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Accountable Care Organizations in the Affordable Care Act

Frank Pasquale[*]

I. INTRODUCTION

On March 23, 2010, Section 3022 of the Patient Protection & Affordable Care Act (PPACA or ACA) established the Medicare Shared Savings Program (MSSP). The MSSP depends on Accountable Care Organizations (ACOs) to coordinate care for large groups of Medicare beneficiaries and reduce their overall costs while maintaining quality.[1] ACOs are a critical part of the PPACA. If they succeed, they could be a model of care coordination critical to cost reductions, quality improvements, and expanded access to care both within and beyond the Medicare program.[2] Their failure would not bode well for the wide array of pilot programs promoted and funded by the PPACA.[3]

Seton Hall was the first law school to host a conference on

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[*] Schering-Plough Professor of Health Care Finance and Regulation, Seton Hall Law School. I would like to thank Gianna Cricco-Lizza, Temi Kolarova, and other members of the Law Review for their excellent work on the symposium. Professors John Jacobi and Kathleen Boozang were also invaluable to planning the event. Deans Rosa Alves-Ferreira and Denise Pinney also offered invaluable contributions to our planning and organization.

[1] Jenny Gold, *FAQ On ACOs: Accountable Care Organizations, Explained*, KAISER HEALTH NETWORK (Oct. 21, 2011), http://www.kaiserhealthnews.org/Stories/2011/January/13/ACO-accountable-care-organization-FAQ.aspx.

[2] Maulik Joshi, American Hospital Association, *Accountable Care Organizations AHA Research Synthesis Report,* American Hospital Association Committee on Research, (June 2010), *available at* http://www.hret.org/accountable/resources/ACO-Synthesis-Report.pdf; *Accountable Care Organizations (ACO): What's an ACO?*, CTRS. FOR MEDICARE & MEDICAID SERVS., (Apr. 5, 2010), http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/ACO/index.html.

[3] For a discussion of pilot programs' importance to health care, *see* Frank Pasquale, *Ending the Specialty Hospital Wars: A Plea for Pilot Programs as Information-Forcing Regulatory Design*, *in* THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS (Einer Elhauge, ed., Oxford Univ. Press 2010). For an accessible account of the role of pilot programs in PPACA, *see* Atul Gawande, *Testing, Testing*, THE NEW YORKER, Dec. 14, 2009, at 34, *available at* http://www.newyorker.com/reporting/2009/12/14/091214fa_fact_gawande.

ACOs. We planned the conference in early 2011, as excitement about ACOs was building in much of the policy community. Moreover, we felt that whatever happened to the ACA in the Supreme Court, the organizational forms suggested by the PPACA regarding ACOs were influencing private sector players. Providers, insurers, and employers were increasingly coordinating to deal with cost and quality concerns.

On March 31, 2011, the proposed rule guiding providers on the establishment of ACOs was released.[4] The negative industry response was nearly immediate: providers felt that they were being asked to move too fast and aggressively on a wide variety of initiatives. For example, merely developing IT systems to keep track of the sixty-five quality performance standards needed to qualify for shared savings payments seemed daunting. Keeping up with the "meaningful use" rulemakings guiding American Recovery and Reinvestment Act of 2009 (ARRA) subsidies for electronic health records (EHRs) was hard enough; now a whole other program was affecting recordkeeping. While federal policymakers had assumed there would be synergies between ACO establishment and a larger health information technology (HIT) revolution,[5] providers felt they were being asked to do too much, too soon. Industry resistance left us wondering if the conference might be rendered irrelevant due to lack of provider interest in establishing ACOs. The MSSP is an incentive program, not a mandate: the private sector must choose to participate if it is to be effective.

We should not have worried. The idea of accountable care proved attractive to private insurers, regardless of its fate at the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS). And by the time of the conference, the regulatory treatment of ACOs had bent toward

[4] Jordan Rau, Phil Galewitz & Bara Vaida, *New ACO Rules Outline Gains And Risks For Doctors, Hospitals*, KAISER HEALTH NEWS (Mar. 31, 2011), http://www.kaiserhealthnews.org/Stories/2011/March/31/ACO-rules.aspx; U.S. DEP'T OF HEALTH AND HUMAN SERVS., FACT SHEET: ACCOUNTABLE CARE ORGANIZATIONS: IMPROVING CARE COORDINATION FOR PEOPLE WITH MEDICARE (Mar. 31, 2011), *available at* http://www.kaiserhealthnews.org/~/media/Files/2011/HHS%20ACO %20Overview%20Fact%20Sheet%2033111.pdf; CMS OFFICE OF MEDIA AFF., FACT SHEET: SUMMARY OF PROPOSED RULE PROVISIONS FOR ACCOUNTABLE CARE ORGANIZATIONS UNDER THE MEDICARE SHARED SAVINGS PROGRAM (Mar. 31, 2011), *available at* http://www.kaiserhealthnews.org/~/media/Files/2011/CMS%20ACO %20Fact%20Sheet%20%20Summary%20Proposed%20Rule%20110331.pdf.

[5] *See, e.g.*, Bob Spoerl, *6 Steps to Building an ACO's Health IT Capacity*, BECKER'S HOSP. REV., June 15, 2012, *available at* http://www.beckershospitalreview.com /hospital-physician-relationships/6-steps-to-building-an-acos-health-it-capability.html.

provider demands. Hospitals and doctors successfully demanded key changes to the regulatory template. Industry, HHS, and CMS were soon singing from the same hymnal.[6] The final rule only imposed thirty-three quality measures, and gave other concessions to those forming ACOs. By the time our conference occurred on October, 28, 2011, ACOs were again a buzzword in health policy, both as specific description related to the MSSP and as a larger catchall term for trends in health care organization and finance.

The *pas de deux* between business and government over ACOs had a larger significance for administrative law scholarship.[7] From the time of its passage in 2010 to the climactic Supreme Court ruling in *NFIB v. Sebelius*, prominent attacks on PPACA have come almost entirely from the right on the political spectrum. The rhetoric of the "constitution in exile" succeeded both in empowering states to resist the ACA's Medicaid expansion and influencing the Commerce Clause jurisprudence of the Court.[8] But the individual mandate survived, as Congress's power to tax prevented the four justices in the joint dissent from using nonseverability doctrine to sweep the ACA from American law forever.

Now that the ACA is to be implemented in earnest, we should expect to hear more critiques of it from the left. Focused on the ethics and effectiveness of leading providers and insurers, these are the critiques most relevant to ACOs. For ACOs to work, many large corporate enterprises will need to delicately balance the interests of

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[6] Mark McClellan (George W. Bush's CMS Director) and Elliott Fisher sang its praises in *Health Affairs*. *See* Mark McClellan and Elliott Fisher, *The ACO Final Rule: Progress Toward Better Care At Lower Cost*, HEALTH AFF. BLOG (Oct. 21, 2011), http://healthaffairs.org/blog/2011/10/21/the-aco-final-rule-progress-toward-better-care-at-lower-cost/; Mark McClellan, Aaron N. McKethan, Julie L. Lewis, Joachim Roski & Elliott S. Fisher, *A National Strategy To Put Accountable Care Into Practice*, 29(5) HEALTH AFF. 982 (2010).

[7] The relative power of business and government in common collaborations has been a frequent topic of inquiry, particularly in agencies regulating competition. The competing imperatives of recognizing business needs, while avoiding corporatist overidentification of state and corporate interests, are a recurring theme in administrative law. *See, e.g.*, Frank Pasquale, *Indecopi as Brand and Holding Company: The Business Model of Governance*, *in* THE ROLE OF THE STATE IN COMPETITION AND INTELLECTUAL PROPERTY POLICY IN LATIN AMERICA: TOWARDS AN ACADEMIC AUDIT OF INDECOPI 91 (Beatriz Boza, ed., 2000) (describing the tensions in a competition law regulator).

[8] The anti-ACA decision became a staple of conservative jurisprudence despite challenging what many commentators believed to be settled law. *See* Mark A. Hall, *Judge Vinson's Tea Party Manifesto*, CONCURRING OPINIONS (Jan. 31, 2011), http://www.concurringopinions.com/archives/2011/01/judge-vinsons-tea-party-manifesto.html.

patients and service providers.[9] Will they truly maintain quality, or game indicators of quality? Will cost-savings come at the expense of patient care? Where are the real opportunities to improve outcomes, and what is mere gaming?[10] Responsive regulation will need to answer all these questions, and many more, as ACO implementation continues.

This introductory essay describes the academic and regulatory agenda for ACOs, and the way our conference authors clarified it. Part II describes the rationale of the ACA in general and the ACO program in particular. Part III explains the left critique of the ACA, and how the ACO program provides a good test case for whether the ACA's model of corporate-government cooperation can actually improve outcomes and reduce costs. Part IV summarizes the positions of our conference speakers. Part V concludes.

II. ACOS IN THE ACA

Critics of the ACA have frequently complained that the legislation does not do enough to improve quality or to cut costs. However, the Act did create incentives for ACOs to challenge traditional health care regulatory models. Elliott Fisher, director of the Center for Health Policy Research at Dartmouth Medical School, describes the "three key attributes" of ACOs: "organized care, performance measurement, and payment reform."[11]

Fisher has argued that insurers are not well-positioned to improve the quality of health care because they "have largely focused on negotiating favorable prices within relatively open networks of providers" instead of trying to improve the health care their members received.[12] He believes that a "virtual network" of physicians could do a better job, if they teamed up with hospitals. An "accountable care

[9] *See* Robert Pear, *Consumer Risks Feared as Health Law Spurs Mergers*, N.Y. TIMES, Nov. 20, 2010, http://www.nytimes.com/2010/11/21/health/policy/21health.html.

[10] David Whelan, *How Cherry Picking Could Hurt Obama's Health Care Plan*, FORBES, July 13, 2009, http://www.forbes.com/forbes/2009/0713/health-obama-insurance-hmo-cherry-picking.html (discussing possibilities for gaming the system).

[11] Elliott S. Fisher et al., *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, 26(1) HEALTH AFF. w44 (2007), *available at* http://content.healthaffairs.org/content/26/1/w44.full.

[12] *Id.* Private insurers have little incentive to keep current subscribers healthy over the long term, since at least half of subscribers on average churn into different plans within three years of signing up with a given plan. *See* Randall D. Cebul et al., *Organizational Fragmentation and Care Quality in the U.S. Healthcare System,* 22(4) J. ECON. PERSPECTIVES 93 (2008), *available at* http://www.aeaweb.org/articles.php?doi=10.1257/jep.22.4.93.

organization" is really a legal network, with certain members and entities entitled to receive payments in exchange for cutting costs or improving quality.

In an ACO, an "extended hospital medical staff" (or "a hospital-associated multi-specialty group practice") can join forces with a hospital and agree to be compensated via a lump sum payment. If the group manages to keep overall costs beneath the lump sum payment, it can share the gains among its members. Each part of the team also has an incentive to work together to keep those they care for healthy. In an ideal world, the ACO responds to concerns about fragmentation raised by several health law experts.[13]

For ACO proponents, virtual networks of physicians and hospitals may provide efficiency and quality gains. However, there are many skeptics. Jeff Goldsmith worries about shadowy new pressures on providers that patients won't be aware of:

> Consumers would not be aware that they were being treated by ACOs. Rather, they would be "attributed" to them: virtual patients of virtual organizations. Aggregate health spending for attributed patients would be tracked, and increases in that spending would be capped using a form of "shadow capitation." ACOs that lived within the caps would get their fees increased. Those that overspent would see their fees reduced or frozen.[14]

Robert Pear has reported that a "frenzy of mergers involving hospitals, clinics and doctor groups eager to share costs and savings" worries consumer advocates and antitrust scholars.[15] "The new law is already encouraging a wave of mergers, joint ventures and alliances in the health care industry," according to Prof. Thomas L. Greaney, an expert on health and antitrust law who spoke at Seton Hall's ACO Conference.[16] As Greaney puts it, "[t]he risk that dominant providers

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[13] *See* the essays in THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS (Einer Elhauge, ed., Oxford Univ. Press 2010).

[14] Jeff Goldsmith, *The Accountable Care Organization: Not Ready for Prime Time*, HEALTH AFF. BLOG (Aug. 17, 2009), http://healthaffairs.org/blog/2009/08/17/the-accountable-care-organization-not-ready-for-prime-time/.

[15] Pear, *supra* note 9 ("In an environment where health care providers are financially rewarded for keeping costs down," [a lawyer for the Consortium for Citizens with Disabilities] said, "anyone who has a disability or a chronic condition, anyone who requires specialized or complex care, needs to worry about getting access to appropriate technology, medical devices and rehabilitation. You don't want to save money on the backs of people with disabilities and chronic conditions.").

[16] Thomas Greaney, *Accountable Care Organizations: A New New Thing with Some Old Problems*, 10 HEALTH LAW OUTLOOK 6 (2010), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1679492; Thomas Greaney,

and dominant insurers may exercise their market power, individually or jointly, has never been greater."[17]

ACOs also implicate fraud and abuse laws, since anti-kickback and other prohibitions can hamstring efforts to create relevant financial incentives. At a recent government workshop on ACOs, participants addressed "circumstances under which collaboration among independent health care providers in an ACO permits ACO providers to engage in joint price negotiations with private payers without running the risk of engaging in illegal price fixing under the antitrust laws."[18] HHS also explored "the different ways in which the Secretary may exercise waiver authority or create new exceptions and safe-harbors related to the physician self-referral law, the Anti-kickback statute and the CMP law in order to encourage the creation and development of ACOs."[19] The American Medical Association (AMA) has pushed for "explicit exceptions to the antitrust laws" for participating doctors.[20] The president of the Federation of American Hospitals says "the fraud and abuse laws should be waived altogether."[21]

Some scholars may share that skeptical view of fraud and abuse laws, at least as they pertain to the types of economic transactions

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The Affordable Care Act and Competition Policy: Antidote or Placebo?, 89 OR. L. REV. 811 (2011). *See also* Cory Capps, PhD & David Dranove, PhD, *Market Concentration of Hospitals* (June 2011), *available at* http://www.ahipcoverage.com/wp-content/uploads/2011/06/ACOs-Cory-Capps-Hospital-Market-Consolidation-Final.pdf.

[17] Greaney quoted in Pear, *supra* note 9. It is hard to read Greaney's work on the topic without concluding that a toxic mix of "doctrinal shortcomings, political pressures, and institutional constraints" have severely compromised antitrust enforcement already. Greaney's 2004 article on antitrust in health care, *Chicago's Procrustean Bed*, also suggests that health care antitrust has, for years, been biased "strongly [in] favor of defendants" due to the persistent failures of Chicago-inspired doctrine to reflect "market imperfections" in health care. There have been some recent wins for federal enforcers against certain major mergers, but the overall record of the past two decades has been one of consolidation. *See, e.g.*, Joe White, *Markets and Medical Care: The United States, 1993–2005*, 85(3) MILLBANK QUARTERLY 143 (2007) ("Hospital managers consolidated systems in order to strengthen their bargaining power with insurers, and studies show that consolidation did indeed enable hospitals to extract higher-than-average price increases.").

[18] Agenda, *Workshop Regarding Accountable Care Organizations, and Implications Regarding Antitrust, Physician Self-Referral, Anti-Kickback, and Civil Monetary Penalty (CMP) Laws*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Oct. 5, 2010), *available at* http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment /PhysicianFeeSched/downloads/100510_Meeting_Agenda.pdf

[19] *Id.*

[20] *Id.*

[21] Pear, *supra* note 9.

necessary to make ACOs work. Over the past twenty years, regulation of fraud and abuse has waxed and waned. In 1996, James F. Blumstein concluded that "the modern American healthcare industry is akin to a speakeasy—conduct that is illegal is rampant and countenanced by law enforcement officials because the law is so out of sync with the conventional norms and realities of the marketplace."[22] Nevertheless, as Joan Krause has shown, there are important public purposes behind these laws.[23] It is therefore troubling to see a hospital leader advocate for them to be swept away *tout court* in the case of ACOs. Policymakers should also be cautious about granting overly broad antitrust exemptions to ACOs in a field where competition law's prerogatives have already been whittled away.[24]

Legal scholar Kevin Werbach once observed that the Internet has been centripetal, "pull[ing] itself together as a coherent whole."[25] For Werbach, network formation theory both explains these centripetal tendencies, and some of "the pressures threatening to pull the Internet apart" into balkanized units.[26] Werbach counsels that governments need to "catalyz[e] network formation, and moderat[e] the forces that push towards excessive concentration of power."[27] These recommendations should also govern new efforts to create "virtual networks" of care in the wake of the ACA. Like many forms of network power, the ACOs could quickly have negative unintended consequences if regulators fail to anticipate the ways they

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[22] Jonathan Blumstein, *The Fraud and Abuse Statute in an Evolving Healthcare Marketplace: Life in the Health Care Speakeasy*, 22 AM. J.L. & MED. 205, 207 (1996). Gray areas in the law remain a problem; *see, e.g.*, Jean M. Mitchell, *The Prevalence of Physician Self-Referral Arrangements After Stark II*, 26(3) HEALTH AFF. W415 (April 2007).

[23] Joan H. Krause, *Regulating, Guiding, and Enforcing Health Care Fraud*, 60 N.Y.U. ANN. SURV. AM. L. 240 (2004).

[24] *Fact Check: Provider Consolidation Drives Up Prices*, AMERICA'S HEALTH INSURANCE PLAN COVERAGE (Feb. 17, 2012), http://www.ahipcoverage.com/2012/02/17/fact-check-provider-consolidation-drives-up-prices/. An alternative is to start regulating dominant ACOs as veritable health care utilities, as critical to regional infrastructure as roads, electricity, or water. *See* Frank Pasquale, *The Limits of Competition*, CONCURRING OPINIONS (Oct. 26, 2009), http://www.concurringopinions.com/archives/2009/10/the-limits-of-competition-and-the-rebirth-of-the-public-option.html. The logic of concentration seems inevitable in the field: insurers and providers have long been in an arms race for bargaining power, and as soon as one side gets permission to merge or acquire, the other clamors for it.

[25] Kevin D. Werbach, *The Centripetal Network: How the Internet Holds Itself Together, and the Forces Tearing it Apart*, 42 U.C. DAVIS L. REV. 343, 343 (2009).

[26] *Id.* at 345.

[27] *Id.* at 346.

could be abused.[28] ACOs may work, but only if policymakers can replace classic instruments of health care regulation with calibrated financing decisions that reflect new industry realities.

III. SITUATING ACOS: COOPTATION, CAPITULATION, OR COOPERATION BY DOMINANT PROVIDERS?

The history of American health care is littered with cost reduction ideas that ran into the buzz saw of quality concerns, provider resistance, or patient rebellion.[29] While capitation promised to incentivize cost discipline, the many health maintenance organizations (HMOs) charged with implementing the concept faced a backlash in the 1990s as they attempted to implement aggressive utilization review.[30] More recently, the less controversial ideas behind gainsharing ran into a number of legal obstacles.[31]

The ACA has emphasized ACOs as both a more and less ambitious form of cost cutting. Implemented as part of a Medicare Shared Savings Program,[32] ACOs are networks of providers and/or

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[28] *See* Frank Pasquale, *Network Power: Forced and Free*, CONCURRING OPINIONS (May 27, 2008), http://www.concurringopinions.com/archives/2008/05/network_power_f.html; Danielle Keats Citron & Frank Pasquale, *Network Accountability for the Domestic Intelligence Apparatus*, 62 Hastings L. J. 1441, 1453–54 (observing mechanisms for the abuse of networks).

[29] GREGG BLOCHE, THE HIPPOCRATIC MYTH (2010); Frank Pasquale, *The Hippocratic Math: How Much Should Society Spend on Health Care?*, 32(4) JOURNAL OF LEGAL MEDICINE 529 (2012) (reviewing GREGG BLOCHE, THE HIPPOCRATIC MYTH (2010)) (critiquing some cost reduction efforts).

[30] Thomas H. Greaney, Managed Care*: From Hero to Goat*, 47 ST. LOUIS U. L.J. 217, 217. (2003); Joe White, *Markets and Medical Care: The United States, 1993–2005*, 85(3) MILBANK QUARTERLY (2007) ("Utilization reductions were part of the reason that cost increases slowed in the mid-1990s. Group/staff HMOs certainly did reduce hospitalization rates. Moreover, health insurers did retreat from many of the methods of utilization controls that they had emphasized in the mid-1990s.") (internal citations omitted).

[31] Gainsharing is a financial arrangement that permits physicians to share in the savings that result when they alter practice patterns. Richard S. Saver, *Squandering the Gain: Gainsharing and the Continuing Dilemma of Physician Financial Incentives*, 98 NW. U. L. REV. 145, 147 (2003). For example, a group of surgeons may engage in bulk purchasing to obtain discounts on surgical equipment, rather than each choosing instruments individually. Start-ups like Groupon and Living Social have exploited this savings model, but residual quality concerns have impeded its adoption in health care settings. Some recent pilot programs have indicated the potential for savings from gainsharing. Mike Kalison, Presentation at the Seton Hall Law Review Symposium on ACOs (Oct. 28, 2011).

[32] PPACA § 3022(a)(1), 124 Stat. 119, 395, codified at 42 U.S.C. § 1395jjj(a)(1). The term ACO originated in a 2006 exchange. Elliott S. Fisher et al., *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, 26(1) HEALTH AFF. w44 (2007), *available at* http://content.healthaffairs.org/content/26/1

hospital(s)[33] that are charged with coordinating care for a group of at least 5,000 Medicare beneficiaries.[34] As of early 2012, HHS had already named thirty-two "health care organizations and providers that are already experienced in coordinating care for patients across care settings" as pioneer ACOs.[35] ACOs can be physician-centered, hospital-centered, or some combination of the two.[36] CMS will reward the provision of quality care by giving providers participating in the ACO a share of the savings if risk-adjusted, per-beneficiary spending levels came in below a benchmark set by the agency at the outset. For example, if benchmark spend were $10,000 apiece for 10,000 beneficiaries in 2014, and the ACO reduced the spend to

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/w44.full. It is designed to solve a classic "chicken and egg" problem in health care reform: whether to start with payment or delivery system reform. *See* Kelly Devers & Robert Berenson, *Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?*, ROBERT WOOD JOHNSON FOUND. (Oct. 2009), *available at* http://www.rwjf.org/files/research/acobrieffinal.pdf, in which the authors state that:

> Many believe that to bend the cost curve while improving quality, we must reform the provider payment system first, because it pays for volume rather than value. Others hold that it is impossible to change the payment system to achieve the desired objectives unless delivery system reform first produces organizations capable of handling an altered payment system. They point to the need for health care professionals, now usually working in separate institutional settings, to work collaboratively and to demonstrate their capacity for handling new payment approaches. To avoid the quandary of where to start first—provider payment or delivery system reform—the ACO concept attempts to combine them.

Id.

[33] Bruce Merlin Fried et al., *Accountable Care Organizations: Navigating the Legal Landscape of Shared Savings and Coordinated Care*, 4 J. HEALTH & LIFE SCI. L. 88 (2010) ("A wide range of professionals may work together to establish ACOs, including physicians in group practice arrangements, networks of individual physician practices, hospitals, and partnerships or joint ventures between hospitals and physician groups. ACOs also may include other forms of groups as the HHS Secretary (Secretary) deems appropriate. By forming an ACO, these healthcare providers commit to being held accountable for the quality, cost, and overall care of Medicare beneficiaries.").

[34] Francis J. Crosson, *The Accountable Care Organization: Whatever Its Growing Pains, The Concept Is Too Vitally Important To Fail*, 30(7) HEALTH AFF. 1250 (2011), *available at* http://content.healthaffairs.org/content/30/7/1250.full. ACOs have also been called "amorphous cluster[s] of possible collaborative models," where hospitals are bound to remain central because "the largest avoidable Medicare costs are hospital related" and "in many communities, the hospital is the only organized care delivery entity capable of executing the model." *Id.*

[35] *Pioneer ACO Model*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://innovations.cms.gov/initiatives/aco/pioneer/ (last visited July 12, 2012).

[36] Physician-centered ACOs could include multispecialty group practices (MSGs) and interdependent physician organizations (IPOs), also known as independent practice associations (IPAs).

$9,000 while maintaining quality levels, $10 million in savings could be attained, some of which would compensate participants in the ACO.

Some may question why ACOs were included in the ACA when more direct cost savings (such as direct discouragement of marginally effective treatments, or reduced reimbursement levels) are also part of the Act. Part of the answer lies in growing Democratic party consensus about government partnering with corporate entities to achieve public ends. There is still a residual divide between "realists" in the Democratic party and more idealistic progressives; as Ed Kilgore states, "on a widening range of issues, Obama's critics to the right say he's engineering a government takeover of the private sector, while his critics to the left accuse him of promoting a corporate takeover of the public sector."[37] But by and large, the realists guided the ACA's drafting. Opposition to the public option became so intense in official Washington (especially among the insurance industry-friendly staffers of Senate Finance Chair Max Baucus) that those pursuing universal coverage have become identified with the very entities they were trying to discipline via health insurance exchanges and delivery system reforms.[38]

Some political commentators rejected the compromises that resulted. Glenn Greenwald offered a multifaceted indictment of Congressional Democrats' bargains with corporate interests:

> The health care bill is one of the most flagrant advancements of . . . corporatism yet, as it bizarrely forces millions of people to buy extremely inadequate products from the private health insurance industry—regardless of whether they want it or, worse, whether they can afford it (even with some subsidies). . . . It's about affirmatively harnessing government power in order to benefit and strengthen those corporate interests and even merging government and the private sector.[39]

Only the full implementation of PPACA will allow us to judge how serious Greenwald's concerns are. Rulemaking on essential

[37] Ed Kilgore, *Left-Right Convergence?*, DEMOCRATIC STRATEGIST (Dec. 16, 2009), http://www.thedemocraticstrategist.org/strategist/2009/12/leftright_convergence.php.

[38] For background on the public option, *see* Frank Pasquale, *Public Option as Private Benchmark*, CONCURRING OPINIONS (June 9, 2009), http://www.concurringopinions.com/archives/2009/06/public-option-as-private-benchmark.html.

[39] Glenn Greenwald, *The Underlying Divisions in the Healthcare Debate*, SALON (Dec. 18, 2009), http://www.salon.com/2009/12/18/corporatism/.

health benefits promises to make most insurance products available on exchanges adequate. However, medical loss ratio waivers granted to some carriers threaten to hamper the ACA's effect.[40] Moreover, affordability is a major concern, especially since the Treasury Department ruled that the 9.5%-of-income limit on the costs of insurance for those making under 400% of the Federal Poverty Line only applies to the cost of a plan for an individual worker, and not for his or her family.[41]

These developments ensure that a harsh spotlight will be cast on ACOs. Will they successfully meld the best of public values and private initiative? Or will they recapitulate the crony capitalism so often identified in the defense and banking sectors? Often, the very interest groups that are supposed to be reined in by pilot programs do their best to alter, influence, or limit those programs. One need only look at the convoluted history of gainsharing pilot programs to get a sense of how, as the "rubber hits the road," various lobbies will be storming veto points to undermine experimentalists' efforts.[42] This is not to say that pilot programs are a sham—I've published a book chapter on pilot programs as information-forcing regulatory design, and Mike Kalison's presentation at the Seton Hall ACO Conference demonstrated some very promising results from gainsharing studies that finally got off the ground. I just want to temper the technocratic optimism at the heart of progressive enthusiasm for the ACA in general, and ACOs in particular.

Like 2009's stabilizations of the financial system, the ACA may be a Pyrrhic victory for the Democratic Party. As one strategist put it: "In their determination to avoid Harry and Louise, they've become

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[40] For loopholes, *see* Frank Pasquale, *Consumer Watchdog on Health Reform Loopholes*, CONCURRING OPINIONS (Apr. 8, 2010), http://www.concurringopinions.com/archives/2010/04/consumer-watchdog-on-health-reform-loopholes.html.

[41] Judy Solomon, *Health Care Coverage Must be Affordable for Families, Too*, CTR. FOR BUDGET AND POLICY PRIORITIES (July 27, 2012), http://www.offthechartsblog.org /health-coverage-must-be-affordable-for-families-too/ ("Treasury's current interpretation of the ACA . . . considers employer coverage affordable for the entire family as long as coverage just for the employee costs no more than 9.5 percent of the family's income. Unfortunately, on average, employer-sponsored health plans charge employees more than twice as much for family coverage as individual coverage. Thus, many workers wouldn't qualify for help buying coverage for their family even though the cost of employer-provided family coverage far exceeded the ACA's 9.5 percent affordability threshold."). Marco Ferreira has written an expanded version of this critique. Ferreira, *Affordability After the ACA*, manuscript on file with author (2012).

[42] *See Hearing on Gainsharing Before the H. Comm. on Ways and Means*, 109th Cong. (2005).

Thelma & Louise."[43] Although it was a characteristically snide and smug observation from inside the Beltway, this bon mot has some chance of coming true. Like most of the conventional wisdom excrudescing from pundits, it's less a reflection of reality than a narrative our entrenched political class enacts. The "politics of reform" will be endlessly refracted in D.C. media celebrities' halls of mirrors, where a twenty-four-hour news cycle is always hungry for "backlash." The lazy conventional wisdom has already coalesced around a narrative of Obama-as-Icarus, perpetually mistaking his cautious incrementalism as creeping socialism.

In the culmination of a decades-long struggle for the soul of the Democratic party, realists routed idealists during the ACA legislative process. They pushed the public option off the table, assuring that public-private partnerships like ACOs and insurance exchanges would be the ACA's primary mechanisms for delivering access to care. The sclerotic Senate's supermajority rules and the Congressional Budget Office's rigid analyses put the realists in the driver's seat, and idealistic progressives were left with little more than the power to refuse the bill that Senate centrists crafted.[44]

By passing the ACA's technocratic and business-centered solutions, Democrats jettisoned populism for an early-twentieth-century progressive vision of technocratic alliances between corporate and government experts.[45] As HHS implements the ACA, we are commencing an endless argument (read: notice and comment rulemaking and subsequent administrative adjudications) over what constitutes an adequate baseline of coverage, what is the fair share of revenue for middlemen like insurers, and what regulatory infrastructure can best vindicate the entitlements (and impose the burdens) specified by the bill. But the fundamental victory of reform—the national commitment that no one should have to choose between death or bankruptcy when confronted with a serious illness—will also endure. That commitment will only prove effective,

[43] That's the verdict on the Obama Administration from a Democratic strategist tweeted by horserace reporter extraordinaire, Chris Cillizza, referencing a 90s-era ad campaign against the Clinton plan for health reform and a film starring two exuberant yet ultimately self-destructive protagonists.

[44] *See* Frank Pasquale, *Politicized Prognostication at the Congressional Budget Office*, CONCURRING OPINIONS (July 28, 2009), http://www.concurringopinions.com/archives/2009/07/politicized-prognostication-at-the-congressional-budget-office.html.

[45] For a discussion of the place of populism and progressivism in American law, *see* J.M. Balkin, *Populism and Progressivism as Constitutional Categories*, 104 YALE L.J. 1935 (1995).

though, if reforms like ACOs manage to improve quality and access.

IV. SYMPOSIUM VIEWPOINTS ON THE FUTURE OF ACOS

ACOs can take a variety of organizational forms, such as integrated delivery systems, primary care or multispecialty medical groups, hospital-based systems, and contractual or virtual networks of physicians such as independent practice associations. Some policymakers worry that shared saving may not adequately motivate providers to change long-established customary practices, however lacking the evidence base may be for those practices. One of our Symposium contributors, Jessica L. Mantel, complements that worry by offering nuanced perspectives based on health services research on the interactions between the delivery system and the payment system.

Mantel's compelling article, *Accountable Care Organizations: Can We Have Our Cake and Eat It Too?,* sounds a judicious note of caution about delivery system innovation. While ACO proponents have offered many excellent ideas for improved health care at lower cost, there have been many other historical efforts to trim "fat" and improve the treatment of chronic conditions. ACOs' political appeal may well spell their undoing as a vector of cost containment.

Washington "wise men" have long insisted that so much health care spending is wasteful, making it possible to cover many more individuals and improve quality by cutting out unnecessary care and using the savings to purchase productive medical interventions.[46] Indeed, some estimates say that a third of care is wasted.[47] However, consider what was long said of the advertising industry: half of marketing budgets are wasted, the only problem is that we don't know which half. That may be far less true in an age of targeted Google AdWords, but no one has yet succeeded in developing the Google of health care. Mantel takes the humbling logic of advertising's black box to healthcare policy, adducing numerous pieces of evidence to demonstrate that it is sometimes very difficult to disincentivize unnecessary care without also discouraging needed interventions.

Mantel also reviews the health policy literature to demonstrate that the potential cost-savings from better management of patients

[46] Ezra Klein, *The Number-Cruncher-in-Chief*, AM. PROSPECT, Dec. 11, 2008, *available at* http://prospect.org/article/number-cruncher-chief.

[47] *See* Rich McManus, *Perhaps One-Third of Health Care Spending is Wasted, Says Brownlee*, NIH RECORD, Apr. 17, 2009, *available at* http://nihrecord.od.nih.gov/newsletters/2009/04_17_2009/story2.htm.

with chronic conditions may be lower than ACO proponents contend.[48] She also doubts that ACOs can do much about long-term inflationary pressures from advances in medical technology. Avoiding expensive technology without sacrificing quality will prove difficult in at least some cases.

Mantel expertly integrates insights from diverse literatures into her contribution to the symposium. Her work raises larger questions for law professors engaging with policy science literatures. How do we assess the validity, replicability, and extrapolability of results? How robust are predictive models? During the debate on health care reform, several experts challenged the Congressional Budget Office's estimates of the overall costs arising out of House and Senate bills.[49] They stated that the CBO's work was particularly dubious because it did not fully take into account the efficiency gains that could arise out of synergistically reinforcing delivery system reforms. Mantel's work gives us some reason to respect CBO's caution about projecting cost savings, however troubling may be the CBO's neglect of many important social values in its calculations.

Given the extraordinary difficulty of validating long-term cost projections, scholars might want to explore other paths forward. The effort will need to begin with humility about the limits and scope of quantitative predictions. For example, George Mason economist Russ Roberts has critiqued problems of reliability and replicability in social science research in a series of well-regarded interviews with leaders in the economics and finance fields.[50] In econometrics, Ed Leamer has complained for years about problematic analyses.[51] Brian Nosek has worried that social scientific practices depart so far from ideals of science that he is co-authoring a series of articles on "scientific utopias" to build support for entirely new modes of open

[48] According to Mantel, studies of both preventative measures and disease management programs have repeatedly found that most fail to produce net cost-savings, and in some cases, the programs even increase health care spending. Jessica Mantel, *Accountable Care Organizations: Can We Have Our Cake and Eat It Too?*, 42 SETON HALL. L. REV. 1393, 1405 (2012).

[49] Michael Ricciardelli, *CBO Wrong on Cost Numbers*, HEALTH REFORM WATCH (Aug. 30, 2009), http://www.healthreformwatch.com/2009/08/30/cbo-wrong-on-health-care-reform-cost-numbers/.

[50] See Roberts's interviews with Ed Leamer, Nicholas Nassim Taleb, and Brian Nosek, *available at* LIBRARY OF ECONMICS AND LIBERTY, http://www.econtalk.org/ (last visited Oct. 10, 2012).

[51] Ed Leamer, *Let's Take the 'Con' Out of Econometrics*, 73 AM. ECON. REV. 31 (1983), *available at* http://www.international.ucla.edu/media/files/Leamer_article.pdf.

research.[52] Finally, Victoria Stodden has led an effort toward open science that would empower those who rely upon research to review the underlying analyses it is based on, and to draw their own conclusions.[53]

Of course, even if all of these critiques and positive projects succeed in better illuminating the data underlying health policy analyses and projections, cost benefit analysis may still fail to grasp the complex dynamics of health care cost and quality trends. We might expect physicians to engage in various forms of income maintenance, whatever plans HHS or state agencies devise. Squeeze the health care cost "balloon" on one side, and it may only bulge out somewhere else.[54] Given the limits of quantitative projection, we need to see more openness to qualitative analysis in the health policy arena.

One promising alternative is "scenario planning," now common in the environmental arena and catching on in business. Scenario planners imagine how a variety of economic, cultural, political, and other developments may interact. As Rob Verchick explains, a more comprehensive approach may be the only way to do justice to the interactions and unexpected consequences inevitable in a complex economy:

> Cost-benefit approaches provide poor measures when they depend on forecasting too many long-term and uncertain costs. . . . [S]cenario planning broadens knowledge by taking a holistic approach to describing circumstances. . . . The strong emphasis on narrative allows the technique to

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[52] Brian A. Nosek & Yoav Bar-Anan, *Scientific Utopia: I. Opening Scientific Communication* (May 5, 2012), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2051047.

[53] Stodden et al., *Reproducible Research*, 12 (5) COMPUTING SCIENCE AND ENGINEERING, 8–13 (September/October 2010, doi: 10.1109/MCSE.2010.113.).

[54] *See, e.g.*, Charles Morris's statement that:

> There is a strongly held opinion, particularly among conservative think tanks, that with multiple competitive private payers, the normal interactions between vendors and payers will gradually create a more efficient health care system. I saw no evidence to support that belief. What actually happens [at the hospital division he observed was that] the billing staff sit down each year; lay out the various payment plans on a spreadsheet, and decide on the division strategy—which surgeons will join which plans, and which carriers will be carried on a nonplan basis, trading higher payments for greater collection risk. Once that strategy is set, it is managed entirely by the collections staff. The surgeons simply join the plans they're assigned to.

CHARLES MORRIS, THE SURGEONS 236 (2007).

capture a problem in its full complexity.[55]

Roger Boesche's essay, *Why Could Tocqueville Predict So Well?*, describes a similar capability in the great French social theorist. As Boesche relates, in Tocqueville's works, "society is an 'ensemble' in which the elements are 'indissolubly united:'"

> [T]he second volume of *Democracy in America* endeavors to demonstrate how language, literature, the relations of masters and servants, the status of women, the family, property, politics, and so forth, must change and align themselves in a new, symbiotic configuration as a result of the historical thrust toward equality.[56]

Tocqueville's work focused on the chain reactions of social change that occurred as social equality spread. In our own time, we need to use similar methods to describe the consequences of a historical thrust toward inequality, particularly with respect to the health care system. How might declining income shares for the middle and lower classes, and increasing shares for the very wealthy, affect providers' goals and incentives? As the very top of the income scale pulls away from health professionals making, say, $140,000 to $800,000 annually, how might these professionals respond to policy initiatives that further cut their share of income?[57]

For example, one might expect that a consolidation of facilities might leave the large players still standing with an opportunity to demand more compensation once they are dominant in a given health care marketplace. In her expert analysis of the interaction of competition law and ACOs, Tara Ragone tries to assure that proper antitrust enforcement against health care titans prevents abusive practices, while not inadvertently discouraging innovative service provision for providers focused on at-risk populations. Her article, *Structuring Medicaid Accountable Care Organizations to Avoid Antitrust Challenges*, focuses on concerns that New Jersey's Medicaid ACO pilot program may trigger federal antitrust concerns. It will prove useful to advisors in any state interested in developing new care models for their Medicaid populations.

There are aspects of the New Jersey Medicaid ACO collaborations that some competition law experts may find troubling.

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[55] ROBERT VERCHICK, FACING CATASTROPHE 242 (Harvard Univ. Press, 2010).

[56] Roger Boesche, *Why Could Tocqueville Predict So Well?*, 11 POLITICAL THEORY 79 (1983).

[57] For figures on the relative income gains of the top 1, 0.1, 0.01, and 0.001%, *see* Frank Pasquale, *Access to Medicine in an Era of Fractal Inequality*, 19 ANNALS OF HEALTH L. 269, 276 (2010).

For example, only one Medicaid ACO is permitted in each defined region, and the ACO must have the support of all the hospitals and at least seventy-five percent of the primary care providers in that region. New Jersey believes that such stringent requirements are necessary to guarantee "clinical integration," a *sine qua non* for the price improvement and cost cutting that ought to be at the core of consumer-oriented antitrust analysis. "Rule of reason" review for New Jersey's pilot Medicaid Accountable Care Organization Demonstration Project[58] ("pilot") seems an appropriately "light touch" antitrust doctrine to apply.[59]

Sound principles of antitrust law support such a move, since the Federal Trade Commission (FTC) and Department of Justice (DOJ) have recognized the potential for clinical integration to boost quality. Given the clear legislative intent of the pilot to encourage clinical integration in the name of quality improvement at reduced costs, it seems likely that the DOJ and FTC will find that the procompetitive advantages to consumers of New Jersey's pilot outweigh its potential harm to competition, and that the anticompetitive aspects of the collaboration are necessary to realize its benefits.[60] All in all, it would be a shame to see antitrust law, reduced to a nearly vestigial role in many purely profit-maximizing industries, scuttle innovation among health care providers who are participating in community-oriented initiatives.

Scenario planning for policy innovation will depend on close attention to the "facts on the ground" in different states' health care markets. Barbara J. Zabawa, Louise G. Trubek & Felice F. Borisy-Rudin's article, *Adopting Accountable Care Through the Medicare Framework*, further confirms the importance of an empirical approach. Zabawa et al. argue that the thought leaders behind ACOs

[58] New Jersey's Medicaid ACO demonstration project is a three-year pilot to test multi-stakeholder, geographic-based Medicaid ACOs.

[59] *See* Tara Ragone, *Structuring Medicaid Accountable Care Organizations to Avoid Antitrust Challenges,* 42 SETON HALL L. REV. 1443 (2012). Antitrust concerns stem from the fact that the pilot increases regional coordination and shared accountability, which can lead to less competition (integration encourages fewer competitors in the markets, which could increase market power). Even where prices are set by the government (Medicare) or effectively capped by government payments to HMOs (much of Medicaid), and not subject to being heavily influenced by anticompetitive collusion, regulators may worry about non-price elements of competition (such as output, quality of services, and innovation).

[60] According to Ragone, the state has articulated a policy to allow the anticompetitive conduct to ensure that the State's goals, and not simply self-serving goals, are furthered, and has suggested a commitment to provide active supervision here. Ragone, *supra* note 59, at 1462.

were cognizant of past failures when designing the Medicare Shared Saving Program, addressing the issues raised by such resistance movements as the "managed care backlash." Zabawa et al. note that New Jersey consists of mainly small practices, but despite this fragmentation, it witnessed precursors of ACOs. These included collaboratives to improve patient safety in the ICU, and a three-year gain-sharing pilot project funded by CMS in 2009.

A multi-tiered governmental guidance and management structure will be necessary to achieve the triple aim of "better health, better care, and reduced costs" via ACOs, along with meaningful patient engagement. Zabawa et al.'s story of Wisconsin accountable care is richly layered, drawing on the authors' decades of experience practicing and teaching health law there. They attest that Wisconsin has a "rich culture of collaboration" with "prominen[t] integrated delivery systems," and report that many health systems there believe that they already provide accountable care. Their account of the Wisconsin Collaborative for Health Care Quality also has important lessons for those who will be discussing and implementing ACOs in the future.[61]

Zabawa et al. believe that accountable care reformers have learned from managed care's difficulties in the 1990s,[62] as especially evidenced in the concessions made between the proposed and final rules on the MSSP.[63] They believe that ACOs are building upon the success of pilot programs in Wisconsin and New Jersey, and will provide effective patient engagement. Zabawa et al. therefore provide targeted, localized evidence that states like New Jersey and Wisconsin may be able to overcome the considerable hurdles to clinical integration and cost control noted in Mantel's work.

The process of clinical integration is not only happening at the macro-level with ACOs, but is also moving forward on the micro-level, in Patient Centered Medical Homes (PCMHs). Sallie Thieme

[61] "Each system has strong affiliations or partnerships with at least one hospital; all have its own employed physician groups, which includes both primary care and specialist; all but two have its own health plan as part of its system; and each has an EMR that the system has been using for many years." Zabawa et al., *Adopting Accountable Care Through the Medicare Framework*, 42 SETON HALL L. REV. 1471, 1479 (2012).

[62] For example, freedom to leave an ACO coupled with the prohibition against referrals and financial incentives to entice beneficiaries to remain in the ACO is arguably a response to the managed care backlash.

[63] The MSSP encourages or mandates the use of shared governance, information technology, multi-professional practitioners, financial incentives, benchmarks, metrics and patient participation; it required population-based accountability, coordinated care, quality health care, and efficiency.

Sanford's insightful article, *Designing Model Homes for the Changing Medical Neighborhood: A Multi-Payer Pilot Offers Lessons for ACO and PCMH Construction*, takes the construction metaphor for health care seriously, and illuminates several important lessons that should guide policymakers going forward. Sanford explains that the PCMH is a primary care initiative "not far removed in principle"[64] from the ACO model; indeed, in some formulations the PCMH is a necessary part of any well-functioning ACO. Sanford reminds us that zoning laws exert a powerful influence on the residential and business activity, often in unseen ways. So too can payment systems and regulatory approaches influence doctors, patients, and hospitals' actions, and can motivate entirely new forms of care delivery.[65] Sanford's article considers how these redesigned "medical homes" could fit into the rezoned "high-performing medical neighborhoods"[66] envisioned by Fisher and others.

As Sanford observes, managed care cut the rate of the health care cost growth dramatically, but provoked a backlash when some members felt trapped in closed networks of providers. New programs need to be sensitive to these concerns and to build up trust among members and providers. Sanford's article explains the Washington Multi-Payer Medical Home Reimbursement Pilot, a multi-payer model which includes additional upfront payments, potential shared savings, downside financial risk, and other elements reflective of "accountable care." This pilot involves most of the state's major insurers in a thirty-two-month project to provide upfront payments for enhanced primary care in selected practices. These practices will also see shared saving if there are reductions in ER visits or hospitalizations beyond set targets.

There are some encouraging models here. Washington's Group Health Cooperative piloted a medical home demo in 2006. As Sanford explains, this project developed patient engagement through electronic health records. It also promoted care plans for the

[64] BARRY R. FURROW ET AL., HEALTH LAW 185 (West, 6th ed. Supp. 2011).

[65] See also Frank Pasquale, *The Three Faces of Retainer Care*, 7 YALE J. HEALTH POL'Y L. & ETHICS 39, 56 (2007) (discussing how interpretations of Medicare and state insurance regulations could affect concierge medicine); Frank Pasquale, *Ending the Specialty Hospital Wars: A Plea for Pilot Programs as Information-Forcing Regulatory Design*, *in* THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS 235 (Einer Elhauge, ed., Oxford Univ. Press, 2010) (discussing the rise of ambulatory surgical centers and specialty hospitals in the context of larger changes in the health care industry).

[66] Elliott S. Fisher, *Building a Medical Neighborhood for the Medical Home*, 359 NEW ENG. J. MED. 1202, 1205 (2008).

chronically ill, more comprehensive physician visits, routine care-term "huddles" to review patient needs, and greater involvement by nurses, pharmacists, medical assistants (and other physician extenders) in coordinating patient care. Additional costs were recouped by significant reduction in ER visits and hospitalizations. Also in Washington, the Boeing Intensive Outpatient Care Program helped align the incentives of a major self-insured airplane manufacturer with employees and providers. Employees were matched with a team of providers who offered health services in a medical home model in exchange for their usual fees plus care management fees. The extra fees were a wise investment: the overall costs for those employees were twenty percent less than a control group.

The Boeing project and others like it suggest that PCMH models function best with upfront funding. Upfront funding is a feature of Washington's multi-payer, multi-site pilot whichlaunched in May 2011. Practice sites in the pilot receive not only their usual fee-for-service payments, but also a monthly care management fee (CMF). This should allow infrastructural investment in care coordination (including technology to advance telemedical practice, emails, and team meetings) and electronic health records. Seven health plans and eight primary care practices have signed on. If quality metrics are maintained and ER visits and hospitalizations are reduced below break-even targets, the practice sites share the financial savings with the insurers; if the targets are not met, the practice sites face downside financial risk, including a reduced CMF. This pilot is intended to support a broader transformation of the healthcare system towards, and Sanford's article considers the lessons it offers for accountable care in general and the PCMH in particular. Sanford's careful research demonstrates that Patient-Centered Medical Homes and Accountable Care Organizations may develop synergistically, if the right legal, policy, and training frameworks are in place.

Overall, the four articles present invaluable research on the past and future of accountable care policy initiatives to achieve the "triple aim" of reducing costs, increasing quality, and enhancing access. Mantel and Ragone offer wake up calls about the policy and legal risks of ACOs. It's impossible to read their articles and to come away with a sense that the road ahead for accountable care will be easy. On the other hand, Zabawa et al. and Sanford have demonstrated that in some settings in Washington, New Jersey, and Wisconsin, efforts to coordinate care have saved money without negatively

impacting patients—and have, on occasion, improved quality as well. Political, economic, and medical trends will determine whether skepticism or optimism toward ACO's was the proper mood as of 2012. Regardless of what they bring, anyone interested in the future of health policy will be richly rewarded by careful reading of these articles.

V. CONCLUSION

The U.S. health care system too often puts profits ahead of patients' interests.[67] Economic incentives must become more fine-tuned. The ACA in general, and ACOs in particular, are worthy efforts to offer incentives to improve quality, control costs, and expand access. Panelists at Seton Hall's ACO conference offered a great deal of insight and advice on how best to accomplish those goals.[68] This volume memorializes notable contributions to this important public dialogue.

[67] Timothy S. Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537 (2006).

[68] *2011 Symposium: Implementing the Affordable Care Act: What Role for Accountable Care Organizations?*, SETON HALL L. REV. (Oct. 28, 2011), http://erepository.law.shu.edu/shlr_symposia/2011/.