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Adopting Accountable Care Through the Medicare Framework

Barbara J. Zabawa, Louise G. Trubek & Felice F. Borisy-Rudin[*]

I. INTRODUCTION

By enacting the Patient Protection and Affordable Care Act of 2010 (ACA),[1] Congress provoked change in the status quo in American health care delivery and payment. Although challenged by conservative voices resistant to change, the ACA survived its recent constitutional challenge.[2] Regardless of how Congress tries to amend the ACA in the future, one vestige of the ACA likely to remain at least in the marketplace, if not in the law, is the concept of accountable care.[3] The ACA created two programs, the Medicare Shared Savings Program (MSSP)[4] and the Pioneer Accountable Care Organization Model ("Pioneer"),[5] which work in parallel to bring the concept of Accountable Care Organizations (ACOs)[6] to the Medicare program. At its core, the accountable care model matches payment for care

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[1] Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010).

[2] Nat'l. Fed'n Indep. Bus. v. Sebelius, 132 S. Ct. 603, 565 U.S. _____, (June 28, 2012) (upholding the ACA's individual mandate as constitutional within Congress's taxing powers).

[3] *See, e.g.*, Abby Goodnough, *New Medical Care Networks Show Savings,* NY TIMES, Sept. 11, 2012, http://www.nytimes.com/2012/09/12/health/policy/medical-care-networks-show-savings-study-finds.html.

[4] 42 U.S.C. § 1395jjj (2010).

[5] Notice, Medicare Program: Pioneer Accountable Care Organization Model: Request for Applications, 76 Fed. Reg. 29249, 29250 (May 20, 2011).

[6] 42 U.S.C. § 1395jjj(a)(1)(A).

with performance-based measures.[7] This is a bold move away from current volume-based payment models.[8]

This paper makes the case that the MSSP serves as a suitable launch pad for the accountable care movement. In Part II, the Article explores the emergence of accountable care in two states with very different health care markets—Wisconsin and New Jersey.[9] Contrasting the health care markets of Wisconsin and New Jersey offers insight into the flexibility of the criteria offered by the MSSP, which will permit all states to adopt ACO models, regardless of their political or commercial environments.

In Part III, the Article highlights some skepticism surrounding ACOs, particularly the fear of a second "managed care backlash" and the concern about abusive market practices. In particular, some critics are concerned that under accountable care, providers will ultimately be forced to compromise quality of care to achieve cost savings, which may create a consumer backlash similar to the demise of managed care in the 1990s.[10] Others express fear that ACOs will push provider consolidation, leading to higher health care costs because of more concentrated market power.[11]

Part IV demonstrates how the MSSP addresses the concerns expressed by skeptics through patient-centered criteria, a legal roadmap to reduce market abuses, and a multi-tiered governance structure. The section explores how the creators of the MSSP learned from the managed care and consumerism movements to improve the chances that ACOs will be sustainable and successful.[12] The patient-centered criteria are critical starting points for ACO success. It is helpful to view the MSSP patient-centered criteria through the lens of Albert O. Hirschman's "exit, voice, and loyalty."[13] The authors propose that ACOs will not realize the full financial

[7] AM. HOSP. ASS'N, ACCOUNTABLE CARE ORGANIZATIONS: AHA RESEARCH SYNTHESIS REPORT 3 (2010), *available at* http://www.aha.org/research/cor/content/aco_cp.pdf [hereinafter AHA RESEARCH SYNTHESIS REPORT].

[8] 76 Fed. Reg. 67802, 67803 (Nov. 2, 2011) (noting that value-based purchasing is a concept that links payment directly to the quality of care provided).

[9] These states were selected based on their variation in the organization of health care delivery.

[10] *See* Blendon, *infra* Part III and note 99.

[11] *See* Rosch, *infra* Part III and note 101.

[12] *See infra* Part IV.A.1–4.

[13] Albert O. Hirschman, *Excerpt from Chapter Eight of* EXIT, VOICE AND LOYALTY: RESPONSES TO DECLINE IN FIRMS, ORGANIZATIONS AND STATES (1970), *in* 24 SOC. CONT. 272, 272 (1994) (discussing two polar options by which a person may respond to unsatisfactory circumstances: leave the situation or speak up for change).

benefit of investing in a value-based model without meaningful patient engagement. The MSSP patient-centered criteria can help these organizations achieve necessary patient engagement and accomplish the triple aim of better health, better care, and reduced costs.[14]

The MSSP legal roadmap includes safety zones to address antitrust and other market abuses. This Article suggests that ACOs, regardless of their participation in the MSSP, should align as closely to the MSSP criteria as possible to avoid legal scrutiny. The MSSP multi-tier system of governance can diffuse the ACO concept throughout the nation. By using a national framework with vertical and horizontal dimensions, the MSSP can allow for variation in local ACOs while providing a mechanism for learning across ACOs regionally and nationally, which is currently occurring in Wisconsin and New Jersey. Part V of this Article revisits Wisconsin and New Jersey, as well as the private market, to understand how the MSSP is impacting collaborative efforts in those markets.

Part VI identifies challenges and gaps in the MSSP that leaders in government and the market need to address to ensure that ACOs continue to thrive and achieve the goals of better health, better care, and lower costs.[15] As noted by Ezekiel Emanuel, there is an inevitable trade-off between rising health care costs and other public goods, such as access to college and good wages for working Americans.[16] Implemented cohesively and comprehensively, the MSSP has the potential to free up the significant resources currently spent on health care so that Americans can benefit from other public goods while not sacrificing their health.

II. THE CASE FOR ACCOUNTABLE CARE

A. *Accountable Care Pays for Value*

No one on either side of the political aisle contends that the United States health care system is optimally cost efficient. Health care spending in the United States amounted to $2.6 trillion in 2010, or 17.9 percent of the entire Gross Domestic Product (GDP), and is

[14] *See infra* Part II.A and note 24.

[15] *See infra* Part VI and note 264.

[16] Ezekiel J. Emanuel, *What We Give Up for Health Care*, N.Y. TIMES (Jan. 21, 2012, 5:41 PM), http://opinionator.blogs.nytimes.com/2012/01/21/what-we-give-up-for-health-care/ (arguing that controlling health care costs is a necessary trade-off in order to maintain other public goods, such as education and national strength).

anticipated to rise to about $4.6 trillion, or 19.8 percent of the GDP by 2020.[17] Researchers have shown that the United States health system lacks quality, particularly in contrast to other industrialized countries.[18] According to one source, one major cause of these problems is that current payment systems encourage volume-driven care, rather than value-driven care.[19] That is, providers "gain increased revenues and profits by delivering more services to more people, fueling inflation in health care costs without any corresponding improvement in outcomes."[20] The volume-based system also unfortunately penalizes providers financially for accomplishing the laudable goals of keeping people healthy, reducing errors and complications, and avoiding unnecessary care.[21] As a result of these persistent problems, there is general agreement that the cost of health care has risen to untenable levels and is threatening the future of Medicare and the economic well-being of the United States.[22]

One solution to the high cost, low quality dilemma is accountable care provided by ACOs.[23] As noted by Thomas Greaney, "ACOs offer a much-needed vehicle for integrating health care delivery and reducing the well-documented shortcomings of the system that are attributable to payment and organizational features

[17] HENRY J. KAISER FAMILY FOUND., HEALTHCARE COSTS: A PRIMER (May 2012), *available at* http://www.kff.org/insurance/upload/7670-03.pdf; CTR. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURES 2010 HIGHLIGHTS (last visited Oct. 6, 2012), *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf; CTR. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURE PROJECTIONS 2010 – 2020 (last visited Oct. 6, 2012), *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2010.pdf; *see also* David Blumenthal, *Performance Improvement in Health Care—Seizing the Moment*, 366 N. ENGL. J. MED. 1953, 1954 (2012) (projecting health care spending to be 20.1% of GDP in 2021 and setting a goal for the federal government to "reduce national health care expenditures by $893 billion over 10 years" in order to hold health care spending to less than 19% of GDP).

[18] *See* T.R. REID, THE HEALING OF AMERICA: A GLOBAL QUEST FOR BETTER, CHEAPER, AND FAIRER HEALTH CARE 31 (2009); Harold D. Miller, *From Volume to Value: Better Ways to Pay for Health Care*, 28 HEALTH AFF. 1418 (2009).

[19] Miller, *supra* note 18, at 1418.

[20] *Id.*

[21] *Id.*

[22] Alex D. Federman et al., *Physicians' Opinions About Reforming Reimbursement: Results of a National Survey*, 170 ARCHIVE INTERNAL MED. 1735, 1735 (2010), *available at* http://acpinternist.acponline.org/sir/docs/rm/journal/federman_phys.pdf.

[23] 42 U.S.C. § 1395jjj(a)(1)(A).

that reward high volume rather than low cost or high quality."[24]

There is no precise definition of accountable care, but health industry leaders have attributed the concept to Dr. Elliott Fisher.[25] In a 2006 *Health Affairs* article, Dr. Fisher described the development of partnerships between hospitals and physicians to coordinate and deliver efficient care.[26] According to the American Hospital Association, the ACO concept seeks to remove existing barriers to improve the value of care.[27] The most significant barrier that the ACO concept seeks to remove is a payment system that rewards the volume and intensity of provided services instead of quality and cost performance.[28] A related, yet independently substantial, barrier that the ACO system seeks to remove is the widely held assumption that more medical care is equivalent to higher quality care.[29] Others have defined accountable care organizations as "affiliations of health care providers that are held jointly accountable for achieving improvements in the quality of care and reductions in spending."[30]

The ACA aimed to establish the MSSP by January 1, 2012, in order to "promote[] accountability for a patient population, coordinate[] items and services under [Medicare] Parts A and B, and encourage[] investment in infrastructure and redesigned care processes for high quality and efficient service delivery."[31] The MSSP final regulations, issued on November 2, 2011, define "accountable care organization (ACO)" as a legal entity that is (1) recognized and authorized under applicable State, Federal, or tribal law, (2) identified by a Taxpayer Identification Number (TIN), and (3) formed by one or more ACO participants that are defined in § 425.102(a) and may also include any other ACO participants

[24] Thomas L. Greaney, *Accountable Care Organizations—The Fork in the Road*, 364 N. ENGL. J. MED. e1 (Jan. 6, 2011), *available at* http://www.nejm.org/doi/full/10.1056/NEJMp1013404; *see also* Federman et al., *supra* note 22, at 1735 (noting that accountable care is gaining considerable attention as a mechanism to "'bend the cost curve' of health care expenditures while maintaining or improving health care quality").

[25] AHA RESEARCH SYNTHESIS REPORT, *supra* note 7.

[26] *Id.* (citing Elliott Fisher et al., *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, 26 HEALTH AFF. w44 (2006)).

[27] AHA RESEARCH SYNTHESIS REPORT, *supra* note 7 (citing Elliott Fisher et al., *Fostering Accountable Health Care: Moving Forward in Medicare*, 28 HEALTH AFF. w219 (2009), *available at* http://content.healthaffairs.org/cgi/reprint/28/2/w219).

[28] *Id.*

[29] *Id.*

[30] Greaney, *supra* note 24.

[31] 42 U.S.C. § 1395jjj(a)(1).

described in § 425.102(b).[32] Upon meeting certain requirements, groups of service providers and suppliers that have established a mechanism for shared governance are eligible to participate as ACOs.[33] Participation in the MSSP is voluntary.[34] The MSSP allows groups of providers and suppliers to work together to manage and coordinate care for Medicare fee-for-service beneficiaries.[35] Once formed, the ACO becomes "accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO."[36]

In conjunction with the MSSP, the U.S. Department of Health and Human Services launched the Pioneer ACO model, which parallels the MSSP program in many ways, but was constructed from the outset to be a limited term experiment "to test the effectiveness of a particular model of payment."[37] Like the MSSP, Pioneer aimed to meet "the three-part aim of better health, better health care, and lower per-capita costs for Medicare, Medicaid and Children's Health Insurance Program beneficiaries."[38] However, in contrast to the

[32] 42 C.F.R. § 425.20. 42 CFR § 425.102(a) includes ACO professionals in group practice arrangements; networks of individual practices of ACO professionals; partnerships or joint venture arrangements between hospitals and ACO professionals; hospitals employing ACO professionals; Critical Access Hospitals that bill under Method II (as described in 42 CFR § 413.70(b)(3)); Rural Health Centers; and Federally Qualified Health Centers. *Id.* 42 CFR § 425.102(b) states that other "ACO participants that are not identified in paragraph (a) of this section are eligible to participate through an ACO formed by one or more of the ACO participants identified in paragraph (a) of this section." 42 C.F.R. § 425.102(b). Note that an "ACO professional" is defined as "an ACO provider/supplier who is either" a physician (doctor of medicine or doctor of osteopathy), a physician's assistant, a nurse practitioner, or a clinical nurse specialist. 42 C.F.R. § 425.20. Also, the definition of hospital limits "hospital," for the purposes of the MSSP, to those hospitals "subject to the prospective payment system specified in § 412.1(a)(1)." Social Security Act §§ 1899(b)(1)(A)–(E); 42 C.F.R. § 425.102(a)–(b).

[33] 42 U.S.C. § 1395jjj(b)(1).

[34] *See* 42 C.F.R. § 425.100 (which uses the permissive word "may" in regard to participation of ACO providers in the Shared Savings Program). *See also* 42 C.F.R. §§ 425.200, 425.202 (outlining terms of the participation agreement, and outlining application procedures).

[35] *See* 42 C.F.R. §§ 425.100, 425.200, 425.202.

[36] *See id.*

[37] CTRS. FOR MEDICARE & MEDICAID SERVS., PIONEER ACCOUNTABLE CARE ORGANIZATION MODEL: GENERAL FACT SHEET (Dec. 19, 2011), *available at* http://www.cap.org/apps/docs/statline/pdf/pioneer_aco_fact_sheet.pdf [hereinafter PIONEER GENERAL FACT SHEET]. Pioneer comes out of the Center for Medicare and Medicaid Innovation, which received its mandate through the ACA amendment to section 1115 of the Social Security Act and was created as of January 1, 2011. *See* 42 U.S.C. § 1315a (amended by ACA § 3021 (2010)).

[38] Notice, Medicare Program: Pioneer Accountable Care Organization Model:

MSSP, the Pioneer ACO was designed to rapidly move large health care organizations to population-based payment arrangements.[39] Pioneer's main purpose is "to support vanguard organizations" in ongoing processes of transformation already entered into by the organizations.[40] Most significantly, Pioneer ACOs were required to commit "to entering outcomes-based contracts with other purchasers (private health plans, state Medicaid agencies, and/or self-insured employers) such that the majority of the ACO's total revenues (including from Medicare) [would] be derived from such arrangements, by the end of the second performance period in December 2013."[41] In creating the Pioneer ACO model, the Center for Innovation chose to focus on large health care organizations, with at least "15,000 aligned beneficiaries" for the non-rural ACOs and greater than 5,000 beneficiaries for the rural ACOs.[42] Consequently, the Pioneer ACOs were expected to already have the necessary legal structure to permit receipt and distribution of incentive payments from the Centers for Medicare and Medicaid Services (CMS).[43]

ACOs can take a variety of organizational forms, such as integrated delivery systems, primary care or multispecialty medical groups, hospital-based systems, and contractual or virtual networks of

Request for Applications, 76 Fed.Reg. 29249, 29250 (May 20, 2011).

[39] PIONEER GENERAL FACT SHEET, *supra* note 37.

[40] *Pioneer Accountable Care Organization (ACO) Model Request for Application*, CTRS. FOR MEDICARE AND MEDICAID INNOVATION I.B (released May 17, 2011), *available at* http://innovations.cms.gov/Files/x/Pioneer-ACO-Model-Request-For-Applications-document.pdf [hereinafter *Pioneer Request*]; *see also Pioneer ACO Model*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://innovations.cms.gov/initiatives/ACO/Pioneer/index.html (last visited Oct. 5, 2012).

[41] *Pioneer Request*, *supra* note 40 at II.I.

[42] *Id.* at I.E.

[43] *See id.* at II.C. The ACA also set up the Independence at Home Medical Practice Demonstration Program that uses "home-based primary care teams." *See* 42 U.S.C. § 1395cc-5, *amended by* ACA § 3024 (2010). Section 3502 of the ACA provides for the Secretary of Health and Human Services "to provide grants to or enter into contracts with eligible entities to establish community based interdisciplinary, interprofessional [health] teams . . . to support primary care practices" and to "integrate clinical and community preventive and health promotion services for patients." 42 U.S.C.A. § 256a-1 (West 2010). The grants may be used to help develop the interdisciplinary teams and/or to provide capitated payments. *Id.* The ACA also provides for a state option under Medicaid to provide "health homes" to individuals with chronic conditions, whereby the "health home" will provide "coordination with a team of health care professionals." 42 U.S.C. 1396w-4, *amended by* ACA § 2703 (2010) (provides a "State option to provide coordinated care through a health home for individuals with chronic conditions," whereby the "health home" will provide medical assistance care through Medicaid).

physicians, such as independent practice associations.[44] However, all ACOs, share a common goal to reduce costs while improving quality in health care through better coordination and collaboration.[45] ACOs reward physicians for collaborating to increase prevention and the quality of care, "while discouraging overtreatment, undertreatment, and sheer profiteering."[46] "Reducing the fragmented provision of care through improvements in care coordination and continuity of care may be necessary" before value-based payment strategies can "successfully contribute to improved health care and cost savings."[47]

B. The Emergence of an Accountable Care Movement

The accountable care movement has emerged at the local level over a period of time, albeit through varying mechanisms and at different paces. One sees two distinct examples of accountable care emergence in Wisconsin and New Jersey.

1. The Wisconsin Story

The Wisconsin health care market has a rich culture of collaboration, which creates an environment ripe for accountable care.[48] Integrated delivery systems are prominent in Wisconsin.[49] These integrated systems, by definition, collaborate with other types of health care stakeholders, such as payers, physicians, and acute care institutions like hospitals.[50] The authors interviewed several Wisconsin providers for this Article, and all were part of an integrated system: UW Health,[51] Marshfield Clinic,[52] Dean Health System,[53] and

[44] *See* 42 U.S.C. § 1395jjj(b); *see also* Greaney, *supra* note 24.

[45] *See* Greaney, *supra* note 24.

[46] Atul Gawande, *The Cost Conundrum: What a Texas Town can Teach us About Health Care*, NEW YORKER, June 1, 2009, at 1, 12, *available at* http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande?currentPage=all.

[47] Federman et al., *supra* note 22, at 1740.

[48] Legislative Symposium, *ACO Innovators: Health System Transformation in Wisconsin*, Evidence-Based Health Policy Project (Feb. 22, 2012), *available at* http://uwphi.pophealth.wisc.edu/programs/health-policy/ebhpp/events/index.htm [hereinafter ACO Innovators Symposium].

[49] *See* John S. Toussaint et al., *Connecting Statewide Health Information Technology Strategy to Payment Reform*, 17 AM. J. MANAG.CARE e80, e86 (2011), *available at* http://www.wchq.org/news/documents/3-18-11_AJMC_Article.pdf; Joe Vanden Plas et al., *Health Care Roundtable*, IN BUS.: MADISON, Feb. 2012, at 44, 47–48.

[50] ACO Innovators Symposium, *supra* note 48.

[51] Interview with Jonathan Jaffery, Medical Director, UW Health Delivery System Innovation, University of Wisconsin School of Medicine and Public Health, in

the Monroe Clinic.[54] In addition, the authors attended a presentation given by a panel of Wisconsin health system leaders that included two additional systems not interviewed: Bellin-ThedaCare Healthcare Partners (Bellin) and Gundersen Lutheran Health System (Gundersen Lutheran).[55] Both of these organizations shared the same integrated system characteristic as the interviewed systems.[56]

Each system has strong affiliations or partnerships with at least one hospital; each has its own employed physician groups, which includes both primary care and specialists; and all but two have their own health plans as part of their systems.[57] In addition, none of the systems were novices with electronic medical records (EMRs); each system has an EMR that it has been using for many years.[58] An EMR is a key ingredient in a successful value-based system of care.[59]

Representatives of many of the Wisconsin systems professed that they are already providing "accountable care." For example, Dr. Jeff

Madison, Wis. (Sept. 19, 2011) (on file with author) [hereinafter Jaffery Interview].

[52] Interview with Paul Van Den Heuvel, Associate General Counsel, Marshfield Clinic, in Madison, Wis. (Sept. 26, 2011) (on file with author) [hereinafter Van Den Heuvel Interview].

[53] Interview with Craig Samitt, President and Chief Exec. Officer, Dean Health System, in Madison, Wis. (Oct. 20, 2011) (on file with author) [hereinafter Samitt Interview].

[54] Interview with Mike Sanders, Chief Exec. Officer, Monroe Clinic, in Monroe, Wis. (Dec. 21, 2011) (on file with author) [hereinafter Sanders Interview].

[55] ACO Innovators Symposium, *supra* note 48.

[56] *Id.*

[57] UW Health's insurance arm is Unity Health Insurance, Dean Health System's insurance arm is Dean Health Plan, Marshfield Clinic's insurance arm is Security Health Plan, and Gundersen's plan is Gundersen Lutheran Health Plan. ACO Innovators Symposium, *supra* note 48.

[58] UW Health, Dean, Bellin, and Monroe Clinic all use Epic, which is based in Madison, Wisconsin, while Marshfield Clinic and Gundersen built their own electronic medical record systems which have been in place for twenty years. Jaffery Interview, *supra* note 51; Van Den Heuvel Interview, *supra* note 52; Samitt Interview, *supra* note 53; Sanders Interview, *supra* note 54; George Kerwin, Chief Exec. Officer, Bellin, Presentation at ACO Innovators Symposium (Feb. 22, 2012) [hereinafter Kerwin Presentation]; Jeff Thompson, Chief Exec. Officer, Gundersen Lutheran, Presentation at ACO Innovators Symposium (Feb. 22, 2012) [hereinafter Thompson Presentation].

[59] *But see* Clifford Goodman, *Savings in Electronic Medical Record Systems? Do it for the Quality*, 24 HEALTH AFF. 1124, 1126 (2005) ("The capacity for transformation will arise when this system enables new forms of high-speed, broadly integrated data collection, analysis, and knowledge development and transfer in a value-based health care market."); James M. Walker, *Electronic Medical Records and Health Care Transformation*, 24 HEALTH AFF. 1118, 1120 (2005) (noting the need for "powerful financial incentives—such as pay-for-performance—that will reward organizations for using EMRs to improve the quality and efficiency of U.S. health care").

Thompson stated that Gundersen Lutheran already has various insured populations for which the system is accountable.[60] Gundersen Lutheran developed a care coordination program that assigned a social worker to manage the care of the top one percent of patients, measured by resource consumption.[61] This care coordination includes addressing social issues of the patient.[62] Unfortunately, this program is not compatible with the current payment system, causing Gundersen Lutheran to lose approximately $10 million in charges each year that the system could otherwise bill.[63] Dr. Craig Samitt similarly noted that Dean Health System already functions as an ACO through its integrated delivery system.[64] Dean's physicians, hospital, and health plan are "working collaborations" that "maximize quality and outcomes without overspending the patient's resources."[65] According to Dr. Samitt, "[a]ccountable care is a delivery system objective, not a payer contract."[66] Dr. Jonathan Jaffery pointed out that UW Health has a quality and safety infrastructure that has been in place for a long time and that Wisconsin has good reporting systems that function to hold providers accountable.[67] Mike Sanders explained that the Monroe Clinic participates in the Wisconsin Collaborative for Healthcare Quality (WCHQ) and views its participation as a method of measuring quality benchmarks on certain chronic diseases.[68]

Indeed, each of the Wisconsin systems highlighted in this Article are part of the Wisconsin Collaborative for Healthcare Quality, which "comprises twenty-seven organizations, representing most of Wisconsin's physicians."[69] The WCHQ came into being in 2002 through the efforts of one physician leader, Dr. John Toussaint, CEO of ThedaCare, who wanted to address the "crisis in healthcare quality and the growing drumbeat for reform."[70] Dr. Toussaint invited the leaders from Dean Health System, Gundersen Lutheran, Bellin Health, and Marshfield Clinic, as well as leaders from eight major

[60] Thompson Presentation, *supra* note 58.
[61] *Id.*
[62] *Id.*
[63] *Id.*
[64] Samitt Interview, *supra* note 53.
[65] *Id.*
[66] *Id.*
[67] Jaffery Interview, *supra* note 51.
[68] Sanders Interview, *supra* note 54.
[69] Toussaint, *supra* note 49, at e81.
[70] *Id.* at e80.

employers from Wisconsin, to "explore the possibility of using quality reporting to improve healthcare."[71] The WCHQ currently partners with business coalitions, consumer advocates, governmental agencies, foundations, and healthcare associations to gain a more balanced and complete understanding of what the current state of health care is and how it can be improved.[72] The WCHQ provides an opportunity for a broad spectrum of stakeholders, many of which compete with one another, to share best practices and gain valuable perspectives.[73] Through a collaborative effort, the WCHQ developed clinical performance data that consumers can use to compare certain quality measures across competing organizations.[74] Thus, the WCHQ not only demonstrates that collaboration may be a more powerful tool than competition, but also the advantage in giving consumers tools to have more "skin in the [health care] game."[75]

Chris Queram, the current CEO of the WCHQ, attributes the collaborative spirit among Wisconsin health care competitors to a systematic dismantling of the regulatory model that occurred approximately twenty years ago.[76] Wisconsin eliminated regulatory

[71] *Id.* at e80–e81.

[72] *Id.* at e81.

[73] *Id.* at e81.

[74] *Id.* at e81–e83. The WCHQ posts clinical performance data on a website. Toussaint *supra* note 49, at e81; *View Our Reports*, WISCONSIN COLLABORATIVE FOR HEALTHCARE QUALITY, http://www.wchq.org/reporting/ (last visited Oct. 5, 2012). Initial results from the performance compilation showed significant variations in costs and quality. Most surprising to the hospital administrators was an inverse relationship between costs and quality—"higher cost hospitals were less likely to meet benchmarks for quality." Merrill Goozner, *Quality, Economy, Transparency: A New Health Care Code*, FISCAL TIMES (May 10, 2010), http://www.thefiscaltimes.com/Issues/Health-Care/2010/05/10/How-A-Wisconsin-Program-Can-Save-Americas-Health-Care-System.aspx. Wisconsin hospitals responded to the data reporting by seeking to improve both quality performance and cost measures. *Id.* Collaborative efforts among competitors to publish pricing terms within the Wisconsin healthcare industry could, however, be viewed as collusion if it were to increase prices or decrease available health care options. *See id.* (citing Michael Cowie, former Federal Trade Commission official). The results noticed in Wisconsin are not unusual. Atul Gawande noticed a similar pattern in Texas. *See* Gawande, *supra* note 46.

[75] Jaffery Interview, *supra* note 51; Samitt Interview, *supra* note 53. "Skin in the game" is a phrase coined by Warren Buffet that refers to insiders investing within the same company that they manage. INVESTOPEDIA FINANCIAL DICTIONARY, http://www.answers.com/topic/skin-in-the-game (last visited Oct. 5, 2012). In the healthcare context, it refers to patients investing in their own health, through healthcare decision-making, healthy life style choices, and copayments. *Id.*

[76] Interview with Chris Queram, Chief Exec. Officer, Wisconsin Collaborative for Healthcare Quality, in Madison, Wis. (Feb. 20, 2012) (on file with author) [hereinafter Queram Interview].

structures such as the Certificate of Need and rate review of insurers.[77] In exchange for eliminating these forms of government regulation, the Wisconsin Hospital Association agreed to a requirement that hospitals submit discharge data to the Wisconsin Office of Healthcare Information so that the state and other stakeholders would have tools to review the health care market.[78] Almost ten years elapsed before this dataset was used for public reporting. Once begun, the public reporting created a dynamic change in the Wisconsin health care culture from what had been an attitude of "denial" by health care providers to one of providers wanting to "get out in front of the data" and "at least" meet the reporting "half-way."[79] Thus, although the government moved away from direct control of the health care market, the demand for transparency in the form of public information encouraged self-regulation and education between providers.[80]

Dr. Toussaint took the initiative to create the WCHQ because he recognized an unacceptable variability in physician quality data.[81] As Medical Director for Touchpoint Health Plan, Dr. Toussaint became familiar with HEDIS® data[82] and was concerned when he learned that the standard of care differed between people in Medicare, Medicaid, and the Touchpoint private plans.[83] According to Mr. Queram, Dr. Toussaint "wanted to build a performance model for all patients regardless of payer."[84] To do that, he needed other providers to participate so that there could be valuable benchmarks against which to measure each of the participants.[85] And, in order for this effort to have credibility in the market, he recognized that the business community needed to play an active role in its development. Trust and cooperation developed slowly. Mr. Queram explains that it took more than a year for the providers and the business partners to develop trust and to find "common ground" and "aspirations . . . to

[77] *Id.*
[78] *Id.*
[79] *Id.*
[80] *Id.*
[81] *Id.*
[82] HEDIS® is a healthcare performance measurement tool, provided by the National Committee for Quality Assurance (NCQA) that "consists of 76 measures across 5 domains of care" and "is used by more than 90% of America's health plans." *WHAT IS HEDIS?*, NCQA, http://www.ncqa.org/tabid/187/Default.aspx (last visited Oct. 5, 2012).
[83] Queram Interview, *supra* note 76.
[84] *Id.*
[85] *Id.*

build a measurement method that works."[86] As noted above, participation in the WCHQ has, for some providers, been the vehicle by which they measure and demonstrate the provision of accountable care in Wisconsin.[87]

2. The New Jersey Story

In contrast to the prevalence of integrated systems in Wisconsin, New Jersey's healthcare market consists mainly of small physician practices.[88] Ten years ago, in 2002, more than sixty percent of New Jersey physicians practiced solo or in small, private two- to five-person groups.[89] New Jersey has remarkably few private multi-specialist groups, and its smaller physician groups tend to be fragmented and non-collaborative.[90]

Yet despite fragmented physician groups, New Jersey has initiatives that are arguably precursors of ACOs. There are collaboratives to improve patient safety in the Intensive Care Unit and to decrease rapid response times.[91] Disease-based collaboratives are working together to decrease pressure ulcers and to improve perinatal care.[92] In 2009, under the auspices of the New Jersey Hospital Association (NJHA), CMS funded a three-year gain-sharing pilot project.[93] The New Jersey Care Integration Consortium provides quality monitoring for improved performance.[94] All members must

[86] *Id.*

[87] Toussaint, *supra* note 49, at e81.

[88] Seminar, NJ Off. Legis. Serv., Rutgers Ctr. for State Health Pol'y, *The New Jersey Physician Workforce: Findings from the NJ State Physician Census* (Oct. 27, 2004), *available at* www.cshp.rutgers.edu/PDF/CSHP_OLS/OLSNJPhysCensus.pdf; *see also* Kevin Post, *Shore Physicians Group Offers Multispecialty Care*, PRESS OF ATLANTIC CITY (March 13, 2012, 5:48 PM), http://www.pressofatlanticcity.com/communities/northfield_linwood_somers-point/shore-physicians-group-offers-multispecialty-care/article_2292e0a0-6d56-11e1-bcfd-0019bb2963f4.html.

[89] *Id.*

[90] Stephen Jones, President and Chief Exec. Officer, Robert Wood Johnson University Hospital System, *Academic Medical Centers and ACOs: Partners in Success or Rivals for Attention in the New Enviroment?*, Presentation at the University of Miami Global Business Forum: The Business of Health Care: Defining the Future (Jan. 12–14, 2011), *available at* http://www.bus.miami.edu/_assets/files/gbf-2011/Jones.pdf,.

[91] Internal Memorandum from Elizabeth A. Ryan, President and Chief Exec. Officer, N.J. Hosp. Assoc., to other N.J. Hosp. Assoc. Officers (Sept. 9, 2011) (on file with author).

[92] *Id.*

[93] *Id.*

[94] Sean Hopkins, Sr. Vice President, Health Economics, N.J. Hosp. Assoc., Address at the NJ HIMSS Spring Event "Health Care Reform School": The National Healthcare Reform Law—What it means to the New Jersey Healthcare Community

participate in the quality collaboratives.[95] All participating hospitals have a consumer on the board and there is an overall steering committee with a quality oversight group.[96] Hospital and physician incentives are aligned.[97] The elaborate incentive system is bonus only and is based on individual performance with no change in current payments from payers.[98]

III. ACO SKEPTICISM

Not everyone is enthusiastic about the move toward ACOs. It is not yet clear whether ACOs will deliver the promised higher-quality, lower-cost system promised. The source of ACO critics' skepticism derives from two complementary perspectives based on the history of efforts to coordinate care and reduce costs. First, critics point to the disappointing managed care experience in the 1990s,[99] and fear that if ACOs focus on keeping costs low without significantly improving access and quality, the ACO movement will be destined to the same fate as managed care.[100]

Second, critics fear that collaborative efforts can be abused, misused, and can create a euphemism for anticompetitive conduct.[101] For example, Commissioner J. Thomas Rosch of the Federal Trade Commission (FTC) believes that the net result of the Medicare Shared Savings Program may be higher costs and lower quality health care, precisely the opposite of the program's goal.[102] From an antitrust standpoint, greater collaboration creates greater potential

(May 26, 2010), PowerPoint presentation *available at* http://njhimss.org/index.php?option=com_content&view=article&id=116:njhimss-spring-eventqhealthcare-reform-schoolq&catid=65:past-events&Itemid=115.

[95] *Id.*

[96] *Id.*

[97] Sean Hopkins, Sr. Vice President Health Economics, Presentation at the N.J. Hosp. Assoc. N.J. Care Integration Consortium: Overview and Implementation (May 26, 2010).

[98] Letter from Elizabeth A. Ryan, President & CEO, N.J. Hosp. Assoc., to Chief Executive Officers, Chief Operating Officers, Chief Financial Officers, Government Relations Officers, N.J. Hosp. Assoc. (Sept. 9, 2011) (on file with author).

[99] Robert J. Blendon et al., *Understanding the Managed Care Backlash*, 17 HEALTH AFF. 80, 81 (1998), *available at* http://content.healthaffairs.org/content/17/4/80.full.pdf+html.

[100] Blendon et al., *supra* note 99, at 80.

[101] J. Thomas Rosch, Comm'r, Fed.Trade Comm'n., *Accountable Care Organizations: What Exactly Are We Getting?*, at 15, Speech at the Am. Bar Assoc. Section of Antitrust Law Fall Forum (Nov. 17, 2011), *available at* http://www.ftc.gov/speeches/rosch/111117fallforumspeech.pdf.

[102] *Id.*

for market manipulation, which could further drive up health care costs.[103]

Critics worry that ACOs are nothing but a revival of the managed care organizations (MCOs) that ultimately proved unpopular in the last part of the twentieth century.[104] In 1998, Robert Blendon wrote that a majority of Americans expressed concern that managed care might deny people the services they need when they are very sick.[105] Others wrote that managed care eroded the trust between health care organizations and consumers because of consumers' fear "of being exploited by health care organizations furthering their self-interest."[106] For example, Mark Schlesinger argued that a prepaid health plan that responds solely to financial incentives will allocate its resources in ways that minimize its expected medical costs, consistent with maintenance of a stable set of satisfied enrollees.[107] The following brief history of managed care and the consumerism movement provides perspective for understanding the ACO movement.

A. *History of Managed Care and Consumerism*

In the early 1980s, MCOs emerged out of concern with rising costs of health care.[108] Congress passed the Health Maintenance Organization (HMO) Act of 1973[109] in response to a call by former President Richard Nixon to address the rising cost of health care before it crippled the productivity of the United States.[110] The ideal model was a strong central managing organization that controlled access to care and restricted the work of health care professionals.[111]

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[103] *Id.*

[104] Final Rule, Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67802, 67805 (Nov. 2, 2011) [hereinafter MSSP Final Rule]; *see also* Blendon, *supra* note 99.

[105] Blendon, *supra* note 99, at 84.

[106] Mark Schlesinger et al., *A Broader Vision for Managed Care, Part 2: A Typology of Community Benefits*, 17 HEALTH AFF. 26, 34 (1998), *available at* http://content.healthaffairs.org/content/17/5/26.full.pdf+html.

[107] *Id.* at 33. For example, Schlesinger notes that "HMOs with these motives thus have little incentive to address problems of substance abuse aggressively—they do not bear the bulk of the costs and would prefer having enrollees with these problems become dissatisfied and switch to another plan." *Id.* This behavior exacerbates the burden of substance abuse for the community as a whole. *Id.*

[108] Edward Richards, *The Rise of MCOs, Public Health Law Map*, LSU LAW CTR., http://biotech.law.lsu.edu/map/TheRiseofMCOs.html (last visited Oct. 5, 2012).

[109] 42 U.S.C. § 300e-10 (1973).

[110] Richards, *supra* note 108.

[111] *See, e.g.*, Ronald Lagoe et al., *Current and Future Developments in Managed Care in*

This model required gatekeeping and capitation (a fixed sum for a package of services), and included substantial cost-saving incentives.[112] Physicians were the major losers: they felt demeaned and frustrated by the dual losses of autonomy and income.[113] Patients were fearful that the new system focused too much on controlling costs instead of delivering services.[114] For example, the media reported that MCOs paid physicians bonuses for limiting patients' health care use.[115] Physicians helped fuel this fear.[116]

The fear and criticism of managed care led to the introduction both in Congress and in state legislatures of more than a thousand bills dealing with consumer protection in managed care.[117] Many labeled these laws as the Patients' Bill of Rights and they were enacted in many states.[118] These documents aimed to create a more humane managed care system by influencing the internal structures of the MCOs and using data-driven evaluation systems.[119] The

the United States and Implications for Europe, 2005 HEALTH RES. POL'Y & SYSTEMS (March 17, 2005), *available at* http://www.health-policy-systems.com/content/3/1/4.

[112] *See* Christopher B. Forrest, *Primary Care Gatekeeping and Referrals: Effective Filter or Failed Experiment?*, 326 BMJ 692, 692–95 (Mar. 29, 2003), *available at* http://www.bmj.com/content/326/7391/692.1.pdf%2Bhtml.

[113] Hal Teitelbaum, Chief Exec. Officer, Crystal Run Healthcare, Presentation at Seton Hall Law Review Symposium: Implementing the Affordable Care Act: What Role for Accountable Care Organizations? (Oct. 28, 2011).

[114] Lagoe et al., *supra* note 111.

[115] Thomas H. Gallagher et al., *Patients' Attitudes Toward Cost Control Bonuses for Managed Care Physicians*, 20 HEALTH AFF. 186, 186 (2001).

[116] Mary Guptill Warren et al., *The Impact of Managed Care on Physicians*, 24 HEALTH CARE MANAGE REV. 44, 44 (1999), *available at* http://www.public.asu.edu/~atssk/ssk_hcmr99.pdf.

[117] Blendon, *supra* note 99, at 81; *see generally* Michael K. Paasche-Orlow et al., *National Survey of Patients' Bill of Rights Statutes*, 24 J. GEN. INTERN. MED. 489–94 (2009), *available at* http://www.springerlink.com/content/j4776732r66m8126/?MUD=MP.

[118] Paasche-Orlow, *supra* note 117; *Patient Rights*, MEDLINE PLUS, U.S. NAT'L LIBRARY OF MED. (Aug. 20, 2012), http://www.nlm.nih.gov/medlineplus/patientrights.html; *Patient's Bill of Rights*, AMERICAN CANCER SOCIETY, (Dec. 22, 2011). For examples of how the United States government views the ACA as a Patients' Bill of Rights, *see Patients' Bill of Rights*, HEALTHCARE.GOV (Feb. 6, 2012), http://www.heatlhcare.gov/law/features/rights /bill-of-rights/index.html; *Reducing Costs, Protecting Consumers: The Affordable Care Act on the One Year Anniversary of the Patient's Bill of Rights*, HEALTHCARE.GOV (Sept. 29, 2011), http://www.healthcare.gov/law/resources/reports/patients-bill-of-rights09232011a.html. Interestingly, the American Hospital Association first proposed a Patient's Bill of Rights in 1973. G. J. Annas, *A.H.A. Bill of Rights*, 9 TRIAL 59–61 (1973).

[119] D. M. Nadzen et al., *Data-driven Performance Improvement in Health Care: the Joint Commission's Indicator Measurement System (IMSystem)*, 19 JT. COMM. J. QUAL. IMPROV. 492–500 (1993), *available at* http://ukpmc.ac.uk/abstract/MED/8313012.

regulatory agencies retained oversight; but substantial governance was transferred to the MCOs and patients.[120] The Patients' Bill of Rights, supported by both physician and patient groups, softened a draconian system.[121] The American Medical Association strongly supported the legislation.[122] Government officials, MCOs, insurers, and large companies who paid for healthcare coverage and wanted to reduce the high cost of health care opposed the Patients' Bill of Rights.[123] The successful passage of the legislation taught the physicians about the power of the alliance of the patient groups and the physicians.[124]

The mixed history of managed care led to the rise of the consumerist approach. It is an alternative to managed care aimed at controlling costs and increasing choice in health care.[125] One definition of consumerism is "individual choice within a health care marketplace characterized by the exchange of money for health care goods or services."[126] According to this theory, the consumer relies on information from many different sources, analogous to the consumer shopping in the supermarket.[127] The consumerist approach tries to differentiate between the consumer and the supposedly passive patient of the past.[128] It views the consumer as different from the

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[120] Louise G. Trubek, *Public Interest Lawyers and New Governance: Advocating for Health Care*, 2002 WIS. L. REV. 575 (2002).

[121] *See, e.g.*, Marin McDonald, *Fighting Against the Evils of For-Profit Health Care: The Patients "Bill of Rights"*, J. POVERTY AND PREJUDICE: SOCIAL SECURITY AT THE CROSSROADS (1999), *available at* http://www.stanford.edu/class/e297c/poverty_prejudice/soc_sec/fighting.htm.

[122] The AMA issued its ethics opinion 10.01 in June 1992, advocating a Patient's Bill of Rights, based on its report, *Fundamental Elements of the Patient-Physician Relationship*, 262 J. AM. MED. ASS'N. (1992), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1001.page.

[123] *See* Trubek, *supra* note 120; *see also* Reid, *supra* note 18, at 37 (explaining that "the money paid to doctors, hospitals, and pharmacies for treatment of insured patients is referred to as 'medical loss'" by the "U.S. health insurance industry."). The for-profit health insurance industry seeks to "maintain a medical loss ratio of about 80 percent." Reid, *supra* note 18, at 37.

[124] *See* Kristin Madison, *Patients as "Regulators"? Patients' Evolving Influence over Health Care Delivery*, 31 J. LEGAL MED. 9, 31–32 (2010), *available at* http://tandfonline.com/doi/pdf/10.1080/01947641003598195; Trubek, *supra* note 120; *see also* Donald M. Berwick, ESCAPE FIRE: LESSONS FOR THE FUTURE OF HEALTH CARE 51–55 (2002).

[125] Madison, *supra* note 124.

[126] *Id.* at 15.

[127] *Id.*

[128] *Id.*

patient, in that the patient is needy and dependent; while the consumer engages in sorting out his or her own preferences by gathering his or her own information.[129] The consumer-patient gathers information from web-based sites such as WebMD® and health care report cards issued by private and public organizations, among other sources.[130] Consumer-directed health care plans are another component of the consumerist approach.[131] These plans feature high deductibles in exchange for lower premiums, requiring purchasers to act more like consumers.[132]

These consumerist approaches allow patients to assert themselves in relation to the physician and also into the health care market.[133] Once mechanisms like health care report cards and easy public reporting of outcomes emerged, reformist providers realized that engagement with patients was essential.[134] By the time the ACA was written, active engagement with patients seemed to be an important strategy for reformist physicians.[135]

Consumerism, however, has important limits. By turning the patient into a consumer and health care into a business, it creates the potential for a "buyer beware" world.[136] Additionally, it risks treating physicians as entrepreneurs rather than professionals bound by a

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[129] L. Rosenberg, *Are Healthcare Leaders Ready for the Real Revolution?*, 39 J. BEHAV. HEALTH. SERV. RES. 215–19 (2012). *But see* PHILIP BREDESEN, FRESH MEDICINE: HOW TO FIX REFORM AND BUILD A SUSTAINABLE HEALTH CARE SYSTEM 114–15 (2010).

[130] *See, e.g.*, WEBMD, http://www.webmd.com/ (last visited Oct. 5, 2012); CHECKPOINT, http://www.wicheckpoint.org/index.aspx (last visited Oct. 5, 2012); *Health Plan Report Card*, NCQA, http://reportcard.ncqa.org/plan/external/plansearch.aspx (last visited Oct. 5, 2012).

[131] Madison, *supra* note 124.

[132] *But see* Paul Krugman, *Patients are not Consumers*, N.Y. TIMES, Apr. 22, 2011, at A23, *available at* http://www.nytimes.com/2011/04/22/opinion/22krugman.html.

[133] Ronald E. Bachman, *Healthcare Consumerism: The Basis of a 21st Century Intelligent Health System*, CTR. FOR HEALTH TRANSFORMATION, 2–3 (2006), *available at* http://www.healthcarevisions.net/f/2006_Healthcare_Consumerism_CHT.pdf; *see also* WYE RIVER GROUP ON HEALTHCARE, AN EMPLOYER'S GUIDE TO HEALTHCARE CONSUMERISM, 7–13 (2006), *available at* http://www.wrgh.org/docs/hc_consumerism_guide.pdf.

[134] *See, e.g.*, Donald M. Berwick, *supra* note 124; Atul Gawande, *The Hot Spotters: Can We Lower Medical Costs by Giving the Neediest Patients Better Care?*, NEW YORKER, Jan. 24, 2011, at 40, *available at* http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande.

[135] Madison, *supra* note 124, at 31–32.

[136] *See, e.g.*, Ha T. Tu & Jessica H. May, *Self-Pay Markets In Health Care: Consumer Nirvana Or Caveat Emptor?*, 26 HEALTH AFF. w217–w226 (2007), *available at* http://content.healthaffairs.org/content/26/2/w217.full.

professional code of ethics.[137] Finally, and most importantly, it assumes that the patient has the ability to be an active consumer.[138] Although the time when patients are most likely to engage the health care system is when they are ill, frail, and weak,[139] a patient who is acutely ill may not be able to act as an active and intelligently involved consumer.[140] For example, a patient who is being transported by ambulance for emergency medical care rarely gets to choose the hospital.[141] Patients who are ill need support systems. The consumerism movement, like managed care, did not sufficiently account for the difficulty in creating an effective role for consumers/patients within a complex health care system.

The accountable care reformers are aware of the skepticism about patient involvement that remains from the previous efforts.[142] They learned from the managed care experience that patient support is essential for changing the delivery of medical care.[143] The public reaction to the MCO tools—gatekeepers, financial incentives, and utilization management—resulted in both market resistance and legislation that watered down the model.[144] Despite this watering down, many of the newly revised MCOs were successful, with many of the changes reducing costs and improving care.[145] The reformers

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[137] *See, e.g.*, Michael Anft, *Hospital, Heal Thyself*, 64 JOHNS HOPKINS MAG. 37, 38–39 (2012) (reviewing MARTY MAKARY, UNACCOUNTABLE: WHAT HOSPITALS WON'T TELL YOU AND HOW TRANSPARENCY CAN REVOLUTIONIZE HEALTH CARE (2012)). For a professional code for physicians, *see, e.g.*, *Code of Medical Ethics*, AM. MEDICAL ASS'N, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics (last visited Oct. 5, 2012). As part of its code, the A.M.A. states that "the relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare." *Opinion 10.015 - The Patient-Physician Relationship*, AM. MEDICAL ASS'N (Dec. 21, 2001), http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10015.page?

[138] Bachman, *supra* note 133; WYE RIVER GROUP ON HEALTHCARE, *supra* note 133.

[139] *See* BREDESEN, *supra* note 129.

[140] *See id.* at 15–16.

[141] Instead, the choice of hospital is considered a medical decision to be made by professionals in accordance with a regional emergency medical services protocol. *See, e.g.*, *Emergency Patient Destinations and Hospital Diversion*, N.Y. STATE DEP'T OF HEALTH, http://www.health.ny.gov/nysdoh/ems/policy/06-01.htm (last visited Oct. 6, 2012).

[142] THOMAS S. BODENHEIMER & KEVIN GRUMBACH, UNDERSTANDING HEALTH POLICY: A CLINICAL APPROACH 199 (5th ed. 2009).

[143] *Id.*

[144] *See generally*, Mark A. Hall, *The 'Death' of Managed Care: A Regulatory Autopsy*, 30 J. HEALTH POLITICS, POL'Y & L. 427 (2005).

[145] *Id.*

learned from consumerism that information could lead to positive changes in healthcare and that technology allows for more transparency of information.[146] The knowledge about system reform and the role of patients—learned from managed care and consumerism—contributed to the design of the MSSP.[147]

B. *Failed Promises of Higher Quality, Lower Costs*

In addition to fearing a repeat of the managed care debacle, other critics merely conclude that ACOs fall far short of presenting a panacea for health care.[148] Some, such as Commissioner Rosch, have expressed concern that "even under the most optimistic scenario," Medicare ACOs will only save the nation "less than one tenth of one percent of expected Medicare expenditures over the next decade."[149] Jessica Mantel contends that in the long term, ACOs may achieve the goal of reducing health care costs by making "compromises in the quality of care they provide to patients, including withholding potentially beneficial care from some patients."[150] Mantel concedes that in the short-term, ACOs have the capacity to reduce wasteful care and better manage care of chronically ill patients.[151] Nevertheless, Mantel argues that eliminating wasteful care will deny some patients beneficial care.[152] She takes the position that managing chronic conditions may not be as cost-effective as expected because of increased administrative costs and greater utilization of services

[146] For another review of the history of patient-centeredness, *see* MICHAEL L. MILLENSON & JULIANA MACRI, URBAN INST., WILL THE AFFORDABLE CARE ACT MOVE PATIENT-CENTEREDNESS TO CENTER STAGE? (2012), *available at* http://www.urban.org/UploadedPDF/412524-will-the-affordable-care-act.pdf.

[147] MSSP Final Rule, 76 Fed. Reg. 67802 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425).

[148] *See generally* Jessica L. Mantel, *Accountable Care Organizations: Can We Have Our Cake and Eat it Too?*, 42 SETON HALL L. REV. 1393 (2012); Rosch, *supra* note 101.

[149] Rosch, *supra* note 101, at 5 (citing CONG. BUDGET OFFICE, BUDGET OPTIONS VOL. I: HEALTH CARE 72–74 (Dec. 2008), *available at* http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf).

[150] Mantel, *supra* note 148.

[151] *Id.* Specifically, Mantel states that because of the financial incentives of "shared savings or higher margins under capitation," there will likely be a reduction in "duplicative tests, unsafe procedures and care lacking in scientific support or sufficient value." *Id.* at 1406. "The economic incentives of ACOs also will foster the adoption of protocols that reduce the risk of medical errors or complications." *Id.* at 1411. In addition, "[t]he financial incentives" of ACOs will "re-orient treatment of chronic conditions away from treating acute episodes of illness toward better prevention and patient management." *Id.* at 1413–14.

[152] *Id.* at 1418.

through care coordination programs.[153] Continuing advances in medical technology will require ACOs to find ways of lowering costs, which will be difficult for organizations that already have low operating costs without sacrificing quality.[154] Finally, Mantel expresses concern that "in practice, some ACOs may stint on the care they provide patients given their financial incentives to do so" (i.e., there will always be "bad apples").[155]

Others have shared some of Mantel's concerns that ACOs may not achieve the higher-quality, lower-cost goal in every case.[156] For example, Donald Berwick has stated that ACOs in high-cost areas have greater potential for achieving cost savings than ACOs in lower-cost areas.[157] Such dismal outlooks are especially discouraging for highly integrated health care organizations, like those that exist in Wisconsin. Such organizations view themselves as already operating leanly.[158]

Another shortcoming of the ACO movement is the fear that the movement will push provider consolidation, further escalating the costs of health care.[159] According to Greaney, "the ACO phenomenon may well encourage some mergers, joint ventures, and alliances that will exacerbate" the market concentration problem.[160] Economic evidence has shown that hospital consolidation in the 1990s raised overall inpatient prices by at least five percent, and by forty percent or more when merging hospitals were located close to one another.[161] Dominant providers can use their market power to seek higher reimbursements, as well as to deny employers and health plans the ability to obtain and use cost and quality data to enable them to shop more effectively.[162]

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[153] Mantel, *supra* note 148, at 1421–23.

[154] *Id.* at 1425–26.

[155] *Id.* at 1418.

[156] Anna Wilde Mathews, *Can Accountable-Care Organizations Improve Health Care While Reducing Costs?*, WALL ST. J., Jan. 23, 2012, http://online.wsj.com/article/SB10001424052970204720204577128901714576054.html (quoting Donald Berwick, former Administrator of the Ctrs. for Medicare and Medicaid Servs.).

[157] *Id.*

[158] *See, e.g.*, Samitt Interview, *supra* note 53.

[159] Greaney, *supra* note 24, at e1–e2.

[160] *Id.*

[161] *Id.* at e2 (citing C. H. Williams et al., *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?*, ROBERT WOOD JOHNSON FOUND. (2006), http://www.rwjf.org/files/research/no9policybrief.pdf).

[162] Greaney, *supra* note 24, at e2.

Indeed, in Wisconsin, seven health systems and a medical school have banded together to collaborate on an accountable care strategy.[163] These systems represent twenty-eight hospitals in Wisconsin, Michigan's Upper Peninsula, and northern Illinois as well as 4,000 affiliated physicians.[164] These systems have combined net annual revenue of nearly $6 billion.[165] This collaboration includes a significant number of hospitals and covers a wide geographic region.[166] Although collaboration and coordination can be useful tools to improve health care quality and efficiency, it will be important for governing bodies to monitor ACO collaborations to ensure that the fears expressed by Mantel and Greaney are not realized.

IV. THE PIVOTAL ROLE OF THE MEDICARE SHARED SAVINGS PROGRAM

Arguably, the most prominent catalyst in the accountable care movement is the Medicare Shared Savings Program (MSSP).[167] The MSSP encourages or mandates the use of shared governance, information technology, multi-professional practitioners, financial incentives, benchmarks, metrics, and patient participation.[168] The program requires population-based accountability, coordinated care, quality health care, and efficiency.[169] It has the potential to transform the current volume-based system of health care to one based on value.[170] The MSSP Final Rule provides elements that allow ACOs to succeed, whether inside or outside the MSSP umbrella.

The MSSP Final Rule achieves two important goals: (1) it builds upon the success of a variety of pilot and experimental programs that have contained the essential elements of accountable care, such as those developed in Wisconsin and New Jersey,[171] and (2) it answers

[163] *Competing Health Systems Launch Regional Partnership*, WISCONSIN HEALTH NEWS (Mar. 20, 2012), http://wisconsinhealthnews.com/topstories/competing-health-systems-launch-regional-partnership.

[164] *Id.*

[165] *Id.*

[166] *Id.*

[167] MSSP Final Rule, 76 Fed. Reg. 67802 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425).

[168] 42 U.S.C. § 1395jjj(b) (2006 & Supp. IV 2010), added by § 3022 of ACA.

[169] *Id.*

[170] *Id.*

[171] Some projects that have provided proof of concept for components of the MSSP ACO include: Physician Group Practice (PGP), Medicaid Section 1115 Waiver, Section 1315 Waiver, Medicare Disproportionate Share Hospital Scheme, and Medicare Health Care Quality Demonstration Programs. *See* Social Security Act §

the skeptics' concerns about collusion, excessive cost controls, inadequate quality, and ineffective patient engagement.[172] The MSSP Final Rule provides answers to the concerns expressed in Part III of this Article through a multi-tiered framework that features patient-centered criteria, a legal roadmap for anti-competitive behavior, and multi-tiered governance structures.[173]

A. The MSSP Patient-Centered Criteria are Critical to ACO Success

The ACO movement rethinks the role of the patient and other stakeholders in the delivery of healthcare, such as employers, insurers, and other community members.[174] Generally, patient-centered care improves outcomes by reducing length of stay, readmissions, and emergency department visits as well as enhancing patient compliance with plans of care.[175] It also improves patient satisfaction.[176] The comments to the MSSP rules indicate that CMS sees patient-centeredness as a crucial aspect to achieving its goals of better care, better health, and lower costs.[177]

ACA mandates that the MSSP adopt a focus on patient-centeredness that is promoted by three broad categories of rules: (1) patient representation in ACO governance, (2) patient engagement processes, and (3) quality measures that MSSP participants must meet in order to obtain shared savings.[178]

1115, Pub. L. 105-33 (1997) (permitting the authorization of cost-neutral "experimental, pilot or demonstration project[s] . . . likely to assist in promoting the objectives of [the Medicaid statute]"); Benefits Improvement and Protection Act § 412, Pub. L. 106-554 (2000); 42 U.S.C. § 1315 (2010) (providing a waiver for certain "experimental, pilot, or demonstration project[s]" that promote the objectives of care for vulnerable populations such as children, the blind, the disabled, and the elderly); 42 U.S.C. §§ 1395–1395ii (2003), *added by* the Medicare Prescription Drug, Improvement, and Modernization Act § 646, Pub. L. 108-173 (2003); Social Security Act § 1866C(b), *added by* the Medicare Prescription Drug, Improvement, and Modernization Act § 646, Pub. L. 108-173 (2003), *amended by* ACA § 3021(c) (2010).

[172] MSSP Final Rule, 76 Fed. Reg. at 67840-44.

[173] *See generally* MSSP Final Rule, 76 Fed. Reg. 67802.

[174] In this Article, we use the word "patient" for clarity. We have chosen to use patient to refer to all references to the person buying or receiving services except when we are specifically discussing consumerism.

[175] Barbara Cliff, *The Evolution of Patient-Centered Care*, 57 J. HEALTHCARE MGMT. 86, 88 (2012).

[176] *Id.*

[177] MSSP Final Rule, 76 Fed. Reg. at 67826 (defining "patient engagement" as "the active participation of patients and their families in the process of making medical decisions.").

[177] *Id.*

[178] A defining event in the use of the term of "patient-centeredness" is the iconic

With regard to ACO governance, the final MSSP Rule requires at least one Medicare beneficiary representative served by the ACO to be on the ACO's governing body.[179] If an ACO is unable to satisfy the requirement of beneficiary representation on its governing body, the MSSP final rules allow ACOs to opt out of the requirement by providing an explanation for having a different composition of its governing body.[180] Any ACO that does not meet the composition criteria must show that it is involving the ACO participants in innovative ways in ACO governance or that it is providing its Medicare beneficiaries with "*meaningful representation* in ACO governance."[181]

For the patient engagement processes, the MSSP requires ACOs to (1) regularly use a "patient experience of care survey,"[182] (2) provide for a beneficiary representative on its governing body,[183] (3) evaluate the health needs of its populations and develop plans to address those populations' needs, to be achieved in part by partnering with community stakeholder organizations,[184] (4) clearly communicate relevant "clinical knowledge/evidence-based medicine

Institute of Medicine report issued in 2001, which identified patient-centeredness as one of the six key goals for health care delivery. INSTITUTE OF MEDICINE, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 40 (2001). The definitions of "patient-centeredness" vary—one is "health care that patients need and is provided when they need and in the manner they want." Karen David et al., *Aiming High for the U.S. Health System: A Context for Health Reform*, 36 J. L. MED. & ETHICS 629, 634–35 (2008). Another definition propounded by the Institute of Medicine applies "patient-centeredness" to all patient interactions with physicians and the health care system as a whole. *Id.*

[179] MSSP Final Rule, 76 Fed. Reg. at 67821, 67976 (to be codified at 42 C.F.R. § 425.106(c)(2)). A "Medicare fee-for-service beneficiary" is one who is enrolled in original Medicare under Parts A and B, but who is not enrolled in a Medicare Advantage plan under Part C, "[a]n eligible organization under section 1876 of the Act," or in "[a] PACE program under section 1894 of the Act." MSSP Final Rule, 76 Fed. Reg. at 67974-75 (to be codified at 42 CFR § 425.20). Also, that a single Medicare beneficiary on the governing body is sufficient to satisfy that component of the MSSP distinctly contrasts to the requirement that "[a]t least 75 percent control of the ACO's governing body must be held by ACO participants." MSSP Final Rule, 76 Fed. Reg. 67976 (Nov. 2, 2011) (to be codified at 42 CFR § 425.106(c)(3)).

[180] MSSP Final Rule, 76 Fed. Reg. at 67976 (to be codified at 42 CFR § 425.106(c)(5)).

[181] *Id.* (emphasis added).

[182] MSSP Final Rule, 76 Fed. Reg. 67976-77, 67984 (to be codified at 42 C.F.R. §§ 425.112(b)(2)(i), 425.500).

[183] MSSP Final Rule, 76 Fed. Reg. at 67977 (to be codified at 42 C.F.R. § 425.112(b)(2)(ii)).

[184] MSSP Final Rule, 76 Fed. Reg. at 67977 (to be codified at 42 C.F.R. § 425.112(b)(2)(iii)).

to beneficiaries" in a way that the beneficiaries can understand,[185] (5) involve each individual beneficiary in a process of "shared decision-making" that reflects that person's "unique needs, preferences, values, and priorities,"[186] (6) develop "written standards for beneficiary access and communication," including a process by which beneficiaries may access their own medical records,[187] and (7) develop an "individualized care program" for beneficiaries in high risk groups to provide for coordinated care throughout an episode of care and during its transitions.[188]

The third patient-centered category relates to the MSSP quality measures. The MSSP contains thirty-three quality performance standards that ACOs must meet before obtaining shared savings.[189] Of the thirty-three quality measures selected for the MSSP, seven are related to the patient's or caregiver's experience of care, to which the final rules give equal weight with measures relating to care coordination and patient safety, preventive health, and at-risk populations.[190] The seven patient experience measures are: (1) "Getting Timely Care, Appointments and Information"; (2) "How Well Your Doctors Communicate"; (3) "Patients' Rating of Doctor"; (4) "Access to Specialists"; (5) "Health Promotion and Education"; (6) "Shared Decision Making"; and (7) "Health Status/Functional Status."[191]

Another quality measure worthy of mention is the adoption and use of Electronic Health Records (EHR) technology. The final MSSP

[185] MSSP Final Rule, 76 Fed. Reg. at 67977 (to be codified at 42 C.F.R. § 425.112(b)(2)(iv)).

[186] MSSP Final Rule, 76 Fed. Reg. at 67977 (to be codified at 42 C.F.R. § 425.112(b)(2)(v)).

[187] MSSP Final Rule, 76 Fed. Reg. at 67977 (to be codified at 42 C.F.R. § 425.112(b)(2)(vi)).

[188] MSSP Final Rule, 76 Fed. Reg. at 67977 (to be codified at 42 C.F.R. § 425.112(b)(4)).

[189] MSSP Final Rule, 76 Fed. Reg. at 67889.

[190] MSSP Final Rule, 76 Fed. Reg. at 67891; MILLENSON & MACRI, *supra* note 146, at 4.

[191] MSSP Final Rule, 76 Fed. Reg. at 67889; MILLENSON & MACRI, *supra* note 146, at 4 n.36. All of these measures are Consumer Assessment of Health Plans Study (CAHPS) measures. MILLENSON & MACRI, *supra* note 146, at 4 n.36. "The CAHPS program is funded and administered by the Agency for Healthcare Research and Quality, which works with a consortium of private and public organizations that includes . . . CMS" and other federal agencies. *Id.* at 4. "These organizations are responsible for conceiving, developing, testing and refining the various CAHPs surveys." *Id.* at 4 n.36. "The CAHPS surveys seek to assess the patient experience of care by addressing behaviors the patient directly observes." *Id.* at 2.

rules do not require MSSP participants to adopt EHR technology, but encourage its adoption by giving it double weight in the calculation of a participant's quality performance score.[192] EHR adoption will be critical to ACOs' ability to monitor population health and improve quality of care. The Pioneer ACO model also emphasizes EHR, and Pioneer ACOs must ensure that no less than fifty percent of their primary care providers are making "meaningful use" of EHR in order to receive EHR incentive payments.[193]

The three broad categories of MSSP patient-centered criteria are a direct response to the lessons learned from the managed care backlash and consumerism movement, discussed in Section III.A of this Article. Incorporating these criteria into ACO development initiatives and keeping patient engagement at the forefront, whether within or outside the MSSP, will allow ACOs to experience greater success and allay many of the fears of rationing and improper leverage of market power.

1. The ACO Exit Challenge

The success of the ACO concept, whether as part of the MSSP or in the commercial market, is subject to Hirschman's "exit, voice, and loyalty" theory.[194] That is, in unsatisfactory situations, people can respond by "exiting" the situation, or raising their "voice" to try and remedy the defects.[195] Hirschman's concept of "loyalty" may modify the response, causing one to stand and fight rather than exit.[196]

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[192] 76 Fed. Reg. at 67802, 67985 (to be codified at 42 C.F.R. § 425.506).

[193] PIONEER GENERAL FACT SHEET, *supra* note 37. Similar beneficiary-oriented provisions guide the Pioneer ACOs: the Pioneer ACO model puts a bit more emphasis on beneficiary involvement in the governance structure and requires both a beneficiary and a patient advocate to sit on the governing body. CTRS. FOR MEDICARE & MEDICAID SERVS., PIONEER ACO MODEL: A BETTER CARE EXPERIENCE THROUGH A NEW MODEL OF CARE, FACT SHEET (Dec. 19, 2011), *available at* http://innovations.cms.gov/Files/fact-sheet/Pioneer-Model-ACO-Beneficiaries-Rights-Fact-Sheet.pdf [hereinafter PIONEER BENEFICIARIES FACT SHEET]. Although one person may satisfy both positions, most of the initial Pioneer ACOs have separate individuals for this responsibility. *Id.* CMS will take an active role in comparing the "experience and health of beneficiaries who are aligned to an ACO in the Pioneer ACO Model against comparable beneficiaries not aligned to an ACO." *Id.* CMS will actively supervise through service utilization analysis, and investigation of "suspect trends" through "beneficiary surveys, audits, and other means." *Id.*; *see also Pioneer Request*, *supra* note 40. Additionally, CMS will hold each Pioneer ACO publicly accountable by posting on its website a public record of each ACO's quality results, including the results from the patient experience metrics. *Id.*

[194] Hirschman, *supra* note 13, at 272.

[195] *Id.*

[196] *Id.* at preface (ed.'s note).

Both the MSSP and the commercial market permit patients to exit the ACO.[197] Medicare beneficiary assignment in the MSSP determines the population of Medicare fee-for-service beneficiaries for whose care the ACO is accountable and determines whether an ACO has achieved savings under the program.[198] The MSSP final rule deliberately permits Medicare beneficiaries to exercise free choice in determining where to receive health care services.[199]

The MSSP further restricts ACO participants from providing incentives to beneficiaries to stay within the ACO, and restricts the ability of ACO providers to refer to one another.[200] Specifically, the MSSP rules prohibit ACOs and ACO participants from providing gifts or other financial incentives to beneficiaries as inducements for receiving items or services from, or remaining in, an ACO.[201] The rules restrict the ability of MSSP participants to refer beneficiaries to other providers and suppliers within the ACO.[202] Medicare beneficiaries assigned to the ACO are free to express their preferences for certain providers and the MSSP rules allow employees or contractors of the MSSP participant to make such referrals in response to such beneficiary preferences.[203]

The freedom to leave an ACO, coupled with the prohibition against referrals and financial incentives to entice beneficiaries to remain in the ACO, is arguably a response to the managed care backlash from the 1990s. Under the current accountable care framework, if ACO patients are disappointed with their experience within the ACO, they may leave, or, in the case of an employer-based plan, they may lobby their employer to switch health care providers.[204] Exit is a very real concern for organizations that invest significant

[197] MSSP Final Rule, 76 Fed. Reg. at 67811.

[198] MSSP Final Rule, 76 Fed. Reg. at 67983 (to be codified at 42 C.F.R. § 425.400(b)).

[199] *Id.*

[200] MSSP Final Rule, 76 Fed. Reg. at 67981 (to be codified at 42 C.F.R. § 425.304(a)(1))

[201] *Id.* ACOs, however, may provide in-kind items or services to beneficiaries if there is a reasonable connection between the items and services and the medical care of the beneficiary and the items or services are preventive care items or services or advance a clinical goal for the beneficiary. Final Rule, 76 Fed. Reg. at 67981 (to be codified at 42 C.F.R. § 425.304(a)(2)).

[202] MSSP Final Rule, 76 Fed. Reg. at 67981 (to be codified at 42 C.F.R. § 425.304(c)(2)).

[203] *Id.*

[204] MSSP Final Rule, 76 Fed. Reg. at 67956–57.

resources into keeping populations healthy.[205] For example, managed care organizations in the 1990s became critical of health promotion and disease prevention efforts.[206] The criticism stemmed from the assumption that the financial payoffs would not occur until "many decades in the future" and would likely "produce their primary benefits in savings for other health plans or for Medicare, if prevention leads to healthier seniors."[207]

Research regarding employee wellness programs has also explored the importance of exit to wellness program success.[208] Specifically, "worksite health promotion programs" are more effective with a "captive audience."[209] According to Kenneth Warner, "the 'captive' nature of the [workforce] is an essential feature of effective health promotion."[210] The less employee turnover, the more effective the health promotion program; whereas high employee turnover, or "exit," undermines the effectiveness of health promotion efforts and thereby reduces the potential cost savings.[211] As a result, organizations that invest in improving patient care through prevention and overall wellness must be cognizant of the potential for exit and, to the extent possible, design a program to address it.

2. Success through Building Trust

The three broad categories of patient-centered criteria regarding patient involvement in ACO governance, patient engagement processes, and quality measures in the MSSP, strike at building and maintaining patient loyalty or trust. Under the Hirschman theory, building "loyalty" can minimize "exit."[212]

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[205] Kenneth E. Warner, *Wellness at the Worksite*, 9 HEALTH AFF. 63, 65 (1990).

[206] Schlesinger, *supra* note 106, at 34.

[207] *Id.*; *see also* Sheila Leatherman et al., *The Business Case for Quality: Case Studies and an Analysis*, 22 HEALTH AFF. 17, 27 (2003) (noting that managed care organizations that implement prevention efforts such as "smoking-cessation programs, diabetes care management and risk reduction" likely encounter delayed costs savings because of enrollee turnover).

[208] Warner, *supra* note 205.

[209] *Id.*

[210] *Id.*

[211] *Id.*

[212] *See generally* Hirshman, *supra* note 13. Americans, however, may be reluctant to provide absolute loyalty; e.g., Hirshman notes that "[t]he traditional American idea of success confirms the hold which exit has had on the national imagination." *Id.* at 274. Relevantly, he believes that "the ideology of exit has been [so] powerful in America" that "the national *disbelief* in the economist's notion that a market dominated by two or three giant firms departs substantially from the ideal competitive model." *Id.* The ability to "transfer [one's] allegiance from . . . firm A

According to one researcher, patient trust differs from patient satisfaction in that "satisfaction refers to the patient's opinions of the physician's actions" that have already occurred,[213] while trust on the other hand, "looks forward" to the future "relationship between the physician and patient" and "is based largely on perceptions about the physician's motivations."[214] Satisfaction tends to be more objective; trust may be more emotional.[215] Patients have described trust as a reflection of a commitment to an ongoing relationship.[216] Thus, building trust reaches deeper into the relationship between the provider and patient and creates loyalty.[217]

Because of the potential for patient exit, building and maintaining trust between ACOs and their patients will be vital to ACO success. Trust can help avoid the financial pitfalls experienced by managed care organizations and employee wellness programs by encouraging the patients to remain in the ACO.[218] Research on patient trust has shown that, compared to patient satisfaction, trust is more strongly associated with treatment adherence and continuity of enrollment than patient satisfaction.[219]

The MSSP offers ideas on how to build patient trust. For example, the patient engagement processes require ACOs to communicate "clinical knowledge" and "evidence-based medicine to beneficiaries in a way that is understandable to them."[220] It also requires "[b]eneficiary engagement and shared decision-making that takes into account the beneficiaries' unique needs, preferences, values, and priorities."[221] The MSSP requires ACOs to coordinate patient care by developing "individualized care program[s] . . . "to promote improved outcomes for . . . patients."[222] This emphasis on individualized care and understandable communication is essential

to . . . firm B" suffices to satisfy the symbolic for exit. *Id.*

[213] David H. Thorn et al., *Measuring Patients' Trust in Physicians When Assessing Quality of Care*, 23 HEALTH AFF.124, 127 (2004).

[214] *Id.*

[215] *Id.*

[216] *Id.*

[217] *Id.*

[218] MSSP Final Rule, 76 Fed. Reg. at 67967.

[219] Thorn, *supra* note 213.

[220] MSSP Final Rule, 76 Fed. Reg. at 67977 (to be codified at 42 C.F.R. §425.112(b)(2)(iv)).

[221] MSSP Final Rule, 76 Fed. Reg. at 67977 (to be codified at 42 C.F.R. §425.112(b)(2)(v)).

[222] MSSP Final Rule, 76 Fed. Reg. at 67977 (to be codified at 42 C.F.R. §425.112(b)(4)(ii)).

to building trust. These criteria force ACOs to begin a dialogue with patients about their care. This dialogue can expand to address the cost effectiveness of the patient's care, which can calm fears of rationing.[223] According to one researcher, patients might be less critical of financial incentives once they understand the dilemmas associated with rising costs, evidence of widespread overuse of health care services, and the challenges of changing physician behavior using nonfinancial incentives.[224] Undertaking such a dialogue may also help develop innovative cost-control strategies that generate less patient concern about potential conflicts of interest that ACO participants might have with regard to shared savings and other financial incentives.[225]

Moreover, meaningful patient dialogue creates true partnerships in health care, which can translate to better health outcomes.[226] Indeed, a recent article highlighted the effectiveness of the Collaborative Chronic Care Network (CCCN), which engages chronically ill patients by having them "experiment with new treatments and closely monitor[s] how the regimens affect[] them day to day."[227] The patients "feed the data into [an] online network through computers or smartphones for doctors to examine."[228] Most significantly, the CCCN focuses on patient-centered care and allows each patient to drive the experimentation.[229] According to one of the physician participants in the network, getting "the best outcomes" requires parents and patients to be true partners.[230]

3. Success through Voice

Creating a dialogue with patients would also give voice to patients, which would serve as an antidote to "exit" and achieve another MSSP patient-centered requirement of meaningful patient involvement in the ACO.[231] This dialogue can be accomplished

[223] Gallagher, *supra* note 115, at 190–91.
[224] *Id.*
[225] *Id.* at 191.
[226] Amy Dockser Marcus, *Patients as Partners*, WALL ST. J., Apr. 16, 2012, http://online.wsj.com/article/SB10001424052702304692804577281463879153408.html.
[227] *Id.*
[228] *Id.*
[229] *Id.* The network also provides patients with an opportunity for "social support," allowing them to "find[] other patients who share[] similar interests or live[] near them." *Id.*
[230] *Id.*
[231] MSSP Final Rule, 76 Fed. Reg. at 67976 (to be codified at 42 C.F.R. §

through the MSSP patient experience of care surveys and patient representation in ACO governance.[232] The MSSP requires ACOs to survey its Medicare patients annually.[233] Thus, at least once each year MSSP Medicare beneficiaries will have the opportunity to voice their concerns about their ACO experience. The patient experience of care surveys should distinguish between more superficial satisfaction questions, align with the ACO's trust-building goal, and convey a deeper concern for the patient's overall health.

The MSSP quality of care measures that relate to patient-caregiver experience reinforce the importance of the patient care surveys.[234] These measures require MSSP participants to give patients voice with regard to the timeliness of their care, appointments and information, the effectiveness of physician communication, their access to specialists, their experience with the ACO health promotion and education efforts, their experience with shared decision making, and their overall health status and functional status.[235] These measures offer a wealth of information about the ACO's effectiveness in creating an appealing patient experience. By learning from patients about their overall experience with the ACO and improving the experience based on what is learned, the ACO has a better chance of retaining patients and gaining new ones because of a positive community reputation.[236]

Meaningful participation in ACO governance—for example, through representation on the ACO governing board—can also give a voice to patients.[237] Patient representation on boards is related to the interest group representation theory of the 1950s and 1960s.[238] The underlying theory of interest group representation states that there are different groups with competing interests, and the voices of the underrepresented must be inserted into the process so that good

425.106(c)(5)).

[232] MSSP Final Rule, 76 Fed. Reg. at 67976–77 (to be codified at 42 C.F.R. § 425.106(c)(2), 425.112(b)(2)(i)).

[233] MSSP Final Rule, 76 Fed. Reg. at 67984 (to be codified at 42 C.F.R. § 425.500(d)).

[234] MSSP Final Rule, 76 Fed. Reg. at 67981, 67984 (to be codified at 42 C.F.R. §425.308(e); §425.500).

[235] MSSP Final Rule, 76 Fed. Reg. at 67889.

[236] Blendon, *supra* note 99, at 89 ("Health care consumers are much more likely to rely on personal experiences or the recommendation of friends and family members" when choosing health plans.).

[237] MSSP Final Rule, 76 Fed. Reg. at 67976-77 (to be codified at 42 C.F.R. § 425.106(c)(2)).

[238] Trubek, *supra* note 120.

public policy can be constructed.[239] The hope is that, by including a patient or beneficiary in the board, discussion will lead to fair decisions.[240]

One can see the effectiveness of voice from the MSSP rulemaking process. The participation of REAP in the rulemaking process for the MSSP rules demonstrates the importance of external policy advocacy.[241] REAP is an alliance for participation in health care governance and regulation.[242] It is based on the National Patient Advocate Program, a national active patient advocacy group.[243] Notably, REAP often supports the comments of the providers and is rarely adversarial to many of the physician complaints.[244] The alliance of disease-based non-profits, such as the American Cancer Society, wrote extensive comments on the proposed rules.[245] The MSSP Final Rule reflects many of the changes proposed by the patient groups as well as the providers.[246]

Meaningful participation in ACO governance is especially important in light of the current lack of such participation, even in highly integrated, high quality health care systems. Representatives of the Wisconsin systems expressed a need for patients to have "more skin in the game,"[247] but none of those systems involved independent patients in the system's governance.[248] The Wisconsin systems recognized that in the new world of value-based reimbursement, patients would not be entitled to every type of treatment available.[249] For example, Dr. Samitt declared that in the new model, "patients need to be willing to forgo procedures that don't work."[250] To prevent the backlash experienced from the managed care movement,

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[239] *Id.*

[240] The effectiveness of consumers on regulatory boards has been questioned. *Id.*

[241] Comment from Regulatory Education and Action for Patients (REAP) to Donald Berwick, Administrator, CTRS. FOR MEDICARE & MEDICAID SERVS., *available at* http://www.regulations.gov/#!documentDetail;D=CMS-2010-0259-0425 (last visited Oct. 5, 2012) [hereinafter REAP Comment] (in reference to CMS-1345-P: Medicare Shared Savings Program: Accountable Care Organizations).

[242] REGULATORY EDUC. & ACTION FOR PATIENTS, http://www.reapforum.org/about (last visited Oct. 6, 2012).

[243] *See* REGULATORY EDUC. & ACTION FOR PATIENTS, *supra* note 242.

[244] *See* REAP Comment, *supra* note 241.

[245] *See id.*; *see also* REGULATORY EDUC. & ACTION FOR PATIENTS, *supra* note 242.

[246] *See generally* MSSP Final Rule, 76 Fed. Reg. 67802 (Nov. 2, 2011).

[247] Samitt Interview, *supra* note 53; Jaffery Interview, *supra* note 51.

[248] Samitt Interview, *supra* note 53; Jaffery Interview, *supra* note 51.

[249] Samitt Interview, *supra* note 53.

[250] *Id.*

however, it will be important for these systems to do more than just instruct patients to be more responsible. These systems must engage patients in meaningful dialogue, including involving patients in ACO governance who are not otherwise affiliated with the ACO through employment or family, for example. Such actions will help build the trust needed for ACOs to succeed.

4. Success through Community Partnerships and Care Coordination

Care coordination with other healthcare stakeholders is another patient engagement process that can engender trust, not only with individual patients, but with entire communities. Specifically, the MSSP rules require participants to partner with community stakeholders to improve the health of the community's population.[251] The rules also require participants to coordinate care across the spectrum of providers throughout an episode of care and during its transitions, such as discharge from a hospital or transfer of care from a primary care physician to a specialist (both inside and outside the ACO).[252]

Creating partnerships with community stakeholders outside the ACO, such as public health agencies, families, workplaces, spiritual leaders, and mental health providers, will facilitate an ACO's ability to move away from the current fragmented system and focus on the patient's overall well-being, not just the patient's health condition. Partnerships compel participants to view health as part of an integrated whole. ACOs can accomplish such partnerships through counseling programs, where trained counselors meet with patients and ask patients questions about their quality of life and how their health impacts that quality.[253] For example, Women Breathe Free is a program in which "nurse health educators provide regular telephone counseling for patients, talking to them about their particular asthma concerns, such as problems related to household cleaning or laundry products and the use of" certain medications that "can exacerbate

[251] MSSP Final Rule, 76 Fed. Reg. 67802, 67977 (Nov. 2, 2011) (to be codified at 42 C.F.R. § 425.112(b)(2)(iii)(A)).

[252] MSSP Final Rule, 76 Fed. Reg. at 67977 (to be codified at 42 C.F.R. § 452.112(b)(4)).

[253] *See, e.g.*, Laura Landro, *The Simple Idea That Is Transforming Health Care*, WALL ST. J., Apr. 16, 2012, at R1, *available at* http://online.wsj.com/article/SB10001424052702304450004577275911370551798.html.

problems."[254] Patients in the program "reported higher levels of asthma-related quality of life and a greater reduction in the use of certain medications."[255] Participants also missed fewer "days of school and work".[256]

Partnerships with mental health providers will also be a critical part of coordinating care to improve health outcomes and reduce costs. According to the report of one Wisconsin health care organization, "when behavioral health services are appropriately integrated with medical services, better patient outcomes and cost reductions of 20 to 30 percent are possible."[257] For example, Intermountain Healthcare found that by treating depressed patients using a mental health integration care model, the average per-patient allowed charges increased less than patients whose depression went unaddressed.[258] In addition, integrating behavioral health with primary care clinics improves the ability to coordinate care, improves patient engagement in behavioral health care, and enhances overall patient experience.[259]

By taking responsibility for the whole patient, ACOs can minimize the perception of market abuses and cherry-picking of healthy enrollees that tainted the managed care movement.[260] Rather than pushing conditions that traditionally fell outside the medical model, such as substance abuse or mental illness, onto other

[254] *Id.*
[255] *Id.*
[256] *Id.*
[257] William Henricks, *Behavioral Health Integration: The Right Prescription for Healthcare*, ROGERS PARTNERS IN BEHAVIORAL HEALTH UPDATE (Mar. 2012) (on file with the author) (citing N. Cummings et al., *The Financial Dimension of Integrated Behavioral/Primary Care*, *in* UNDERSTANDING THE BEHAVIORAL HEALTHCARE CRISIS (Cummings & O'Donohue, eds., 2011).
[258] Henricks, *supra* note 257 (citing B. Reiss-Brennan, *Cost and Quality Impact of Intermountain's Mental Health Integration Program*, 55 J. HEALTHCARE MGMT. 1, 1–18 (2010)).
[259] Henricks, *supra* note 257 (citing S. Bartles, *Improving Access to Geriatric Mental Health Services: A Randomized Trial Comparing Treatment Engagement with Integrated versus Enhanced Referral Care for Depression, Anxiety, and At-Risk Alcohol Use,* 161 AM. J. PSYCHIATRY 1455, 1455–62 (2004)); *see also* Jean M. Cassidy et al., *Behavioral Healthcare Integration in Obstetrics & Gynecology*, MEDSCAPE GENERAL MEDICINE (May 15, 2003), *available at* http://www.ncbi.nlm.nih.gov/pubmed/14603140 (emphasizing the need for the inclusion and integration of services that identify, treat and medically manage behavioral health issues in the practice of obstetrics and gynecology).
[260] Schlesinger, *supra* note 106, at 32–33 (citing D. R. GERSTEIN & H. J. HARWOOD, TREATING DRUG PROBLEMS (1990) (stating that managed care organizations failed to treat substance abuse, leaving the costs to "fall on employers, family members or the criminal justice system")).

community stakeholders such as employers, families, and the criminal justice system, ACOs can partner with these stakeholders to help treat the whole person.[261] Community stakeholders that see a sincere interest in improving population health, as the MSSP rules require, are less likely to criticize large collaborations of health care providers. Moreover, larger collaborations of providers and community partners may be more effective in improving population health, lending legal justification for certain mergers and joint ventures. This approach is similar to the FTC's approach to "clinical integration" programs that improve quality and reduce costs through interdependent and cooperative multi-provider collaborations.[262] Legitimate clinical integration is likely to survive antitrust scrutiny from the FTC.[263]

For true collaborative care to occur and succeed, patients, along with employers and insurers, must be part of the equation and be just as willing to sacrifice and change the status quo.[264] For example, employers can encourage healthy activities such as smoking cessation programs and exercise.[265] In Wisconsin, many insurers offer partial rebates on health activities, such as participation in exercise programs and community-supported agriculture shares programs.[266] The concept of patient responsibility and engagement was not part of the managed care movement in the 1990s, but it must be part of the current ACO movement if it is to succeed.[267] Consumer engagement is at the front end of ACO development rather than a response to managed care with the Patient Bill of Rights.

B. The MSSP Legal Roadmap to Reduce Abusive Practices

The MSSP provides a legal framework in which participating organizations can operate. In part, this legal framework addresses

[261] Schlesinger, *supra* note 106, at 32–33.

[262] J. Thomas Rosch, Comm'r, Fed.Trade Comm'n, Clinical Integration in Antitrust: Prospects for the Future, Remarks at the Am. Bar Assoc. 2007 Antitrust in Healthcare Conference, 7 (Sept. 17, 2007), *available at* http://www.ftc.gov/speeches/rosch.shtm.

[263] *Id.* at 8–10 (citing two F.T.C. Advisory Opinion Letters regarding MedSouth and Suburban Health Organization); *see also* Rosch, *supra* note 101.

[264] Samitt Interview, *supra* note 53; Van Den Heuvel Interview, *supra* note 52.

[265] Van Den Heuvel Interview, *supra* note 52.

[266] For example, in Wisconsin, local HMOs provide partial rebates to subscribers for purchasing Community Supported Agriculture (CSA) shares. *See, e.g.*, FAIRSHARE CSA COALITION, http://www.csacoalition.org/our-work/csa-insurance-rebate/ (last visited Oct. 5, 2012).

[267] Sanders Interview, *supra* note 54.

the abusive market practice fears expressed by Greaney. Softening the usual legal restrictions concerning health care organization collaboration provides additional incentives for health care organizations to adopt the MSSP concept, which DHHS will monitor, as opposed to operating in the commercial ACO world only.[268] For example, MSSP participants receive certain waivers of the physician self-referral law and the federal anti-kickback statute, including waivers for ACO participation, shared savings distributions, compliance with the Physician Self-Referral Law, and patient incentives.[269] Additionally, MSSP participants are afforded some protection against antitrust concerns, in order to allow collaboration.[270]

With regard to anti-trust concerns, such as those raised by Greaney, the FTC and the DOJ provided guidance for ACOs that are eligible and intend to, or have been approved to, operate in the MSSP.[271] The guidance is also useful for ACOs that intend to operate in the commercial market.[272] The guidance states that an ACO will be evaluated by the antitrust agencies under the "rule of reason analysis," which evaluates "whether the collaboration is likely to have anticompetitive effects and, if so, whether the collaboration's potential for procompetitive efficiencies are likely to outweigh those effects."[273] The guidance creates an antitrust safety zone for ACOs in the MSSP.[274] Specifically, independent ACO participants that provide a common service must have a combined share of thirty percent or less of each common service in each participant's primary service area, wherever two or more ACO participants provide that service to patients from that primary service area.[275] ACOs that "exceed the 30

[268] MSSP Final Rule, 76 Fed. Reg. 67802, 67840 (Nov. 2, 2011); Fed. Trade Comm'n & Dep't of Justice, Final Policy Statement: Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67026-32 (Oct. 28, 2011) [hereinafter Antitrust Enforcement Policy].

[269] Interim Final Rule: Final Waivers in Connection with the Shared Savings Program, 76 Fed. Reg. 67992-01 (Nov. 2, 2011).

[270] *See* Antitrust Enforcement Policy, 76 Fed. Reg. 67026.

[271] *Id.*

[272] *Id.*

[273] *Id.* at 67027.

[274] *Id.* at 67026.

[275] Antitrust Enforcement Policy, 76 Fed. Reg. 67031. Calculating the primary service area (PSA) for an ACO is complex. For each participant in an ACO, and each service provided by that participant, a "primary service area (PSA)" is defined as "the lowest number of postal zip codes from which the ACO participant draws at least 75 percent of its patients." *Id.* The ACO has a share in the PSA of a participant

percent primary service area share may still fall within the safety zone if [they qualify] for a 'rural exception.'"[276] ACOs with a dominant participant—for example, with a greater than fifty percent share in its primary service area—may also fall within the safety zone.[277] These ACOs are granted access to the safety zone only if: (1) there are no other ACO participants that provide the common service in that primary service area; and (2) the dominant participant does not require private payers to contract exclusively with the ACO or otherwise restrict private payers' ability to contract or deal with other provider networks or ACOs.[278]

This relaxed standard of review is being accorded to ACOs in the MSSP and Pioneer programs because the antitrust agencies view the MSSP rules as generally consistent with clinical and financial integration efforts that they have approved in the past.[279] For example, the FTC and DOJ have approved of physician or multi-provider joint ventures that share substantial financial risk for the purpose of achieving overall efficiency for the venture.[280] The agencies have also approved joint ventures that "implement an active and ongoing program to evaluate and modify practice patterns by the venture's providers and [that] create a high degree of interdependence and cooperation among the providers to control costs and ensure quality."[281] The agencies consider organizations that meet MSSP requirements to be "reasonably likely to be bona fide arrangements intended to improve the quality, and reduce the costs, of providing medical and other health care services through their participants' joint efforts."[282] Thus, closely following the MSSP requirements, like the patient-centered criteria, may help ACOs outside the MSSP avoid scrutiny by the FTC and DOJ.

The legal waivers and safety zones, however, do not provide carte blanche protection against antitrust issues. ACOs under both MSSP

when that participant provides services for the ACO. *Id.*

[276] *Id.* at 67029. The "rural exception" applies when the "physician's or physician group practice's primary office is in a zip code that is classified as 'isolated rural' or 'other small rural.'" *Id.*

[277] *Id.*

[278] *Id.*

[279] Rosch, *supra* note 101, at 4 (citing U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, at Statement 8 (1996), *available at* http://www.ftc.gov/bc/healthcare/industryguide/policy/index.htm).

[280] Antitrust Enforcement Policy, 76 Fed. Reg. 67026–27.

[281] *Id.*

[282] *Id.*

and Pioneer must still take care to avoid garnering more than fifty percent of the market share in a specific primary service area.[283] Moreover, regardless of an ACO's primary service area shares or other indicia of market power, ACOs should avoid improper exchanges of prices or other competitively sensitive information among competing participants.[284] They should also avoid: (1) preventing or discouraging private payers from directing or incentivizing patients to choose certain providers through anti-steering, anti-tiering, guaranteed inclusion, most-favored-nation, or similar contractual clauses or provisions; (2) tying sales of the ACO's services to the private payer's purchase of other services from providers outside the ACO (and vice versa); (3) contracting on an exclusive basis with ACO physicians, hospitals, ambulatory surgery centers or other providers, thereby preventing or discouraging those providers from contracting with private payers outside the ACO; and (4) restricting a private payer's ability to make available to its health plan enrollees cost, quality, efficiency, and performance information to aid enrollees in evaluating and selecting providers in the health plan, if that information is similar to the cost, quality, efficiency, and performance measures used in the MSSP.[285] In essence, regardless of MSSP participation, all ACOs may minimize the chance of legal challenges by adopting MSSP elements and goals, particularly the MSSP's patient-centered criteria.

C. The MSSP Can Help "Spread" Accountable Care Using Multitier Governance

The MSSP framework is multi-tier—local organizations placed in a national framework. MSSP created a national framework to encourage the formation of coordinated, collaborative local health care delivery. The framework allows for variation in the ACOs so that they can respond to and respect local conditions. The variation in the local organizations allows for learning across the ACOs regionally and nationally.

1. The National Framework

The MSSP program provides the national government with

[283] *See Pioneer Request*, *supra* note 40 (stating an understanding that the Antitrust Policy Statement designed for MSSP ACOs would also apply to Pioneer ACOs); *see also* 76 Fed. Reg. 67026–27.

[284] 76 Fed. Reg. 67026–28.

[285] *Id.* at 67030.

leverage to bring up lagging states and health care providers to join in the accountable care movement. This ability to pull up "laggards" is important for states and providers taking the lead on transitioning to a value-based payment system.[286] For example, about sixty percent of Wisconsin providers have been cooperating in self-monitoring practices through the WHCQ.[287] This cooperation helps to minimize the need for governmental mandates. Yet many Wisconsin practices, particularly small practices and specialty clinics, consider cooperative self-monitoring to be a low priority, and have no "business reason to do this absent a mandate."[288] The refusal of "stragglers" to participate creates an unfair and uneven marketplace.[289] As a result, some Wisconsin healthcare industry stakeholders believe that government intervention is necessary.[290] For example, when collecting provider quality data, some health care providers refuse to submit data to the repository.[291] According to one health care leader, such unequal commitment to measuring quality may require "legislative action to assure that all providers are reporting."[292]

The need to "scale up" can be seen in the national framework—it includes incentives and tools to encourage value care and flexibility for local conditions. The hope of shared savings provides a financial incentive.[293] Other tools encourage improving value—use of electronic records, metrics, stakeholder participation, and benchmarks.[294] The framework also reduces the barriers to the formation of ACOs such as anti-trust concerns and potential fraud and abuse violations.[295] The MSSP rule continues fee-for-service,

[286] *See, e.g.*, Tanja A. Borzel, *Why there is no 'Southern Problem': On Environmental Leaders and Laggards in the European Union*, 7 J. EUR. PUB. POL'Y 141, 147–49, 158–60 (2000), *available at* http://dx.doi.org/10.1080/135017600343313 (discussing how "domestic mobilization by social actors" can "pull" the "laggard" states to comply with European Union policy).

[287] Queram Interview, *supra* note 76.

[288] *Id.*

[289] *Id.*

[290] *Id.*

[291] Toussaint, *supra* note 49; Queram Interview, *supra* note 76.

[292] Toussaint, *supra* note 49, at e88.

[293] MSSP Final Rule, Fed. Reg. 67802, 67985–87 (Nov. 2, 2011) (to be codified at 42 C.F.R. §§ 425.600–04).

[294] MSSP Final Rule, Fed. Reg. at 67975–76, 67984–85 (to be codified at 42 C.F.R. §§ 425.106, 425.500, 425.506, 425.602).

[295] *See, e.g.*, Charles F. Sabel & William H. Simon, *Contextualizing Regimes: Institutionalization as a Response to the Limits of Interpretation and Policy Engineering*, 110 MICH. L. REV. 1265, 1304–05 (May 2012) (describing methods that lawmakers use to "induce, facilitate, and monitor contextualizing regimes").

makes the program voluntary, and allows choice of physicians.[296] This framework encourages the slow movers to consider the move to value-based care.[297]

The MSSP provides a national method to encourage those who are not "early movers" by leveraging Medicare.[298] Medicare is essential because it is a national program, in contrast to Medicaid, which is controlled at the state level. Part of this acceleration process is occurring in specific ways. For example, the CMS Innovation Center has created the "Advance Payment ACO Model," to which certain organizations can apply to receive advance payments to establish an ACO.[299] CMS created this program partly in response to comments regarding the proposed MSSP rule.[300] This model removes funding barriers for certain organizations to enter into the ACO arena.[301] The MSSP also allows fee-for-service billing to continue. Both of these provisions encourage health care providers to make the move to coordinated care while preserving some aspects of the traditional volume-based model.[302] CMS is also driving the linking of patient satisfaction to provider compensation—surveys, report cards, and the creation of well-validated quality metrics.[303] Finally, the MSSP "safety zone" provides a legal basis that can be used to align with commercial programs.[304]

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[296] MSSP Final Rule, Fed. Reg. at 67975 (to be codified as 42 C.F.R. § 425.100).

[297] Jaffery Interview, *supra* note 51.

[298] *Id.*

[299] CTRS. FOR MEDICARE & MEDICAID SERVS., ADVANCE PAYMENT ACCOUNTABLE CARE ORGANIZATION MODEL FACT SHEET, (Oct. 20, 2011), *available at* http://innovations.cms.gov/Files/fact-sheet/Advance-Payment-Model-ACO-Fact-Sheet.pdf [hereinafter ADVANCE PAYMENT ACO FACT SHEET].

[300] *Id.*

[301] *Id.*

[302] Note that certain providers may not participate in the MSSP, at least initially. MSSP Final Rule, Fed. Reg. at 67977 (to be codified at 42 C.F.R. §425.114(a)). Under section § 425.114(a), participation in the Shared Savings Program is not permitted if one of the ACO participants "participates in the independence at home medical practice pilot program under section 1866E of the Act, a model tested or expanded under section 1115A of the Act that involves shared savings, or any other Medicare initiative that involves shared savings" such as the PGP, or the Pioneer ACO model. *Id.* Yet the models are fluid, and participants in one may subsequently switch to the other. *See, e.g.*, CTRS. FOR MEDICARE & MEDICAID SERVS., PIONEER/MEDICARE SHARED SAVINGS PROGRAM APPLICATION CROSSWALK http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Crosswalk_Instructions-Pioneer_Applicants.pdf (last viewed Oct. 6, 2012).

[303] MSSP Final Rule, Fed. Reg. at 67976 (to be codified at 42 C.F.R. § 425.112).

[304] MSSP Final Rule, Fed. Reg. at 67840–44, 67977 (to be codified at 42 C.F.R. § 425.202).

The ACA has carefully carved out a space for the ACO amid the existing regulations for health care organizations at the federal and state levels. Like other related provisions within the ACA, the MSSP concept of ACOs builds on ideas that have already succeeded in a variety of pilot and experimental programs. Some projects that have provided proof of concept for components of the MSSP ACO include: Physician Group Practice (PGP),[305] Medicaid Section 115 Waiver,[306] Section 1315 Waiver,[307] Medicare Disproportionate Share Hospital Scheme,[308] and Medicare Health Care Quality.[309]

The national framework allows for ongoing monitoring and feedback. The enthusiasm for ACOs is largely based on their perceived ability to reduce costs and provide improved care.[310] The expansion to a national scale makes oversight and shared learning essential. In the difficult conversion to ACOs, there is likely to be confusion and backsliding. The ACO rules do provide for auditing and feedback, and careful attention to these oversight functions is essential.

2. Diffusing the ACO Model

New Jersey's adoption of accountable care models after other states exemplifies discursive diffusion. Discursive diffusion theory suggests that various processes, including financial incentives, public discussion of waste and excessive costs, and evidence of geographically based poor outcomes, subtly transform national discourse and thus local organizations.[311] Diffusion is encouraged by the national frameworks that create the incentives to allow moving healthcare organizations to view the new concepts as practical.[312] Discursive diffusion allows leaders to diffuse their models to laggards through these various mechanisms. For example, when reports are

[305] *See* Benefits Improvement and Protection Act, § 412, Pub. L. No. 106-554 (2000).

[306] *See* Social Security Act,§ 1115, 42 U.S.C. § 1315 (2006); *see also Waivers,* MEDICAID.GOV, https://www.cms.gov/MedicaidStWaivProgDemoPGI/03 _Research&DemonstrationProjects-Section1115.asp (last visited Oct. 6, 2012).

[307] *See* 42 U.S.C. § 1315 (2006).

[308] *See* §§ 1395–1395ii.

[309] Medicare Health Care Quality (MHCQ), 42 U.S.C. § 1866C(b), *added by* Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) § 646 (Pub. L. 108-173), and *amended by* ACA §3021(c) (2010).

[310] For a cautionary paper, *see generally* Mantel, *supra* note 148.

[311] David M. Trubek & Louise G. Trubek, *Hard and Soft Law in the Construction of Social Europe: The Role of the Open Method of Coordination*, 11 EUR. L. J. 343, 357 (2005).

[312] *Id.*

written in terms set by new models of care, new concepts with definitions of reality embedded in them come to be accepted at all levels.[313] The role of consultants who widely advertise and indicate their ability to transform an existing organization into an ACO contributes to the diffusion, especially with the availability of websites and electronic information.[314] The Brookings-Dartmouth ACO Learning Network Services is one example.[315] It offers webinars, implementation work groups, member-driven conferences, and online tools and resources.[316] The MSSP encourages extensive use of metrics and benchmarks.[317] When healthcare providers see their performance benchmarked against others and against guidelines, "they must confront new policy paradigms and take on broad new concepts and vocabularies."[318]

A number of the Wisconsin health care organizations expressed a desire to serve as leaders in the ACO movement and therefore set the benchmarks that others should follow. For example, George Kerwin, Chief Executive Officer of Bellin, stated that he hopes to share Bellin's experience as a Pioneer ACO with other entities not part of the pioneer system.[319] Dean expressed having aspirations of national leadership.[320] Marshfield Clinic noted that it would rather be in control of implementing solutions to health care problems rather than responding to ultimatums.[321] Interestingly, this desire to lead is occurring despite the assumption that organizations that already operate in an efficient, high-quality manner will likely lose money in the short-term.[322] It is through leadership like that aspired to by

[313] *Id.*

[314] *See, e.g.*, *The Brookings-Dartmouth Partnership*, DARTMOUTH INST. FOR HEALTH POLICY & CLINICAL PRACTICE, http://www.brookings.edu/about/centers/health/about-us/collaborations (last visited Oct. 6, 2012).

[315] *Id.*

[316] *Id.*

[317] MSSP Final Rule, Fed. Reg. 67802, 67976 (Nov. 2, 2011) (to be codified at 42 C.F.R. § 425.112).

[318] Trubek & Trubek, *supra* note 311.

[319] Kerwin Presentation, *supra* note 58.

[320] Samitt Interview, *supra* note 53.

[321] Van Den Heuvel Interview, *supra* note 52; *see also* Toussaint, *supra* note 49 (noting that Wisconsin's implementation of health care quality measures and information sharing among Wisconsin providers and insurers has been voluntary and consensus driven but that at some point, it may be necessary for legislative action to assure that all providers comply with reporting expectations).

[322] Thompson Presentation, *supra* note 58 (noting that Gundersen's care coordination program is not compatible in the current payment system and causes Gundersen to lose approximately $10 million in charges each year that the system

Wisconsin health care organizations that will help diffuse best practices in the ACO model.

3. Learning Across ACOs

In addition to the vertical interaction between the local ACOs and the MSSP national framework, interaction between the ACOs and the community at the local level, and between ACOs around the country, are important dimensions. The flexibility and variety among the local ACOs permits and requires learning across regions.[323] The multi-tier structure was pioneered in the disease-management programs, and promoted in the community health centers.[324] These programs rely on regional communication across clinics to share data and successes and failures. These horizontal networks contribute to the success of the programs.[325]

V. ADOPTION OF THE MSSP AND OTHER ACO MODELS POST-ACA

Since the passage of the ACA, the rapid adoption of ACO models is notable. Wisconsin and New Jersey, the two states that are part of this study, demonstrate this rapid adoption. All the Wisconsin providers examined for this paper expressed a belief that they were providing accountable care before the ACA created a statutory mandate for the MSSP. Although take-up of the MSSP among Wisconsin providers has been quite diverse, the MSSP has appeared to fuel the already-existing interest in the ACO concept. Dean Health System was selected along with Bellin to participate as a "Pioneer ACO," but only Bellin decided to move forward with that option.[326] Bellin's Chief Executive Officer stated that Bellin moved forward with the Pioneer ACO model for several reasons: (1) it had been participating in the Medicare Advantage program, which has a similar capitated reimbursement model to the Pioneer ACO model; (2) the Medicare fee-for-service population consisted of twenty-seven

could have otherwise billed).

[323] *See* Louise G. Trubek & Maya Das, *Achieving Equality: Health Care Governance in Transition*, 29 AM. J. L. & MED. 395, 412 (2003).

[324] *Id.*

[325] *Id.*

[326] CTRS. FOR MEDICARE & MEDICAID SERVS., FACT SHEET ON THE PIONEER ACCOUNTABLE CARE MODEL (Dec. 19, 2011), *available at* http://innovations.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf (listing Bellin Thedacare Healthcare Partners as one of thirty-two Pioneer ACOs). Allina Health, a Minnesota health care system that serves Minnesota and Western Wisconsin, is also one of the thirty-two Pioneer ACOs, but is not discussed in this Article because it is based in Minnesota. *Id.*

percent of Bellin's total population, which is a significant enough number to make a difference, but not so significant that it would cause Bellin to collapse if the Pioneer ACO model fails to work; and (3) to better compete in the crowded Northeast Wisconsin healthcare provider market.[327]

Dean decided to pursue the two-sided risk ACO model instead of the Pioneer ACO model in part because it was not servicing Medicare Advantage patients and therefore would not be ready to launch a capitated model with Medicare patients by January 1, 2012, the start of the first Pioneer ACO performance period.[328] Dean fully intends, however, to become a Pioneer ACO at some point in the future.[329] Marshfield Clinic opted to continue its participation in the Medicare Physician Group Practice (PGP) demonstration, in which it was one of two physician groups who experienced shared savings in each year of the five-year demonstration period.[330] The other eight physician groups did not experience shared savings in all five years.[331] Finally, although the Monroe Clinic is excited about the concept of accountable care, it has decided to take the "wait and see" approach with regard to adopting any accountable care model, either within the MSSP or outside of it.[332]

In New Jersey, the MSSP is contributing to increased attention to collaborative, coordinated care. The prominent example of accountable care development in New Jersey is the New Jersey-based legislation for Medicaid ACOs.[333] A reformist physician in Camden,

[327] Kerwin Presentation, *supra* note 58 (noting that the approximately one million people living in Northeast Wisconsin can choose from Aurora, Affinity, Prevea/St. Vincent and St. Mary's, as well as Bellin).

[328] Dr. Craig Samitt, President and Chief Exec. Officer, Dean Health System, Presentation at ACO Innovators Symposium (Feb. 22, 2012).

[329] *Id.*

[330] Van Den Heuvel Interview, *supra* note 52; CTRS. FOR MEDICARE & MEDICAID SERVS., BROCHURE ON MEDICARE PHYSICIAN GROUP PRACTICE DEMONSTRATION 4 (July 2011), *available at* https://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf [hereinafter PGP FACT SHEET].

[331] *Id.* at 4–6.

[332] The March 2012 opening of a new building received priority over other plans to align physician compensation with global reimbursement initiatives. Sanders Interview, *supra* note 54.

[333] Legislative findings and declarations; accountable care organization (ACO) models as a tool to improve health care, N.J.S.A. § 30:4D-8.1 (2011); John V. Jacobi, Presentation at the Seton Hall Law Review ACO Symposium: Implementing the Affordable Care Act: What Role for Accountable Care Organizations? (Oct. 28, 2011), *available at* http://www.healthreformwatch.com/2011/11/02/livestream-podcast-seton-hall-law-review-aco-symposium/; Jeffrey Brenner, Founder and Executive Director of the Camden Coalition of Healthcare Providers, Presentation at

New Jersey, in cooperation with local hospitals, developed a program to serve high-cost, low-income patients through innovative tools.[334] A law professor, public interest lawyer, and physicians formed a group to enact statewide legislation to encourage this type of organization that they also termed an accountable care organization.[335] Though significantly different from the MSSP model, the legislation, with the aid of business support, provides a framework for developing other community-based ACOs in New Jersey.[336] This legislation encourages a community organizing approach.[337] While the incentives to develop the New Jersey Medicaid ACO are based on the low reimbursement rates for Medicaid and the substantial inequality in health care, calling it an "ACO" helped the legislation to pass.[338] The use of the ACO name also contributes to a more general acceleration of the transformation of health care organizations throughout the state.[339]

The commercial sector is demonstrating interest. The Blue Cross Blue Shield plan in New Jersey is participating in an acquisition of a communication network in order to "transform the delivery of health care in our country."[340] The Chief Executive Officer of the information technology company Lumeris stated that "[t]his innovative cloud-based solution will be fundamental to the success of payer-led accountable care initiatives nationwide."[341] Another initiative is the increasing formation of multispecialty practices. One

the Seton Hall Law Review ACO Symposium: Implementing the Affordable Care Act: What Role for Accountable Care Organizations? (Oct. 28, 2011), *available at* http://www.healthreformwatch.com/2011/11/02/livestream-podcast-seton-hall-law-review-aco-symposium [hereinafter Brenner Presentation].

[334] Gawande, *supra* note 134.

[335] Renee Steinhagen, John V. Jacobi, & Jeffrey Brenner, Presentations at the Seton Hall Law Review ACO Symposium: Implementing the Affordable Care Act: What Role for Accountable Care Organizations? (Oct. 28, 2011), *available at* http://www.healthreformwatch.com/2011/11/02/livestream-podcast-seton-hall-law-review-aco-symposium/.

[336] Joel C. Cantor, *Opinion: A Tale of Two ACOs*, NJ SPOTLIGHT (Feb. 7, 2012), http://www.njspotlight.com/stories/12/0206/1910/.

[337] Brenner Presentation, *supra* note 335.

[338] Cantor, *supra* note 336.

[339] *See id.*; *see generally* Elizabeth G. Litten, *ACOs: Getting More for Less,* 204 N.J.L.J. 522 (2011).

[340] *Blue Plans and Lumeris Complete Acquisition of Nation's Largest Real-Time Health Care Communications Network*, MARKETWATCH (Mar. 14, 2012), http://www.marketwatch.com/story/blue-plans-and-lumeris-complete-acquisition-of-nations-largest-real-time-health-care-communication-network-2012-03-14 (quoting Daniel J. Hilferty, President and Chief Executive Officer of Independence Blue Cross).

[341] *Id.*

article describing the initiation of these practices in New Jersey stated that "[s]uch group practices are being formed across the country as the government and health-insurance industry shift to paying for care based on the value of service rather than the volume of services."[342]

Nationwide, by the end of 2011, nearly one hundred health care organizations were developing contracts with private health plans based on an accountable care model, which included tying payment to improving patient care across the continuum and reducing overall spending growth.[343]

VI. LOOKING AHEAD: CHALLENGES AND OPPORTUNITIES

The transformative change to value-based care is underway, led by MSSP and joined by private payers. As the movement picks up steam, one challenge is whether governance through the national framework, horizontal sharing by ACOs, and patient-centeredness will be sufficient to move value-based care forward. The MSSP national framework may not supply adequate monitoring and measuring oversight.[344] For example, it is not clear how the MSSP framework as currently designed will provide oversight for private payers.[345] The rules do not provide tools or guidance to encourage sharing of knowledge and resources. There is no encouragement for horizontal linkages in the MSSP rules. In their filing with CMS, the REAP group noted the absence in the rules of encouragement for regional and statewide horizontal links.[346] The patient-centered goal has real limits in how it is framed. There are no requirements for participation in community planning for healthcare.[347] The group representation of patient interests is placed exclusively in the patient representative on the ACO governing board.[348]

Another challenge is the integration of ACOs into broader health care policy. As ACOs create their own internal organization,

[342] Post, *supra* note 89.

[343] Elliott S. Fisher et al., *Building the Path to Accountable Care*, 365 NEW ENGL. J. MED. 2445, 2445 (2011).

[344] Elliot Fisher & Stephen Shortell, *ACOs: Making Sure We Learn From Experience*, COMMONWEALTH FUND BLOG (Apr. 12, 2012), http://www.commonwealthfund.org/Blog/2012/Apr/ACOs-Making-Sure-We-Learn-from-Experience.aspx.

[345] *Id.*

[346] REAP Comment, *supra* note 242.

[347] *See* 76 Fed. Reg. at 67802-21; Brenner Presentation, *supra* note 338.

[348] MSSP Final Rule, 76 Fed. Reg. 67802, 67976 (Nov. 2, 2011) (to be codified at 42 C.F.R. §425.106(c)(2)).

will they make sure to integrate into broader medical, geographic, and patient networks? External networks that monitor stakeholder involvement are important. Some networks form to work on policy.[349] Others form to work on participation in delivery of services.[350] These networks can operate bottom-up or top-down.[351] These groups can provide support for the embedding and developing of effective patient engagement at all levels, from the local ACOs to the national framework. Three examples of the value of such external advocacy are: (1) patient participation in managed care in Wisconsin,[352] (2) community organizing in New Jersey,[353] and (3) REAP in the ACO rules debate.[354] In Wisconsin, the patient participation occurred in the initial passage of legislation encouraging MCO development.[355] After the national backlash against managed care organizations, Patients' Bills of Rights were promoted.[356] In Wisconsin, some physicians and patient groups united to work on the Wisconsin version.[357] While separate ACOs are competing in the market, collaborative efforts to maintain and improve the model, such as the Wisconsin example, are essential. These external local collaborations of physicians, community providers, and patient groups can provide training for patient representatives, provide information on community needs, and link to ACOs in other locations.

External stakeholders such as the National Committee for Quality Assurance, national patient advocacy groups, and major ACOs can develop a network that can facilitate learning across the ACOs. Fisher and Shortell suggest such groups can gather information on successes and failures in contract design, organizational capabilities, impact on patients, and impact on

[349] *See, e.g.,* Elliott Fisher, *Research*, The Dartmouth Inst. for Health Pol'y & Clinical Res., Geisel School of Med. at Dartmouth, *available at* http://tdi.dartmouth.edu/initiatives/accountable-care-organizations/research.

[350] *See, e.g., iPhysicianHub & ACO Services*, iPHYSICIANHUB, http://iphysicianhub.com/HubContent/PhysicianHubAndACOServices.aspx (last visited Oct. 5, 2012).

[351] *See* Trubek & Trubek, *supra* note 311.

[352] *See supra* section II.B.1 and notes 49 and 76.

[353] *See supra* section II.B.2 and notes 91 and 94.

[354] *See* REGULATORY EDUCATION & ACTION FOR PATIENTS, *supra* note 242.

[355] Louise G. Trubek, *Making Managed Competition a Social Arena: Strategies for Action*, 60 BROOK. L. REV. 275, 275, 298 (1994).; Queram Interview, *supra* note 76.

[356] Patient Rights and Resolution of Patient Grievances, WIS. ADMIN. CODE D.H.S. §§ 94.01–94.54 (2010) (providing for administrative regulation of patient rights in Wisconsin).

[357] Trubek, *supra* note 120, 591–92.

community-level heath and costs.[358] These groups can do this, in part, by monitoring how well the private and public payers are producing the data and making the data transparent.[359] However, Fisher and Shortell admit that there are major challenges to track performance at both the ACO level and the community level: "Without community-level aggregation, we will be hard pressed to know whether the new payment model is having an impact on what matters: the quality of affordability of care and the health of our communities."[360]

VII. CONCLUSION

The MSSP is not a panacea for all of the nation's ills in health care delivery and payment, but it holds much promise for achieving the goals of better health, better care, and lower costs. It is evident that the MSSP has incorporated lessons learned from the managed care and consumerism movements, particularly with including patient-centered criteria so that patients are engaged in ACO development and operation at the outset. The MSSP patient-centered criteria can serve as a model for all ACOs that wish to attain patient buy-in and ultimately, the full financial benefit of a value-based payment health care system. The MSSP also furnishes a framework for the ACO movement to spread across providers who can learn from one another, set new standards, and unify the fragmented system around providing all patients with high quality care at lower costs.

[358] Fisher & Shortell, *supra* note 344.
[359] *Id.*
[360] *Id.*