

6-9-2014

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Recommended Citation

Smith, Matthew (2014) "Lessons from the Enemy: HMO to ACO," *North Carolina Central University Science & Intellectual Property Law Review*: Vol. 7 : Iss. 1 , Article 10.

Available at: <https://archives.law.nccu.edu/siplr/vol7/iss1/10>

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LESSONS FROM THE ENEMY: HMO TO ACO

*Matthew Smith**

I hate admitting that my enemies have a point.¹

Introduction

Among the many pieces of the Patient Protection and Affordable Care Act (ACA),² accountable care organizations (ACOs)³ are among Congress's few seductions. Organizations who choose to participate in the program are promised new payments in exchange for changed incentives. While only the payment structures of those tempted organizations are directly impacted, Congress's hopes for cascading effects make ACOs' scope ambitious.⁴ Congress aims to control health-care costs while maintaining (or improving) quality and access;⁵ as some commenters have skewered: "have [their] cake and eat it too."⁶ Its starting point was unenviable. A century of undirected evolution left the country with a labyrinth of healthcare delivery systems.⁷ The payment structures that developed to accommodate, and influence, these various systems can seem similarly convoluted. However, efforts to tame these unwieldy structures are not new, nor is the realization that quality and access concerns are entwined with payment reform.⁸ With this history of success and failure to build on, ACOs incorporate some lessons of past reforms.

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1. SALMAN RUSHDIE, *THE SATANIC VERSES* 118 (Random House Trade Paperback ed., Random House 2008) (1988).

2. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010).

3. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 19,528 (Apr. 7, 2011).

4. *Id.* at 19,530-4 (proposed Apr. 7, 2011) (final rule published 76 Fed. Reg. 67801 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425.102).

5. *Id.* at 19,531.

6. Jessica Mantel, *Accountable Care Organizations: Can We Have Our Cake and Eat It Too?*, 42 SETON HALL L. REV. 1393, 1394 (2012).

7. *See generally* PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982).

8. For a dated, but thorough, discussion of some of the earliest reforms through the late 1970s, *see Id.* at 235-419; For a more recent study of current

But not all. ACOs attempt to meld the effective and popular aspects of health maintenance organizations (HMOs) into the varied delivery systems across the country.⁹ Proponents are quick to highlight how ACOs are not a reincarnation of HMOs.¹⁰ After all, HMOs have a bad name.¹¹ Consequently, ACOs attempt this melding without the most maligned aspects of HMOs: the rationing of care and lack of patient choice.¹² Unfortunately, these were some of the very aspects that drove HMOs' success in controlling costs.¹³ Instead, ACOs focus on changing individual physician practice patterns.¹⁴ This paper argues this focus is too narrow. Some aspects of financial accountability that drove HMOs' successes, and were the conceptual basis for ACOs,¹⁵ have been neglected in the transition from concept to policy. In this respect, at least, it is not that ACOs are too much like HMOs, but that they are too little.

In focusing exclusively on physician practice patterns, the systemic balance¹⁶ bolstering HMOs' success in controlling costs is ignored. For ACOs that already have inherent accountability for systemic capacity, those most closely resembling old-style HMOs to begin with, correcting this neglect is not critical to their success. However, while financial accountability for individual physicians should remain the focus of ACOs, the successful elements of systemic accountability can be introduced to bolster not only success within ACOs, but outside them in the broader healthcare market. In

payment reforms, see Eric Schneider et al., *Payment Reform*, RAND HEALTH (2011), http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR841.pdf.

9. Michael Birnbaum, *A Conversation with Donald Berwick on Implementing National Health Reform*, 37 J. HEALTH POL. POL'Y & L. 709, 723 (2012).

10. *Id.*

11. E.g. Thomas William Malone & Deborah Haas Thaler, *Managed Health Care: A Plaintiff's Perspective*, 32 TORT & INS. L.J. 123 (1996).

12. Birnbaum, *supra* note 9, at 723.

13. E.g. Melinda Caliendo, *In Considering New Care Model, Stigmatism of HMO at Forefront*, NJBIZ (Oct. 29, 2012), http://www.njbiz.com/article/20121029/NJBIZ01/121029877/-1/this_weeks_issue/&template=printart.

14. Birnbaum, *supra* note 9, at 722.

15. Elliot S. Fisher et al., *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, 26(1) HEALTH AFF. w44, w44 (2007), available at <http://content.healthaffairs.org/content/26/1/w44.full.html>.

16. Systemic balance, or systemic capacity, is used in this paper to refer to the efficient supply of healthcare resources available in a healthcare community. These resources include both personnel, including physicians, and healthcare facilities. See *infra* Part II.A.

their effort to avoid HMO comparisons, ACOs are missing a critical aspect of cost control.

Part I defines ACOs and their relationship to HMOs, and explains why they may have a chance for a larger and more lasting impact. The relationship between ACOs and HMOs is important not only as predecessor and successor, but because analogies to HMOs both help define ACOs and tell a cautionary tale for their future. Part II furthers that comparison by identifying some beneficial characteristics of HMOs that are absent from ACOs. As this paper focuses in particular on HMOs' inherent ability to balance capacity, the cost implications of capacity imbalance in the healthcare system are discussed. Part III discusses the focus and purpose of the regulations that created ACOs and how those regulations may indirectly affect capacity balance. This section also discusses ACOs' positioning to make capacity decisions and ways in which those decisions might be encouraged.

I. The Idea: From HMO to ACO

The traditional fee-for-service payment model, in which payment is based on the volume and intensity of services delivered, incentivizes the provision of more services.¹⁷ More services cost more. ACOs are not the first reform to co-opt this syllogism. Since the Health Maintenance Organization Act of 1973¹⁸ removed barriers to managed care,¹⁹ managed care has sought to limit unnecessary volume and intensity through gatekeeping, capitation payments, and cost-saving incentives.²⁰ It worked. As costs have continued to rise, so too has the prevalence of managed care.²¹ HMOs, where patients pay a fixed fee in exchange for highly-controlled healthcare, are the pinnacle of this move towards micromanaging the basic incentive structure of healthcare.²²

17. Stanley S. Wallack & Christopher P. Tompkins, *Realigning Incentives In Fee-For-Service Medicare* 22(4) HEALTH AFF. 59, 61-2 (2003).

18. 42 U.S.C. § 300e-10 (1973).

19. Edward Richards, *The Rise of MCOs*, Public Health Law Map, LSU Law Ctr., <http://biotech.law.lsu.edu/map/TheRiseofMCOs.html>. Last updated April 19, 2009.

20. See Christopher B. Forrest, *Primary Care Gatekeeping Referrals: Effective Filter or Failed Experiment?*, 326 BRIT. MED. J. 692 (Mar. 29, 2003).

21. David Mechanic, *The Rise and Fall of Managed Care*, 45 J. HEALTH & SOC. BEHAV. 76, 77 (2004).

22. *Id.*

A. An Inverse Definition

HMOs were not universally, or even mostly, well-received. Physicians resented their lost autonomy and income potential, while patients feared quality of care was sacrificed to cost.²³ The legislative responses to these concerns included patient bills of rights and increased regulatory oversight.²⁴ However, these responses both limited the growth of health maintenance organizations and diluted their effectiveness.²⁵ The HMO experience—wildly unpopular, if somewhat effective, cost control—influenced ACO policy formation. ACOs were designed to exclude some of HMOs least popular features, while retaining their cost-saving benefits.²⁶ Most specifically, ACOs do not force patients to use particular providers.²⁷ While ACOs are loosely defined, proponents are near-universal in defining what they are not: HMOs. Donald Berwick, former CMS administrator, emphasized ACOs “pull[] one of the two fangs out of managed care: loss of choice.”²⁸ ACOs do this by eliminating HMOs most unpopular hallmarks: gate-keeping, closed networks, and capitation.²⁹ Defining ACOs as an inverse, of course, is neither precise nor necessarily accurate.

Yet ACOs elude simple definition. As ACOs began trending in 2010 and 2011, health conference attendees’ favorite joke compared them to unicorns—everyone had heard of them, but no one had ever seen one.³⁰ They are a concept defined by the policy implementing them. Healthcare.gov, a consumer-focused government information site, defines ACOs as “a group of health care providers who give coordinated care, chronic disease management, and thereby improve

23. 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); Robert J. Blendon et al., *Understanding the Managed Care Backlash*, 17(4) *HEALTH AFF.* 80 (1998).

24. Blendon, *supra* note 23.

25. *See generally*, Mark A. Hall, *The Death of Managed Care: A Regulatory Autopsy*, 30(3) *J. HEALTH POLITICS, POL’Y & L.* 427 (2005).

26. Barbara J. Zabawa et al., *Adopting Accountable Care Through the Medicare Framework*, 42 *SETON HALL L. REV.* 1471, 1485-92 (2012).

27. *Id.* at 1497-8.

28. Birnbaum, *supra* note 9 at 723.

29. *Id.*

30. Sherri Sellmeyer, *ACOs: Cloven Hooves and a Horn?* *HEALTHCARE REFORM BLOG* (Mar. 15, 2011, 10:01 AM), <http://hl-isy.com/Healthcare-Reform-Blog/March-2011/ACOs>.

the quality of care patients get.”³¹ Almost as an afterthought, and emphasizing the quality component over the cost component, the site mentions ACOs’ defining feature: “the organization’s payment is tied to achieving health care quality goals and outcomes that result in cost savings.”³² The Center for Medicare and Medicaid Services’ (CMS) regulations are more explicitly circular. “Accountable care organization (ACO) means a legal entity that is. . . formed by one or more ACO participants. . .” “ACO participant means an individual or group of ACO provider(s). . .that . . .comprise(s) an ACO. . .”³³ While not particularly helpful, these definitions illustrate the difficulty in succinctly defining an organization whose quintessential characteristic is its payment structure. That payment structure, in turn, is defined in terms of the goals its proponents hope to achieve. Those goals, which CMS poetically coins the “three-part aim,” are “(1) Better care for individuals; (2) better health for populations; and (3) lower growth in expenditures.”³⁴ Despite any circularity, it is this payment structure and the goals it is hoped to achieve that define ACOs. Unfortunately, ambitious payment structures accommodate neither easily marketable description nor easy regulatory definition.

The payment structure ACOs are designed to accommodate builds philosophically on previous programs. During the 1990s, CMS first demonstrated through a group of experimental projects that financial incentives could induce providers to deliver more cost-efficient care.³⁵ These projects, unlike ACOs, were more limited in their cost-saving mechanisms. CMS shared savings from providers’ use of cheaper alternatives to expensive supplies and medications with hospitals.³⁶ Hospitals then shared some of these financial benefits with providers.³⁷ While the program was successful in limiting cost

31. Accountable Care Organization, <https://www.healthcare.gov/glossary/accountable-care-organization/>

32. *Id.*

33. Definitions, 42 C.F.R. § 425.20 (2013).

34. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,804 (2011); Donald Berwick, CMS administrator at the time of the ACO regulations adoption, originally termed this “the triple aim.” Donald M. Berwick et al., *THE TRIPLE AIM: CARE, HEALTH, AND COST*, 27(3) *HEALTH AFF.* 759 (2008).

35. R. Wilensky et al., *Gain Sharing: A Good Concept Getting A Bad Name?*, 26(1) *HEALTH AFF.* w58, w58-w67 (2007), <http://content.healthaffairs.org/content/26/1/w58.full>.

36. *Id.* at w62.

37. *Id.*

growth, then-current laws prohibited the financial relationships the program necessarily entailed.³⁸ The agency chose to halt expansion beyond the demonstration stage until Congress changed those laws.³⁹ This did not stop further experiments into the concept, however. Since 1995, CMS has undertaken fifty-seven demonstration projects to study different strategies of cost-containment,⁴⁰ prompting some to snipe that a “holy grail” that solves both the country’s quality and cost problems is unattainable.⁴¹

ACOs are an outgrowth of those demonstration projects which optimists seem to view as that very panacea.⁴² It is that goal and those policies that define ACOs. Insofar as they are defined broadly as a new payment philosophy and not the organizational structure and policies attempting to implement that philosophy, the optimists may have their panacea. Such an all-encompassing definition, however, probably does a disservice to previous and concurrent reform efforts. Many reforms since the 1973 HMO Act, and the ACA’s major cost reforms—most fashionably, but not exclusively, ACOs—work to shift the basic payment structure away from a fee-for-service model.⁴³ Defining ACOs as the philosophical shift away from the fee-for-service model is thus simplistic and overgenerous. Nonetheless, these specific policies attempting to foster that philosophical shift outline ACOs. ACOs themselves are merely the organizations that have signed up.

B. A Policy Construct

ACOs as a policy are largely an accumulation of best practices of those previous projects. The projects tested the effectiveness of concepts including coordinated care, chronic disease management,

38. *Id.*

39. *Id.*

40. List of demonstration projects and associated reports, *available at* <http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Medicare-Demonstrations.html>.

41. Theodore Marmor & Jonathon Oberlander, *From HMOs to ACOs: The Quest for the Holy Grail in U.S. Health Policy*, 27(9) J. GEN. INTERNAL MED. 1215 (2012).

42. *See generally* Donald M. Berwick, *ACOs: Promise, not Panacea*, 318(10) JAMA 1038 (2012).

43. Timothy C. Gutwald, *Bending the Health Care Cost Curve*, 90-JUN MICH. B. J. 20, 21 (2011).

and consumer-focused healthcare.⁴⁴ Not all demonstrations improved quality of care; of those that did not all decreased costs.⁴⁵ Nonetheless, these projects contributed to ACO policy and are expected to continue to do so. As the first CMS initiative to employ a pay-for-performance scheme for physicians, the Physician Group Practice (PGP) Demonstration Project was the most conceptually similar project to ACOs.⁴⁶ Under this program ten large physician groups, ranging in size from 232 to 1,291 affiliated physicians, were compensated under traditional fee-for-service terms but were additionally incentivized with “performance payments” based on quality measures and cost savings over set benchmarks. Four of the ten were able to sustain significant cost savings, while all “undoubtedly” improved access, care, and quality.⁴⁷

While the PGP Demonstration is ACOs’ most direct predecessor, other demonstrations also contributed conceptually. Of the ongoing demonstration projects, seven projects’ participants were disqualified from participation as ACOs until their projects’ termination because the projects were so similar as to involve duplicative payments.⁴⁸ Further, demonstration projects continue to be part of CMS’ strategy for improvements. Through an Innovation Center established under the ACA,⁴⁹ CMS continues to run projects and incorporate successful concepts into its national program.⁵⁰

While these demonstration projects showed the cost saving philosophies inherent to HMOs could be applied in different contexts, the demonstration participants were often large integrated health systems or large multi-specialty practice groups.⁵¹ In short, much like

44. See List of demonstration projects and associated reports, *supra* note 40.

45. *Id.*

46. See generally OFFICE OF RESEARCH, DEV., AND ORG., DEP’T OF HEALTH AND HUMAN SERVICES, MEDICARE PHYSICIAN GROUP PRACTICE DEMONSTRATION (2011).

47. OFFICE OF RESEARCH, DEV., AND ORG., DEP’T OF HEALTH AND HUMAN SERVICES, REPORT TO CONGRESS: PHYSICIAN GROUP PRACTICE DEMONSTRATION PROJECT EVALUATION REPORT (2009).

48. Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,831-4 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425.102); 42 U.S.C. § 1395jjj(b)(4) (2013).

49. Patient Protection and Affordable Care Act, § 3021, 42 U.S.C. § 1315a (2010).

50. 76 Fed. Reg. at 67,835-6 (2011) (comments and responses discussing the Innovation Center).

51. PGP Demonstration Project, *supra* note 46.

the original HMOs. Seven of the ten PGP participants, in fact, ran or owned an associated HMO.⁵² Viewing size as a prerequisite limited the concept's scalability; the majority of providers in the United States practice in a solo or small-group setting.⁵³ Unlike large systems where a patient receives all (or most of) their care within the system, solo and small-group physician practices provide only a fraction of a patient's total care.⁵⁴ Individual physicians have too little connection to, and too little control over, the other care their patients receive to be held responsible for total costs.⁵⁵ Thus, under the project's model, while an HMO or a large multi-specialty group could be held responsible for a patient's total cost, physicians in small practices could not be. This limitation prevented any findings from the project from being applied on a large scale.

A Dartmouth researcher, Elliot Fisher, is credited with bridging this gap.⁵⁶ He suggested that the provision of healthcare is not as fragmented as the number of individual and small-practice physicians might suggest.⁵⁷ Even when the delivery of patient care is not coordinated through an integrated organization, it is most often focused around a local hospital and the physicians practicing therein.⁵⁸ From this insight, he suggested the appropriate locus for cost accountability was the "extended hospital medical staff."⁵⁹ As such a group of physicians, anchored (at least theoretically) around a local hospital, provided the majority of a patient's care, that community of physicians could be held accountable for a patient's total cost. While critics noted community accountability bucks the trend away from consolidated care (a backlash from the managed care of the 1990s) and long held notions of physician autonomy,⁶⁰ Congress and CMS seized upon the idea.

52. *Id.*

53. Lawrence P. Casalino et al., *Benefits of and Barriers to Large Medical Group Practice in the United States*, 163(16) ARCHIVES OF INTERNAL MED. 1958 (2003).

54. Fisher, *supra* note 15 at w44.

55. Fisher, *supra* note 15.

56. *Id.* at w52-w53.

57. *Id.* at w45.

58. *Id.*

59. *Id.*

60. Amy M. Lischko et al., MASS. MED. SOC'Y, PHYSICIAN PAYMENT REFORM 31-2 (2008).

Applying the idea to practice, ACOs hold primary care physicians, as the representatives for that physician community, responsible for total patient costs.⁶¹ This broad accountability parallels the HMO model, which holds a health plan or integrated health system accountable for patients' total cost. Thus, proponents contend, ACOs achieve the integrative benefits of HMOs without all of their restrictions.⁶² The structural differences permitting this are 1) holding individual physicians accountable for patient costs rather than a large group or integrated health system, 2) contracting directly with providers instead of contracting through a health plan intermediary, and 3) greater flexibility in allowing different types of organizations to participate.⁶³ While some of these structural differences limit the ways ACOs may control costs, they also hold the potential for ACOs to have a wider ranging impact than did HMOs.

C. An Expanded Impact

ACOs share HMOs' emphasis on primary care, but increased flexibility and geographic spread expand their possible reach and impact, and any integrative benefits accompanying them. More thoroughly integrated health systems, like HMOs, are limited in their systemic impact to the urban areas they predominantly serve. The HMO model is ill-suited to smaller markets because of the integral part economies of scale play in their cost savings.⁶⁴ Correspondingly, HMO penetration rates are negatively correlated with market size.⁶⁵ They have little means (or motive) to change markets outside their own. The greater flexibility of ACOs is the response. Participation in the ACO program is not limited to large physician groups or those with an institutional sponsor.⁶⁶ While these flexibilities are designed

61. Assignment of Medicare Fee-for-service Beneficiaries to ACOs, 42 U.S.C. § 1395jjj(c) (2010).

62. Birnbaum, *supra* note 9 at 723.

63. Kelly Devers & Robert Berenson, *Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?* URBAN INST. 5 (2009).

64. Douglas Wholey et al., *Scale and Scope Economies Among Health Maintenance Organizations*, 15(6) J. HEALTH ECON. 657 (1996).

65. Large Metropolitan Markets Have Highest HMO Penetration Rates According to New Research from InterStudy Publications" PRNEWswire, http://insurancenewsnet.com/article.aspx?a=featured_pr&n=1&id=15242#.UTeT4jCOK So (last visited Sept. 8, 2013).

66. Medicare Shared Savings Program, 42 U.S.C. § 1395jjj(b) (2010); Eligible providers and suppliers, 42 C.F.R. § 425.102 (2012).

to bring greater numbers into the integrative fold, an emphasis on primary care may, in part, limit costs.

In addition to cost savings, other benefits are hoped to accompany this emphasis. Primary care does appear to have a positive impact on population health. This relationship appears to be independent of increased healthcare supply generally.⁶⁷ Though increased total physician supply is associated with improved health outcomes, increased supplies of primary care physicians show stronger correlation.⁶⁸ More directly, while some sociodemographic factors associated with increased primary care supply cloud results, evidence suggests that primary care has a positive influence on several measures of population health.⁶⁹ Among the factors that contribute to these improved outcomes is primary care's increased focus on prevention, early management of health problems, and reduction of unnecessary specialty care.⁷⁰ These qualitative factors logically suggest cost efficiencies. In practice, the relationship between cost efficiencies and either early management or preventative care is less certain.⁷¹ Despite this uncertainty Congress, through the ACA, made clear their desire for an increased role for primary care.⁷²

CMS further emphasized the centrality of primary care physicians in its ACO regulations. While the greater flexibility ACOs offer allows any physician to form an ACO, Medicare beneficiaries are assigned to an ACO based on the primary care services a primary care provider (PCP) delivers.⁷³ PCPs are defined as physicians with a specialist designation of general practice, primary care, internal medicine, or geriatric medicine.⁷⁴ Given Dr. Fisher's insight to hold a community of physicians responsible for patient costs, the choice of primary care physicians as the locus was perhaps the most obvious

67. Richard A. Cooper, *States With More Physicians Have Better-Quality Health Care*, 28(1) HEALTH AFFAIRS w91 (2009).

68. *Id.*

69. Barbara Starfield et al., *The Effects Of Specialist Supply On Populations' Health: Assessing The Evidence*, HEALTH AFFAIRS (2005). <http://content.healthaffairs.org/content/early/2005/03/15/hlthaff.w5.97.full.pdfhtml>.

70. Barbara Starfield et al., *Contribution of Primary Care to Health Systems and Health*, 83(3) MILBANK QUARTERLY 453, 474-83 (2005).

71. Joshua T. Cohen et al., *Does Preventative Care Save Money?*, *Health Economics and the Presidential Candidates*, 358 NEW ENG. J. MED. 661 (2008).

72. Patient Protection and Affordable Care Act, 42 U.S.C. § 1395jjj(c) (2010).

73. Basic Assignment Methodology, 42 C.F.R. § 425.402 (2012).

74. Definitions, 42 C.F.R. § 425.20 (2012).

option, but not the only one. While the statute specifies beneficiary assignment to an ACO based on utilization of primary care services,⁷⁵ the statute does not mandate who provide those services. Many commenters suggested specialists providing primary care services should be eligible for beneficiary assignment.⁷⁶ While CMS's final rule blends these two approaches, the statute's intentional emphasis on primary care is retained, and assignment is done first through the services a PCP provides. While this does not prohibit a specialist from providing primary care services, assignment based on those services occurs only in the absence of a PCP.⁷⁷ It is this emphasis on primary care throughout the ACO regulations, and throughout the ACA, that proponents contend will encourage preventative medicine and discourage overutilization, ultimately limiting costs.⁷⁸

HMOs' awkward fit in small markets, and physician fears in all markets, contributes to a limited spread and depth of integrative benefits. Of the HMOs operating in rural areas, most are network HMOs instead of fully integrated systems.⁷⁹ As a diluted version of the fully integrated HMO model, network HMOs' integrative benefits appear more limited. For example, HMO networks have limited impact on referral patterns in rural areas because the lower number of available physicians curtails HMOs' ability to control the entire sphere of a patient's care.⁸⁰ A primary care provider (PCP) may have little choice but to refer to an out-of-network specialist with no participating specialists nearby. HMOs' limited presence in smaller and rural markets further limits any wider integrative effects they might exert.

ACOs, in contrast, are explicitly envisioned to extend to rural markets. CMS changed ACO eligibility requirements to encourage the "highly desired" participation of rural health clinics.⁸¹ Medicare's

75. Patient Protection and Affordable Care Act, 42 U.S.C. § 1395jjj(c) (2010).

76. Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,854-6 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425.102).

77. *Id.*

78. Peter Boland et al., *Accountable Care Organizations Hold Promise, But Will They Achieve Cost and Quality Targets?*, *MANAGED CARE* 12, 13 (Oct. 2010), available at <http://www.managedcaremag.com/archives/1010/1010.ACOs.html>.

79. Anthony Wellever, *Implications of HMOs for Rural Providers and Consumers*, 14(3) *J. RURAL HEALTH* 268 (2008).

80. *Id.*

81. Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,813 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425.102).

(and potentially ACOs') much larger patient base amplifies any systemic integrative benefits ACOs may generate. In communities integrated systems already serve, ACOs may extend integrative incentives to physicians wary of the HMO model. As some physicians resist attempts to integrate fearing lost autonomy,⁸² ACOs may offer a model that allows such practitioners to maintain their autonomy while reaping some of the benefits of integration. To the extent ACOs confer these benefits and alleviate physicians' fears of lost autonomy, they both extend the geographic reach and deepen the penetration of integrative benefits.

Not everyone is convinced ACOs can limit costs or improve quality of care. Some contend that medical "waste" cannot be eliminated without accompanying reductions in quality.⁸³ In creating incentives to eliminate such waste, ACOs may create incentives to reduce quality. Even proponents acknowledge that ACO growth will be limited to the extent they are perceived as "HMOs in drag."⁸⁴ If consumers associate ACOs with the lack of choice and rationing of care popularly associated with HMOs, patients will be reluctant to see participating physicians. These reservations illustrate both the challenges ACOs face and the external forces that may limit the cost savings they are able to achieve.

ACOs' ability to achieve cost savings directly is also questioned. These critics suggest the ever increasing costs of medical technology alone will make the cost savings ACOs achieve fickle and ephemeral.⁸⁵ Because preventative medicine's cost efficiency is inconsistent, this too may not be the source of savings proponents imagine. Some studies even suggest preventative medicine increases costs.⁸⁶ If born out, while not necessarily fatal, such quality and cost concerns urge increased regulatory oversight. These concerns emphasize the importance of the continuous improvement (partially through demonstration projects) ACOs' policy structure hopes to facilitate. The factors that may limit the cost savings ACOs are able to achieve only heighten the need to fully exploit any benefits ACOs may offer.

82. See Casalino et al., *supra* note 53.

83. Mantel, *supra* note 6.

84. Devers & Berenson, *supra* note 63 at 5.

85. Mantel, *supra* note 6 at 1426.

86. Joshua Cohen et al., *Does Preventative Medicine Save Money? Health Economics and the Presidential Candidates*, 358 N. ENG. J. MED. 661 (2008).

Systemic Balance: From Patient to Provider

ACOs will not exactly replicate the successes HMOs enjoyed in controlling costs. ACOs' intentional differences from HMOs place constraints on these savings. The rationing of care and lack of patient choice closely associated with the HMO model did constrain costs, but were omitted from the ACO model because their unpopularity ultimately limited HMOs' spread.⁸⁷ HMOs used rationing and limitations on choice as indirect constraints on systemic capacity.⁸⁸ Single entity HMOs could directly constrain capacity through their personnel and facility construction decisions. These capacity constraints contributed to the model's cost savings,⁸⁹ but are absent from ACOs. While such constraints perhaps lie outside the patient-centered focus of the program, they are within the scope of the legislation. Ignoring them unnecessarily limits ACOs' cost saving potential.

Congress outlined its goals for ACOs via the ACA. The act authorizes "the Secretary [to] establish a shared savings program . . . that promotes accountability for a patient population and coordinates items and services under [Medicare] parts A and B . . . , and encourages investment in infrastructure and redesigned care processes for high quality and efficient care delivery."⁹⁰ In formulating its ACO regulations, CMS was careful to stay within this statutory authorization. In doing so, CMS adopted a markedly patient and provider centered approach, to the exclusion of system structure. CMS detailed its eight goals for ACOs in its first proposed rule, referencing them in its final rule.⁹¹ Of these eight goals, seven focus on the internal operation of an ACO, most frequently in how those goals affect patients. The only listed external goal refers to care transitions, targeting smooth coordination for patients.⁹² Given CMS's concerns that quality may be sacrificed to cost efficiencies,⁹³ this focus on patients is understandable. Further, the statute's mention of quality places this

87. See generally *Mechanic*, *supra* note 21.

88. In contrast, most single-payer systems use direct restraints. Neelam K. Sekhri, *Managed Care: The US Experience*, 78(6) BULL. WORLD HEALTH ORG. 830, 837 (2000).

89. *Id.*

90. Medicare Shared Savings Program, 42 U.S.C. § 1395jjj(a)(1) (2010).

91. Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 19,528, 19,533-4 (proposed April 7, 2011) (to be codified at 425 C.F.R. pt. 425).

92. *Id.*

93. Birnbaum, *supra* note 9 at 722.

focus squarely within the bounds of the statute. However, the regulations narrow the focus beyond the statute's requisites. The HMO experience may have driven CMS concerns about quality, and CMS may have written its regulations to avoid direct mention of integration to avoid inciting fears of loss of choice. Nonetheless, in narrowing its focus, CMS neglects potential cost-saving, integrative opportunities.

The regulations focus their reform efforts on individual behavior rather than system structure. This focus stems from the value-based purchasing concept that CMS hopes will replace the traditional fee-for-service model.⁹⁴ Value-based purchasing "links payment directly to the quality of care provided," and thus does not encourage volume in the way the traditional model does.⁹⁵ This reflects a view that individual provider incentives are driving the overutilization of care. Even physicians agree the fee-for-service model contributes to overutilization.⁹⁶ But other factors also certainly contribute.⁹⁷ In focusing exclusively on individual provider incentives, however, systemic factors driving higher costs are ignored. While encouraging change in individual physician behavior via value-based purchasing is a direct means to control costs, ACOs could also encourage broader systemic change that influences patient decisions and community capacity decisions.

A. Community Capacity Decisions

Community capacity encompasses all the medical facilities and providers in a defined region, including physicians, hospitals, and ancillary facilities.⁹⁸ Attempts to manage capacity as a cost control mechanism have addressed physicians and facilities separately. Many states passed certificate of need (CON) laws that imposed regulatory controls on the construction of new medical facilities, including hos-

94. Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 19,528, 19,530 (proposed April 7, 2011) (to be codified at 25 C.F.R. pt. 425).

95. *Id.*

96. Ezekiel J. Emanuel & Victor Fuchs, *The Perfect Storm of Overutilization*, 299(23) JAMA 2789 (June 18, 2008).

97. *Id.*

98. This is the definition used in this paper and corresponds with Fishers' concept. Fisher, *supra* note 15.

pitals and ancillary facilities.⁹⁹ The federal government followed suit with the National Health Planning and Resources Act of 1974.¹⁰⁰ These laws were enacted to counter a perceived oversupply of medical facilities, but were unpopular as they effectively imposed upper limits on facility supply and entrenched established players.¹⁰¹ In time, policymakers reversed course, deciding the laws were constraining facility supply with undue burdens, and thereby increasing costs.¹⁰² The federal law was repealed, with many states following suit.¹⁰³ Nonetheless, many states continue to use CON laws as a mechanism to control costs through facility capacity.¹⁰⁴ Amid the politics and subjective requirements of CON decisions, the efficacy of these laws continues to be questioned.¹⁰⁵

Physician capacity has also received policymakers' attention. This capacity refers to both the total number of physicians for a defined population and the services those physicians provide.¹⁰⁶ As such, physician capacity reflects not only the number of physicians, but the mix of primary care and specialist physicians.¹⁰⁷ Competitive entrance into medical schools, the subsidization of medical education, and licensure requirements were all implemented to ensure the quality of physician care.¹⁰⁸ However, state licensure requirements and competitive medical school admissions erect barriers to entry into the profession, and thus also influence the market dynamics of physician supply. Government funding of medical education decreases barriers

99. Mark E. Kaplan, Comment, *An Economic Analysis of Florida's Hospital "Certificate of Need" Program and Recommendations for Change*, 19 FLA. ST. U. L. REV. 475, 478 (1991).

100. National Health Planning and Resources Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975) (repealed 1986).

101. Lauretta Wolfson, *State Regulation of Health Facility Planning: The Economic Theory and Political Realities of Certificates of Need*, 4 DEPAUL J. HEALTH CARE L. 261 (2001).

102. *Id.* at 269-72.

103. *Id.*

104. Lauretta Wolfson, *State Regulation of Health Facility Planning: The Economic Theory and Political Realities of Certificates of Need*, 4 DEPAUL J. HEALTH CARE L. 261 (2001).

105. Tracy Yee et. al., *Health Care Certificate-of-Need Laws: Policy or Politics?*, INSTITUTE FOR HEALTHCARE REFORM (MAY 2011), http://www.nihr.org/CON_Laws.html.

106. See Fisher, *supra* note 15 at w53.

107. *Id.*

108. Richard Cooper, *Human Inputs: The Health Care Workforce and Medical Markets*, 26 J. HEALTH POL. POL'Y & L. 925, 927 (2001).

(for instance, subsidizing students' debt), thus influencing total physician capacity, but also influences the composition of that capacity by funding specialist training. Since their implementation, these quality measures have been commandeered to influence the size and composition of physician supply, rather than its quality.¹⁰⁹ While regulatory action typically lags identified supply issues, policymakers continue to make adjustments in response to capacity.¹¹⁰

Policies to influence physician location decisions have also been popular. While the last twenty years has seen an increase in the total number of physicians, large geographic capacity variations persist.¹¹¹ Capacity management policies have influenced physicians' decisions,¹¹² but location preferences remain the major determinant of capacity in a given region.¹¹³ Illustratively, programs to encourage physicians to locate in underserved areas are estimated to have a significant, but small, effect (10%).¹¹⁴ This combination of preferences and policies results in large variations. Washington, DC has over three times as many specialists per capita as Wichita, KS, but less than twice as many primary care physicians.¹¹⁵ Physicians, like other workers, make location decisions based on personal preferences and market conditions. However, regulatory structures, especially those involving financial incentives, can influence their choices.¹¹⁶ This demonstrates that policies encouraging balanced capacity and market forces effect physician workforce composition. ACO policy,

109. *Id.* at 927.

110. David Blumenthal, *New Steam from an Old Cauldron — The Physician-Supply Debate*, 350 *NEW ENG. J. MED.* 1780 (2004).

111. *Id.*

112. Denis Bolduc et al., *The Effect of Incentive Policies on Practice Location of Doctors: A Multinomial Probit Analysis*, 14(4) *J. LAB. ECON.* 703 (1996).

113. David C. Goodman, *Trends: Twenty-Year Trends In Regional Variations In The U.S. Physician Workforce*, *HEALTH AFF.* (2004), <http://content.healthaffairs.org/content/early/2004/10/07/hlthaff.var.90.full.pdf> (lasted visited Mar. 7, 2013).

114. George M. Holmes, *Increasing Physician Supply in Medically Underserved Areas*, 12(5) *LAB. ECON.* 697 (2005).

115. *Washington, DC (HRR)*, *DARTMOUTH ATLAS OF HEALTHCARE* (2006), <http://www.dartmouthatlas.org/data/region/profile.aspx?loc=344.>; *Wichita, KS (HRR)*, *DARTMOUTH ATLAS OF HEALTHCARE* (2006), <http://www.dartmouthatlas.org/data/region/profile.aspx?loc=348>.

116. Bruce E. Carpenter, *An Analysis of the Location Decision of Young Primary Care Physicians*, 27(2) *ATLANTIC ECON. J.* 135 (1999); A.H. Krist et al., *Title VII funding and physician practice in rural or low-income areas.*, 21(1) *J. RURAL HEALTH* 3 (2005).

therefore, will not only influence this workforce composition but may be managed to influence it.

B. The Costs of Imbalance

Congress recognized the importance of primary care when establishing the shared savings program, and mandated primary care utilization determine a beneficiary's ACO assignment.¹¹⁷ This assignment places accountability for patient cost squarely on PCPs. CMS's regulations emphasize primary care through their direct effect on the provision of healthcare to beneficiaries, but do not encourage any systemic effects they might induce. This narrowing was not necessary to comply with the statute's terms, and misses an important part of the original ACO concept in failing to establish physician accountability for community capacity. Elliot Fisher's original "extended medical staff" model¹¹⁸ envisioned an institutional component to the group accountable for patient cost. "The most important reason to focus on hospitals and their medical staffs is to establish accountability for decisions about capacity."¹¹⁹ That institutional component of a group of physicians, subsequently termed ACOs, would enable an influence on those community capacity decisions that have an impact on cost. Such capacity decisions impact cost through their effects on supply sensitive services.

Demand for such services increases as their supply increases. In Fisher's original conception, supply sensitive services included office "visits, specialist consultations, tests, imaging services, and the use of institutional settings (rather than outpatient settings) for care."¹²⁰ Empirical studies suggest this relationship holds true. There are over double the number of magnetic resonance imaging machines per capita in the United States performing nearly double the number of exams compared to the OECD average.¹²¹ Living in an area with increased hospital capacity is associated with higher rates of hospital utilization, even after controlling for demographic and health differ-

117. Medicare Shared Savings Program, 42 U.S.C. § 1395jjj(c) (2010).

118. Fisher, *supra* note 15.

119. *Id.* at w52-3.

120. *Id.*

121. ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, Health at a Glance 2011: OECD Indicators, 85 (Jan. 11, 2013) OCED.ORG available at <http://www.oecd.org/health-systems/health-at-a-glance.htm>.

ences.¹²² Neither is associated with improved health outcomes. Further examples exist: chronically-ill patients are more likely to receive care in the inpatient setting; the supply of hospital beds influences physicians' discharge and admission decisions.¹²³ These studies overwhelming point towards excess facility capacity driving demand. However, excess capacity driving demand extends beyond facilities.

Physician services also exhibit supply-sensitive demand. Composition and supply of physicians correlates strongly with their utilization.¹²⁴ American patients receive significantly more cardiac revascularization procedures—almost twice as many as the next highest country—than other OECD members.¹²⁵ Capacity may even influence individual patient decisions. A patient with chest pain may be more likely to forgo scheduling an appointment with a PCP in favor of an appointment with a cardiologist if the cardiologist has sufficient time to schedule the patient quickly. Likewise, an underemployed specialist is likelier to schedule more frequent check-ups than medically necessary. Forty-one percent of the variation in spending across regions is statistically attributable to differences in community capacity.¹²⁶ This increase in spending does not appear to improve outcomes, as increased specialist supply does not correlate with increased population outcomes.¹²⁷

This data suggests gross imbalances in community capacity are significantly increasing costs. It was this problem that ACOs were originally envisioned, at least in part, to address. The institutional component (hospitals or multi-specialty practice groups) of an ACO envisioned to facilitate rebalancing, however, was rejected as overly restrictive and an unnecessary limitation on the scope of the program.¹²⁸ Managed care uses rationing and limitations on choice to

122. Elliot S. Fisher, et al., *Associations Among Hospital Capacity, Utilization, and Mortality of U.S. Medicare Beneficiaries, Controlling for Sociodemographic Factors*, 34(6) HEALTH SERVS.RESEARCH 1351, 1351 (2000).

123. Elliot S. Fisher, et al., *The Implications of Regional Variations in Medicare Spending, Part 1: The Content, Quality and Accessibility of Care*, 138(4) ANNALS OF INTERNAL MED. 273, 273 (2003).

124. *Id.* at 286.

125. OECD, *supra* note 121 at 28-29.

126. John Wennberg, *Geography and the Debate over Medicare Reform*, 21(2) HEALTH AFF. (2002): w96-w114. Web Exclusive, available at <http://www.dartmouth.edu/~jskinner/documents/WennbergGeographyandtheDebate.pdf>.

127. Starfield *supra* note 69 at w5-105.

128. Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,813 (Nov. 2, 2011).

serve as capacity constraints, while traditional HMOs have controlled capacity more directly. ACOs, on the other hand, lack a clear entity to make those capacity decisions and serve as a constraint on capacity-driven costs.

C. The Missing Integration

HMOs' integrated finances create an intrinsic organizational incentive to efficiently balance capacity. Integrative benefits can extend much further, though they differ among horizontal, vertical, and functional integrations. Despite the sound economic underpinnings of these benefits, misunderstanding these variants has created unrealistic expectations from, and is a source of continued disenchantment with, integration.¹²⁹ For instance, vertical integration may facilitate quality improvements, but does little to alter market power. Thus, providers vertically integrating with expectations of increased bargaining power may be disappointed, and even neglect potential quality benefits.¹³⁰ In this light, prudent recognition and encouragement of potential benefits can help ensure those benefits' realization.

Functional integrations, either horizontal or vertical, merge the operations of entities without complete, formal integration. While also yielding varied benefits, functional integrations' narrower scope make them less prone to misguided expectations. Examples include clinical and financial integration. Proponents contend clinical integration (often broadly characterized under the coordinated care umbrella) yields quality improvements with lessened anticompetitive by-products vis-à-vis full integration.¹³¹ With this narrow scope (and purpose), few providers would expect increased market power from participation in such a merger. Similarly, integrated finances might incentivize efficient capacity decisions and create economies of scale, but expectations of care quality improvements would be minimal. The widely touted ACO does not have the benefit of such modest

129. Lawton Burns & Mark Pauly, *Integrated Delivery Networks: A Detour On the Road to Integrated Health Care?*, 21(4) HEALTH AFF. 128, 128-30 (2002).

130. Generally, economic theory does not purport that vertical integration increases market power. However, in the healthcare context, integrated delivery systems may be able to offer integrated products to payers that fragmented providers could not, and thus wield greater market power.

131. Tara Adams Ragone, *Structuring Medicaid Accountable Care Organizations to Avoid Antitrust Challenges*, 42 SETON HALL L. REV. 1443, 1449 (2012) (arguing integrated clinical care can thwart anti-trust challenges to New Jersey Medicaid ACOs).

expectations.¹³² Nonetheless, an entity that enables the benefits of these various forms of integration will be necessary to achieve CMS's three-part aim.¹³³ ACOs hope to fill this role.

Neither horizontal nor vertical integrative benefits alone can hope to fulfill CMS's three-part aim. Horizontal integration, the merging of providers offering the same or similar services, allows economies of scale and increased market power, but may have only indirect effects on care coordination. For example, the merger of several solo practitioners into a single entity may result in efficiency gains when they are then able to share administrative personnel or overhead expenses, but have little effect on patient care. Importantly for ACOs, horizontal integration of the smallest groups creates larger patient datasets, enabling the population view of health the three-part aim requires.¹³⁴

While the ACO regulations encourage some horizontal integration with threshold size requirements to ensure that population view,¹³⁵ the benefits ACOs hope to achieve most resemble those from vertical integration.¹³⁶ Gains flow from vertical integration when improved coordination overcomes the costs of decreased organizational specialization.¹³⁷ In economic parlance, gains from improved coordination decrease transaction and monitoring costs.¹³⁸ In the common parlance of ACOs, these decreases in transaction costs translate into care coordination: better communication amongst a patient's providers resulting in more harmonized care. This combination of horizontal and vertical benefits—increased care coordination and fostering a population view of health—are the integrative benefits CMS touts.

132. Marmor, *supra* note 41 at 1216.

133. Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27(3) HEALTH AFF. 759, 763 (2008).

134. Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,808 (2011).

135. Medicare Shared Savings Program, 42 U.S.C. § 1395jjj (b)(2)(D) (2010).

136. Vertical integration in the healthcare context often refers to the integration of financing (e.g. insurers) and healthcare providers. In this context, however, vertical integration is used in the economic sense to mean integrations between different members of the value chain. Vertical integrations in this sense would include integrations between physicians and hospitals, or physicians offering different services.

137. Burns, *supra* note 129 at 129.

138. *Id.*

Financial accountability, in the form of shared savings, is the mechanism to incentivize these benefits.

1. The Institutional Component

The major advantage HMOs possessed, and ACOs hope to possess, is the cost accountability integrated systems enable. Integration of payor, provider, and institutional components fostered this accountability in the HMO model. Central to CMS's three-part aim is a similar "integrator" able to accept accountability for each of these three components.¹³⁹ Kaiser Permanente, often regarded as a model HMO, is touted as an example of such an integrator.¹⁴⁰ The "value-based purchasing" concept ACOs embody is meant to fill the payor component of integration.¹⁴¹ As a provider organization, ACOs inherently fill the provider role. Missing is the institutional component.

As originally explained in both Fisher's "extended medical staff" and CMS administrator Berwick's "triple aim," such an integrator contained this institutional component.¹⁴² This assumed some level of integration. The institutional component would enable capacity decisions encompassing the entire continuum of care patients in a community receive. CMS, however, has soundly "reject[ed] the proposition that an entity that is under single control. . . would be more likely to achieve the three-part aim [of better care, better health, and lower costs]," in favor of more inclusive flexibility and the accompanying potential for expanded participation.¹⁴³ Further, CMS worried that an institutional component would encourage attempts to restrict provider networks, hindering patients' choice.¹⁴⁴ Without a required

139. Berwick, *supra* note 133 at 763.

140. *Id.*

141. Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,803-4 (April 7, 2011) ("We view value-based purchasing as an important step to revamping how care and services are paid for, moving increasingly toward rewarding better value, outcomes, and innovations instead of merely increased volume.").

142. Berwick, *supra* note 133 at 763.(That role might be. . . a powerful, visionary insurer; a large primary care group in partnership with payors; or even a hospital, with some affiliated physician group, that seeks to be especially attractive to payors."); Fisher, *supra* note 15 at w45 ("fostering the development of accountable care organizations comprising local hospitals and the physicians who work within and around them").

143. Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,843 (Nov. 2, 2011).

144. *Id.* at 67,808.

institutional component, however, ACOs lack HMOs' inherent capacity balancing incentive.

Those ACOs with an institutional component have an engrained interest in maintaining their existing capacity. As such, a hospital-sponsored ACO would be unlikely to rebalance capacity in favor of competing, but more efficient, institutions. Competitive pressures dictate full utilization of the ACO institution's existing capacity, and consequently incentivize a balance between community needs and that existing capacity, but not the capacity of the entire system. A hospital-sponsored ACO in a market with competitors is incentivized to fully utilize its existing facilities, with community needs only setting an upper limit on capacity. Further, in attempting to maximize utilization, those institutions have a direct economic interest in encouraging use of supply-sensitive services. While ACOs without an institutional component lack direct control over capacity decisions, they also lack this profit incentive to utilize existing capacity. Fisher's conception recognizes the problem of competing capacity, but concludes physician services are sufficiently concentrated in many communities to make ACOs feasible.¹⁴⁵ Likewise, the integrator Berwick imagines cares for a defined population with a specified payor, and thus contains an inherent institutional component.¹⁴⁶ This component's absence dilutes the capacity balancing effects ACOs might make possible in communities with multiple provider groups.

2. The Personnel Component

For Fisher, the more important implications of his study were not the institutional component of practice patterns, but the concentration of care.¹⁴⁷ As "physicians adapt their practices to work with whatever resources are available," the observed concentration of care supports a causal link between supply of specialist services and their demand.¹⁴⁸ In placing financial accountability on referring physi-

145. Fisher, *supra* note 15 at w46.

146. Berwick, *supra* note 133.

147. Fisher, *supra* note 15 at w48; see also *id.* at w46 (Fisher's empirical results showed 62% of doctors performing inpatient services, of which 90% were performed at a single hospital. This served as the institutional component of his "extended medical staff." That "extended medical staff" accounted for 73% of the care patients of those doctors received, implying concentration of care.).

148. *Id.* at w53. See also David Goodman, *Preventing Ruin, or the Ruin of United States Health Care?* 32 J. LEGAL MED. 61, 71 (2011).

cians, with greater emphasis on a PCP being that referring physician,¹⁴⁹ the concept hoped to encourage less specialist-intensive practice patterns, and thus controls costs. Outside physician groups which only refer internally (large multispecialty practice groups or HMOs), however, changed practice patterns have no direct effect on the personnel component of capacity.

The ACA and ACOs seek to influence personnel capacity through other means. Changing practice patterns have indirect effects on such capacity. As a source of referrals dries up and specialists' income decreases, the desirability of practicing in a given specialty should diminish. Market dynamics would diminish supply of those specialists in parallel. Bolstering this market dynamic, ACO efforts to coordinate care¹⁵⁰ between PCPs and specialists may reduce duplicative care and thereby decrease demand for specialist services. Further, specialists aligned with an ACO may increase their productivity (and income) if they receive higher margin referrals from the ACO, rather than filling their schedule with follow-ups and lower margin services. Thus, ACOs may decrease unwarranted demand for specialists generally while increasing the productivity of aligned specialists. This should make alignment attractive for specialists, and thus competition among specialists for alignment should reinforce other market forces limiting supply. These dynamics should complement other components of the ACA which encourage adjustments to the composition and geographic distribution of physician supply.

The ACA seeks to adjust composition through an increase of both primary care providers and specialists in shortage.¹⁵¹ Despite research indicating specialists may generate their own demand,¹⁵² the ACA does nothing to discourage practice in overrepresented specialties. Similarly, the ACA encourages an increase in supply of providers in rural and underserved areas, but does little to discourage practice in overrepresented areas.¹⁵³ Fisher's conception introduced a mechanism through which systemic capacity balance, both its institu-

149. Diane Rittenhouse, Stephen Shortell, & Elliot Fisher, *Primary Care and Accountable Care—Two Essential Elements of Delivery System Reform*, 361(24) N. ENG. J. MED. 2301, 2301 (2009).

150. Required Processes and Patient-centeredness Criteria, 42 C.F.R. § 425.112 (2012).

151. Elayne J. Heisler, CONG. RESEARCH SERV., PHYSICIAN SUPPLY AND THE AFFORDABLE CARE ACT 11-18 R42029, at 15-17 (Jan. 15, 2013).

152. See *infra* part IIB.

153. Heisler, *supra* note 151 at 18-23.

tional and personnel components, might be encouraged with market forces. However, neither Fisher nor Berwick counter the institutional incentives to maintain existing capacity. Both rely on market forces to balance personnel capacity. In moving from conception to implementation, ACOs have expanded beyond their original capabilities. While the original conception envisioned some element of integration between providers and institutions, no such integration is now required of ACOs. Without required integration, the benefits of integrated care, including the care coordination at the center of ACOs' quality benefits and systemic balance, must come from elsewhere.

ACOs are an experiment in achieving integrative benefits outside a completely integrated environment. HMOs represent one end of the integrative spectrum. Multispecialty practice groups—less integrated than an HMO, but still containing many elements of integration—were a logical place to attempt to apply these integrative benefits outside the fully integrated context. A large number of multispecialty practice groups, especially those with HMO experience, were among the PGP demonstration participants.¹⁵⁴ These groups have an inherent incentive to balance the personnel component of capacity. Similarly, physician groups associated with a hospital (or insurance company, though examples are rare) have an inherent incentive to balance the institutional component of capacity. Before the final rule was published, several commenters even erroneously assumed ACO groups would have a required hospital association.¹⁵⁵ CMS explicitly concluded such a requirement would preclude flexibility, and was thus undesirable.¹⁵⁶

While this flexibility is ACOs' ultimate attraction, several features of ACOs frustrate the capacity realignment inherent to the integrated model.¹⁵⁷ In fact, some of the definitional features that distinguish ACOs from HMOs work against such realignment. CMS distinguishes HMOs from ACOs because ACOs place "the patient at the center."¹⁵⁸ Retention of both the fee-for-service (FFS) payment model and patient choice are two of the major contributors to this

154. PGP Demonstration Project, *supra* note 47.

155. Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,814 (Nov. 2, 2011).

156. *Id.*

157. Rittenhouse, *supra* note 149 at 2302-3.

158. Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,805 (Nov. 2, 2011).

patient-centeredness. FFS payments, in contrast to the capitated payments of HMOs, limit the financial incentive to restrict a patients' care, and are maintained under ACOs.¹⁵⁹ ACOs do not limit patient choice, as Berwick emphasized, because a provider network is not defined: patients are free to select and switch providers.¹⁶⁰ While legitimate policy choices, these ACO features work against capacity realignment. The combination of FFS and the free choice of patients allows a patient to circumvent their PCP and seek specialist care or ancillary services independently. These are among the supply sensitive services Fisher identified as contributing to unnecessary costs.¹⁶¹ Further, those specialist and ancillary service providers (institutions) are not necessarily part of the ACO structure, and thus do not necessarily share its incentives.¹⁶²

With ACOs' and the ACA's emphasis on primary care, PCPs will be an integral part of any capacity adjustments that ACOs encourage. The organizational flexibility integral to CMS's vision for ACO expansion suggests only PCPs will be a common feature of all ACOs. Of the current (through January 31, 2013) ACOs, physician groups sponsor fifty-six percent, though these ACOs often cover significantly fewer lives than the thirty-six percent of ACOs hospitals sponsor.¹⁶³ These groups have either an engrained mechanism to balance personnel capacity (in the case of multispecialty groups) or no personal financial interest in personnel capacity (in the case of PCP groups). Combined with CMS's emphasis on PCPs, these physician group-sponsored ACOs could be well positioned to make responsible community capacity decisions, and thus encourage the systemic balance that contributed to HMOs' success in cost control.

159. *Id.*

160. Bimbaum, *supra* note 9 at 722.

161. Fisher, *supra* note 15 at w53.

162. Lawton Burns & Mark Pauly, *Accountable Care Organizations May Have Difficulty Avoiding the Failures of Integrated Delivery Networks of the 1990s*, 31 HEALTH AFF. 2407, 2413 (2012).

163. David Muhlestein, *Continued Growth of Public and Private Accountable Care Organizations*, HEALTH AFF. BLOG (Feb. 19, 2013, 12:47 PM), <http://healthaffairs.org/blog/2013/02/19/continued-growth-of-public-and-private-accountable-care-organizations/>.

III. Accountability: From Individual to Integrated

Despite their positioning, ACOs are encouraged to do little to foster systemic balance. The ACO regulations encourage such systemic change only indirectly. Small groups are required to organize into larger groups and may consequently add horizontal integrative benefits, though the requirement is geared towards statistically significant results, not any integrative benefits.¹⁶⁴

The focus of behavior change is individual practice decisions. CMS's only attempt to influence "systematic" change was the introduction of a two-sided risk model.¹⁶⁵ This model would have forced ACOs to eventually share the downside risk of any potential shared saving, transferring risk from CMS to providers. Forcing providers to share the financial risks of ineffective care with payors and patients would have created organic incentives for cost efficiency. Predictably, physicians were not pleased.¹⁶⁶ CMS abandoned this option in favor of a one-sided model to encourage broader participation.¹⁶⁷ Even this notion of "systematic" change did not parallel Fisher's ideal in changing systemic incentives, but instead focused on providers' and suppliers' behavior.¹⁶⁸

In their current form, the regulations seek to change the practice patterns the FFS model encouraged without focusing on the system that reinforces those patterns. Patient decisions, and the ways in which physicians may influence them, intentionally receive little attention. CMS "vigilantly" aims to retain the same level of patient freedom of choice as the traditional (FFS) Medicare program.¹⁶⁹ The regulations are left fostering systemic balance only incidentally and indirectly. Despite this, the regulations give ACOs an operational and structural mechanism that positions them to make community capacity decisions, were they empowered or encouraged to do so.

164. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,808.

165. *Id.* at 67,907.

166. *Id.*

167. *Id.*

168. *Id.* at 67,908.

169. *Id.* at 67,804.

A. Structural Potential to Capacity Balance

The structural components the regulations give ACOs facilitate some integrative benefits contributing to systemic balance, but do little to encourage capacity balance directly. Nonetheless, their structure does give CMS continuing power to influence decisions. ACOs must satisfy quality measures to be eligible to receive shared savings. These quality measures offer the most direct vehicle to influence ACO behavior. Further, the regulations governing eligible participants and the assignment of beneficiaries to ACOs emphasize primary care. This emphasis exerts indirect pressures on personnel composition and institutional capacity.

The selection of entities eligible to form ACOs and the assignment of beneficiaries to those ACOs emphasizes primary care over other physician services. The ACA specified four groups (subject to expansion by the Secretary) that would be eligible to form ACOs: group practices, networks of individual practices, collaborations between hospitals and ACO professionals,¹⁷⁰ and hospitals employing ACO professionals.¹⁷¹ While CMS recognized this restriction would prohibit some (perhaps desirable) entities from forming an ACO, it found any expansion of eligible entities unnecessary.¹⁷² Because the ACA mandates ACO beneficiary assignment based on utilization of primary care services, specialist ACOs could be ACOs without any assigned beneficiaries (and thus without the possibility of shared savings).¹⁷³ In denying eligibility and thus limiting participation, CMS's refusal to bow to specialists' interests demonstrated their focus on primary care.

However, it is the assignment of beneficiaries, not eligibility of entities, which is the principal mechanism stressing primary care. Beneficiaries are assigned to an ACO based on the primary care services provided. If a patient receives a plurality of such services from a participating PCP, the patient is assigned to that PCP's ACO.¹⁷⁴ If primary care was not received from a PCP, a beneficiary may be

170. The statute defines "ACO professionals" as including physicians and a variety of mid-level providers. Medicare Shared Savings Program, 42 U.S.C. § 1395jjj (2010).

171. *Id.* at § 1395jjj(b)(1)(D).

172. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,812.

173. *Id.*

174. Basic Assignment Methodology, 42 C.F.R. § 425.402 (2012).

assigned based on primary care services rendered by a participating specialist.¹⁷⁵ This assignment methodology forces accountability first to a PCP, emphasizing the coordinating role of primary care. Despite numerous comments suggesting otherwise, CMS narrowly defined PCPs to both incentivize and emphasize this role.¹⁷⁶ The narrow definition channels CMS resources through PCPs before dispersing them to any other providers. The final rule is CMS's effort to balance the two extremes, allowing ACO beneficiary assignment to a specialist, but only if no other ACO PCP provides more primary care services¹⁷⁷ while not expanding the definition of primary care.

Quality measures must be met before an ACO is eligible to receive shared savings.¹⁷⁸ These measures are among CMS's most direct instruments to dictate ACO behavior. Congress sought to ensure ACOs did not reignite patients' fears of HMOs: the loss of choice and rationing of care. To do so, it granted the Secretary the power to create these measures.¹⁷⁹ Because failure to comply with these measures cancels any financial gain to ACOs, quality measures are obvious vehicles to demand activity facilitating capacity rebalance.

However, both the measures' purposes and their implementation might make this more difficult. First, balancing personnel and facility capacity would inevitably involve the constriction of supply of some areas: specialists, facilities or both. While empirical evidence suggests that such a restriction would not necessarily reduce the quality of care patients receive,¹⁸⁰ a similar argument was made for HMO's unpopular rationing of care.¹⁸¹ This is exactly the result the quality measures exist to prevent. As the statute specifies these measures are to "evaluate the quality of care furnished by the ACO[,]"¹⁸² capacity-focused quality measures might also exceed the Secretary's rulemaking authority. Second, providers might be reluctant to accept new quality measures. In the proposed rule, CMS had sixty-six quality measures. After considerable protest from commenters who thought the number of metrics increased reporting burdens and diluted the

175. *Id.*

176. Definitions, 42 C.F.R. § 425.20 (2012).

177. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,892-6.

178. Medicare Shared Savings Program, 42 U.S.C. § 1395jjj(d) (2010).

179. Marmor, *supra* note 41, at 1216.

180. Fisher, *supra* note 15; Emanuel, *supra* note 96.

181. Mechanic, *supra* note 21.

182. Medicare Shared Savings Program, 42 U.S.C. § 1395jjj (b)(2)(3)(B).

measures' effectiveness, the number was reduced to thirty-three.¹⁸³ Despite their likely efficacy, these considerations constrain any additional measures CMS might impose to few in number and strictly within their statutory authorization.

While the purpose of the Shared Savings statute constrains the options to promote more balanced capacity, several possibilities exist; the quality measures making ACOs eligible to receive shared savings remain the most obvious means to control ACOs' actions. PCP providers need to be encouraged to identify effective and cost-efficient specialists and ancillary facilities in their community. Patients who otherwise have no preference could then be referred to those providers and facilities without constraining patient choice. This would exert additional pressure on excess supply within the system. Additional quality measures might encourage efficiency as an additional factor in referral decisions, though to stay within the statutory authorization promoting quality and systemic balance simultaneously would be a prerequisite. Any measures designed exclusively to promote capacity balance would fall outside the Secretary's authorization. Similarly, ACOs could be encouraged to recruit those specialists and facilities to their organization and thereby introduce them directly to the integrated incentive structure. While specialist-PCP relationships could be thus encouraged, ACOs should be discouraged from creating exclusive relationships with large institutional providers. In doing so, CMS would be preventing ACOs from enabling such providers to maintain existing capacity in disregard of community capacity needs.

A. Operational Structure and Possibilities

Some operational characteristics mandated in the ACO regulations may facilitate capacity rebalancing, even if they do not encourage it. Care coordination, continuous improvement, and the required governance structure either indirectly foster or position ACOs to make these decisions. Both the regulation's care coordination measures and its mandated governance structure accomplish this, in part, through their emphasis on primary care. Further, both emphasize a population view of patient care absent from traditional medicine but necessary for conscientious community capacity decisions. The regu-

183. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,871 (2011).

lations aim to encourage continuous improvement, in step with the gradual nature of any capacity rebalance.

As one of the defining benefits of integrated healthcare, coordinated care did not escape policymakers' attention. The care coordination regulations are the only direct attempt to encourage integrative benefit. This is done indirectly through their emphasis on patient centeredness, and directly by fiat. As part of its application materials, ACOs must submit defined "methods and processes . . . to coordinate care" and identify target patients that would benefit from individualized care programs.¹⁸⁴ While the efficacy of these (essentially) reporting requirements in improving quality or decreasing costs is still unclear, any effects on capacity will be indirect. Theoretically, reducing duplicative care should decrease demand for some capacity and thus place downward pressure on its supply. Because demand for supply-sensitive services often expands to meet capacity, however, generated demand elsewhere in the community might counterbalance any downward pressure on capacity supply these measures exert. The organic balance HMOs achieved through aligned financial incentives is absent. While mandated assessments¹⁸⁵ will help institutionalize these gradual improvements, thus reinforcing any capacity adjustments, any capacity effects seem likely to be incidental. The care coordination regulations give ACOs the vantage point to view any capacity imbalances, yet encourage only a passive role in rebalancing. Despite this passive role, the regulations add a governance structure further positioning them to make capacity decisions.

ACOs' mandated board structure ensures a community and primary care perspective beneficial to such community capacity decisions. ACOs must have a governing board composed of both Medicare beneficiaries and ACO participants (providers and suppliers).¹⁸⁶ Because a governing board has not been part of the stereotypical small practice, any broader view of the organization and community needs may already facilitate rebalance. The regulations skew the perspective of the board in mandating seventy-five percent be composed of ACO participants, likely PCPs, and contain at least one Medicare beneficiary without a financial interest in the ACO.¹⁸⁷ While the ben-

184. Required Processes and Patient-Centeredness Criteria, 42 C.F.R. § 425.112(b)(3) & (4)(1) (2012).

185. 42 C.F.R. § 425.112(a)(3)(ii).

186. Shared Governance, 42 C.F.R. § 425.106(c)(2) (2012).

187. 42 C.F.R. § 425.106(c)(8) (2012).

eficiary representative is included in the governance structure to ensure “focus on the beneficiary in all facets of ACO governance[,]”¹⁸⁸ (patient-centeredness) the representative’s inclusion may also add the community perspective to make appropriate capacity decisions. The seventy-five percent composition requirement is designed to ensure the organization is “provider driven.”¹⁸⁹ Being “provider driven” has the dual advantages of encouraging a primary care focus and limiting outsized institutional influences. Thus, institutional providers with existing capacity are limited in the influence they exert over capacity decisions. CMS’s explicit rationale for this board is to ensure “strategic direction” and alignment with the three-part aim.¹⁹⁰ Like other facets of ACOs, the “patient centeredness” the regulations encourage qualifies this board to make capacity decisions. In its broadest interpretation, the three-part aim includes rebalancing and is thus already in the boards’ purview. However, consideration of such an abstract goal only implicitly within their purview may be unlikely without more explicit guidance.

Whether in the current regulatory structure or a modified one, any capacity rebalancing coordinated care, market dynamics, or improved governance enables is unlikely to occur or stabilize immediately. The current system reinforcing volume and intensity evolved as stakeholders’ incentives diverged over many years.¹⁹¹ Reversing this trend will not occur overnight. While the ACO program terminates on December 31, 2015,¹⁹² even changes that have taken place by then are unlikely to be institutionalized. CMS will almost certainly extend the program if the results proponents predict occur. Drawing from its experience in earlier demonstration projects, CMS’s mean estimate is more modest at \$470 million in net savings to Medicare over the three-year lifespan of the program.¹⁹³ This represents only a small fraction of estimated Medicare spending over that same three years (\$1.54 trillion),¹⁹⁴ though CMS predicts both savings to the Medicare

188. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,821.

189. *Id.* at 67,820.

190. *Id.* at 67,817.

191. *See generally* Starr, *supra* note 7.

192. Agreement with CMS, 42 C.F.R. § 425.200(b) (2012).

193. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,973.

194. Medicare 2013 Baseline, CONG. BUDGET OFF. (Feb 5, 2013), http://www.cbo.gov/sites/default/files/cbofiles/attachments/43894_Medicare2.pdf.

program and net payments to providers. With providers' investments to participate in the program, CMS predicts providers will realize a 2.9 benefit-cost ratio.¹⁹⁵ Even if results prove more modest than these estimates, however, CMS and providers should commit to the program beyond this three-year window. Savings as capacity realigns and waste from supply-sensitive services decreases may not be immediately apparent. Along with these capacity adjustments, the most lasting impacts on the healthcare system will not occur until the philosophical shift away from FFS extends beyond the Medicare ACO program. Encouraging commercialization will extend this spread.

Despite ACOs limited effects on capacity, their potential to effect change on the payment structure of American healthcare remains large. Including commercial variants, ACOs are expanding more rapidly and touching more lives than expected. Even before the January 2013 announcement of 106 new ACOs (bringing the total number of ACOs to more than 250),¹⁹⁶ upward estimates predicted ACOs were reaching thirty-one million lives.¹⁹⁷ ACOs' potential for widespread impact is apparent. If ACOs continue to spread to the commercial payor sector, their effect will include not only Medicare's payment structure, but that of the entire healthcare system. This increasing success and extended impact only increases their attractiveness as a vehicle to balance capacity.

Summary

Despite policymakers' careful distinctions, as a newer vehicle to deliver integrated healthcare, ACOs are an ideological successor of HMOs. Echoing a consumerist approach, ACOs attempt to do so by keeping patients central to decisions. In applying this focus too narrowly, however, ACOs are missing some of the critical elements of cost control HMOs possessed. With supply driven demand accounting for a significant portion of wasted healthcare spending, balancing

195. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,973.

196. More Doctors, Hospitals Partner to Coordinate Care for Medicare, U.S. Department of Health & Human Services (January 10, 2013), <http://www.hhs.gov/news/press/2013pres/01/20130110a.html>.

197. *Id.* CMS estimates ACOs cover a more modest four million lives. See Gabriel Perna, *Surprise Surprise: ACOs are Touching More Patients than Expected*, www.healthcare-informatics.com/article/surprise-surprise-acos-are-touching-more-patients-expected (Dec. 5, 2012).

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the capacity of healthcare resources is one of these critical elements. While ACOs' current regulatory structure encourages appropriate capacity only indirectly, that structure positions them to make conscientious community capacity decisions. ACO boards should be encouraged to make such capacity decisions through their relationships with other providers and additional quality measures. Capacity considerations should inform ACO policy as it continues to evolve. The systemic changes likely to impact cost, however, are unlikely to be realized during the program's short lifespan. As such, the ACO program will have to be extended to have any effect on capacity.