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Accountable Care Organizations: Can We Have Our Cake and Eat it Too?

Jessica L. Mantel[*]

I. INTRODUCTION

The health care debate has largely focused on the provisions of the Affordable Care Act (the ACA) aimed at expanding health insurance coverage to all Americans, most notably the individual mandate requirement. The ACA, however, also takes important steps to address the companion challenge of making health care coverage affordable by reigning in health care costs. These steps include various initiatives under the ACA that encourage the formation of accountable care organizations (ACOs)—clinically integrated organizations of primary care physicians and other providers that, through various payment mechanisms, are rewarded for both raising the quality and lowering the cost of care provided to their patients.[1]

Many believe that ACOs hold great promise for achieving cost savings given their financial incentives to do so.[2] But proponents of ACOs do not simply contend that ACOs can stabilize health care costs; they also claim that ACOs can simultaneously improve the quality of care provided to patients. Indeed, President Obama has identified ACOs as an important strategy for lowering health care spending while improving the quality of care.[3] To support their

[*] Assistant Professor, University of Houston Law Center. Thank you to Frank Pasquale and Jessica Roberts and the participants at Arizona State University Law School's Junior Scholars Forum for their useful discussions and suggestions; and to Emily Lawson and Matthew Mantel for their research support.

[1] Medicare Shared Savings Program, 42 U.S.C.A. § 1395jjj(a)(1) (West 2012); *see also* Jeff Goldsmith, *Accountable Care Organizations: The Case for Flexible Partnerships Between Health Plans and Providers*, 30 HEALTH AFF. 32, 33 (2011) ("Some policy advocates believe that the way to stabilize health care costs is to engage providers in a form of population-based cost management—that is, to compel providers to constrain costs across the population of an entire community.").

[2] *See, e.g.*, Anna Wilde Mathews, *Can Accountable-Care Organizations Improve Health Care While Reducing Costs?*, WALL ST. J., Jan. 25, 2012, http://online.wsj.com/article/SB10001424052970204720204577128901714576054.html.

[3] *See* Letter from Barack Obama, President of the U.S., to Edward Kennedy and

claim, proponents point to entities such as Kaiser Permanente, the Mayo Clinic, Intermountain Health Care, and the Geisinger Health System, all highly integrated organizations that provide high quality care at lower costs than other providers.[4] By encouraging other providers to form similar organizations, so the argument goes, we can check rising health costs without resorting to rationing health care or otherwise sacrificing the quality of care.

So can ACOs really reduce healthcare expenses without diminishing quality? Can we have our cake and eat it too? This Article suggests that the answer is both yes and no. ACOs clearly can reduce costs without sacrificing quality by trimming "fat" from the health care system and improving the treatment of patients with chronic conditions. However, the opportunities for ACOs to achieve savings without adversely impacting patient care likely are far fewer than their supporters contend. In the long-term, ACOs do not present a painless solution to the challenge of rising health care costs. If ACOs are to effectively slow down health care inflation, they can do so only by making some compromises in the quality of care they provide patients, including withholding potentially beneficial care from some patients.

This Article proceeds in four parts. Part II describes the potential for providers to lower health care costs without diminishing quality through the elimination of wasteful medical interventions and better management of patients with chronic conditions. Part II goes on to explain that the health care system, as currently organized, has limited capacity to realize these potential savings. Part III explores ACOs' capacity to achieve what the current system has failed to do—achieving cost savings without sacrificing quality or rationing health care—and concludes that the optimism of ACO proponents is not

Max Baucus, Senators, U.S. Cong. (June 2, 2009), *available at* http://www.whitehouse.gov/blog/the-president-spells-out-his-vision-on-health-care-reform/ (stating that the President's proposals to cut health care spending include encouraging physicians to form ACOs, which will also improve the quality of care for Medicare patients).

[4] *See* DAVID NEWMAN, CONG. RESEARCH SERV., R41474, ACCOUNTABLE CARE ORGANIZATIONS AND THE MEDICARE SHARED SAVINGS PROGRAM 3 (2010) ("ACOs are modeled on entities seen as quality leaders in health care, such as Kaiser Permanente, the Mayo Clinic, the Cleveland Clinic, and Geisinger Health System. All of these exemplars are highly integrated providers . . . ."); Jenny Gold, *'Poster Boys' Take a Pass on Pioneer ACO Program*, KAISER HEALTH NEWS (Sept. 14, 2011), http://www.kaiserhealthnews.org/Stories/2011/September/14/ACO-Pioneers-Medicare-hospitals.aspx (noting that the Mayo Clinic, Cleveland Clinic, Geisinger Health System, and Intermountain Health Care have been touted as models for ACOs).

without some merit. Part IV cautions against viewing ACOs as a painless solution to rising health care costs, arguing that although ACOs clearly can achieve some savings without adversely impacting quality, there are limits to their ability to do so. Part V concludes that in the long-term ACOs cannot successfully restrain the growth in health care costs without withholding potentially beneficial care from some patients, and urges health care analysts and policymakers to consider what regulatory oversight may be necessary to ensure that ACOs ration care in a fair and equitable manner.

II. THE POTENTIAL FOR IMPROVED PATIENT CARE AND LOWER COSTS

Most physicians and patients associate more medical care with higher quality care.[5] After all, if you get what you pay for, spending less on health care implies lower quality care.[6] Influential health policy analysts, however, present a more optimistic view, arguing that we can reduce the volume and intensity[7] of care provided in the United States without adversely impacting quality.[8] Although contrary to conventional wisdom, this position is not without some merit. First, much of the medical care provided to patients is of little or no value, that is, it is wasteful.[9] Eliminating wasteful care thus could reduce health care costs without compromising the quality of

[5] *See* JOHN E. WENNBERG ET AL., THE DARTMOUTH INST. FOR HEALTH POLICY AND CLINICAL PRACTICE, TRACKING THE CARE OF PATIENTS WITH SEVERE CHRONIC ILLNESS: THE DARTMOUTH ATLAS OF HEALTH CARE 11 (2008) ("Most policy makers, physicians, and patients assume that more care is better care . . . ."); Elliott Fisher et al., *Fostering Accountable Health Care: Moving Forward in Medicare*, 28 HEALTH AFF. 219, 220 (2009) (emphasis in original), *available at* http://content.healthaffairs.org/content/28/2/w219.full.pdf+html (noting "the widespread belief—often in the face of relevant evidence to the contrary—that *more* medical care means *better* medical care").

[6] *See* Caryl E. Carpenter et al., *Issues of Cost and Quality: Barriers to an Informed Debate*, 4 J. EVALUATION IN CLINICAL PRACTICE 131, 135 (1998) (noting that "[m]any Americans subscribe to a general maxim—you get what you pay for, including health care. . . . Clearly, if quality of health care is defined in terms of quantity, then spending less will mean less quality.").

[7] The intensity of care refers to the amount and complexity of services utilized when treating a patient. *See* DAVID MARCINKO, DICTIONARY OF HEALTH INSURANCE AND MANAGED CARE (2006) (defining "intensity to services").

[8] *See* WENNBERG, *supra* note 5, at 11 (concluding that expending more medical resources and providing more care generally do not yield higher quality care).

[9] *See id.* at 4 ("[W]e waste on overtreatment in this country . . . . "); Donald M. Berwick, Thomas W. Nolan & John Whittington, *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759, 765 (2008) ("A mainstay of reduction and control of per capita costs would be yearly initiatives to reduce waste in all of its forms . . . ."); Carpenter, *supra* note 6, at 133 (arguing that our "cost problem" stems from the high cost of inappropriate care due to clinical inefficiency).

care.[10] Many health policy analysts also argue that our health care system can achieve savings without sacrificing quality through better management of patients with chronic conditions.[11] Specifically, they contend that improved treatment of chronic conditions can reduce medical expenses downstream by avoiding the care associated with preventable complications, such as avoidable emergency room visits, hospital admissions or readmissions, and expensive ancillary services.[12]

Unfortunately, the health care system as currently organized has limited capacity to reduce waste or improve the management of 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. Reducing waste and improving patient management therefore requires fundamental changes in how we pay for and deliver care.

A. *The Waste Hypothesis*

Experts contend that the U.S. health care system commonly provides care that is wasteful. A diagnostic or treatment procedure may be judged wasteful because it is ineffective or unsafe, provides marginal or uncertain benefits, or results from medical error or other inefficiencies.[13] The first category—ineffective or unsafe care—includes tests that do not provide useful diagnostic or therapeutic information[14] and services that are not clinically effective

[10] *See* LINDSAY A. MARTIN ET AL., INST. FOR HEALTHCARE IMPROVEMENT, INCREASING EFFICIENCY AND ENHANCING VALUE IN HEALTH CARE: WAYS TO ACHIEVE SAVINGS IN OPERATING COSTS PER YEAR 2 (2009) ("[H]ealth care systems can indeed drive out waste, and thereby reduce associated cost, from their systems, while maintaining or improving quality.").

[11] *See* Bruce Fireman et al., *Can Disease Management Reduce Health Care Costs By Improving Quality?*, 23 HEALTH AFF. 63, 64 (2004) (stating that champions of disease management argue that improving the quality of care provided to patients with chronic conditions can prevent costly complications and exacerbations, thereby reducing hospitalizations and other costs).

[12] *See* NAT'L QUALITY FORUM, WASTE NOT, WANT NOT: THE RIGHT CARE FOR EVERY PATIENT 2, 4 (2009), *available at* http://www.qualityforum.org/Publications/2009/07/Waste_Not,_Want_Not__The_Right_Care_for_Every_Patient.aspx (noting that emergency room visits and hospital readmissions could be avoided through better coordination of care and expanded access to primary care).

[13] *See* Alan Garber et al., *The Promise of Health Care Cost Containment*, 26 HEALTH AFF. 1545, 1547 (2007) (describing wasteful care as care that "is ineffective, is delivered in an inefficient manner, or simply represents care of little value").

[14] *See* Peter Boland et al., *Accountable Care Organizations Hold Promise, But Will They Achieve Cost and Quality Targets?*, MANAGED CARE 12, 14 (Oct. 2010), *available at* http://www.managedcaremag.com/archives/1010/1010.ACOs.html (stating that

in addressing a patient's condition.[15] It also includes care that may provide some clinical benefit to the patient, but poses health risks that clearly outweigh any potential benefit.[16] The second category—care of insufficient or uncertain benefits—includes care that provides only slight clinical benefit compared to the cost of such care,[17] and tests and services where the clinical benefits to a patient have not yet been fully validated.[18] The final category—inefficient care—includes both duplicative procedures[19] and tests and treatments that are more costly than alternative tests and treatments of similar therapeutic value.[20] It also includes care provided to address either preventable complications or unnecessary harms to patients that result from medical errors or failures to implement protocols that reduce risks.[21]

Many believe that eliminating wasteful care would produce significant cost savings without diminishing the quality of care.[22] This so-called waste hypothesis is not without empirical support. Through

unnecessary care includes services that do not provide useful diagnostic or therapeutic information); Maxwell J. Mehlman, *Health Care Cost Containment and Medical Technology: A Critique of Waste Theory*, 36 CASE W. RES. L. REV. 778, 785 (1986) ("A technology is ineffective if it produces no discernible benefit to the patient.").

[15] *See* Timothy Stoltzfus Jost, *The American Difference in Health Care Costs: Is There a Problem? Is Medical Necessity the Solution?*, 43 ST. LOUIS U. L.J. 1, 13 (1999) (stating that a test or procedure is medically unnecessary if it is not appropriate or effective for addressing a patient's condition); Berwick, *supra* note 9, at 765 (2008) (asserting that wasteful care includes unscientific care).

[16] *See* Mehlman, *supra* note 14, at 785 ("A technology or its particular use is considered unsafe, and therefore perhaps wasteful, when its risks exceed the benefits to the patient.").

[17] *See id.* at 784 (defining wasteful medical technology to include "technologies that do not yield adequate net benefits").

[18] *See* Jost, *supra* note 15, at 13 (stating that medically unnecessary care includes tests or procedures where the benefit to the patient is not known or not yet fully known).

[19] *See* Boland, *supra* note 14, at 14 (stating that preventable ancillary services include duplicative procedures); Berwick, *supra* note 9, at 765 (stating that waste includes procedures, tests, and visits that represent rework).

[20] *See* Mehlman, *supra* note 14, at 789 ("A technology might also be regarded as wasteful if it is expected to yield the same net benefit as another technology but at a greater cost—that is, if it is not the most efficient, cost-effective technology to treat or to diagnose a patient's condition.").

[21] *See* Boland, *supra* note 14, at 14 (explaining that unnecessary care includes "[p]reventable complications: [e]vents that cause unnecessary harm to the patient and cost to the system above and beyond the natural progression of an illness or injury").

[22] *See* Jost, *supra* note 15, at 2 (discussing the belief that eliminating waste from the health care system would save enormous sums of money, with perhaps the rationing of beneficial care not necessary to check health care costs).

their studies of chronically ill Medicare beneficiaries, John Wennberg and his colleagues at the Dartmouth Institute for Health Policy and Clinical Practice have documented wide variation in spending across both geographic regions and hospitals. Specifically, they found that patients in high-spending regions and hospitals visit physicians more frequently, make greater use of specialists, and receive more diagnostic tests, procedures, and inpatient care.[23] Despite this large variation in the utilization and intensity of care, regions and hospitals with lower per capita spending generally achieve aggregate patient outcomes at least equal to their higher spending counterparts, and even score higher on many quality dimensions.[24] Moreover, the variation in medical spending is not attributable to differences in the prevalence of disease or other population characteristics,[25] but rather reflects differences in clinical decisions.[26] These findings suggest that the volume and intensity of care provided to patients can be reduced without adversely impacting patient outcomes.[27]

Studies that examine the appropriateness of certain care reinforce the Dartmouth researchers' conclusion that a significant

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[23] *See* WENNBERG, *supra* note 5, at 13 (finding variation in utilization and intensity among geographic regions and academic medical centers).

[24] Wennberg and his colleagues summarized their findings on the association between spending and quality as follows:

> [A]t the population level, our research and that of others has shown that more resources and more care (and more spending) are not necessarily better. Patient populations with similar chronic illness, followed over time once they become ill, do not enjoy improved survival or better quality of life if they live in regions with more care. In fact, the care they receive appears to be worse. They report being less satisfied with their care than peers in regions that spend less, and having more trouble getting in to see their physicians. The most surprising and significant difference between regions is that mortality is higher in high-spending regions. In other words, your chances of dying increase in regions where the health care system delivers more care.

See WENNBERG, *supra* note 5, at 4. Wennberg and his colleagues found similar results among high-spending and low-spending hospitals. *See id.* at 54. They hypothesized that the higher mortality rates observed in higher-spending regions and hospitals stems from the fact that most medical treatments pose some risk, and the more care a patient receives (particularly hospital-based care), the greater the risks. Moreover, as care becomes more complex, with more and more physicians involved, miscommunication and errors are more likely. *See id.* at 13.

[25] *See id.* at 3 (noting that differences in the level of illness account for only a small fraction of the variation in the amount of care delivered).

[26] *See id.* at 15 (hypothesizing that higher utilization results from differences in clinical decisions in the "gray areas" of medicine, with those practicing in areas with higher capacity showing a clinical preference toward greater intensity).

[27] *Id.* at 12 ("Our studies consistently show that more resources and greater utilization of medical care do not result in better outcomes.").

portion of medical care provided in the United States is unnecessary. For example, one recent study found that fifty-three percent of patients undergo an artery-clearing procedure following a heart attack even though research shows that the procedure offers no benefit and the national guidelines issued by the American Heart Association and American College of Cardiology state that the procedure should not be performed.[28] Physicians also regularly prescribe antibiotics for pharyngitis (sore throat), despite research showing very little evidence of its effectiveness.[29] Experts also estimate that at least one-third, and perhaps as many as half, of the seventy million CT scans performed each year are unnecessary.[30] These findings further support the contention that we can significantly lower health care costs without harming quality simply by eliminating wasteful care.

Although estimates of the amount of wasteful care provided in the U.S. vary, most agree that it is substantial,[31] perhaps as high as thirty percent.[32] If correct, reducing or eliminating this wasteful medical care could yield significant cost savings, perhaps rendering unnecessary the need to ration health care in order to check rising costs.[33]

B. Better Management of Patients with Chronic Conditions

Many health care experts contend that improving the management of patients with chronic conditions offers a second

[28] *See* Michelle Fay Cortez, *Guidelines Don't Curb Unnecessary Treatment for Heart Attack Patients*, BLOOMBERG (July 11, 2011, 4:00 PM), http://mobile.bloomberg.com/news/2011-07-11/guidelines-don-t-curb-unnecessary-treatment-for-heart-attack-patients.

[29] *See* Jamie C. Brehaut et al., *Do Physician Outcome Judgments and Judgment Biases Contribute to Inappropriate Use of Treatments? Study Protocol*, 2 IMPLEMENTATION SCI. 18, 21 (2007) (discussing overuse of antibiotics for treatment of sore throats).

[30] *See* Melody Petersen, *Over Exposed: The Startling Truth About CT Scans*, GOOD HOUSEKEEPING, July 2010, at 144 (discussing overuse of CT scans).

[31] *See* Robert A. Berenson, *Shared Savings Program for Accountable Care Organizations: A Bridge to Nowhere?*, 16 AM. J. MANAGED CARE 721, 721 (2010) ("Although experts dispute the exact amount of wasted spending, it is generally thought to be substantial.").

[32] *See* WENNBERG, *supra* note 5, at 4 ("Various estimates for the amount we waste on overtreatment in this country range between twenty to thirty cents on every health care dollar spent."); Garber, *supra* note 13, at 1545 ("[S]everal broad strands of the health literature suggest that spending could be reduced by as much as 30 percent without adversely affecting health.").

[33] *See* Jost, *supra* note 15, at 2 (discussing the belief that eliminating waste from the health care system would save enormous sums of money, perhaps with the rationing of beneficial care not necessary to check health care costs).

opportunity for lowering costs without adversely impacting quality. Many Americans suffer from chronic health conditions such as hypertension, high cholesterol, heart disease, and diabetes, with more than a quarter of the population suffering from multiple conditions.[34] These patients often see multiple clinicians,[35] take numerous drugs, and may require frequent hospitalizations and ancillary services.[36] Not surprisingly then, chronic conditions are expensive to treat and account for a disproportionately large share of health care spending, with as much as two-thirds of total health care spending directed toward the quarter of Americans with multiple chronic conditions.[37] Reducing the intensity and volume of health care consumed by those with chronic conditions thus represents a primary target for those seeking to rein in health care costs. In particular, experts argue that chronic-care patients often require costly care to treat avoidable complications, and that reducing these complications through better patient management would yield significant cost savings.

Numerous studies have shown that those with chronic

[34] *See* Press Release, U.S. Dep't Health & Human Servs., HHS Issues New Strategic Framework on Multiple Chronic Conditions (Dec. 14, 2010), *available at* http://www.hhs.gov/news/press/2010pres/12/20101214a.html. Two-thirds of Medicare beneficiaries suffer two or more chronic conditions, with twelve percent having six or more chronic conditions. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., CHRONIC CONDITIONS AMONG MEDICARE BENEFICIARIES 10 (2011), *available at* http://www.cms.gov/TheChartSeries/Downloads/ChartbookFinal.pdf (based on 2008 data).

[35] *See* Jeff Luck et al., *What is the Business Case for Improving Care for Patients with Complex Conditions?*, 22 J. GEN. INTERNAL MED. 396, 396 (2007) (discussing treatment of patients with multiple chronic conditions).

[36] *See* ROBERT WOOD JOHNSON FOUND., CHRONIC CARE: MAKING THE CASE FOR ONGOING CARE 12 (2010), *available at* http://www.rwjf.org/files/research/50968chronic.care.chartbook.pdf ("People with multiple chronic conditions have substantially more physician contacts, use more prescription drugs, and are more likely to be hospitalized each year . . . .").

[37] *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., MULTIPLE CHRONIC CONDITIONS: A STRATEGIC FRAMEWORK 10 (2010), *available at* http://www.hhs.gov/ash/initiatives /mcc_framework.pdf ("The resource implications for addressing multiple chronic conditions are immense: 66% of total health care spending is directed toward care for the approximately 27% of Americans with multiple chronic conditions."). *See generally* CATHERINE CRAIG ET AL., INST. FOR HEALTHCARE IMPROVEMENT, CARE COORDINATION MODEL: BETTER CARE AT LOWER COST FOR PEOPLE WITH MULTIPLE HEALTH AND SOCIAL NEEDS 2 (2011), *available at* http://asmdc.org/members/a76/attachments/IHICareCoordinationModelWhitePaper2011.pdf ("Individuals with chronic conditions consume a high proportion of health care services; chronic conditions are expensive to treat and a major driver of increased health care spending.").

conditions often receive poor quality care. The Institute of Medicine has found that physicians often fail to follow recommended protocols when treating patients with chronic conditions.[38] For example, although cardiologists generally follow clinical guidelines more than other specialists, studies have found that they only do so seventy percent of the time.[39] These patients also see multiple physicians who far too often provide conflicting medical advice or prescribe incompatible or contraindicated drugs.[40] In addition, chronically ill patients frequently do not receive the necessary support and patient education they need to ensure that they adhere to recommended medication or self-care regimens.[41] For many patients, then, their chronic conditions are poorly controlled or go untreated, leading to acute complications in many cases.[42]

The exacerbation of chronic illness often results in the need for costly care, including emergency department visits and hospitalizations.[43] Experts contend that some of this care could be avoided through better management of patients' chronic

[38] *See* COMM. ON QUALITY HEALTH CARE IN AMERICA, INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 10 (2001) (noting that despite the development of evidence-based guidelines for many chronic conditions, there exists tremendous variability in practice); *see also* Deborah Peikes et al., *Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries*, 301 JAMA 603, 604 (2009) ("[C]hronically ill beneficiaries often do not receive treatment that has been shown to be effective for their conditions.").

[39] *See* NAT'L QUALITY FORUM, *supra* note 12, at 4.

[40] *See* Luck, *supra* note 35, at 396 (stating that patients with chronic conditions are at risk of receiving potentially conflicting treatment strategies); Peikes, *supra* note 38, at 603–04 ("Chronically ill patients often see multiple physicians . . . who may be incompletely aware of each other's care, prescribe incompatible or contraindicated treatments, or provide conflicting advice.").

[41] *See* Bodenheimer et al., *Patient Self-management of Chronic Disease in Primary Care*, 288 JAMA 2469, *available at* http://wmhcc.org/workfiles/mh_professional/Patent_Self-Management.pdf (discussing studies showing that physicians often fail to provide chronically ill patients with adequate information); INST. OF MED. OF THE NAT'L ACADS., LIVING WELL WITH CHRONIC ILLNESS: A CALL FOR PUBLIC HEALTH ACTION 4–10 (2012), *available at* http://www.nap.edu/catalog.php?record_id=13272 (noting that one reason for patient non-adherence is inadequate patient education).

[42] *See* CONG. BUDGET OFFICE, AN ANALYSIS OF THE LITERATURE ON DISEASE MANAGEMENT PROGRAMS 2 (2004), *available at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/59xx/doc5909/10-13-diseasemngmnt.pdf (explaining the meaning of disease management).

[43] For example, studies have found that chronically ill patients' noncompliance with prescribed medication regimens leads to negative health consequences, including hospital admissions. *See* INST. OF MED. OF THE NAT'L ACADS., *supra* note 38, at 4–10 (2012).

conditions.[44] For example, asthma events—the leading cause of trips to the emergency room among teenagers—could be drastically reduced through better patient monitoring and adherence to treatment protocols.[45] Similarly, proper management of patients with congestive heart failure (CHF) following their discharge from a hospital could significantly reduce the rate of hospital readmissions.[46]

Not surprisingly, health policy analysts have long argued that improving the quality of care provided to the chronically ill will yield cost savings by preventing costly, urgent treatment. The health care literature includes numerous examples supporting this position. For example, several studies have found that chronic disease self-management programs—programs designed to improve patients' self-management of their illnesses—can reduce the use and cost of health services.[47] Similarly, CareSupport, a state Medicaid initiative in Oregon, yielded annual savings of $5,000 for each participating Medicaid beneficiary through better coordination of their care.[48] CareSupport generated these savings while maintaining or improving the patient's quality of life.[49] Executing similar strategies throughout the health care system thus has the potential to lower costs while maintaining or even improving patient outcomes.

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[44] *See* JACK MEYER & BARBARA MARKHAM SMITH, HEALTH MGMT. ASSOCS., CHRONIC DISEASE MANAGEMENT: EVIDENCE OF PREDICTABLE SAVINGS 2 (2008), *available at* http://www.idph.state.ia.us/hcr_committees/common/pdf/clinicians/savings_report.pdf (claiming that interventions targeting chronically ill patients achieve savings through reduced hospitalizations and emergency department use).

[45] *See* Boland, *supra* note 14, at 15 (2010) (noting that asthma events are the number one reason for teenage admission to the emergency room, and that most could be avoided with better-understood treatment protocols and mobile monitoring technology).

[46] *See* Berwick, *supra* note 9, at 759 ("[W]ell-designed demonstration projects have shown for years that the rate [of readmission for Medicare beneficiaries with CHF] can be reduced by more than 80 percent with proper management of patients.").

[47] *See* Chad Boult & Erin K. Murphy, *New Models of Comprehensive Health Care for People with Chronic Conditions*, *in* LIVING WELL WITH CHRONIC ILLNESS: A CALL FOR PUBLIC HEALTH ACTION, *supra* note 41, app. B 285, at 293 (2012) (discussing chronic disease self-management programs).

[48] *See* Douglas McCarthy & Sarah Klein, *The Triple Aim Journey: Improving Population Health and Patients' Experience of Care, While Reducing Costs*, 48:1421 COMMONWEALTH FUND 3 (July 22, 2010), http://www.commonwealthfund.org/Publications/Case-Studies/2010/Jul/Triple-Aim-Improving-Population-Health.aspx (discussing the CareSupport program).

[49] *See id.*

C. *Why We Can't Get There from Here: Fee-For-Service and Fragmentation*

If simply eliminating wasteful care and better managing the care provided to chronically ill patients could solve the problem of rising health care costs, why have we not already done so? The answer lies in large part with the current manner in which we pay for care—fee-for-service. As described below, the incentives inherent in fee-for-service promote high volume and high intensity care, discourage efficient practices, and promote a fragmented system lacking a coordinated approach to patient care.

Unlike most other goods and services, medical care generally is paid for by health insurers, government insurance programs, and employers, rather than the consumer-patient.[50] Insulated from the full cost of their medical care, patients have little incentive to consider the cost of such care. Many patients then expect their health care providers to provide all medical care of potential benefit, no matter how slight the potential benefit or costly the care.[51] Physicians and other health care professionals, in turn, not only are trained to "do everything possible to help patients,"[52] but also have strong economic incentives to satisfy their patients' demands.[53]

The manner in which payors reimburse physicians and other health care providers further encourages the high rates of utilization. Both private and public payors typically pay for their enrollees' health care on a fee-for-service basis, with providers receiving a separate payment for each unit of service they provide.[54] Basing providers'

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[50] *See* D. ANDREW AUSTIN & JANE G. GRAVELLE, CONG. RESEARCH SERV., RL34101, DOES PRICE TRANSPARENCY IMPROVE MARKET EFFICIENCY? IMPLICATIONS OF EMPIRICAL EVIDENCE IN OTHER MARKETS FOR THE HEALTH SECTOR 9–10 (2008) (explaining that hospital care and other care for complicated episodes is mostly paid for by public health programs and private insurers).

[51] *See* Jost, *supra* note 15, at 15 ("[I]f the questioned test or procedure is likely to be of any benefit, the informed patient may expect or demand it."); Jerry L. Mashaw & Theodore R. Marmor, *Conceptualizing, Estimating, and Reforming Fraud, Waste, and Abuse in Healthcare Spending*, 11 YALE J. ON REG. 455, 458 ("The reliance on third-party payments to finance medical care strengthens patients' own bias towards using whatever methods are available when their health is at stake.").

[52] *See* Mehlman, *supra* note 14, at 781.

[53] *See* Gloria Bazzoli, *Medical Service Risk and the Evolution of Provider Compensation Arrangements, in* UNCERTAIN TIMES: KENNETH ARROW AND THE CHANGING ECONOMICS OF HEALTH CARE 144 (Peter Hammer et al., eds., 2003) ("[I]f physicians seek profit like other economic actors, they will satisfy patient demands under fee-for-service payment because it holds potential for increasing their income.").

[54] *See* Harold D. Miller, *From Volume to Value: Better Ways to Pay for Health Care*, 28 HEALTH AFF. 1418, 1419 (2009), *available at*

payment on the quantity, and not the quality, of care rewards the excessive provision of medical care.[55] Physicians, for example, can increase their incomes by encouraging repeat office visits or otherwise increasing the supply of services they provide their patients.[56] Indeed, empirical studies have documented that physicians paid on a fee-for-service basis provide more care to their patients than physicians paid under alternative payment models, such as capitation or salary.[57] Hospitals similarly can increase their

http://content.healthaffairs.org/content/28/5/1418.full.pdf+html (defining fee-for-service as paying providers a predetermined amount for each discrete service provided). As the term is used in this Article, however, it also includes a separate payment to a provider for bundled services, such as payments to a provider on a per diem or per episode basis. A per diem payment involves paying an institutional provider, such as a hospice provider, a single, fixed payment for each day of care it provides to a patient, whereas institutional providers paid on a per episode payment receive a single, lump sum payment that covers all care provided during a relatively continuous episode of care. *See* ANNE B. CASTO & ELIZABETH LAYMAN, AM. HEALTH INFO. MGMT. ASSOC., PRINCIPLES OF HEALTHCARE REIMBURSEMENT 7, 9 (2006), *available at* http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_030575.pdf. Like fee-for-service, per diem and per episode payment methodologies give providers incentives to provide more treatments. For example, although providers paid on a per diem basis have incentives to lower the cost care provided in a single day, they have incentives to increase the duration of care as well as the number of patients receiving care. *See* I.H. Monrad Aas, *Incentives and Financing Methods*, 34 HEALTH POL'Y 205, 209–10 (1995) (stating that per diem rates for hospitals, while resulting in lower average costs per day, can stimulate use of hospitals and prolongation of hospital stays, thereby potentially leading to higher total costs); Marc Jegers et al., *A Typology for Provider Payment Systems in Health Care*, 60 HEALTH POL'Y 255, 265 (2002), *available at* http://hamahangi.behdasht.gov.ir/uploads/291_1628_Typology%20of%20Payment.pdf (noting that paying New Jersey hospitals on a per diem basis lowered costs per diem, but the average length of stay per patient increased). Similarly, providers paid on a per episode basis have incentives to increase revenues by treating more cases, even though they have incentives to control the cost of cost of individual cases. *See* Miller, *supra*, at 1419–20 (comparing the financial incentives inherent in various payment methodologies).

[55] *See* INST. OF MED. OF THE NAT'L ACADS., REWARDING PROVIDER PERFORMANCE: ALIGNING INCENTIVES IN MEDICARE 25–26 (2007) (discussing the incentives of the Medicare fee-for-service payment system that result in overutilization); Miller, *supra* note 54, at 1418 ("Physicians, hospitals, and other providers gain increased revenues and profits by delivering more services to more people . . . ."); Arnold S. Relman, *Doctors as the Key to Health Care Reform*, 361 NEW ENG. J. MED. 1225, 1225 (2009), *available at* http://www.nejm.org/doi/full/10.1056/NEJMp0907925 ("Most doctors are paid on a fee-for-service basis, which is a strong financial incentive for them to maximize the elective services they provide[,] . . . a major factor in driving up medical expenditures.").

[56] *See* Bazzoli, *supra* note 53, at 144 ("[A]s the agent for a patient, a physician will increase the supply of services as long as his or her marginal reimbursement exceeds marginal costs . . . .").

[57] *See* Robert Town et al., *Market Power and Contract Form: Evidence from Physician Group Practices*, 11 INT'L J. HEALTH CARE FIN. ECON. 115, 131 (2011) ("Numerous

revenues by admitting more patients or expanding their services.[58] Fee-for-service thus encourages the provision of care of marginal or uncertain benefits, as doing so increases providers' incomes and satisfies patient demands that providers do everything possible to improve a patient's health.[59]

Fee-for-service not only promotes a higher volume of care, but it also skews the system toward more costly interventions. Because fee-for-service payment rates are largely based on the time, resources, and expertise involved in treating a patient, more sophisticated, labor-intensive tests and procedures garner higher payment rates than less intensive interventions.[60] Higher payments for specialized care in turn encourage physicians to select specialized fields over primary care.[61] Because specialists are more likely to provide high-tech, invasive tests and treatments, their care tends to be costly, particularly relative to the low-tech, primary and preventive care provided to chronically ill patients by primary care physicians.[62] Higher rates for more sophisticated care also incentivize providers to

papers have demonstrated an empirical link between FFS payment and increased provision of services . . . .").

[58] *See* Berwick, *supra* note 9, at 761 (noting that "[u]nder current market dynamics and payment incentives, it is entirely rational for hospitals to try to fill beds and to expand services," and in doing so hospitals "can protect profits best by protecting and increasing revenues").

[59] *See* James C. Robinson, *Theory and Practice in the Design of Physician Payment Incentives*, 79 MILBANK Q. 149, 152 (2001) (arguing that by paying for care on a piece-rate basis, fee-for-service "result[s] in an input-intensive, gold-plated form of service that expends resources as if they had no alternative uses and enjoys life as if there were no tomorrow").

[60] *See* Ezekiel J. Emanuel & Victor R. Fuchs, *The Perfect Storm of Overutilization*, 299 JAMA 2789, 2789–90 (2011) (commenting on the current system's bias toward paying significantly more for procedures, rather than for evaluation and management).

[61] *See* Hoangmai H. Pham & Paul B. Ginsburg, *Unhealthy Trends: The Future of Physician Services*, 26 HEALTH AFF. 1586, 1590 (2007) ("[L]ow incomes for [Primary Care Physicians] make these career paths unattractive to new physicians. Among recent medical school graduates, a falling number choose to train in primary care specialties . . . ."); Bryan Vaughn et al., *Can We Close the Income Gap Between Specialists and Primary Care Physicians?*, 29 HEALTH AFF. 933 (2010) (explaining that because physicians have much greater wealth potential if they choose a specialty career than if they choose a primary care career, medical students typically choose a specialty career over a primary care career).

[62] *See* Mashaw, *supra* note 51, at 473–75 (stating that "we have too many highly trained or highly specialized [physicians]" and that "[t]his trend toward specialization skews our medical system toward invasive and expensive interventions and away from primary and preventive care and care-giving at a low-tech level for those with chronic illnesses and impairments," as high-technology medicine is associated with specialized practice).

acquire the latest medical technology.[63] Yet many of these highly specialized and costly interventions are no more effective than lower cost, low-tech alternatives.[64] Consequently, the greater specialization and use of technology that results from fee-for-service often promotes higher cost care that is of limited marginal utility.

Fee-for-service also discourages efforts to address the many systemic inefficiencies that plague our health care system. First, piecemeal payment for acute care hinders greater collaboration and coordination among providers. By paying primary care physicians, specialists, hospitals, and other providers separately for the care they provide, fee-for-service encourages providers to operate in separate "silos," with each provider focusing only on the care they individually provide to patients.[65] Moreover, fee-for-service generally pays providers only for care provided directly to patients, and not for the time required to coordinate care with other providers.[66] Providers thus have little incentive to coordinate the care they provide to patients.[67]

This lack of coordination, or fragmentation, among providers is a primary cause of the poor care chronically ill patients receive, as well as a significant contributor to the overutilization of health care. Primary care physicians, specialists, hospitals, and other providers often do not share with one another pertinent information about a patient.[68] For example, primary care physicians frequently do not

[63] *See* Pham & Ginsburg, *supra* note 61, at 1591 (stating that financial incentives cause physicians to favor services that are paid for particularly well over other services, and that physicians have increased their capacity to provide diagnostic and therapeutic procedures within their practices).

[64] *See, e.g.*, Kenneth Thorpe, *The Rise in Health Care Spending and What to Do About It*, 24 HEALTH AFF. 1436, 1443 (2005) (discussing a study finding that the least costly drug for treatment of hypertension among type 2 diabetics was as effective as the newer, more costly drugs); G. Barbas et al., *New Technology and Health Care Costs—The Case for Robot-Assisted Surgery*, 363 NEW ENG. J. MED. 701, 704 (2010) (stating that existing evidence fails to show that the long-term outcomes of robot-assisted surgery are superior to those of conventional procedures).

[65] *See* Berwick, *supra* note 9, at 761 (stating that current payment incentives lead hospitals "to focus only on care within their walls," with readmissions due to defects outside the hospitals deemed not their responsibility); Thomas Bodenheimer, *Coordinating Care—A Perilous Journey Through the Health Care System*, 358 NEW ENG. J. MED. 1064, 1064 (2008) (noting the lack of coordination among providers).

[66] *See id.* at 1066 ("Most dollars are paid to physicians on the basis of . . . face-to-face visit time rather than the between-visit time required for care coordination.").

[67] *See* Bazzoli, *supra* note 53, at 143 ("[F]ee-for-service promotes inefficiency because it lacks the incentives to coordinate care across providers . . . .").

[68] *See* Bodenheimer, *supra* note 65, at 1064 (summarizing studies that found that providers often provide insufficient information to one another on a timely basis);

provide information to their patients' specialists, and vice versa.[69] This lack of communication commonly results in the duplication of tests.[70] In addition, providers who are unaware of the care provided by other health care professionals cannot ensure that the patient receives care in the lowest cost setting.[71] The lack of coordination also exacerbates preventable complications, particularly among chronically ill patients. For instance, patients often do not receive appropriate follow-up care after their discharge from a hospital,[72] increasing the likelihood of complications requiring re-hospitalization. Similarly, patients seeing multiple providers may receive different diagnoses and treatment plans for their condition, or may be prescribed incompatible medications.[73] As discussed in Part II.C, this fragmented nature of the health delivery system contributes to higher health care costs.

Second, fee-for-service further deters efficient practices by penalizing providers who adopt cost-saving initiatives that reduce the amount of care provided.[74] As noted above, under a fee-for-service

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Peikes, *supra* note 38, at 603–04 ("Chronically ill patients often see multiple physicians . . . who may be incompletely aware of each other's care.").

[69] For example, one 2000 study found that pediatricians failed to provide any information to their patients' specialists in thirty-eight percent of referrals, and that the specialists failed to provide the referring physician feedback forty-six percent of the time. *See* Christopher B. Forrest et al., *Coordination of Specialty Referrals and Physician Satisfaction with Referral Care*, 154 ARCHIVES OF PEDIATRIC & ADOLESCENT MED. 499, 502 tbl.1 (2000). *See generally* Bodenheimer, *supra* note 65, at 1064 ("[R]eferrals from primary care physicians to specialists often include insufficient information, and consultation reports from specialists back to primary care physicians are often late and inadequate.").

[70] *See* Bazzoli, *supra* note 53, at 143 (stating that fee-for-service does not encourage providers "to avoid costly service duplication").

[71] *See id.* (stating that fee-for-service does not encourage providers "to select the lowest cost setting for care").

[72] For example, in a 2005 survey of U.S. adults hospitalized in the previous two years for a chronic or acute illness, one-third reported that no follow-up arrangements were made after they were discharged from the hospital. *See* Cathy Schoen et al., *Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries*, HEALTH AFF. – SUPPLEMENTAL WEB EXCLUSIVES: W5-509–W5-525 (2005), *available at* http://content.healthaffairs.org/content/early/2005/11/28/hlthaff.w5.509.full.pdf+html?sid=64bc4e6c-ac84-4fae-a6a4-4e27a3e7830f.

[73] *See* Berenson, *supra* note 31, at 721 (noting that the fragmented care that results from competent clinicians practicing in silos produces different diagnoses and treatment plans and prescribing incompatible medications).

[74] *See* Boland, *supra* note 14, at 16 (noting that under fee-for-service, providers are not paid to implement proven cost savings programs). S*ee also* Berwick, *supra* note 9, at 761 (explaining that hospitals have few incentives to address systemic efficiencies that would reduce their revenues or admission rates, as doing so would threaten hospitals' profits).

system, providers can increase their revenues by providing more services.[75] Providers therefore have little incentive to implement programs or protocols that would decrease the amount of care they provide. For example, although studies have shown that discharge clinics and hospitalist programs can dramatically reduce the rate of hospital readmissions,[76] few hospitals have invested in such programs.[77] Providers also are slow to adopt protocols that reduce the risk of complications or medical errors, particularly those that require coordination among different providers across multiple care settings.[78] Instead, fee-for-service incentives have resulted in a health care system primarily focused on the detection and acute treatment of disease, and not the reduction of preventable health risks.[79]

Finally, many physicians and other health care professionals lack the capacity to adopt practices that will improve their management of chronically ill patients or reduce inappropriate care. As noted above, fee-for-service encourages providers to operate in separate "silos," with almost sixty percent of physicians practicing in solo practice or group practices with fewer than ten physicians.[80] These small practices generally lack the resources to implement many of the strategies known to improve the quality of care. Perhaps most importantly, few have implemented electronic medical records,[81]

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[75] *See supra* notes 53–58 and accompanying text.

[76] *See* Boland, *supra* note 14, at 19.

[77] *See id.* at 16 (stating that hospitals do not have financial incentives to implement discharge clinics and hospitalist programs).

[78] *See, e.g.,* Atul Gawande, *The Checklist,* NEW YORKER, Dec. 10, 2007, at 86 (describing the failure of hospital ICUs to adopt a checklist proven to reduce central line infections).

[79] *See* Bobby Milstein et al., *Analyzing National Health Reform Strategies with a Dynamic Simulation Model*, 100 AM. J. OF PUB. HEALTH 811, 811 (2010) (commenting that the medical industry "overemphasiz[es] disease detection and treatment while missing opportunities to reduce preventable risk and protect people's health").

[80] In an analysis of physician practice arrangements for 2007-2008, the American Medical Association (AMA) found that the percentage of physicians practicing in different types of arrangements was as follows: 24.6% in solo practice, 21.4% in groups of two to four physicians, 12.9% in groups of five to nine physicians, 12.1% in groups of ten to forty-nine physicians, and only 4.6% in groups of more than fifty physicians. 21.2% of physicians were employed by hospitals and other institutions. AMERICAN MEDICAL ASSOCIATION, THE PRACTICE ARRANGEMENTS OF PATIENT CARE PHYSICIANS 2007-2008: AN ANALYSIS BY AGE COHORT AND GENDER (2009), *available at* www.ama-assn.org/resources/doc/health-policy/prp-200906-phys-prac-arrange.pdf.

[81] *See* Chun-Ju Hsiao et al., *Electronic Health Record Systems and Intent to Apply for Meaningful Use Incentives Among Office-Based Physician Practices: United States, 2001–2011*, NCHS Data Brief No. 79 (2011) (reporting findings from the National Ambulatory Medical Care Survey) ("Small practices generally have less capacity to implement electronic medical records."). Although physicians are increasingly

which can improve the coordination of care through the sharing of patient information among providers,[82] reduce duplicative services,[83] and promote compliance with evidence-based guidelines.[84] Health information technology also can help providers identify both inefficient practices and high-cost patients that may benefit from better patient management.[85] In addition, these small practices often lack the personnel and capacity to adopt a team approach to caring for patients with chronic illness[86] or implement clinical pathways that would improve the quality of care.

With the current health care system unlikely to achieve cost savings through the elimination of waste or improved patient management, many have argued for reforming how we pay and deliver health care. Part III discusses the leading proposal for doing so—accountable care organizations.

III. THE CASE FOR ACOS

Many health policy analysts have concluded that we cannot achieve cost savings through the elimination of waste and better patient management unless we shift away from our fragmented, fee-for-service system to a system where large, integrated organizations assume financial responsibility for their treatment decisions.[87] These organizations are referred to as accountable care organizations

incorporating electronic health records (EHR) into their practices, preliminary estimates from 2010 suggest that only one-third of physicians have an EHR system meeting the criteria for a basic system. *Id.*

[82] *See* Ashish K. Jha et al., *A Progress Report on Electronic Health Records in U.S. Hospitals*, 29 HEALTH AFF. 1951, 1956 (2010) ("Use of the [electronic health] records has also been associated with improved coordination of care through the electronic exchange of information.").

[83] *See* Boland, *supra* note 14, at 19 (stating that a system-wide EHR can reduce duplicative services).

[84] *See* Menachemi & Brooks, *infra* note 126.

[85] *See* Boland, *supra* note 14, at 13 ("Relational databases allow health plans and medical administrators to retroactively analyze cost drivers, and predictive modeling software can identify high expense groups."); Brent C. James & Lucy A. Savitz, *How Intermountain Trimmed Health Care Costs Through Robust Quality Improvement Efforts*, 30 HEALTH AFF. 1185, 1189 (2011) (discussing the benefits of health information technology).

[86] *See* Shortell & Casalino, *supra* note 81, at 95 ("Small practices generally . . . less frequently use teams to care for patients with chronic illness.").

[87] *See* Jeff Goldsmith, *Accountable Care Organizations: The Case for Flexible Partnerships Between Health Plans and Providers*, 30 HEALTH AFF. 32, 33 (2011) ("Some policy advocates believe that the way to stabilize health care costs is to engage providers in a form of population-based cost management—that is, to compel providers to constrain costs across the population of an entire community.").

(ACOs). But proponents of ACOs do not simply contend that ACOs can stabilize health care costs; they also claim that ACOs can simultaneously improve the quality of care provided to patients. As described below, their optimism is not without support. Nevertheless, as discussed in Part IV, there is reason to believe that ACO proponents overstate the potential for ACOs to lower costs without adversely impacting the quality of care.

A. *ACOs: An Introduction*

An ACO generally is defined as a local organization comprised of and controlled by primary care physicians, specialists, and other providers that are jointly accountable for the cost and quality of the full continuum of care delivered to a patient population.[88] Accountability for both cost and quality goals are achieved by paying ACOs through an alternative payment methodology that rewards both cost savings and improvements in care. In addition, by focusing on providers, the ACO model imposes joint accountability for both costs and quality at the level of actual care delivery, rather than on insurers and HMOs.[89] The ACO model thus seeks to reform health care in two fundamental ways. First, the model would achieve payment reform by shifting financial responsibility for the aggregate cost of care from payors to providers, and by tying providers' reimbursement levels to the quality of care they provide. Second, the model reforms the delivery system by moving away from one

[88] *See* Boland, *supra* note 14, at 12 ("An ACO is generally defined as a local health care organization with a network of providers such as primary care physicians, specialists, and hospitals that are accountable for the cost and quality of care delivered to a particular population."); Kelly Devers & Robert Berenson, *Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?*, TIMELY ANALYSIS OF IMMEDIATE HEALTH POL'Y ISSUES 1 (Oct. 2009) ("An ACO is a local health care organization and a related set of providers (at a minimum, primary care physicians, specialists, and hospitals) that can be held accountable for the cost and quality of care delivered to a defined population."); Thomas L. Greaney, *Accountable Care Organizations: A New New Thing with Some Old Problems*, HEALTH L. OUTLOOK 2 (2010) ("The ACO concept envisions a legal entity comprised of and controlled by providers that would assume financial responsibility for the cost and care of a defined population . . . while being subject to a variety of quality standards and information reporting requirements."); Mark McClellan et al., *A National Strategy To Put Accountable Care Into Practice*, 29 HEALTH AFF. 982, 982 (2010) ("ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth.").

[89] *See* Devers, *supra* note 88, at 3 ("Developers of the ACO concept also emphasize accountability, but focus directly on health care providers and the delivery system instead of insurers and HMOs. . . . The new approach, then, emphasizes accountability at the level of actual care delivery.").

structured to manage acute health problems to a system organized around clinically integrated providers focused on preventive care and management of long-term health issues.

ACOs are held accountable for the cost of care delivered to a patient population through various payment mechanisms that reward efficiency and/or penalize inefficiency, namely shared savings, shared savings and risk, and capitation.[90] Under the shared savings model, the ACO continues to receive fee-for-service based payments, but payors also reward an ACO that meets or exceeds its targeted cost savings with a bonus equal to a percentage of the savings.[91] The shared savings and risk model similarly entitles an ACO to a percentage of any savings, but also penalizes those who do not meet targeted cost savings with a downward adjustment in their fee-for-service payments.[92] Finally, under the capitated model, in place of fee-for-service payments an ACO would receive a single monthly payment for each insured it cares for, thereby forcing an ACO to internalize the cost of care it provides.[93]

The ACO model also includes economic incentives for ACOs to improve quality by tying a portion of an ACO's reimbursement to its performance on quality benchmarks.[94] For example, an ACO that performs poorly on the relevant quality measures may be ineligible for any bonus payment under the shared savings or shared savings and risk payment models, even if the ACO lowers the cost of care.[95] Public reporting of an ACO's quality performance also promotes holding an ACO accountable to the extent such information affects an ACO's reputation.[96]

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[90] *See* David Balto, *Making Health Reform Work: Accountable Care Organizations and Competition*, CTR. AM. PROGRESS 5 (Feb. 28, 2011), *available at* http://www.americanprogress.org/wp-content/uploads/issues/2011/02/pdf/aco_competition.pdf (discussing the various models for giving ACOs incentives for cost control); *see generally* Chad Mulvany, *Weighing the Benefits and the Risks of ACOs*, 64 HEALTHCARE FIN. MGMT. 48, 48 (2010) (stating that the economic incentives in the ACO model tie some portion of provider reimbursement to cost efficiency).

[91] *See* Balto, *supra* note 90, at 5 (explaining the shared savings payment model).

[92] *See id.* (explaining the shared savings and risk payment model).

[93] *See id.* (explaining the capitation payment model).

[94] *See* Mulvany, *supra* note 90, at 48 (stating that the economic incentives in the ACO model tie some portion of provider reimbursement to quality benchmarks).

[95] *See, e.g.*, 42 C.F.R. 425.100(b) (2012) (stating that ACOs participating in the Medicare shared savings program are eligible for shared savings only if they meet the minimum quality performance standards, among other requirements).

[96] *See* Devers, *supra* note 88, at 1 ("Public reporting of cost and quality information to affect public perception of an ACO's worth is another way of holding the ACO accountable for its performance.").

Through these payment reforms, policymakers hope to shift the health care system away from a fragmented system focused on acute and specialized care. Under the ACO model, an ACO's participating providers are jointly accountable for the full spectrum of care provided to patients (whether or not provided by the ACO's participating providers). The ACO model of shared accountability thus encourages providers to look beyond the care they individually provide a patient during an episode of illness.[97] It encourages providers to "deliver more efficient and coordinated care"[98] and focus on patients' long-term health, including the prevention of serious health problems.[99]

The ACO model received the imprimatur of health care reform when it was incorporated into the Affordable Care Act as the Medicare Shared Savings Program.[100] Under the program, ACOs that successfully lower the cost of care provided to Medicare beneficiaries will share a portion of the savings they generate for the Medicare program, provided they meet certain quality standards.[101] In addition to the Shared Savings Program, the Centers for Medicare and Medicaid Services (CMS) has established the Pioneer ACO Model for organizations with experience operating as ACOs.[102] Under this program, participating ACOs will receive higher levels of reward and assume greater financial risk than ACOs participating in the Shared Savings Program.[103] In year three of the Pioneer ACO Model program, CMS will begin testing a capitated payment model, with eligible ACOs receiving a monthly per-beneficiary amount in lieu of part of or all of the ACO's fee-for-service payments.[104]

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[97] *See* Jackson Williams, *The "Shared Accountability" Approach to Physician Payment: Four Options for Developing Accountable Care Organizations*, 7 IND. HEALTH L. REV. 185, 188 (2010) (explaining that the ACO model of shared accountability imposes "accountability [for] . . . the long-term health status of patients, not simply for the care that an individual professional delivers during a particular episode of illness").

[98] *See* Boland, *supra* note 14, at 12.

[99] *See* Williams, *supra* note 97, at 188 (stating that the ACO model of shared accountability imposes accountability for the long-term status of patients).

[100] Patient Protection and Affordable Care Act, Pub. L. 111-148, sec. 3022 (2010).

[101] U.S. DEP'T OF HEALTH AND HUMAN SERVS., SUMMARY OF FINAL RULE PROVISIONS FOR ACCOUNTABLE CARE ORGANIZATIONS UNDER THE MEDICARE SHARED SAVINGS PROGRAM 4 (2011), *available at* https://www.cms.gov/MLNProducts/downloads /ACO_Summary_Factsheet_ICN907404.pdf.

[102] CTRS. FOR MEDICARE & MEDICAID SERVS., PIONEER ACCOUNTABLE CARE ORGANIZATION MODEL: GENERAL FACT SHEET 1 (2011), *available at* http://innovations.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf.

[103] *See id.* at 4.

[104] *See id.*

B. ACOs: The Case for Optimism

Proponents of the ACO model contend that ACOs are well-positioned to achieve what the current system has largely failed to do—reduce wasteful care and the cost of treating chronically ill patients without compromising quality. First, the financial incentives under the ACO model encourage ACOs to find ways to care for their patients while both using fewer resources and providing high quality care. Eliminating wasteful care and better managing the care provided to those with chronic illness will be important components of an ACO's efforts to achieve this goal.[105] Second, as large, clinically and financially integrated organizations, ACOs have the resources and capacity to implement these strategies.

Tying an ACO's participating providers' reimbursements to the overall cost of care they provide to patients uncouples providers' incomes, either in whole or in part, from the volume and intensity of services they provide.[106] As explained above, fee-for-service encourages a business model where providers generate higher incomes by increasing the volume and intensity of services they provide.[107] In contrast, the opportunity for shared savings or capitated payments under the ACO model ties ACO providers' incomes to the total resources used to treat their patient population. This shift therefore requires a new business model, as ACOs must identify ways in which to care for their patients using fewer resources.[108]

The elimination of wasteful care will be an essential part of an ACO's efforts to provide cost-effective patient care. To generate shared savings or higher margins under capitation, ACOs will be motivated to reduce duplicative tests, unsafe procedures, and care

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[105] *See infra* notes 109–111 and accompanying text.

[106] *See* Fisher, *supra* note 5, at 221 ("With accountability for overall costs and quality, providers' incomes can begin to be decoupled from the volume and intensity of services they provide.").

[107] *See supra* Part II.C. For example, hospitals seeking to expand their profits frequently do so by (1) expanding their capacity, particularly in high-margin services such as interventional cardiology and intensive care, and (2) recruiting additional procedure-oriented specialists. *See* WENNBERG, *supra* note 5, at 15 (discussing hospitals' financial incentives to expand their capacity). The ability of physicians to drive demand for these services by increasing the number of patients referred for such care helps ensure that a hospital's expanded capacity will be utilized. *See generally id.* (discussing the dynamics of supply-driven demand).

[108] *See* Boland, *supra* note 14, at 16 ("Delivery systems such as ACOs will be given incentives to implement more cost-effective patient care models . . . .").

lacking scientific support or sufficient value.[109] The ACO model also rewards the more judicious use of high-cost technologies, inpatient care, and specialists, thereby encouraging greater reliance on less intensive medical care, lower-cost treatment settings, and primary care.[110] The economic incentives under the ACO model also will foster the adoption of protocols that reduce the risk of medical errors or complications.[111]

The financial incentives under the ACO model also should spur ACOs to re-orient treatment of chronic conditions away from treating acute episodes of illness toward better prevention and patient management, as doing so may reduce emergency room visits, hospital admissions, and ancillary services associated with preventable complications.[112] Whereas under fee-for-service providers generally only focus on the care provided to patients within their four walls, holding ACOs accountable for all care provided to a patient gives ACOs strong incentives to coordinate the care provided to patients across all care settings.[113] For example, ACOs would have the financial incentive to better manage care transitions for chronically ill patients, ensuring that all of the patient's providers and other care-givers have needed information and provide appropriate follow-up care.[114] In addition, ACOs may devote more resources to monitoring patients with chronic conditions and intervening earlier when

[109] *See* Newman, *supra* note 4, at 11 (stating that ACOs can generate shared savings by reducing unnecessary or duplicative services).

[110] *See* Mulvany, *supra* note 90, at 48 (explaining that the economic incentives of the ACO model rewards providers for using high-cost technologies more judiciously; *see* Newman, *supra* note 4, at 11 (stating that ACOs will seek to promote lower-cost treatment options).

[111] *See* Berwick, *supra* note 9, at 765 (stating that organizations that much reduce per capita costs would seek to eliminate waste, including errors); *see also* Fisher, *supra* note 5, at 221 (explaining that under the ACO model, "[i]nnovations that improve quality while reducing overall utilization (and costs) can be rewarded or at least not penalized").

[112] *See* Boland, *supra* note 14, at 13 ("Under new payment schemes [that hold providers accountable for the cost of care], it will be an economic necessity to avoid preventable admissions, readmissions, complications, ancillary services, and emergency room visits.").

[113] *See* Newman, *supra* note 4, at 9 (stating that to generate shared savings, ACOs will improve coordination of care).

[114] *See* MICHAEL TRISOLINI ET AL., THE MEDICARE PHYSICIAN GROUP PRACTICE DEMONSTRATION: LESSONS LEARNED ON IMPROVING QUALITY AND EFFICIENCY IN HEALTH CARE ix (2008) (commenting that the Medicare demonstration that served as a model for the Shared Savings Program gave participating organizations a financial incentive to better manage the many care transitions required for treatment of chronic diseases).

patients show the first signs of deterioration.[115] An ACO also likely would take steps to promote greater compliance with recommended clinical guidelines in order to improve the quality of care provided to those with chronic conditions and limit preventable complications.[116]

ACOs seeking cost-saving measures also may be slower to expand their capacity through the acquisition of new technology, increasing the supply of hospital beds, and employing additional specialists.[117] This in turn may reduce the frequency of care provided to ACO patients, as studies have found that the supply of these medical resources creates its own demand. For example, Wennberg and his colleagues at the Dartmouth Atlas Project have documented a strong positive association between rates of diagnostic testing and imaging exams and the supply of equipment needed to perform these tests.[118] Similarly, the Dartmouth Atlas Project found a positive correlation between (1) hospitalization rates for most medical (non-surgical) conditions and the per capita supply of staffed hospital beds, and (2) admission rates to intensive care units and the supply of ICU beds.[119] Regions with a higher number of physicians per capita, particularly those specialists treating chronic illnesses, also showed higher physician visit rates.[120] Moreover, as noted above, the Dartmouth Atlas Project found that regions providing more care did not achieve

[115] *See* Berwick, *supra* note 9, at 764 (explaining that an integrator such as an ACO would assign more value and many more resources to the monitoring and interception of early signs of deterioration among patients with chronic heart failure).

[116] *See* Newman, *supra* note 4, at 11 (stating that financial incentives encourage ACOs to develop or adopt existing care protocols to improve management of diseases, increase preventive services, and encourage early diagnosis).

[117] ACOs may limit their capacity in an effort to better match supply to the patient population's needs. In addition, they may hesitate to acquire new technologies or make capital investments absent clear evidence that such investments sufficiently improve care so as to justify their costs. *See* Berwick, *supra* note 9, at 765 (stating that an "integrator" such as an ACO would view new technologies and capital investment with skepticism, and would better match supply to underlying needs).

[118] *See* WENNBERG, *supra* note 5, at 10 (discussing the association between rates of diagnostic testing and imaging exams and the supply of equipment).

[119] *See id.* (discussing the correlation between supply of hospital beds and ICU beds and rates of hospitalization and ICU admissions).

[120] *Id.* (discussing the relationship between the supply of physicians and physician visits). Although a possible explanation for the positive relationship between supply and utilization may be that regions with sicker patients acquire more medical resources because their patients require more care, researchers at the Dartmouth Atlas Project also found that the prevalence and severity of illness accounts for remarkably little of the variation in utilization rates across regions. *See id.* at 9.

better patient outcomes at the population level.[121] To the extent then that an ACO limits its capacity, doing so likely would reduce its provision of "supply-sensitive" care without necessarily affecting the quality of care at the population level.

In addition to having the motivation to lower costs through the elimination of waste and better patient management, proponents contend that ACOs also have the resources and capacity to do so. As large, clinically and financially integrated organizations, ACOs have several advantages over the current, fragmented system of care that is largely populated by small group practices. First, ACOs can address the problems of fragmentation by bringing within one organization the various physicians, other health professionals, and institutional providers needed to treat patients with chronic conditions.[122] In doing so, the ACO can improve coordination among the various providers treating a patient and better implement initiatives that require cooperation among multiple providers operating in different treatment settings.[123]

Second, ACOs are better positioned to implement electronic health records given their deeper financial resources and economies of scale.[124] As discussed previously, electronic health records are instrumental to providers' efforts to reduce waste and provide better care to chronically ill patients. By facilitating the sharing of patient information among an ACO's participating providers, electronic health records promote better coordination among the multiple providers treating a chronically ill patient. This sharing of information also reduces the need for duplicative tests and procedures.[125] In addition, use of electronic health records can promote greater compliance among ACO physicians with evidence-based guidelines, thereby reducing the amount of unnecessary or inappropriate care and promoting more effective care for chronically

[121] *See supra* notes 22–24 and accompanying notes.

[122] *See* Devers, *supra* note 88, at 721 ("ACOs offer the promise of decreasing fragmentation of healthcare delivery by bringing under one virtual roof the various medical specialists and other health professionals and institutions that need to coordinate care for the growing number of patients with multiple chronic conditions.").

[123] *See* Boland, *supra* note 14, at 16 (commenting that preventing avoidable events requires that "measures and methodologies be implemented across all departments and services").

[124] *See* Shortell & Casalino, *supra* note 81, at 95 ("Small practices generally have less capacity to implement electronic medical records . . . .").

[125] *See* Boland, *supra* note 14, at 19 (noting that system-wide electronic medical records reduce duplicative services).

ill patients.[126]

Third, ACOs, with their electronic health records, larger patient populations, and financial resources, can generate the statistically reliable data needed to support efforts to improve efficiency and quality.[127] Retrospective analysis of patient data can reveal areas where significant gaps exist between actual practice and known best practices,[128] gaps the ACO can then address through staff training or the development of patient care protocols. Analysis of patient outcomes also may identify certain practices that either increase or reduce the risk of complications requiring costly care. For example, Intermountain Health Care, one of the model organizations for ACOs, discovered during its review of patient data that the risk of wound infections was much lower when patients were administered prophylactic antibiotics two hours before surgery. Intermountain Health Care then developed clinical protocols based on these findings that reduced its rate of post-surgical infections by fifty percent.[129] Analysis of patient data also can help ACOs identify the high-risk, high-cost patient populations most likely to benefit from better patient management.[130]

Finally, ACOs are more likely than small physician groups to have experienced administrators that can promote the elimination of wasteful care and better patient management. For example, ACO administrators can promote the effective utilization of health information technology, oversee the development of clinical pathways, and coordinate the implementation of cost-effective patient

[126] *See* Richard Hillestad et al., *Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, and Costs*, 24 HEALTH AFF. 1103, 1110 (2005) (stating that electronic medical record systems can promote integration of evidence-based recommendations for preventive care and management of chronically ill patients); Nir Menachemi & Robert G. Brooks, *Reviewing the Benefits and Costs of Electronic Health Records and Associated Patient Safety Technologies*, 30 HEALTH MED. SYSTEMS 159, 165 (2006) (stating that clinical decision-making systems can improve diagnostic and treatment regimen decision-making by linking to evidence-based practice guidelines).

[127] *See* Stephen M. Shortell & Lawrence P. Casalino, *Health Care Reform Requires Accountable Care Systems*, 300 JAMA 95, 95 (2008) ("Small practices generally . . . are less able to provide statistically reliable and valid data on quality and efficiency measures.").

[128] *See* Boland, *supra* note 14, at 16 (explaining the potential for retrospective analytical tools to identify medical events and the rate of those events, with practices then compared to best-practices databases).

[129] *See* Carpenter, *supra* note 6, at 135 (discussing Intermountain Health Care's continuous quality improvement projects).

[130] *See* Boland, *supra* note 14, at 16 (stating that accountable care organizations can use upfront analytics to identify, at-risk, high-cost populations).

care models.[131] ACO management also can monitor the practice patterns of individual physicians and other providers, taking action against those who fail to adhere to organizational objectives.[132] Finally, ACO administrators can engage in careful, prospective resource planning, guarding against excess capacity and ensuring that an ACO's resources match the needs of its patient population.[133]

IV. ACOS AND THE COST-QUALITY TRADE-OFF

ACOs' potential to eliminate wasteful care and better manage patient care offers hope that ACOs can successfully contain costs without adversely impacting, and perhaps even improving, the quality of care. And yet we should view with skepticism the promise that ACOs can painlessly contain costs. First, eliminating much of the care considered "wasteful" involves eliminating care that will prove beneficial to some patients. Second, the potential cost savings from better management of patients with chronic conditions may be lower than ACO proponents contend. Third, long-term inflationary pressures from advances in medical technology will require ACOs to continuously find new ways of lowering health care costs savings, but doing so without sacrificing quality will prove difficult. Finally, even if in theory ACOs could successfully reduce costs without compromising the quality of care, in practice some ACOs may stint on the care they provide patients given their financial incentives to do so.

[131] *See* James & Savitz, *How Intermountain Trimmed Health Care Costs Through Robust Quality Improvement Efforts*, 30:6 HEALTH AFF. 1185, 1185, 1187 (2011) (explaining that Intermountain Health Care improved the quality of clinical care while lowering costs by creating "an administrative structure that uses its robust clinical information to oversee the performance of care delivery and to drive positive change," and that its leaders demanded a strategic plan that included creating information systems for clinical and financial management and a management structure to oversee the delivery of clinical care).

[132] *See* Gregory Pelnar & Gretchen Weiss, *Rule of Reason Analysis for Accountable Care Organizations*, 11 ANTITRUST SOURCE 1, 6 (2011) (noting that ACOs "may monitor the contributions of their physicians to achieving savings and high quality scores"). For example, if management identifies a physician who fails to adhere to clinical protocols, does not coordinate effectively with other providers, or consistently provides higher cost care, they may elect to educate the physician in areas where he or she is deficient, reduce the physician's bonus, or terminate the physician's contract with the ACO. *See id.* (stating that ACOs may reward high performing physicians with higher compensation and threaten lower performers with termination).

[133] *See* Devers, *supra* note 88, at 1–2 (stating that one of the essential characteristics of an ACO is the capability of prospectively planning budgets and resource needs).

A. *The Waste Hypothesis—Revisited*

As discussed in Part II.A, many contend that a significant portion of the care provided by the United States healthcare system is "wasteful," "ineffective," "unnecessary," and "inappropriate." Such terminology suggests that eliminating wasteful care need not result in patients being denied potentially beneficial care. Indeed, eliminating care that is duplicative, wasteful, or unsafe may prove a painless approach to reducing costs. But much of the care considered "wasteful" falls under a different category of waste—care of uncertain or insufficient clinical effectiveness.[134] For the reasons discussed below, curbing the provision of such care by ACOs inevitably involves eliminating care that does some good.

For many medical treatments, there exists insufficient data concerning the treatment's clinical effectiveness,[135] as evaluating a

[134] *See* Ari Hoffman & Steven Pearson, *'Marginal Medicine': Targeting Comparative Effectiveness Research to Reduce Waste*, 28 HEALTH AFF. w710, w711 (2009) (noting that the most likely source of potentially wasteful care is marginal medicine, that is, care lacking adequate evidence of clinical benefit, and care whose costs exceed its marginal benefits); Henry Aaron, *Waste, We Know You are Out There*, 359 NEW ENG. J. MED. 1865, 1866 (2008) (stating that "most" of the care labeled as waste is not useless care but provides some benefit).

[135] *See* Jan Blustein & Theodore Marmor, *Cutting Waste by Making Rules: Promises, Pitfalls, and Realistic Prospects*, 140 U. PA. L. REV. 1543, 1555–56 (1992). Variations in medical care are greatest when uncertainty exists regarding the clinical benefits of alternative treatments. *See Opportunities to Increase Efficiency in Health Care: Health Reform Summit of the Committee on Finance* (2008) (statement of Peter Orszag, Director, Cong. Budget Office) ("Variations in health care are often most dramatic when there is uncertainty about what kind of treatment to administer."). On the other hand, when the clinical evidence clearly supports a particular course of treatment, studies have found little variation across providers. *See* WENNBERG, *supra* note 5, at 14 ("[W]here clinical evidence is strong, the diagnosis is certain, and when doctors agree on the course of treatment, there is remarkably little variation from region to region."). To address weaknesses in the clinical science, many advocate greater research of patient outcomes and the development of evidence-based clinical guidelines. *See* WENNBERG, *supra* note 5, at 18 ("Many physicians and policymakers will argue that what is needed are evidence-based clinical guidelines . . . ."). Indeed, the Affordable Care Act establishes the Center for Quality Improvement and Patient Safety, a new center charged with developing and disseminating best practice guidelines. H.R. 3590, §§ 3013, 10303 (2010). While these efforts to promote more evidence-based medicine are certainly worthwhile, substantial uncertainty in medicine will remain, as testing the effectiveness of diagnostic tests or therapies is often extremely expensive and sometimes raises serious ethical issues. *See* Blustein, *supra* note 135, at 1549 (describing some of the problems with clinical trials). While epidemiological studies and other methods can yield helpful information, they too raise challenges for the physicians who must interpret them. *See id.* (describing alternatives to controlled clinical trials as useful but imperfect). In addition, few studies track a treatment's long-term impact on a patient's health. *See* Barbara Evans, *Seven Pillars of a New Evidentiary Paradigm: The Food, Drug, and Cosmetic Act Enters the*

treatment's clinical efficacy often takes years, particularly with regards to its long-term impact on patients' health.[136] Some care lacking clear evidence establishing clinical efficacy certainly would prove wasteful, either because it provides no clinical benefit or its benefits are no greater than lower-cost alternatives. But, for many of these so-called "wasteful" treatments, time will clearly establish the treatment's clinical benefit for particular patients.[137] To the extent that an ACO limits the provision of a treatment until its effectiveness is verified, patients denied the treatment in the interim would be denied potentially beneficial care.

Similarly, ACO providers who elect not to provide their patients care that on average may be of little to no value nevertheless may adversely impact the quality of care provided to some patients. Even when we possess information on a treatment's overall clinical effectiveness, statistical projections based on large population averages may hide significant variation among patients. Because patient conditions and characteristics can vary, a given intervention may affect patients differently.[138] Consequently, a treatment that on average has little clinical effectiveness, and thus appears "wasteful," in fact may be very effective for a small group of patients.[139] For example, while the drug clopidogrel (Plavix) generally has no benefit over aspirin in preventing myocardial infarction and stroke, for approximately one in every two hundred patients the drug in fact prevents myocardial infarction and stroke.[140] Therefore, a treatment's potential clinical benefits for an individual patient often remain uncertain, with some care that, on average, is of no, or merely marginal, benefit potentially benefitting some patients.[141]

Genomic Era, 85 NOTRE DAME L. REV. 419, 446–47 (2010) (noting that few clinical trials are of sufficient duration to allow for the detection of an intervention's long-term effects on health). So although more research on patient outcomes will improve the scientific basis for medical decisions, the limits of science and constant medical innovation mean much uncertainty will remain.

[136] *See* Evans, *supra* note 135.

[137] *See* Hoffman & Pearson, *supra* note 134, at w712 (stating that care considered wasteful because there remains uncertainty regarding its clinical effectiveness "may turn out to be highly effective, at least for some patients").

[138] *See* Aaron, *supra* note 134, at 1866 ("A given intervention typically affects individual patients differently").

[139] *See* Jost, *supra* note 15, at 15 (stating that statistical projections based on large populations may suggest that a particular treatment is of marginal value, when in fact it may be of value for particular patients).

[140] *See* Hoffman & Person, *supra* note 134, at w714 (discussing the potential benefits of clopidogrel).

[141] *See* Jost, *supra* note 15, at 15 ("Given the infinite variability of patients and

Finally, many treatments are considered wasteful not because they provide no clinical benefit, but because their benefits may be insufficient when compared to the treatment's cost.[142] Eliminating care on cost-benefit grounds would, by definition, involve denying care that is of potential benefit to patients.[143] For example, chemotherapy for advanced cancer may only add a few weeks of life at a cost of tens of thousands of dollars.[144] While many would consider the cost of such treatment as outweighing its potential benefit, few would claim that extending a patient's life by a few weeks is of no benefit. Thus, while limiting care of uncertain or insufficient clinical value may be justified on utilitarian grounds, their elimination certainly would not be "painless"; rather, it necessarily includes eliminating care that would be effective for some patients.[145]

B. Better Management of Patients with Chronic Conditions—Revisited

As discussed above in Part III.B, supporters of ACOs contend that ACOs can achieve substantial savings while improving patient outcomes not only through the elimination of inefficient care, but also through better management of chronically ill patients. Specifically, proponents contend that through enhanced screening and monitoring, improved patient education,[146] better coordination of care, and greater adherence to best medical practices, ACOs will

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conditions, it is often quite difficult to know with any precision how useful any test or procedure will be ex ante."). *See also* Mashaw, *supra* note 51, at 465 (stating that the task of defining "waste" and "abuse" in medicine is greatly complicated by the use of "averages to make judgments about individual cases").

[142] *See supra* note 15 and accompanying text.

[143] *See* Blustein, *supra* note 135, at 1560–61 ("When cutting waste on economic grounds, we inevitably eliminate some services that do some good."); Aaron, *supra* note 134, at 1866 ("Even those interventions deemed excessively costly actually help some patients.").

[144] *See* Hoffman and Pearson, *supra* note 134, at w713 (discussing the cost-effectiveness of chemotherapy for advanced cancer).

[145] *See* Blustein, *supra* note 135, at 1564 ("[B]ecause the spectrum of care includes care that is effective, . . . we must watch out for immoderate promises about painless 'waste cutting.'").

[146] *See supra* notes 45–47 and accompanying text (discussing examples of medical interventions that both improved quality while lowering costs). *See also* S.H. Woolf, *A Closer Look at the Economic Argument for Disease Prevention*, 301 JAMA 536, 536 (2009) (stating that childhood immunizations, smoking cessation counseling, and aspirin prophylaxis among patients at increased risk for cardiovascular disease yield net cost savings); L.B. Russell, *Preventing Chronic Disease: An Important Investment, But Don't Count on Costs Savings*, 28 HEALTH AFF. 42, 44 (2009) (explaining that vaccination against pneumococcal pneumonia reduces spending for adults ages 50–64 with certain chronic conditions).

reduce the complications associated with chronic conditions. This in turn will yield cost savings by decreasing the use of acute care services. Unfortunately, sweeping statements about the cost-saving potential of improved care for chronically ill patients may be overreaching.

Although some improvements in the care provided to chronically ill patients can both improve patient outcomes while containing costs, a review of the health economics literature suggests that most do not. Studies of both preventive measures and disease management programs[147] have repeatedly found that most fail to produce net cost savings, and in some cases the programs even increase health care spending.[148] One primary reason for these findings is the high costs of the programs themselves. While better chronic care can reduce the frequency of costly acute treatments for complications, these cost savings may not make up the costs associated with additional physician visits and monitoring, increased use of medications, and patient counseling.[149] Similarly, while earlier detection of a disease may prevent having to treat the disease later in a more serious and costly form, the screening costs for healthy people often far outweigh any savings from earlier treatment of those with

[147] The term disease management refers to a range of activities intended to address shortcomings in current medical treatment. Specifically, disease management programs aim to help patients better manage their chronic conditions, improve the monitoring of patients' symptoms and treatment plans, promote closer adherence to evidence-based guidelines, and better coordinate the care provided to patients seeing multiple providers. *See* CONG. BUDGET OFFICE, *supra* note 42, at 2 (explaining what disease management is).

[148] *See* Joshua Cohen et al., *Does Preventive Care Save Money? Health Economics and the Presidential Candidates*, 358 NEW ENG. J. MED. 661, 662 (2008) (reviewing numerous studies of preventive measures and concluding that most do not save money); Russell, *supra* note 146, at 42 (arguing that prevention usually increases medical spending); Bobby Milstein et al., *Analyzing National Health Reform Strategies with a Dynamic Simulation Model*, 100 AM. J. PUB. HEALTH 811, 812 (2010) (concluding that better preventive and chronic care do not typically reduce total health care costs); Soeren Mattke et al., *Evidence for the Effect of Disease Management: Is $1 Billion a Year a Good Investment?*, 13 AM. J. MANAGED CARE 670, 670 (2007) (reviewing the literature on disease management and concluding that there is little evidence disease management leads to a net reduction of direct medical costs); Luck, *supra* note 35, at 400 (stating that the published literature on disease management does not provide evidence that improved care for patients with complex conditions produce cost savings); CONG. BUDGET OFFICE, *supra* note 42, at 1 (concluding that the evidence of cost savings from disease management is quite limited).

[149] *See* Milstein et al., *supra* note 148, at 812 (stating that good preventive and chronic care typically does not reduce total health care costs even though it can reduce the frequency of more costly acute complications and urgent hospital visits, as it requires additional visits and medications).

the disease.[150] The incentive payments typically offered to providers to better manage care also may outweigh any reduction in utilization.[151]

Ironically, better care also can result in *higher* utilization rates. For example, more frequent screenings may increase costs by resulting in the unnecessary treatment of "false positives," with some of those treatments leading to costly complications and side-effects.[152] In addition, improved care sometimes only slows down a disease's progression, thus simply delaying, but not avoiding, the cost of treating complications.[153] Moreover, because better care often extends the life of persons with chronic conditions, improved patient management may result in chronically ill patients consuming more care over time, particularly as many will develop additional chronic conditions as they age.[154]

Clearly, medical interventions that fail to produce net savings still may be worthwhile. Improved care for those with chronic conditions can increase patients' length and quality of life at a reasonable cost—that is, they are cost-effective and thus a good use of

[150] *See* Ron Goetzel, *Do Prevention Or Treatment Services Save Money? The Wrong Debate*, 28 HEALTH AFF. 37, 37 (2009) ("[S]creening costs for healthy people far outweigh treatment costs for the few who develop the disease."); Cohen, *supra* note 148, at 661 ("[S]creening costs will exceed savings from avoided treatment in cases in which only a very small fraction of the population would have become ill in the absence of preventive measures."); CONG. BUDGET OFFICE, LESSONS FROM MEDICARE'S DEMONSTRATION PROJECTS ON DISEASE MANAGEMENT, CARE COORDINATION, AND VALUE-BASED PAYMENT 1–2 (2012) (stating that evaluations of Medicare programs involving disease management and care coordination found that in nearly every program, "spending was either unchanged or increased relative to the spending that would have occurred in the absence of the program").

[151] For example, a study of Medicare disease management and care coordination programs by the Congressional Budget Office found that programs using care managers integrated into physicians' offices did not yield sufficient savings in regular Medicare expenditures to off-set the additional fees paid to program participants for enhanced care coordination. *See* CONG. BUDGET OFFICE, *supra* note 150, at 4 (discussing results from Medicare demonstration programs using care managers).

[152] CONG. BUDGET OFFICE, *supra* note 42, at 6. For example, when Carol Smith, a former smoker, got a CT scan for the purpose of detecting early lung cancer, physicians found a lesion in her lung. A subsequent surgical biopsy revealed that the lesion was benign, but complications from the surgery left her in intensive care for two weeks and without full use of her left arm. *See* Petersen, *supra* note 30.

[153] *See* CONG. BUDGET OFFICE, *supra* note 42, at 14 (noting that disease management programs might merely change the timing of significant expenditures by postponing, rather than preventing, the need for acute treatment).

[154] *See* KAISER FAMILY FOUND., HEALTH CARE COSTS: A PRIMER 25 (2012) (stating that one reason for growing health care costs is developments in medicine and medical technology that enable people to live longer, often with chronic conditions that require ongoing medical care).

society's resources.[155] Nevertheless, we should view with skepticism claims that ACOs can painlessly lower health care costs simply by better managing the care provided to their chronically ill patients.

C. *The Long-Term Challenge of Technology-Driven Inflation*

As discussed in Part III, ACOs clearly have the potential to lower costs without harming quality by eliminating obviously wasteful practices and adopting patient management techniques known to reduce costs. The inflationary effect of advances in medical technology, however, will require ACOs to continuously find new ways of lowering costs. For the reasons discussed below, in the long term ACOs likely will be unable to do so without compromising the quality of care they provide to their patients.

Advances in medical technology[156] are the major contributor to rising health care costs,[157] accounting for one-half to two-thirds of

[155] *See* Fireman, *supra* note 11, at 73 (stating that most of the medical interventions recommended for treatment of patients with chronic conditions are cost-effective, in that "[t]hey increase the length and quality of life at a cost that is reasonable – a good value compared with other services . . . ."); Cohen et al., *supra* note 148, at 662 ("Some preventive measures . . . may still be worthwhile because they confer substantial health benefits relative to their cost."); Milstein, *supra* note 79, at 812 ("[G]ood preventive and chronic care is typically cost-effective (improving health at reasonable cost and thus arguably worth doing) . . . .").

[156] Technology advances include innovations and improvements in medical equipment, pharmaceuticals, and procedures. *See* Carpenter, *supra* note 6, at 133 (defining medical technology advances).

[157] *See* Jessica Mantel, *Setting National Coverage Standards for Health Plans Under Healthcare Reform*, 58 U.C.L.A. L. REV. 221, 240 (2010) ("By far the largest factor contributing to increasing healthcare costs is advances in medical technology."). While some new technologies decrease costs, most increase health care expenditures. *See* Carpenter, *supra* note 6, at 133 ("While some technologies are cost decreasing, the majority in health care are cost increasing."). Because the price for new medical technologies generally is quite high, price inflation for healthcare typically exceeds the inflation rate for other goods and services. *See* Mantel, *supra*, at 240. In addition, new technologies that identify additional patients with a condition increase the population receiving care, which in turn increases health expenditures. *See* Carpenter, *supra* note 6, at 133 ("Some new technologies identify and expand the population in need of care without necessarily offering new or better ways to treat the conditions. Similarly, new technologies that allow treatment of previously untreatable conditions often raise health expenditures by increasing the number of patients receiving treatment. *See* Mantel, *supra* at 240 ("By increasing the number of health conditions for which there exist potentially beneficial treatments, advances in medical technology have caused significant increases in aggregate utilization of healthcare services."); *see* Mathias Goyen & Jorg F. Debatin, *Healthcare Costs for New Technologies*, 36 (Suppl.) EUR. J. NUCL. MED. MOL. IMAGING, S139, S140 (2008) (stating that new technologies affect health care costs by developing treatments for previously untreatable conditions). New technologies that merely ameliorate symptoms but do not cure or slow-down a disease also result in higher expenditures. *See* Carpenter,

annual medical spending increases.[158] With new breakthroughs in biomedical and genetics research occurring with greater frequency, future advances in technology likely will place even greater pressure on costs.[159] Consequently, any initial savings achieved by ACOs eventually would be overcome by rising costs attributable to medical advances.[160] If in the long-term ACOs are to successfully rein in rising health care costs, they must continuously find new ways to achieve cost savings.

Unfortunately, there are reasons to doubt ACOs' long-term potential to achieve new cost savings without sacrificing the quality of care provided to patients. As discussed in Part III.A, ACOs could painlessly lower costs by eliminating medical interventions shown to be unsafe, clinically ineffective, duplicative, or more costly than comparable alternatives. Once ACOs exploit this "low hanging fruit," however, further reductions in so-called wasteful care would involve denying patients care of uncertain or insufficient clinical value. As previously discussed, eliminating care of uncertain or insufficient clinical value inevitably involves denying some patients potentially beneficial care.[161]

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supra note 6, at 133 ("Some of our newest biotechnologies are not even aimed at cure but merely amelioration of symptoms. This is likely to result in higher expenditures because treatment will extend over a longer period of time without affecting a cure.").

[158] *See* Goyen & Debatin, *supra* note 157, at 36 ("Most experts believe that medical technology advances account for half to two-thirds of annual spending increases.").

[159] *See* Gregg Bloche, *Beyond the "R Word"? Medicine's New Frugality*, 366 NEW ENG. J. OF MED. 1951, 1952 (2012) (explaining that even if we could eliminate all waste, medical costs will eventually rise again given the high rate of medical inflation, and therefore in the long-term we must "start saying no to some beneficial care"); Henry J. Aaron, *The Unsurprising Surprise of Renewed Health Care Cost Inflation*, 31 HEALTH AFF., w85 (Jan. 23, 2002), *available at* http://content.healthaffairs.org/content/early/2002/02/23/hlthaff.w2.85.full.pdf+html (stating that the forces driving up costs over the long haul are intensifying given that the staggering fecundity of biomedical research is increasing); *see also* David S. Hilzenrath, *What's Left to Squeeze? Managed-Care Firms Find Health Costs Rising – and Cuts Harder to Come By*, WASHINGTON POST, July 6, 1997, at H01 (referencing the opinion of Robert J. Rubin, former president of the Lewin Group, who stated that controlling costs may be harder to do in the future when research in genetics and biotechnology produce important breakthroughs). For example, new cancer therapies can cost in the $100,000 range. *See* Lola Butcher, *Oncology Community Concerned About CMS ACO Proposal*, ONCOLOGY TIMES 40 (2011) (noting the high cost of two new cancer therapies, Sipuleucel-T (Provenge) at $90,000 for a three-month course of treatment and ipilmumab (Yervoy) at $120,000 for a four-dose regimen).

[160] *See* Blustein, *supra* note 135, at 1566 (arguing that savings achieved from a one-time reduction in expenditures would inevitable be dwarfed by rising costs attributable to the medical care inflation).

[161] *See supra* Part IV.A.

Similarly, mature ACOs that have already successfully lowered costs through improved treatment of patients with chronic conditions may find generating further savings a significant challenge. As two commentators have noted, "[t]he greatest amount of quality improvement engendered by disease management occurs when additional care is provided to patients who have not been receiving available beneficial care."[162] When an organization successfully improves its patients' health, however, further improvements in health status may be difficult to achieve. For example, an ACO that significantly reduces the readmission rate for its patients hospitalized for congestive heart failure may have little room for improvement, with further reductions in the readmission rate proving elusive. Mature ACOs also may find that any marginal improvement in the health of its chronically ill patients fails to yield net cost savings, as any savings generated from fewer hospital admissions and other reductions in acute care frequently will be outweighed by the cost of the disease management program itself.[163] These challenges may explain why a study of new chronic disease management techniques adopted by Kaiser Permanente found that the interventions failed to yield absolute cost savings—as a mature integrated delivery system, Kaiser Permanente had already harvested the benefits of good patient management, including reductions in hospital admissions and short average length-of-stays.[164]

So although ACOs' initial efforts to eliminate wasteful care and better manage chronically ill patients may produce cost savings without adversely impacting the quality of care, for mature ACOs, finding further cost savings without compromising quality may prove extraordinarily difficult.[165] ACOs thus do not offer a permanent

[162] Francis Crosson & Philip Madvig, *Does Population Management of Chronic Disease Lead to Lower Costs of Care?*, 23 HEALTH AFF. 76, 78 (2004).

[163] To yield net savings, a disease management program must significantly reduce hospital admissions rates and other care associated with treating preventable complications. Opportunities for such savings are far greater when a disease management program targets a sicker population. *See* Ariel Linden & Julia Adler-Milstein, *Medicare Disease Management in Policy Context,* 29 HEALTH CARE FIN. REV. 1, 3–4 (2008) (explaining that to break even a disease management program must reduce hospital admissions rates, and that it is easier to do so with a sicker population because disease programs targeting sicker populations are likely to reduce the greatest percentage of hospitalizations).

[164] *See* Crosson & Madvig, *supra* note 162, at 77–78 (discussing the results of Fireman and colleagues' study on Kaiser Permanente's disease management program over the period 1996–2002).

[165] *See id.* at 78 ("[I]ncremental disease management interventions, beyond those already achieved by mature [Integrated Delivery Systems], will prove to be elusive in

solution to rising health care costs if we also insist that they not sacrifice quality.

D. ACOs and the Risk of Under-treatment

Even if in theory ACOs could successfully contain costs while improving the quality of care, in practice some ACOs may stint on the care they provide patients. First, under the ACO payment model, ACOs have a financial incentive to withhold medically appropriate care from their patients in order to increase their shared savings or profit margins. Second, an ACO seeking to limit costs may fail to ensure that it has sufficient resources at the organizational level to meet the full range of needs among its patient population. Although tying an ACO's payment to its performance on various quality measures provides some protection against this risk of under-treatment, weaknesses in quality measures mean some patients will remain vulnerable.

Under the ACO payment models, providers profit by minimizing the cost of care provided to patients. A primary means by which ACOs will limit costs is through their gatekeeping role—that is, determining which services should be provided to individual patients. In this gatekeeping role, ACOs may limit patient care by making fewer referrals to specialists, ordering fewer tests, and eliminating high-tech, expensive treatments. To the extent that there is much fat in the current system of care, limiting such care may not necessarily harm the quality of care.[166] There is the very real risk, however, that some ACO providers may go beyond trimming fat and deny or delay providing their patients appropriate medical interventions in order to maximize their shared savings or profit margins.[167] The ACO

the end for payers."); SIEMENS, NAVIGATING THE PERFECT STORM: HEALTHCARE IN 2010 AND BEYOND 8 (2010), *available at* http://www.medical.siemens.com/siemens/en_US/gg_hs_FBAs/files/IT_Solutions_And_Consulting/New_2009/ARRA/2010-11-10_NavigatingthePerfectStorm11-10_A9133-101897-C1-4A00.pdf (noting that one health care executive at a large health care system had found cutting costs to be "getting harder," as the system had already "picked most of the low-hanging fruit in terms of cost containment").

[166] *See supra* Part I.A.

[167] *See* Stephen Ubl, *ACOs: Improved Care or Roadblocks to Innovation*, HEALTH AFF. BLOG (Apr. 25, 2011, 1:41 P.M.), http://healthaffairs.org/blog/2011/04/25/acos-improved-care-or-roadblocks-to-innovation/ (noting the danger of ACOs stinting on care); National Health Council's Comments on CMS-1345-P (2011) (stating that the financial incentives under the Medicare Shared Savings Program "could lead to underutilization of new and/or costlier technologies that have the potential to improve individual patient outcomes"); Pelnar & Weiss, *supra* note 132 ("[B]ecause the ACO model financially rewards provider organizations for achieving cost savings,

model thus poses a real risk of under-treatment, particularly for patients requiring costly, complex care.

In addition, resource allocation decisions at the organizational level may result in ACO patients having diminished access to medically appropriate care. Because ACOs must provide care to their patients using fewer resources, ACO administrators and professionals not only must be more judicious in what care they provide to individual patients, but also must establish spending priorities at the organizational level. For example, an ACO may decide to lower its costs by reducing its nursing staff, limiting the number of specialists in the ACO, eliminating inpatient beds, or delaying the acquisition of new technology.[168] Although the findings of the Dartmouth group suggest scaling back on available services may not adversely impact quality, some ACOs may go beyond trimming excess resources. To the extent that an ACO fails to maintain adequate resources to meet its patient population's needs, its patients will have diminished access to necessary care.

Recognizing the risk of under-treatment, the ACO model ties an ACO's payments to its performance on selected quality measures.[169] For example, ACOs participating in the Medicare Shared Savings Program must report on thirty-three quality measures[170] and perform

it creates an inherent incentive to undertreat and underutilize . . . ."). For example, oncologists have expressed concern that ACOs will prematurely refer their cancer patients to a hospice program in lieu of specialty care that may produce better patient outcomes, but at a higher cost. *See* Butcher, *supra* note 159, at 40 (2011) (discussing oncologists' concerns about ACOs withholding appropriate care from cancer patients).

[168] *See* David Mechanic, *Cost Containment and the Quality of Medical Care: Rationing Strategies in an Era of Constrained Resources*, 63 MILBANK MEMORIAL FUND Q. 453, 463 (1985) (stating that setting priorities under constrained budgets may result in the delay of initiation of a new technology, service or unit, reducing staff, closing beds, eliminating nonessential services, and constraining other major costs). *Cf.* PHILIP BETBEZE, HEALTHLEADERS MEDIA INTELLIGENCE, REFORM'S IMPACT: STAFF AND SERVICE CUTS EXPECTED 10 (Dec. 2011), *available at* http://content.hcpro.com/pdf/content/274037.pdf (reporting that forty-three percent of respondents to a survey of health industry leaders stated that their facility will likely cut services as a result of implementation of the Affordable Care Act, and fifty-five percent stated that they will cut staff).

[169] *See* Pelnar & Weiss, *supra* note 132, at 6 (stating that one purpose of quality measures is to prevent ACOs from under-treating patients); Eric C. Schneider et al., *Payment Reform: Analysis of Models and Performance Measurement Implications*, RAND CORP., 32, 38 (2011) (stating that a key role of performance measures in a global or share savings payment model is to ensure that quality does not decline and ACOs do not reduce care inappropriately as ACOs seek to reduce the cost of treating patients).

[170] *See* 76 FED. REG. 67802, 67889–90 (Nov. 2, 2011) (Table I listing thirty-three

at the thirtieth percentile or better on at least seventy percent of the quality measures. In addition, ACOs exceeding the minimum threshold would be eligible for a larger proportion of any savings the ACO generates for the Medicare program.[171] While holding ACOs financially accountable for their performance on selected quality measures certainly affords some protection against ACOs' stinting on care,[172] for the reasons discussed below, many patients will remain vulnerable.[173]

The performance measures used to assess the quality of care provided by ACOs likely will be less comprehensive than necessary to protect against ACOs stinting on care. The initial set of quality measures under the Medicare Shared Savings Program, for example, focuses on certain conditions and services,[174] leaving important areas of clinical practice unaddressed, such as treatment for cancer, severe arthritis, or chronic pain.[175] To be fair, CMS has stated that in the future it will select additional measures applicable to these and other domains of care.[176] Currently available measures, however, largely focus on prevention and certain aspects of chronic care, and developing new measures that address the full range of services and clinical settings will take time. In the short term, the absence of quality measures across all domains of care may leave some ACO patients vulnerable to under-treatment as ACOs strive to lower the cost of care.[177]

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performance measures adopted in the final rule).

[171] *See id.* at 67897–98 (finalizing rule that ACOs perform at the thirtieth percentile or better on at least seventy percent of the quality measures).

[172] *See* Mulvany, *supra* note 90, at 48 (stating that the ACO payment model "penalizes providers that stint on care solely to meet financial goals"); *see* Schneider et al., *supra* note 169, at 38 (2011) (stating that the role of performance measures under the ACO model is "to monitor the quality of care delivered by participants in the ACO and to ensure that quality does not decline as clinicians seek to reduce the cost of treating the ACO population").

[173] In an effort to achieve costs below applicable expenditure benchmarks and boost their performance on quality measures, ACOs also have an incentive to avoid high-risk patients who are less likely to be healthy and comply with their providers' orders. *See* Pelnar & Weiss, *supra* note 132, at 6 (stating that ACOs may avoid high risk patients in order to achieve high quality metric scores).

[174] The performance measures in the final rule for the shared savings program include measures addressing diabetes, hypertension, heart disease, and chronic obstructive pulmonary disease (COPD). *See* 76 FED. REG. 67802, 67889–90 (Nov. 2, 2011) (Table I listing thirty-three performance measures adopted in the final rule).

[175] *See id.*

[176] *See id.* at 67886 (stating that CMS will consider additional measures addressing cancer and other conditions in future rulemaking).

[177] *See* Pelnar & Weiss, *supra* note 132, at 8 (stating that an ACO performing well

Even for those domains of care for which CMS selects quality performance measures, the measures may not adequately guard against diminished quality. Most of the measures selected by CMS under the Shared Savings Program are process measures that evaluate the extent to which a provider delivers a specific clinical service at a specific point in time.[178] Process measures, however, are unlikely to provide a complete picture of the quality of care ACOs provide to their patients. First, because process measures are based on current treatment norms, process measures cannot be developed for the many areas of medicine lacking a strong scientific basis or consensus as to best practices.[179] Second, process measures may be a crude measure of the quality of care provided to patients,[180] as the selected process measures focus on discrete interventions and do not measure all processes of care that impact a patient's health.[181] In addition, process measures simply measure whether a procedure was performed and do not measure other attributes of care that may be important indicators of quality, such as a health care professional's expertise or operator skill.[182] Finally, process measures fail to measure what ultimately matters—patient health.[183] To the extent the nexus between the measured process and a patient's health is weak, evaluating whether an ACO performed a particular process may tell us little about whether the ACO's clinical interventions improved

on reported quality measures may not mean that it has not engaged in restricting or delaying care in ways not reflected in the quality measures); Butcher, *supra* note 159, at 40 (commenting that the absence of quality measures for cancer care may result in cancer patients being denied new, expensive drugs given ACOs' financial pressures).

[178] Examples of process measures selected by CMS for inclusion in the Shared Savings Program include screening for fall risk (measure 13), depression screening (measure 18), colorectal l cancer screening (measure 19), mammography screening (measure 20), and percentage of adults who had their blood pressure measured within the preceding 2 years (measure 21). *See* 76 FED. REG. 67802, 67889–90 (listing quality measures adopted in final rule).

[179] *See* Marshall Chin & Naoko Muramatsu, *What is the Quality of Quality of Medicare Core Measures?: Rashomon-like Relativism and Real-World Applications*, 46:1 PERSPECTIVES IN BIOLOGY AND MED. 5, 12 (2003) (stating that confusing, limited, or conflicting data often makes impossible the consensus necessary to develop process measures).

[180] *See id.* at 12 (discussing the limitations of process measures).

[181] *See id.* (noting that process measures capture elements of care but miss important outcomes).

[182] *See* Jonathan Mant, *Process versus Outcomes Indicators in the Assessment of Quality of Health Care*, 13 INT'L J. FOR QUALITY IN HEALTH CARE 475, 478 (2001) (explaining that that process measures cannot capture important determinants of patient outcomes such as technical expertise and operator skill).

[183] *See* Douglas L. Wood, *Measure Health, Not Care*, MINNESOTA MED. 2 (Apr. 2012) (stating that process measures do not address the health of an individual or population).

patient health.[184]

Similarly, the patient experience measures included under the Medicare Shared Savings Program may fail to reveal problems with the quality of clinical care provided to ACO patients. Patient surveys ask patients to report on their satisfaction with their care, their perceptions of the quality of care, and their perceptions of what specific care they received.[185] Studies repeatedly have found that measures of patients' general satisfaction fail to adequately discriminate among providers, with less than ten percent of the variance in patients' responses attributable to differences in the care provided.[186] While measures of specific patient experience appear to better discriminate among providers, most of the variance in responses is due to differences in patients' perceptions and random error.[187] Problems in the reliability and validity of patient satisfaction and experience measures reflect the fact that patient reports are subjective and subject to reporting biases.[188] For example, research suggests that patient report measures are unreliable after a delay or more than six weeks and are more prone to error when patients must

[184] As explained by one commentator, because process measures reflect current treatment norms, they are only as good as the clinical evidence underlying those norms. *See* Avedis Donabedian, THE DEFINITION OF QUALITY AND APPROACHES TO ITS ASSESSMENT 119 (1980) ("The major drawback in the use of process for the assessment of the quality of care is the weakness of the scientific basis for much of accepted practices."). Unfortunately, much uncertainty exists regarding the effectiveness of various clinical interventions. *See supra* notes 134–36 and accompanying text.

[185] *See* Maxwell Drain & Paul Clark, *Measuring Experience from the Patient's Perspective: Implications for National Initiatives*, JHG ONLINE W4–6, W4–6 (2004) (explaining the different types of information that can be obtained from patient surveys).

[186] *See* Chris Salisbury et al., *Patients' Experience and Satisfaction in Primary Care: Secondary Analysis Using Multilevel Modeling*, BMJ (Oct. 12, 2010), *available at* http://www.bmj.com/content/341/bmj.c5004 (discussing studies showing that measures of patients' satisfaction discriminate poorly between practices, doctors, and hospitals, with random error and differences in patients' perceptions accounting for 90–97%of the variance in patients' responses).

[187] *See id.* (reporting that 20.2 percent of the variance in wait for appointment outcome was due to differences between practices, with the remaining 79.1 percent attributable to differences in individual patients' perceptions and random error); Mala Rao et al., *Patients' Own Assessments of Quality of Primary Care Compared with Objective Records Based Measures of Technical Quality of Care: Cross Sectional Study*, BMJ (June 29, 2006), *available at* http://www.bmj.com/content/333/7557/19 (finding low correlation between patients assessments of their care and the evidence-based measures of clinical outcomes).

[188] *See* Drain & Clark, *supra* note 185, at W4–7 ("[Patient] evaluations tend to be subjective, subject to reporting biases, and difficult to interpret . . . .").

recall multiple instances of care.[189] Consequently, scores on patient experience measures may not be reliable indicators of the quality of care patients receive.

Recognizing these weaknesses in process and patient experience measures, CMS plans to add additional outcome measures to its selected quality measures.[190] Whereas process measures focus on what care was actually provided to a patient, outcome measures assess what we ultimately care about—the patient's health status. That is, outcome measures assess the end result of clinical intervention,[191] such as morbidity rates, the severity of a patient's chronic condition, and hospital re-admission rates. In focusing on patient's health, outcome measures better protect patients against poor quality care. In particular, longitudinal measures of changes in patients' functional status, morbidity, and quality of life may guard against the risk of under-treatment, as such patient outcomes depend on the mix of services provided to patients over time.[192]

Outcome measures, however, also are problematic. Assessing whether an ACO provides high-quality care requires comparing the health status of an ACO's patients to the patients of other providers. Disparities in observed patient outcomes across providers, however, may be due to chance rather than differences in the quality of care provided. Consequently, the sample size of the measured data must be large enough to minimize the possibility that perceived differences in outcomes result from random variation, rather than differences in the quality of care.[193] Statistical power also depends on the frequency

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[189] *See id.* at W4–8–9 (discussing problems with patient reports).

[190] *See* 76 Fed. Reg. 67802, 67873.

[191] *See* Willis et al., *Measuring Quality*, 31 AUSTRALIAN HEALTH REV. 276, 278 (2007) (discussing process and outcome quality measures).

[192] *See* Schneider, *supra* note 169, at 40 ("Measurement of longitudinal changes in functional status and quality of life may be the most effective way to assess whether providers are optimally applying services within the ACO.").

[193] *See* Mant, *supra* note 182, at 478 (discussing the need to eliminate random variation as an explanation for observed differences in patient outcomes). *See also* Schneider, *supra* note 169, at 12 (noting the need to obtain sufficient numbers of observations to estimate performance with a reasonable degree of confidence). As one commentator illustrated:

> [T]o detect a 30% difference in outcome between two units performing carotid endarterectomy with 80% power at a significance level of 5%, with one unit achieving a 7% death and complication rate and another unit a 10% rate, would require the audit of 1422 carotid endarectomies in each unit. Given that hospitals in New York State each performed an average of 50 carotid endarectomies a year in 1995, such a difference is unlikely to be detected.

with which the measured outcome occurs, with a larger sample size needed to detect small differences in quality.[194] To the extent an ACO's patient population is not large enough to ensure an adequate sample size, regulators will be unable to detect differences in the quality of care provided by an ACO and other providers, putting ACO patients at risk of under-treatment.[195]

Measures of patient outcomes also do not necessarily correlate with the actual quality of care provided to patients, as numerous other factors external to treatment impact a patient's health.[196] Often these factors are largely outside the ACO's control, such as the patient's non-compliance with their physician's instructions, lifestyle factors, poverty, and the strength of a patient's social support system.[197] In addition, evaluating clinical outcomes is complicated by the fact that the health status of patients treated for a particular condition depends not only on the quality of the care they receive, but also on whether they suffer other unrelated medical conditions. For example, the functional status of a stroke patient may be low not because they receive poor quality care following their stroke, but because of an unrelated intervening event affecting their health, such

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Mant, *supra* note 182, at 476.

[194] *See* Mant, *supra* note 182, at 478. For example,

> [s]ince the target complication rate in carotid endarectomy is low (6%), monitoring outcome will only have limited ability to detect whether an individual surgeon's true complication rate is greater than 6%. For example, if a surgeon's 'true' complication rate was 8%, one would need to monitor the outcome of 1200 operations to detect that this surgeon's rate was greater than 6% with 80% power at a significance level of 5%.

Id.

[195] Because ACOs generally assume responsibility for a larger patient population than those cared for by a single hospital or physician group, for many measures an ACO's patient population may be sufficiently large to ensure an adequate sample size. *See* Schneider, *supra* note 169, at 35 ("Because the enrolled populations under the global payment and ACO shared savings program models will tend to be larger than those of a single hospital, group, or physician, it may be easier to obtain adequate sample sizes for performance measurement."). For some measures, however, this may not prove to be the case.

[196] *See* Pelnar & Weiss, *supra* note 132, at 9 ("Outcome measures may not reflect actual quality of care delivered because they are influenced by many external variables . . . ."). Data on patient outcomes for longer-term courses of treatment are especially prone to confounding factors given that they involve collecting data over longer time periods. *See* Chin & Muramatsu, *supra* note 179, at 10 ("Longer-term courses will be more likely to capture ultimate health status, but are prone to confounding by other intervening events not related to the quality of care.").

[197] *See* Mant, *supra* note 182, at 476 (discussing factors other than health care that are determinants of health).

as a myocardial infarction.[198] Although adjusting the data for variation in patient characteristics can reduce the possibility that observed differences in data are due to factors other than the quality of care (a process known as risk-adjustment), methodologies for doing so are often inconsistent and produce contradictory results.[199] For some domains of care, these challenges may render it impossible to develop statistically valid outcome measures that would detect true differences in the quality of care.

A final concern regarding outcome measures is that the data used for measuring patient outcomes often is incomplete, inaccurate, or subject to manipulation by providers.[200] Assessments of ACOs' quality of care entail comparing their performance on quality measures to the performance of other providers. To be a fair comparison, performance comparisons must take into account clinical, demographic, and other differences among providers' patients that may affect patient outcomes (i.e., the performance measures must be risk adjusted).[201] Accurate comparisons of providers' performance, however, require complete data of sufficient clinical detail to allow for sophisticated risk adjustment.[202] Unfortunately, the needed patient data is often incomplete, lacks sufficient detail, or is inaccurate due to errors in diagnosis coding.[203]

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[198] *See* Chin & Muramatsu, *supra* note 180, at 10 (noting that unrelated myocardial infarction complicates measurement of a stroke patient's health status).

[199] For example, one study comparing the performance of four vendors performing risk-adjustment on the same patient data found that their risk-adjusted measurements of inpatient hospital mortality varied significantly, with forty-three percent of hospitals showing higher-than-expected mortality under one vendor's method having lower-than-expected mortality under another's methods. *See* Peter Pronovost & Richard Lilford, *A Road Map for Improving the Performance of Performance Measures*, 30 HEALTH AFF. 569, 569 (2011) (discussing a study of vendors' risk-adjustment performance).

[200] *See id.* at 570 (commenting that measures calculated using discharge data are often imprecise, as the risk for misclassification is high); Pelnar & Weiss, *supra* note 132, at 9 ("The reliability of metrics for measuring the quality of care is also limited by the available data, which are likely to come from medical documentation or claims data.").

[201] *See* A.E. Powell et al., *Using Routine Comparative Data to Assess the Quality of Health Care: Understanding and Avoiding Common Pitfalls*, 12 QUALITY & SAFETY IN HEALTH CARE 121, 124 (2003) ("Performance comparisons between healthcare providers need to take into account whether the measures being compared derive from similar patient groups, . . . so retrospective risk adjustment is required.").

[202] *See id.* at 124 (explaining that sophisticated risk adjustment requires detailed information about which patients have certain characteristics).

[203] *See* Ian Scott & Michael Ward, *Public Reporting of Hospital Outcomes Based on Administrative Data: Risks and Opportunities*, 184 MED. J. OF AUSTRALIA 571 (2006) (noting that data used for quality assessment is "often inaccurate, incomplete, or

Comparing providers' performance also can be hampered by differences in the way providers record patient data. Specifically, researchers have found that when providers are subject to quality assessment, they often engage in "upstaging," that is, changing how they record patient data so as to increase their patients' risk profile.[204] To the extent ACOs engage in upstaging, this would lead to variations in quality scores that would be incorrectly attributed to variations in the quality of care, rather than differences in the recording of patient data.[205]

These inherent limitations of performance measures mean that for many domains of care, regulators cannot monitor the quality of care provided by ACOs.[206] So while tying an ACO's payments to its performance on selected quality measures offers patients some protection against under-treatment, performance measures alone will not ensure that ACOs generate cost savings without stinting on care.[207]

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provide insufficient clinical detail, with accuracy of diagnosis coding variable); Powell, *supra* note 201, at 124 (the detailed information needed to conduct risk adjustment "is rarely routinely available" in part because "the data set is incomplete or inaccurate in certain aspects"); Welke et al., *Chance, Bias, and Confounding: Threats to Valid Measurement of Quality in the Context of Pediatric Cardiac Surgery*, PEDIATRIC CARDIAC SURGERY ANNUAL 81 (2010) (noting that often data used for quality assessment "lack the desired granularity").

[204] *See* Powell et al., *supra* note 201, at 124 (describing the problem of upstaging—the grading of patients over time shifting upwards, perhaps as providers give greater attention to the initial assessment of severity).

[205] As explained by one group of authors:

> As the definitions of severity drift upward [due to changes in how patient data is recorded], the highest risk patients in one category are moved up to the next highest category where they are lower risk relative to the other patients in the group, The highest risk patients from that group get moved up too, so each risk category loses some of its more severe cases and gains less severe cases. The outcomes (for example, mortality and morbidity) for each risk category considered separately thus appear to improve as the "pool" of severity within them is diluted.

Id. at 124.

[206] *See* Rachel Werner & Robert McNutt, *A New Strategy to Improve Quality: Rewarding Actions Rather Than Measures*, 301 JAMA 1375, 1375 (2009) ("[Q]uality may be feasibly measured for only a narrow and discrete portion of clinical care.").

[207] *See* ROBERT BERENSON & RACHEL BURTON, URBAN INST., ACCOUNTABLE CARE ORGANIZATIONS IN MEDICARE AND THE PRIVATE SECTOR: A STATUS UPDATE 8 (Nov. 3, 2011), http://www.urban.org/UploadedPDF/412438-Accountable-Care-Organizations-in-Medicare-and-the-Private-Sector.pdf ("It is unclear whether quality measures currently are up to the tasks assigned to them, that is, to ensure that cost savings will not be achieved by stinting on care."); Pelnar, *supra* note 132, at 6 (2011) (stating that ACO quality measures may not ensure quality care "because restricting

V. OVERSIGHT OF ACOS' RATIONING OF CARE

Although ACOs have the potential to produce cost savings without sacrificing the quality of care they provide patients, there clearly are limits to their potential to do so. In the long-term, ACOs cannot solve the problem of rising health care costs unless they make compromises in the quality of care they provide to patients, including withholding potentially beneficial care from some patients. In other words, we should recognize that ACOs must balance cost and quality considerations. Of fundamental importance, then, is how to best ensure that ACOs balance cost and quality concerns in a manner that is both reasonable and equitable. This Part concludes by briefly highlighting some issues health analysts and policymakers should consider in determining what regulatory oversight may be necessary to ensure that ACOs ration health care fairly.

While in some cases limiting care on cost-benefit grounds may be justified, as discussed in Part III.D, the financial incentives under the ACO model could lead some providers to go too far, delaying or denying their patients appropriate care. To guard against this risk of under-treatment, some may advocate for aggressive regulatory oversight of ACOs' clinical decisions. Before imposing potentially burdensome regulatory constraints on ACOs, however, we should assess whether the risk of under-treatment is significant enough to warrant a far-reaching regulatory response. Specifically, we should examine whether certain factors temper the impact of ACOs' financial incentives to stint on care, particularly at the level of the individual physician. If so, a more moderate regulatory response to the risk of under-treatment of ACO patients may be called for.

Although the financial incentives under the ACO model give ACOs an incentive to stint on patient care, various considerations may counteract such financial considerations. Foremost among these factors is an ethics and culture among the medical profession which emphasizes fidelity to patients. For example, the AMA ethical guidelines echo long-standing ethical principles requiring physicians to show fealty to their patients' best interest over cost considerations, stating that "[w]hile physicians should be conscious of costs . . . ,

or delaying care may generate cost savings without triggering a decline on reported quality measures"); Ubl, *supra* note 167 ("[W]hile meeting quality measures may be a necessary condition for quality care, it is certainly not a sufficient condition."). For a more optimistic view of the potential for quality measures to guard against under-treatment of ACO patients, *see* Zabawa et al., *Adopting Accountable Care Through the Medicare Framework*, 42 SETON HALL L. REV. 1471 (2012).

concern for the quality of care the patient receives should be the physician's first consideration."[208] These professional medical ethics are inculcated in physicians during their medical education and training. As explained by Ezekiel Emanuel and Victor Fuchs:

> Medical school education and postgraduate training emphasizes thoroughness. When evaluating a patient, students, interns, and residents are trained to identify and praised for and graded on enumerating all possible diagnoses and tests that would confirm or exclude them. The thought is that the more thorough the evaluation, the more intelligent the student or house officer. Trainees who ignore the improbable "zebra" diagnoses are not deemed insightful. In medical training, meticulousness, not effectiveness, is rewarded.[209]

The physician culture further reinforces this training, with those physicians that are thorough and aggressive—who "do everything for the patient"—held in high regard, while more prudent physicians risk being deemed incompetent.[210] In addition, the American medical culture values physicians being on the cutting edge of their field, thereby encouraging use of the newest technologies and techniques.[211] So although financial incentives will incentivize physicians to consider the cost of care provided to patients, professional values may deter physicians from stinting on medically appropriate care.

Additional factors may further counteract ACOs' financial incentives to undertreat their patients. First, the fear of malpractice lawsuits may deter an ACO's participating providers from denying their patients costly care that on balance is appropriate given its potential benefits.[212] Competition among providers for patients provides a second, albeit modest, counter-pressure against under-treatment. ACOs may fear that should they develop a reputation for

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[208] AMA Code of Medical Ethics, Opinion 2.09 (2011), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion209.page?.

[209] *See* Emanuel & Fuchs, *supra* note 60, at 2789–90.

[210] *See id.*; *see also* Mashaw & Marmar, *supra* note 51, at 458 (stating that the American medical culture promotes aggressive intervention).

[211] *See* Mashaw & Marmar, *supra* note 51, at 476–77 ("Our medical culture inculcates the value of being at the cutting edge of one's field, and that often entails the use of the newest and often the most expensive techniques.").

[212] *See* Mehlman, *supra* note 14, at 858 ("The fear of malpractice is probably the most effective pressure on providers to refrain from denying nonwasteful technology to patients.").

providing low quality care, they may face declining demand for their services as patients seek alternative providers.[213] Finally, informed consent rules reinforce the malpractice and competitive considerations that may deter ACO providers from stinting on care, particularly in those jurisdictions that require providers to inform patients of all available treatment options. In a culture where patients expect to receive all potentially beneficial care, patients informed of alternative but costly treatment options denied them by their ACO understandably would be outraged.[214] Fearing that these patients may file a malpractice claim or switch providers, ACO providers who under informed consent laws must disclose to patients alternative treatment options may hesitate to deny or delay such care.[215] In sum, together these considerations may prove a powerful force in deterring ACO providers from delaying or denying their patients medically appropriate care.

Despite these considerations, financial incentives likely will lead at least some ACO providers to provide subpar care. Although tying an ACO's payments to its performance on various quality standards affords patients some protection against under-treatment, additional safeguards may be necessary given the inherent limitations of performance measures, as discussed in Part III.D. For example, some have advocated requiring an external appeals process that would allow ACO patients to obtain independent medical review of their physicians' medical decisions (including a decision to deny or delay certain treatments).[216] In addition, government regulators and

[213] Although the difficulties faced by patients in evaluating the care they receive may limit their ability to make informed choices among providers, some providers nevertheless are motivated to provide high quality care in order to protect their reputations. *See* DEP'T OF JUSTICE & FED. TRADE COMM'N, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 17 (2004) (stating that although there exists informational and payment barriers to effective competition, competition can play an important role in enhancing quality of care); Anne Frølich et al., *A Behavioral Model of Clinician Responses to Incentives to Improve Quality*, 80 HEALTH POL'Y 179, 187 (2007) (discussing a study of Wisconsin hospitals finding that public reporting of quality performance made hospitals more likely to adopt quality improvement programs); David Hyman, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, n.364 (2005) (stating that one motive of providers for improving quality may be concern for their reputation).

[214] *See* Blustein & Marmor, *supra* note 135, at 1556 (stating that some patients would be outraged if denied potentially beneficial care).

[215] *See* Mehlman, *supra* note 14, at 860 ("One aspect of malpractice law that may exert a particularly powerful pressure on providers to furnish patients with nonwasteful technology is the principle of informed consent.").

[216] *See* Myrl Weinberg, National Health Council Comments on CMS-1345-P, at 3 (2001) (urging CMS to establish an appeals process for patients under the Medicare

independent monitors could review a random sample of ACO patient records to ensure that ACOs are not arbitrarily denying patients appropriate treatments.[217]

In addition to protecting patients against under-treatment at the level of the individual patient, regulators should ensure that ACOs, at the organizational level, have sufficient resources to meet their patients' needs. As discussed in Part III.D, an ACO seeking to limit its costs may fail to maintain sufficient resources at the organizational level to meet the full range of patients' needs. To guard against poor resource-allocation decisions at the organizational level, regulators should consider whether to establish standards addressing ACOs' capacity. For example, federal and state regulators could establish standards intended to ensure that ACOs have a sufficient number of specialists among its physicians. Where an ACO lacks the capacity to itself provide the full range of medical care, regulators should monitor whether such ACOs are denying or delaying referring patients to outside specialists and other providers who can meet the patients' needs.

Regulators also should consider whether to promulgate standards addressing ACO payment arrangements and assumption of financial risk. For example, perhaps there should be limits on the extent to which individual practitioners participating in ACOs face financial risk for the cost of their individual treatment decisions, with participating physicians instead rewarded based on their economic performance as a group. Indeed, in its proposed waivers for the Medicare Shared Savings Program, the Office of the Inspector General invited comments on the potential risk of underutilization raised from ACO physicians and other participants bearing risk for the cost of care they provide to ACO patients.[218] Similarly, for those ACOs accepting capitation from private payors, regulatory review of agreed-upon rates may be necessary to ensure that ACOs receive sufficient revenue to meet their patients' needs. Regulators also should consider whether to establish financial solvency and cash reserve requirements for ACOs assuming financial risk in order to guard against financially-strapped ACOs stinting on patient care.

Shared Savings Program).

[217] *See* Ubl, *supra* note 167 (proposing that "independent monitors oversee the ACOs to protect against arbitrary 'stinting'"). In its final rule for the Shared Savings program, CMS stated that it will audit ACOs in order to ensure that patients receive appropriate care. *See* 76 Fed. Reg. at 67967.

[218] *See* 76 FED REG. 19655, 19660 (April 7, 2011) (inviting comments on the risk of underutilization and stinting).

In addition to concerns regarding whether ACOs will appropriately balance cost and quality considerations, there is the additional concern that ACOs may not allocate care equitably among their patients, with some patients receiving higher quality care than others. Numerous studies have documented racial, ethnic, and gender disparities in health care. For example, a 2002 Institute of Medicine report found that racial and ethnic minorities often receive lower quality care relative to patients of European descent, disparities that cannot be explained by differences in insurance coverage, access to care, income, education, or patient preferences.[219] Other studies have found that physicians often ignore or delay treating women's symptoms.[220] These disparities may reflect conscious and unconscious stereotyping and selective empathy that influence providers' decisions. For example, in making decisions regarding the most appropriate course of treatment, physicians take into account the likelihood that patients will comply with therapeutic recommendations, patients' dietary practices, family and social support, living conditions, pain tolerance, and other factors.[221] To the extent that a patient's race, gender, or other characteristics bias a physician's evaluation of these factors, there will be disparities in the quality of care provided.[222] Financial incentives to reduce costs, such as those reflected in the ACO model, could further exacerbate these disparities.[223]

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[219] *See* COMM. ON UNDERSTANDING AND ELIMINATING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, INST. OF MED., UNEQUAL TREATMENT: WHAT HEALTHCARE PROVIDERS NEED TO KNOW ABOUT RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (2002).

[220] *See* Michelle Oberman & Margie Schaps, *Women's Health and Managed Care*, 65 TENN. L. REV. 555, 565 (1998) (discussing gender bias in physicians).

[221] *See* Maxwell Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. OF HEALTH POL'Y, L. & ETHICS 95, 101 (2001) (describing patient characteristics that influence physicians' treatment decisions).

[222] *See id.* at 104 (commenting that to the extent race-related preconceptions affect physicians' expectations and suppositions, racial disparities in clinical judgment ensue). *See also* Barbara Noah, *Racial Disparities in the Delivery of Health Care*, 35 SAN DIEGO L. REV. 135 (1998) ("Physicians' treatment decisions may reflect unstated prejudices—negative or pessimistic assumptions about their African American patients' family support networks, dietary practices, or adherence to recommended post-treatment care-regimens.").

[223] *Cf.* Sidney Watson, *Race, Ethnicity and Quality of Care: Inequalities and Incentives*, 27 AM. J.L. & MED. 203, 223 (stating that capitation creates special risks for minority patients). With their emphasis on evidence-based rules for clinical decisions, to some extent ACOs may be able to counteract the bias that leads to deviations from appropriate care. *See* Bloche, *supra* note 221, at 118 ("Incentives to adhere to evidence-based protocols . . . [would] penalize race-related deviations."). However, gaps in the clinical science and variation among patients limits the extent to which

Should there be evidence of differential treatment among ACO patients, regulatory action to address such inequalities may be warranted. For example, the set of quality measures used to evaluate ACOs' performance could include measures that evaluate the care ACOs provide to vulnerable patient populations.[224] In addition, regulators could require ACOs to monitor and address disparities in the provision of care to patients, and educate their professionals on how gender, race, cultural and other factors may influence their clinical judgment.

VI. CONCLUSION

Although ACOs clearly have opportunities to achieve savings without adversely impacting patient care, this Article argues that those opportunities may be far fewer than policymakers hope. In the long-term, ACOs cannot successfully dampen health care inflation unless we allow them to make some compromises in the quality of care they provide. Moreover, even if ACOs potentially could sufficiently rein in costs while improving the quality of care, in practice ACOs have clear financial incentives to stint on the care they provide patients. Policymakers and scholars therefore should not assume that ACOs will achieve savings without compromising the quality of care they provide to patients. Instead, they should recognize that some ACO patients will receive lower quality care as ACOs seek to balance cost and quality considerations. Of fundamental importance, then, is how to best ensure that ACOs balance cost and quality concerns in a manner that is both reasonable and equitable, issues that merit careful deliberation and robust debate. This Article seeks to prompt discussion of these concerns as

evidence-based rules can guide medical decision making, leaving many medical decisions matters of professional discretion. *See* sources cited *supra* note 135 and accompanying text. *See also* Bloche, *supra* note 221, at 101 (noting that the potential for detailed decision rules to restraint clinical discretion is limited by empirical uncertainty about medical interventions). Moreover, even if ACOs could develop comprehensive evidence-based rules, the subjectivity and incompleteness in observing and interpreting patients' clinical signs and symptoms allows for bias to effect the application of such rules. *See* Bloche, *supra* note 221, at 101–02 ("The scope of practitioners' discretion is further widened by the subjectivity and inevitable incompleteness of clinical observation and interpretation. . . . [such that] [e]ven if we could craft a comprehensive set of evidence-based rules for clinical decision making, this subjectivity and incompleteness would make application of the rules a matter of considerable discretion for . . . the treating physician.").

[224] *Cf.* Watson, *supra* note 223, at 223–24 (proposing that managed care organizations receive a bonus for reducing racial disparities in medical care, as measured by performance criteria).

our health care delivery system continues to move toward the ACO model.