicare only.”).

<sup>219</sup> See generally 42 U.S.C. § 1395jjj (statutorily creating the MSSP, which caters only to Medicare beneficiaries).

<sup>220</sup> See generally 42 U.S.C. § 1395jjj. But see KAISER FAM. FOUND., EMERGING MEDICAID ACCOUNTABLE CARE ORGANIZATIONS: THE ROLE OF MANAGED CARE 1, 2 (2012) (“The ACA also authorized a demonstration project for the creation of pediatric ACOs within Medicaid and/or the Children’s Health Insurance Program (CHIP). The demonstration project is currently unfunded, but states have begun to plan and implement Medicaid ACO initiatives themselves.”)

<sup>221</sup> John V. Jacobi, *Multiple Medicaid Missions: Targeting, Universalism, or Both?*, 15 YALE J. HEALTH POL’Y, L., & ETHICS 89, 106 (2015) (“The ACA created an ACO payment program in Medicare, but did not create a similar program in Medicaid.”).

short-sighted as “Medicaid disproportionately covers the poor, disabled, and elderly . . . .”<sup>222</sup> Similarly, many of these Medicaid beneficiaries are people of color who are regularly denied access to quality care—or care in general.<sup>223</sup> In effect, because ACOs are statutorily formed to care for Medicare beneficiaries—as opposed to Medicare *and* Medicaid beneficiaries—“[t]he process of creating ACOs may reinforce racial or ethnic differences in sites of care,”<sup>224</sup> as well as intensify existing disparities in health for racial and ethnic minorities.<sup>225</sup> While this likely was not the intention of the architects of the ACA, such a statutory loophole disproportionately impacts Medicaid beneficiaries who greatly need access to comprehensive quality care. It is critical, however, that this statutory loophole be addressed to ensure that all those who need health care are able to access the benefits of the ACO model of care.

#### B. Medicaid and ACOs: An Opportunity for Partnership?

Several states have taken steps that effectively counteract this large loophole in the ACO program, including Colorado, Minnesota, Oregon, and Utah.<sup>226</sup> The structure of these Medicaid ACOs vary

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<sup>222</sup> *Id.* See also KAISER FAM. FOUND., *supra* note 225, at 1 (“Medicaid is the nation’s public health insurance program for low-income Americans, covering close to 60 million children, families, seniors, and people with disabilities.”).

<sup>223</sup> Craig Evan Pollack & Katrina Armstrong, *Accountable Care Organizations and Health Care Disparities*, 305 J. AM. MED. ASS’N 1706, 1706 (2011) (“Racial/ethnic disparities in health are well documented in the United States. These disparities arise, in part, because of differences in the site of care. Black and white patients tend to receive care from different clinicians who work at different hospitals and in different health care systems.”); Ryan E. Anderson et al., *Quality of Care and Racial Disparities in Medicare Among Potential ACOs*, 29 J. GEN. INTERNAL MED. 1296, 1296 (2014) (“Because care for racial and ethnic minorities is concentrated among physicians and hospitals with fewer resources, advanced provider groups ready to participate in ACO programs may disproportionately care for white patients.”).

<sup>224</sup> Pollack & Armstrong, *supra* note 223, at 1706.

<sup>225</sup> See Anderson et al., *supra* note 223, at 1296.

<sup>226</sup> Virgil Dickson, *Reform Update, States test Medicaid ACOs to cut costs*, MOD. HEALTHCARE (July 1, 2014), <http://www.modernhealthcare.com/article/20140701/NEWS/307019965>. In total, there are currently fifteen states with Medicaid ACO models of care; Jacobi, *supra* note 221, at 106 (“Experimental programs are growing in several states . . . built on the structure of coordinated care, shared clinical decision-making among a large group of Medicaid providers, and some form of reward for delivering high-quality care while containing cost.”);

from state to state,<sup>227</sup> though recent data shows that they all are effective.<sup>228</sup> However, the common characteristic among the current Medicaid ACOs is how they are formed; Medicaid ACOs have all been *legislatively* created by states.<sup>229</sup> This is a critical point to note when considering the formation of Medicaid ACOs on a national scale, as the politics of a given state legislature could drastically impact the creation of a Medicaid ACO, and, as a result, compromise a Medicaid beneficiary's ability to access comprehensive care.<sup>230</sup>

With this in mind, it would be prudent for the CMS to incentivize Medicaid ACOs through their current ACO programing rather than leave it to each state legislature.<sup>231</sup> Such a Medicaid ACO

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KAISER FAM. FOUND., *supra* note 220, at 1, 2–5. *See generally* Douglas Hervey et al., *The Rise and Future of Medicaid ACOs*, LEAVITT PARTNERS 1, 4 (Sept. 2015), <http://cqrcengage.com/trinityhealth/file/tyuVip0U4gR/LeavittMedicaidACOSep2015.pdf> (Figure 1 mapping the states that have passed legislation for Medicaid ACOs); Tricia McGinnis, *A Unicorn Realized? Promising Medicaid ACO Programs Really Exist*, THE COMMONWEALTH FUND (Mar. 11, 2015), <http://www.commonwealthfund.org/publications/blog/2015/mar/unicorn-realized-medicaid-acos> (describing each of the Medicaid ACOs).

<sup>227</sup> *See* KAISER FAM. FOUND., *supra* note 220, at 4; Dickson, *supra* note 226 (“The [Medicaid] models differ significantly from state to state.”); Hervey et al., *supra* note 226, at 4 (“[N]o two states’ initiatives are alike. States’ ACO experiments depend on their historical relationship with managed care and their own unique challenges associated with their low-income and chronically ill populations. State ACOs differ in their organizational structures, governance, provider eligibility requirements, covered populations, scope of services, required functions, payment models, and quality measures.”).

<sup>228</sup> *See* McGinnis, *supra* note 226.

<sup>229</sup> *See* Hervey et al., *supra* note 226, at 4 (“Despite the historical and anticipated growth of Medicaid ACOs, most states’ efforts are still relatively nascent as they must undergo lengthy planning processes, accommodate differing stakeholder concerns, and navigate complex federal and state legislative and regulatory requirements in order to implement a Medicaid ACO.”).

<sup>230</sup> This point is exemplified by the recent trend of states refusing to expand their Medicaid program following the landmark decision of *National Federation of Independent Business v. Sebelius*. *See Nat’l Fed’n Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2607 (2012) (holding that “Congress is not free . . . to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding [for not expanding coverage].”). However, the reasoning there may be indicative of the fact that Medicaid ACOs cannot be *imposed* on states. *See id.* at 2607–08.

<sup>231</sup> This strategy of incentivizing participation in the formation of state Medicaid ACOs should be done in a manner that does not punish states for not participating, as the ACA was thought to do through the expansion of the Medicaid

model could simply mirror the current structure of the Medicare ACO model in which ACOs are able to earn shared savings by improving the quality of care provided and decreasing the cost of care.<sup>232</sup> However, these Medicaid ACO programs would need to allow for variations among states based on demographics, needs, and available funds.<sup>233</sup> By incentivizing the formation of Medicaid ACOs, the CMS—in partnership with participating states—could help close this existing statutory gap in access to care for a vulnerable population that is desperately in need of high quality, comprehensive care.

### CONCLUSION

As with any initiative, only time will tell whether the ACO model of care will be able to effectuate the major changes it is designed to bring to the American health system. While this Comment offers some criticisms and suggested solutions—based on a review of the available literature—it should not be seen as a call to eliminate the ACO model of care.<sup>234</sup> Rather, this Comment intends to support and build on the current conversation concerning the ACO model of care, as well as offer strategies for continuously improving the model. As the ACO model of care continues to be refined, policymakers and health care providers alike will likely be able to better meet the desired balance embodied in the “Triple Aim.” However, achieving this balance requires that all stakeholders work collaboratively to refine a model of care that promises to provide quality care at a lower cost for more Americans. In many cases, it already has.

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program in each state. *See id.* Incentivizing, without “blackmailing,” participation in Medicaid ACOs would thus keep with the logic of *National Federation of Independent Business v. Sebelius*. *See id.*

<sup>232</sup> *See supra* Part II.

<sup>233</sup> *See supra* note 227.

<sup>234</sup> *See* Francis J. Crosson, *The Accountable Care Organization: Whatever Its Growing Pains, The Concept Is Too Vitally Important To Fail*, 30 HEALTH AFF. 1250, 1250 (2011) (“[N]one [of the criticisms] should serve to prevent the evolution of this [ACO] model, because the alternative to a fundamental restructuring of how health care is delivered and paid for in the United States is likely to be a type of indiscriminate cost cutting that will leave the nation with a damaged health care system, reduced access to care services, and declining quality of care.”).