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Ending the “Doc Fix”: How Repealing the Sustainable Growth Rate Could Give Medicare Beneficiaries Better Access to Primary Care Through Accountable Care Organizations

Alisha Trotter*

I. INTRODUCTION

When President Lyndon B. Johnson signed Medicare into law in 1965¹ he stated, “No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings they have so carefully put away over a lifetime so that they might enjoy dignity in their later years.”²

Prior to Medicare, only about 55 percent of senior citizens in the United States had health insurance.³ This low number was largely attributed to seniors having retired and not being eligible to receive care from their employers.⁴ Before the 1930s, people primarily paid for health care out of

* Alisha Trotter is a 2014 JD Candidate at Seattle University School of Law. She was inspired to write this piece after volunteering at low-income clinics and seeing multiple disparities within the health care system. Alisha hopes that her article will influence individuals within health care systems to think of innovative ways to efficiently deliver high quality care while being cost effective. Alisha would like to thank her friends and family for their continued and unyielding support, Dean Annette Clark of Seattle University School of Law for helping her develop her article, and Becca Rausch for helping her brainstorm ideas for this article. Finally, Alisha would like to thank the staff of the Seattle Journal for Social Justice for their hard work and help in improving this article.

¹ Social Security, Health Insurance for Aged and Disabled, 42 U.S.C. § 1395(c) (1965).

² HEALTH CARE FIN. ADMIN., MEDICARE 2000: 35 YEARS OF IMPROVING AMERICANS’ HEALTH AND SECURITY, 2 (2000), available at <http://media.jsonline.com/documents/Medicare2000.pdf>.

³ See Tom Dowdal, *Medicare from the Start to Today*, NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE, <http://rs9.loc.gov/medicare/history.htm>.

⁴ See Randall R. Bovbjerg et al., *U.S. Health Care Coverage and Costs: Historical Development and Choices for the 1990s*, 21 J.L. MED. & ETHICS 148 (1993).

their own pockets.⁵ If they could not afford the service or the medicine they would either not obtain it, or they “paid” for it by sacrificing their financial health. In the 1930s, the “Blues” plans were the true beginnings of health insurance as we know it.⁶ Instead of paying out of pocket, the “Blues” plans provided pre-paid hospital care and began providing reimbursement for physician services.⁷ Like modern insurance, the “Blues” plans covered in-hospital surgical care as well as medical services.⁸ The “Blues” policies were organized by hospital associations at the state level and offered private coverage for hospital care.⁹ Under these plans, anyone could sign up, and premiums were based on a community rating, which meant everyone paid the same rate regardless of age, health status, or claims history.¹⁰ Once the plans proved to be viable, ordinary insurers,¹¹ or “commercial” companies, began to cover medical bills and used underwriting to assess insurability and set premiums.¹² Under both the “Blues” plans and commercial policies, payments were made retroactively to providers on a fee-for-service basis for virtually all services deemed medically necessary.¹³ When providers are paid on a fee-for-service basis it means that they are paid for each service performed.¹⁴

⁵ *Id.* at 142.

⁶ *Id.* at 143.

⁷ Marc Lichtenstein, *Health Insurance from Invention to Innovation: A History of the Blue Cross and Blue Shield Companies*, BLUE CROSS AND BLUE SHIELD (Nov. 12, 2012), <http://www.bcbs.com/blog/health-insurance.html>.

⁸ Bovbjerg et al., *supra* note 4, at 141–42.

⁹ *Id.*; *Healthcare Crisis History*, PBS, <http://www.pbs.org/healthcarecrisis/history.htm> (last visited July 1, 2013).

¹⁰ Bovbjerg et al., *supra* note 5, at 141, 143; *See Glossary: Community Rating*, HEALTHCARE.GOV <https://www.healthcare.gov/glossary/community-rating/> (last visited Feb. 24, 2013).

¹¹ It was mainly life insurance companies that began adopting these practices. Bovbjerg et al., *supra* note 4, at 141, 143.

¹² *Id.*

¹³ *Id.* at 143.

¹⁴ *Glossary*, HEALTHCARE.GOV, <http://www.healthcare.gov/glossary/f/fee.html> (last visited July 1, 2013).

These early "Blues" plans, followed by the commercial plans, set the pattern for health coverage that still dominates US health financing.¹⁵ However, during that earlier era, cost problems did not exist because benefits and payments were at low levels, few people had coverage, and medical technology did not exist to provide sophisticated care.¹⁶ But during the 1940s and 1950s, the beginnings of price increases were becoming visible as the proportion of the population with health insurance grew rapidly.¹⁷ In an effort to compete for workers, employers began providing private health insurance as a fringe benefit to employees, making the cost of health care less prohibitive.¹⁸ Despite the expansion of private health insurance, many seniors¹⁹ were excluded because they were retired and did not receive health insurance coverage from an employer.²⁰ While the federal government supplied some health services, it was only to identifiable "federal" populations like the armed services, veterans, and the Indian Health Service (operated on reservations)²¹ which left the poor, the frail, and the aged to fend for themselves.²² President Johnson's remarks when he signed the Medicare Bill²³ embodies the vision behind Medicare: expand

¹⁵ Bovbjerg et al., *supra* note 4, at 141, 143. The Pierce County Medical Bureau, which was a pioneer program in Tacoma, Washington now known as Regence BlueShield, provided the basis for Blues plans existing today. *Who We Are*, HEALTH CARE SERV. CORP., http://www.hcsc.com/who_we_are.html (last visited July 1, 2013).

¹⁶ Bovbjerg et al., *supra* note 4, at 141, 143.

¹⁷ *Id.* at 141, 145, 148. Health plans began to offer broader coverage of services and higher limits on dollars payable to compensate for medical care becoming more expensive and elaborate. *Id.* at 146. Many more medications were available to treat a range of diseases, which included new vaccines. PBS, *supra* note 10. Tax subsidies were also helping to extend health insurance to much of the middle class, and in response to the increase in those who had insurance, the federal Hill-Burton Act made available grants to expand and modernize hospital capacity. *Id.* at 141, 145–46.

¹⁸ *Id.* at 145; PBS, *supra* note 9.

¹⁹ "Those within the Social Security system and past retirement age." Bovbjerg et al., *supra* note 4, at 148.

²⁰ *See id.*

²¹ *Id.* at 145.

²² *See id.* at 148.

²³ *See supra* text accompanying note 2.

high quality medical care to seniors and provide financial protection against the frequent and sometimes devastating cost of illness.²⁴

Today, Medicare primarily serves as the nation's health insurance for elderly citizens ages 65 and older.²⁵ Because many seniors are retired, they live on a fixed income and dwindling savings.²⁶ By providing health insurance to seniors, Medicare has helped to reduce poverty as well as increase life expectancy among the elderly.²⁷ However, Medicare as it was originally conceptualized is no longer providing adequate health care coverage for seniors because it is becoming increasingly difficult for seniors to obtain primary care. Because Medicare reimburses primary care physicians at a low rate for the medical services they provide, primary care physicians are unable to afford to treat Medicare patients.²⁸ Many physicians must consider expenses such as business loans, overhead, and malpractice insurance when deciding if they can afford to accept Medicare beneficiaries, and many are finding that they cannot afford to run their businesses.²⁹ This in turn makes it harder for Medicare beneficiaries to find primary care physicians.³⁰ An American Medical Association survey found that overall, 17 percent of physicians restricted the number of Medicare

²⁴ HEALTH CARE FIN. ADMIN., *supra* note 2, at 4.

²⁵ CENTER FOR MEDICARE & MEDICAID SERVICES, WHAT IS MEDICARE? 1 (Sept. 2011), *available at* <http://www.medicare.gov/Pubs/pdf/11306.pdf>. Medicare also serves people who are permanently disabled with end stage renal disease. *Id.*

²⁶ *See* HEALTH CARE FIN. ADMIN., *supra* note 2, at 2.

²⁷ *Id.* at 33.

²⁸ *See* MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 91 (2012), *available at* http://www.medpac.gov/chapters/Mar12_Ch04_CORRECTED.pdf; AM. MED. ASS'N, AMA ONLINE SURVEY OF PHYSICIANS: THE IMPACT OF MEDICARE PHYSICIAN PAYMENT ON SENIORS ACCESS TO CARE (2010), *available at* http://media.washingtonpost.com/wpsrv/outlook/documents/medicare_survey_results_061810.pdf.

²⁹ *See* Steve Daniels, *Doctors Who Take Medicare Scarce*, ABC EYEWITNESS NEWS (May 10, 2012), http://abclocal.go.com/wtvd/story?section=news/abc11_investigates&id=8656615.

³⁰ *See* MEDPAC, *supra* note 28, at 91.

patients in their practice.³¹ The top two reasons for this are because Medicare payment rates are too low and the ongoing threat of future payment cuts makes Medicare an unreliable payer.³² These threats are especially concerning for primary care physicians, whom the survey found made up 31 percent, or approximately one third, of physicians who restrict the number of Medicare patients.³³

This is particularly problematic when considering the role of primary care physicians and their potential for reducing health care costs. Primary care is associated with prevention of illness and death, as well as improvement in equitable distribution of health care services.³⁴ An increasing body of literature shows that primary care physicians are associated with longer life expectancy and higher patient health ratings as compared with physicians who specialize in a particular area of medicine.³⁵ Because of the preventative nature of primary care physicians, the ability to see one regularly is key to reducing patient costs because healthier patients have fewer complications, thus reducing the need to spend an exorbitant amount on health care.³⁶ Although specialists are often best qualified to provide care within their areas of expertise for patients with more advanced clinical conditions, primary care physicians have been shown to deliver care similar in quality to that of specialists for certain conditions, such as diabetes and hypertension, while using fewer resources.³⁷ While many Medicare patients seek specialists for their ailments, the need for primary

³¹ AM. MED. ASS'N, *supra* note 28.

³² *Id.*

³³ *Id.*

³⁴ Glen Cheng, *The National Residency Exchange: A Proposal to Restore Primary Care in an Age of Microspecialization*, 38 AM. J.L. & MED. 158, 163 (2012).

³⁵ *Id.*

³⁶ See Margaret Ann Cross, *Spend Money on Healthy People*, MANAGED CARE (2004), <http://www.managedcaremag.com/archives/0408/0408.wellpeople.html>.

³⁷ M. RENEE ZEREHI, AM. COLLEGE OF PHYSICIANS, HOW IS A SHORTAGE OF PRIMARY CARE PHYSICIANS AFFECTING THE QUALITY AND COST OF MEDICAL CARE?: A COMPREHENSIVE EVIDENCE REVIEW 5 (2008), available at http://www.acponline.org/advocacy/where_we_stand/policy/primary_shortage.pdf.

care physicians in the Medicare arena is arguably more significant in improving health outcomes, disease prevention, cost effectiveness, and coordination of care.³⁸

Care coordination is a function that supports information sharing across providers, patients, types and levels of service, sites, and time frames.³⁹ The goal of care coordination is to ensure that patients' needs and preferences are achieved, and that care is efficient and of high quality.⁴⁰ Care coordination is most needed by persons who have multiple ailments that cannot be met by a single clinician or clinical organization.⁴¹ These individuals' conditions are ongoing, the severity of which being subject to change over time.⁴² An evidence review by the American College of Physicians⁴³ found that an increase in one primary care physician per 10,000 people in a state was associated with a reduction in overall spending of \$684 per Medicare beneficiary.⁴⁴ By comparison, an increase of one specialist per 10,000 people was estimated to result in an increase in overall spending of \$526 per Medicare beneficiary.⁴⁵

The value of primary care manifests itself in lower costs as a result of reduced hospitalization, improved prevention, and better coordination of

³⁸ See Cheng, *supra* note 34, at 162–63.

³⁹ SARAH HUDSON SCHOLLE, NAT'L COMM. ON VITAL AND HEALTH STATISTICS, MEANINGFUL MEASURES OF CARE COORDINATION 3 (Oct. 13, 2009), available at <http://www.ncvhs.hhs.gov/091013p9.pdf>.

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.*

⁴³ The American College of Physicians (ACP) is a national organization of internists (physician specialists) who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. *About ACP: Who We Are*, AM. COLL. OF PHYSICIANS, http://www.acponline.org/about_acp/who_we_are/ (last visited Aug. 28, 2013). ACP is the largest medical-specialty organization and the second largest physician led group in the U.S. *Id.*

⁴⁴ *Id.* at 5.

⁴⁵ *Id.*

chronic disease care.⁴⁶ The importance of access to primary care physicians is echoed in the Medicare Payment Advisory Commission's (MedPAC)⁴⁷ report to Congress, which found that Medicare beneficiaries looking for primary care physicians had greater difficulty during the two preceding years.⁴⁸ MedPAC's concern is reasonable considering there were 47.5 million people enrolled in Medicare in 2010,⁴⁹ and by 2030 more than 80 million people will be on Medicare due to retiring baby boomers.⁵⁰ The potential for primary care to reduce health care costs should be at the forefront of health care policy, especially when Medicare spent \$549 billion for items and services in 2011,⁵¹ and that amount is likely to increase with the amount of people projected to be on Medicare.

With the ever-increasing cost of health care, this prospect has fiscal experts concerned about how Medicare will support all of its beneficiaries.⁵² These statistics and estimates have forced the government to reexamine its

⁴⁶ David Kinsman & Jacquelyn Blaser, *Primary Care Provides Patients with Better Outcomes at Lower Cost, Urgent Need to Prevent Shortages of Primary Care Physicians*, AM. COL. OF PHYSICIANS, http://www.acponline.org/pressroom/primary_shortage.htm (last visited July 2, 2013).

⁴⁷ MedPac is a 17 member independent Congressional agency that advises the U.S. Congress on issues affecting the Medicare program. In addition to advising Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee for service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare. The Medicare Payment Advisory Commission, *About MedPac*, MEDPAC, <http://www.medpac.gov/about.cfm> (last visited July 2, 2013).

⁴⁸ MEDPAC, *supra* note 28, at 91.

⁴⁹ U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES (2012), <http://www.census.gov/compendia/statab/2012/tables/12s0146.pdf>.

⁵⁰ MEDPAC, CONTEXT FOR MEDICARE PAYMENT POLICY 3-4 (2008), available at http://www.medpac.gov/chapters/Mar08_ch01.pdf. See NY TIMES, *Medicare*, <http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/medicare/index.html> (last visited July 1, 2013).

⁵¹ CTRS. FOR MEDICARE & MEDICAID SERVS., *Trustees Report & Trust Fund* (Apr. 23, 2012, 1:07 PM), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html?redirect=/reportstrustfunds/>.

⁵² See David M. Herszenhorn, *For Many House Democrats, Cost Is the Concern*, NY TIMES, Mar. 4, 2010, available at <http://prescriptions.blogs.nytimes.com/2010/03/04/for-many-house-democrats-cost-is-the-concern/>. See also *supra* note 50.

approach to health care financing through the Patient Protection and Affordable Care Act (ACA).⁵³ Signed into law by President Barack Obama in 2010,⁵⁴ the ACA proposed Accountable Care Organizations under the Medicare Shared Savings Program to address the current problems with Medicare.⁵⁵ Accountable Care Organizations (ACOs) are groups of health care professionals responsible for the overall care of patients who have original Medicare (those not in a Medicare Advantage private plan).⁵⁶ Providers aim to coordinate care for patients and manage chronic disease with the goal of achieving health care quality goals and outcomes that result in cost savings.⁵⁷ Providers who voluntarily meet certain quality criteria are eligible to share in the cost savings they achieve for the Medicare program.⁵⁸

Because ACOs are a shift toward a payment mechanism that emphasizes quality over volume, they have the potential to serve as a platform for encouraging primary care providers to continue accepting Medicare beneficiaries. The problem of primary care physicians not accepting Medicare patients can be largely attributed to the sustainable growth rate (SGR).⁵⁹ The SGR is a component of the formula used to calculate

⁵³ See STAFF OF THE WASH. POST, LANDMARK: THE INSIDE STORY OF AMERICA'S NEW HEALTH CARE LAW AND WHAT IT MEANS FOR US ALL 113 (1st ed. 2010) [hereinafter LANDMARK].

⁵⁴ HEALTH CARE REFORM: SUPPLEMENTARY MATERIALS, 2012 1 (Barry R. Furrow et al. eds., 2012) [hereinafter Furrow et al.].

⁵⁵ See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 10, 307, 3022, 124 Stat. 119, 395, 940 (2010) (amending title XVIII of the Social Security Act, 42 U.S.C. § 1395 (2006), by adding § 1899, "Shared Savings Program"); Section 3022; Furrow et al., *supra* note 54, at 210.

⁵⁶ *Shining a Light on Health Insurance Rate Increases*, CTRS. FOR MEDICARE & MEDICAID SERVS., (Dec. 29, 2010), <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ratereview.html>.

⁵⁷ *Glossary: Accountable Care Organization*, HEALTHCARE.GOV, available at <https://www.healthcare.gov/glossary/accountable-care-organization/>.

⁵⁸ Furrow et al., *supra* note 54, at 211.

⁵⁹ ALLYSON Y. SCHWARTZ & JOE HECK, MEDICARE PHYSICIAN PAYMENT INNOVATION ACT OF 2012 1, available at <http://heck.house.gov/sites/heck.house.gov/files/Medicare%20Physician%20Payment%20Innovation%20Act%20Framework.pdf>.

physician payments for providing services to Medicare beneficiaries⁶⁰ and contributes to lower reimbursement rates.⁶¹ Lower reimbursements are a result of Medicare expenditures exceeding the SGR formula's statutory target.⁶² If spending exceeds the cumulative spending target for Medicare expenditures over a certain period, future updates are reduced to bring spending back in line with the target. Although this article will mostly discuss the SGR as it affects traditional Medicare, I will also be discussing the effects of the formula on Medicare Advantage because it affects 27 percent of Medicare beneficiaries (13.1 million individuals) whom are enrolled in a plan.⁶³

In this article, I propose that repealing the SGR would provide a platform for ACOs to be implemented as an alternative payment method for traditional Medicare, and in turn encourage primary care physicians to continue accepting Medicare beneficiaries. If achieved, primary care providers would not continually be subject to the drastic payment cuts caused by the SGR and would be rewarded by sharing in the cost-savings primary care providers achieve for their role in practicing preventative care methods. First, I will discuss how Medicare has historically operated; second, I will discuss the different ways Medicare has tried to control costs through various payment methods; third, I will describe the characteristics of ACOs and why they could be used to encourage providers to continue accepting Medicare beneficiaries; and fourth, I will examine the skepticism surrounding ACOs.

⁶⁰ AM. MED. ASS'N, MEDICARE AND THE SUSTAINABLE GROWTH RATE 6, *available at* http://www.ama-assn.org/resources/doc/mss/cola_medicare_pres.pdf.

⁶¹ *See* SCHWARTZ & HECK, *supra* note 59, at 1.

⁶² CONG. RESEARCH SERV., MEDICARE PHYSICIAN PAYMENT UPDATES AND THE SUSTAINABLE GROWTH RATE SYSTEM (2006), *available at* <http://www.ascrs.org/download/gov/Medicare%20Physician%20Payment%20Updates%20and%20the%20Sustainable%20Growth%20Rate%20SGR%20System.pdf>.

⁶³ THE HENRY J. KAISER FAMILY FOUND., MEDICARE ADVANTAGE FACT SHEET, (Nov. 30, 2012), *available at* <http://www.kff.org/medicare/upload/2052-16.pdf>.

II. MEDICARE 101

A. *The Logistics*

Managed by the Center for Medicare and Medicaid Services (CMS),⁶⁴ Medicare is divided into four parts: Part A covers hospital insurance; Part B is supplemental medical insurance;⁶⁵ Part C, called Medicare Advantage, is a plan offered by private companies that contract with Medicare to provide Part A and Part B benefits;⁶⁶ and Part D offers prescription drug coverage through insurance companies or other private companies.⁶⁷ Parts A and B are considered traditional Medicare.⁶⁸ All eligible beneficiaries are automatically enrolled in Part A, and Part B enrollment is optional.⁶⁹

Part A finances inpatient hospital services, care in a skilled-nursing facility for continued treatment or rehabilitation after hospitalization, home health care services, and hospice care for the terminally ill.⁷⁰ Under Part A, Medicare pays for all reasonable expenses, minus a deductible amount for the first 60 days, and then afterwards, a daily coinsurance payment is also charged.⁷¹

Part B pays for physicians' services and outpatient hospital services, including emergency room visits, ambulatory surgery, diagnostic tests, laboratory services, outpatient therapy, occupational-therapy, and durable

⁶⁴ CMS is a federal agency that runs Medicare and Medicaid. *Glossary - C*, MEDICARE.GOV, <http://www.medicare.gov/glossary/c.html> (last visited July 2, 2013).

⁶⁵ John K. Iglehart, *The American Health Care System: Medicare*, 327 NEW. ENG. J. MED. 1467, 1469 (1992), available at http://www.stanford.edu/~jay/health_class/Readings/Lecture03/iglehart_medicare.pdf.

⁶⁶ *Medicare Advantage Plans Cover All Medicare Services*, MEDICARE.GOV, <http://www.medicare.gov/what-medicare-covers/medicare-health-plans/what-medicare-advantage-plans-cover.html#> (last visited July 2, 2013).

⁶⁷ *How to Get Drug Coverage*, MEDICARE.GOV, <http://www.medicare.gov/sign-up-change-plans/get-drug-coverage/get-drug-coverage.html#> (last visited July 2, 2013).

⁶⁸ Patricia Barry, *Figuring Out Your Choices*, AARP (May 7, 2012), <http://www.aarp.org/health/medicare-insurance/info-04-2011/medicare-choices.html>.

⁶⁹ Iglehart, *supra* note 65, at 1469.

⁷⁰ *Id.*

⁷¹ *Id.*

medical equipment.⁷² Generally Part B does not pay for routine physical examinations, preventative care, or services not related to the treatment of illness.⁷³ However, provisions in the ACA allow for coverage of some preventative care services.⁷⁴ Under Part B, Medicare pays 80 percent of the approved amount for covered services in excess of an annual deductible.⁷⁵

B. Funding Medicare

Medicare is funded by two trust funds: the Hospital Insurance trust fund and the Supplementary Medical Insurance (SMI) trust fund, both of which are maintained by the Department of Treasury.⁷⁶ Though maintained by the Department of Treasury, the Social Security Act established the Medicare Board of Trustees to oversee the financial operations of both funds.⁷⁷ The board is made up of members that include the Secretary of Treasury, the Secretary of Labor, the Secretary of Health and Human Services, and the Commissioner of Social Security.⁷⁸ The Hospital Insurance trust fund, which itself is funded by payroll taxes from employees and employers, finances Medicare Part A.⁷⁹ Medicare Parts B and D are funded by the SMI trust fund, which is financed primarily through a combination of monthly

⁷² *Id.*

⁷³ *Id.*

⁷⁴ LANDMARK, *supra* note 53, at 121.

⁷⁵ Iglehart, *supra* note 65, at 1467, 1469.

⁷⁶ CONG. RESEARCH SERV., MEDICARE PROVISIONS IN PPACA (P.L.111-148) 13 (2010), available at http://www.coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=55a563ed-0be1-4715-9fd3-ad0bf6e9b2bf.

⁷⁷ THE BDS. OF TRS. OF THE FED. HOSP. INS. AND FED. SUPPLEMENTARY MED. INS. TRUST FUNDS, THE 2012 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 1 (2012), available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2012.pdf> [hereinafter THE BDS. OF TRS. OF THE FED. HOSP. INS.].

⁷⁸ *Id.*

⁷⁹ CONG. RESEARCH SERV., *supra* note 76, at 13. Each pays a tax of 1.45 percent on earnings. *Id.* Self-employed workers pay 2.9 percent of their net income. THE BDS. OF TRS. OF THE FED. HOSP. INS., *supra* note 77, at 10.

premiums paid by current enrollees and general revenues.⁸⁰ Parts B and D are two separate accounts within the SMI trust fund.⁸¹

Projections of Medicare costs are highly uncertain due to unknown scientific advances⁸² and the feasibility of cost saving measures in the ACA.⁸³ Expenditures like the continuing growth in the volume and intensity of services provided per beneficiary, the increasing number of beneficiaries enrolling in Medicare, and the continuing improvements in life expectancy all suggest that Medicare costs will continue to increase and put financial stress on Medicare's trust funds.⁸⁴

While the Hospital Insurance fund is projected to be exhausted⁸⁵ by 2024,⁸⁶ the SMI Trust fund may have a brighter financial outlook.⁸⁷ The SMI trust fund is financed by Medicare beneficiary premiums and general revenue.⁸⁸ The Medicare Board of Trustees projects the SMI trust fund will remain in financial balance in the future due to premiums being set at a level to meet expected costs each year.⁸⁹ However, the aging population and rising health care costs will cause the SMI fund projected costs to grow

⁸⁰ CONG. RESEARCH SERV., *supra* note 76, at 13.

⁸¹ U.S. SOCIAL SEC. ADMIN., 2009 ANNUAL REPORT SUMMARY 1 (2009), *available at* <http://www.socialsecurity.gov/history/pdf/tr09summary.pdf>.

⁸² THE BDS. OF TRS. OF THE FED. HOSP. INS., *supra* note 77, at 2–3.

⁸³ *Id.* at 46.

⁸⁴ *See id.* at 21–22.

⁸⁵ Medicare Hospital Insurance program is considered insolvent when revenues and trust fund balances will not cover 100 percent of projected costs. Paul N. Van de Water, *Medicare Is Not “Bankrupt”: Health Reform Has Improved Program’s Financing*, CTR. ON BUDGET AND POLICY PRIORITIES (June 3, 2013), *available at* <http://www.cbpp.org/cms/index.cfm?fa=view&id=3532>.

⁸⁶ THE BDS. OF TRS. OF THE FED. HOSP. INS., *supra* note 77, at 27.

⁸⁷ *See id.* at 45.

⁸⁸ General revenues include special payments by states, fees on manufacturers, and fees on importers of brand-name prescription drugs. SOC. SEC. AND MED. BDS. OF TRS., A SUMMARY OF THE 2012 ANNUAL REPORTS (2012), *available at* <http://www.ssa.gov/oact/trsum/index.html>; THE BDS. OF TRS. OF THE FED. HOSP. INS., *supra* note 77, at 45.

⁸⁹ THE BDS. OF TRS. OF THE FED. HOSP. INS., *supra* note 77, at 45.

rapidly, from 2 percent of GDP in 2011 to 4 percent of GDP by 2087.⁹⁰ Because expenditures have exceeded the statutory target, the SGR would cause a 31 percent reduction in payments, which the Medicare Board's projection assumes.⁹¹ As stated before, the SGR requires payments to providers to be reduced if expenditures exceed a statutory target in order to move spending back towards the target path.⁹²

Congress, however, prevented this decrease, as it has been doing since 2003, and decided to keep rates unchanged until January 1, 2014.⁹³ Congress acting to delay or "freeze" physician payment rates creates an artificial projection of how much premiums will be set at in the future.⁹⁴ Because the SMI fund is projected to make up more of GDP, it suggests that premiums will increase in order to continue sustaining the SMI fund.⁹⁵ This is a problem because it can lead to Medicare beneficiaries not being able to afford health care due to premiums being too expensive. The fact that the growth projection is based on a 31 percent reduction in payment rates, but that rates have not been reduced that low, suggests that premiums will be significantly higher than anticipated.

C. The "Un"-Sustainable Growth Rate

One of the criticisms of Medicare is its antiquated design.⁹⁶ Medicare was designed to look like the old "Blues" plans in that hospital inpatient care,

⁹⁰ SOC. SEC. AND MED. BDS. OF TRS., *supra* note 88.

⁹¹ THE BDS. OF TRS. OF THE FED. HOSP. INS., *supra* note 77, at 7.

⁹² Paul N. Van de Water, *The Sustainable Growth Rate Formula and Health Reform*, CTR. ON BUDGET AND POLICY PRIORITIES, (Apr. 21, 2010), available at <http://www.cbpp.org/cms/index.cfm?fa=view&id=3166>.

⁹³ Mark Merlis, *Health Policy Briefs: Medicare Payments to Physicians*, HEALTH AFFAIRS (Jan. 10, 2013), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=83.

⁹⁴ See THE BDS. OF TRS. OF THE FED. HOSP. INS., *supra* note 77, at 45–46.

⁹⁵ See generally *id.*; CONG. RESEARCH SERV., *supra* note 76, at 13–14.

⁹⁶ Charles Hardin, *Testimony of Charles Hardin, Council for Government Reform*, NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE, (Sept. 8, 1998), available at <http://rs9.loc.gov/medicare/hardintest.html>; Julie Barnes, *Moving Away From Fee-for-Service*, THE ATLANTIC (May 7, 2012, 5:45 PM),

physician office visits, as well as surgery were covered.⁹⁷ With this design comes the retroactive fee-for-service payment method, which rewards overutilization⁹⁸ and does not consider the quality of care delivered.⁹⁹ As mentioned before, when providers are paid on a fee-for-service basis, it means they are paid for each service performed.¹⁰⁰ A fee-for-service payment method offers little incentive to discourage delivering unnecessary services because reimbursements are not based on quality or the impact on patients' health.¹⁰¹ However, some providers enjoy this method of payment because it provides economic and clinical autonomy over the provider's practice.¹⁰² Being able to establish prices for services and structure their clinical work at their professional discretion allows providers to exercise economic and clinical autonomy over their practice.¹⁰³ While maintaining autonomy is important, billing on a fee-for-service schedule is part of what makes our current health care system unsustainable.¹⁰⁴

Providers that care for traditional Medicare beneficiaries are paid (or reimbursed) on a fee-for-service basis.¹⁰⁵ Thus, the SGR affects them because the formula is used to calculate physician payments.¹⁰⁶ Medicare

<http://www.theatlantic.com/health/archive/2012/05/moving-away-from-fee-for-service/256755/>.

⁹⁷ *Id.*

⁹⁸ Overutilization is the unnecessary treatment, tests, and studies that patients undergo each year that leads to waste and high costs. See Martin Sipkoff, *Who's Tackling Rampant Overutilization? Health Plans!*, MANAGED CARE, available at <http://www.managedcaremag.com/archives/0912/0912.utilization.html>.

⁹⁹ AM. MED. ASS'N, PHYSICIAN PAYMENT REFORM: EARLY INNOVATORS SHARE WHAT THEY HAVE LEARNED 3 (2012), available at <http://www.ama-assn.org/resources/doc/washington/physician-payment-reform-white-paper.pdf>.

¹⁰⁰ HEALTHCARE.GOV, *supra* note 14.

¹⁰¹ Barnes, *supra* note 96.

¹⁰² See generally Richard A. Culbertson & Philip R. Lee, *Medicare and Physician Autonomy*, 18 HEALTH CARE FIN. REV. 2, 119–20 (1996), available at <http://www.ssa.gov/history/pdf/MedicarePhysicalAutonomy.pdf>.

¹⁰³ See *id.*

¹⁰⁴ Barnes, *supra* note 96.

¹⁰⁵ See MEDPAC, *supra* note 28, at 91.

¹⁰⁶ See *id.*; AM. MED. ASS'N, *supra* note 60, at 6.

payments for Part B services are made on the basis of a fee schedule that physicians bill to Medicare.¹⁰⁷ In an effort to create a sustainable growth path for Part B expenditures, the Center for Medicare Services has used the SGR formula to calculate physician payments for providing services to Medicare patients.¹⁰⁸ Created under The Balanced Budget Act of 1997, the SGR formula was established because of the concern that the Medicare fee schedule itself would not adequately constrain overall increases in spending for physicians' services.¹⁰⁹ The SGR is the statutory method for determining the annual updates to the Medicare physician fee schedule;¹¹⁰ however, it is not based on actual health care practices.¹¹¹ The SGR is derived from four factors: 1) the estimated percentage of changes in physicians' fees; 2) the number of fee-for-service beneficiaries; 3) the percentage growth in real GDP (ten year moving average) per capita; and 4) the changes in laws and regulations.¹¹² Under the SGR, cumulative Medicare spending on physicians' services is supposed to follow a statutory target that depends on the rates of growth in physicians' costs, Medicare enrollment, and real gross domestic product per person.¹¹³ If spending in a given year exceeds the SGR target for that year, then the amounts paid to physicians for each service provided¹¹⁴ are supposed to be reduced in the following year in order to move total spending back towards the target path.¹¹⁵

The SGR formula is problematic because it attempts to limit Medicare spending for physicians' services by restraining payment rates without

¹⁰⁷ CONG. RESEARCH SERV., *supra* note 62, at 1.

¹⁰⁸ AM. MED. ASS'N, *supra* note 60, at 6; CONG. RESEARCH SERV., *supra* note 62, at 2.

¹⁰⁹ CONG. RESEARCH SERV., *supra* note 63, at 1.

¹¹⁰ *Id.*

¹¹¹ AM. MED. ASS'N, *supra* note 60, at 6.

¹¹² CONG. RESEARCH SERV., *supra* note 62, at 3.

¹¹³ *Id.* See THE BDS. OF TRS. OF THE FED. HOSP. INS., *supra* note 77, at 35.

¹¹⁴ "This is typically known as the fee-for-service model where providers are paid a specified amount for each service provided." *Fee-for-Service (FFS)*, HEALTHINSURANCE.INFO, <http://healthinsurance.info/HIFFS.HTM> (last visited July 2, 2013).

¹¹⁵ Van de Water, *supra* note 92.

limiting the growth in volume and complexity of services.¹¹⁶ As noted before, medicine and health care continues to grow in complexity with new innovations. In general, health care costs reflect increases in the earnings of health care professionals, growth in the utilization and intensity of services, and other medical cost inflation.¹¹⁷ Because the sustainable growth rate greatly underestimates the increase in the volume and complexity of doctors' services, the formula requires more severe cuts as each year passes.¹¹⁸

Since 2003, Congress has stepped in to prevent impending reductions.¹¹⁹ Not surprisingly, this year Congress voted to freeze physician payment rates at the 2012 payment levels.¹²⁰ However, these fixes only contribute to increasing the cost of Medicare because freezing payment rates does not account for rising health care costs, so the gap continues to grow, and the potential cuts get larger over time.¹²¹ The cost of implementing this year's patch, or "doc fix," is costing nearly a \$25.2 billion spread over ten years.¹²² As a result, doctors cannot afford to accept Medicare beneficiaries because they are getting paid lower rates in light of expensive costs for providing care.

D. Medicare Advantage (Part C)

As an alternative to traditional Medicare fee-for-service, Congress made several policy changes to encourage private plan participation in Medicare and enrollment growth under the Balanced Budget Act of 1997 in an effort

¹¹⁶ *Id.*

¹¹⁷ THE BDS. OF TRS. OF THE FED. HOSP. INS., *supra* note 77, at 41.

¹¹⁸ Van de Water, *supra* note 92.

¹¹⁹ THE BDS. OF TRS. OF THE FED. HOSP. INS., *supra* note 77, at 45–46.

¹²⁰ *Sustainable Growth Rate*, AM. ACAD. OF DERMATOLOGY, <http://www.aad.org/member-tools-and-benefits/practice-management-resources/health-system-reform-resource-center/sustainable-growth-rate> (last visited July 2, 2013).

¹²¹ See Neil Waldron, *Medicare Payments to Physicians and the Sustainable Growth Rate*, ROCKY MOUNTAIN HEALTH PLANS (Dec. 3, 2012), <http://www.rmhp.org/blog/2012/12/medicare-payments-to-physicians-and-the-sustainable-growth-rate-sgr-rmhp/>.

¹²² Merlis, *supra* note 93.

to save more money.¹²³ The assumption was that private plans would operate more efficiently than traditional Medicare.¹²⁴ Medicare Advantage (MA) plans receive a capitated payment per beneficiary instead of a fee for each service, and are considered by federal policymakers as a way of controlling the growth of health care costs due to the greater incentive to innovate and use care management techniques.¹²⁵ Under capitation, a doctor, medical group, hospital, or integrated health system, receives a certain flat fee for every month for taking care of an individual enrolled in a managed health care plan¹²⁶ regardless of the cost of that individual's care.¹²⁷ Thus, it forces providers to efficiently use services because they are only allotted a certain amount to spend on a patient per month.¹²⁸ Capitation was meant to create incentives for efficiency, cost control, and preventative care in health care.¹²⁹ Given that the majority of individuals enrolled in a health plan will never use health care services within any given month, capitation arrangements should naturally "balance out" the high utilizers of

¹²³ See LANDMARK, *supra* note 53, at 119. Medicare Advantage plans receive capitated payments from both the Hospital Insurance and Supplementary Medical Insurance Part B trust fund accounts. THE BDS. OF TRS. OF THE FED. HOSP. INS., *supra* note 77, at 1.

¹²⁴ Tanaz Petigara & Gerard Anderson, *Payments to Medicare Advantage Plans*, HEALTH POLICY MONITOR (2009), available at http://www.hpm.org/en/Surveys/Johns_Hopkins_Bloomberg_School_of_Publ_H_USA/13/Payments_to_Medicare_Advantage_Plans.html (origins of health policy idea).

¹²⁵ *Id.* See *Capitation*, AM. MED. ASS'N, <https://www.ama-assn.org/ama/pub/physician-resources/practice-management-center/claims-revenue-cycle/managed-carecontracting/evaluating-payment-options/capitation.page> (last visited July 2, 2013). There is a fee for service component in some Medicare Advantage plans. *Id.*; THE BDS. OF TRS. OF THE FED. HOSP. INS., *supra* note 77, at 311.

¹²⁶ Managed Care is any system that manages health care delivery to control costs. *Definition of Managed Care*, MEDICINET.COM, <http://www.medterms.com/script/main/art.asp?articlekey=4270> (last visited July 2, 2013). Typically, managed care systems rely on primary care physicians who acts as a gatekeeper for other services such as specialized medical care, surgery, and physical therapy. *Id.*

¹²⁷ Mark Hagland, *How Does Your Doctor Get Paid?: The Controversy Over Capitation*, PBS, <http://www.pbs.org/wgbh/pages/frontline/shows/doctor/care/capitation.html> (last visited July 10, 2013).

¹²⁸ See AM. MED. ASS'N, *supra* note 125.

¹²⁹ Hagland, *supra* note 127.

health care in health plans with those who use little to no health care every month.¹³⁰ Despite the perceived benefits capitation can offer, perverse incentives can arise when delivering health care. For example, some providers may withhold care or provide less expensive care in an effort to save money.¹³¹ Also, depending on what the capitated payments are, payments may not provide enough money to fund the kinds of preventative services that capitation should theoretically encourage.¹³² This is probably why MA plans work for people when they are relatively well, but fall short of traditional Medicare when patients are sick or disabled.¹³³ Patients with long-term and chronic conditions are often denied coverage for necessary care, or their coverage is terminated under Medicare Advantage.¹³⁴

Another issue with MA is that it costs more than traditional Medicare.¹³⁵ Currently, Medicare pays MA plans based on a bidding system under which payments are determined by comparing bid plans that reflect the plans' estimated costs to a benchmark.¹³⁶ Plans bidding below the benchmark receive their bid plus a rebate equal to 75 percent of the difference between the bid and the benchmark, and plans that bid above the benchmark receive the benchmark.¹³⁷ However, plans that bid above the benchmark must require that each enrollee pay a premium equal to the difference between the bid and the benchmark.¹³⁸ While some plans have used the excess money to offer drug coverage without premiums and extra benefits, such as vision care and gym memberships, the government pays the MA plans on

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² *Id.*

¹³³ See Jordan Rau, *Research Finds Link Between Poor Health and Seniors Switching Out of Private Medicare Plans*, KAISER HEALTH NEWS (Feb. 4, 2013), <http://www.kaiserhealthnews.org/Stories/2013/February/04/Medicare-Advantage-disenrollment.aspx>.

¹³⁴ *See id.*

¹³⁵ Hagland, *supra* note 127.

¹³⁶ Furrow et al., *supra* note 54, at 201–02.

¹³⁷ *Id.* at 202.

¹³⁸ *Id.*

average 113 percent of the regular Medicare rates for doctors, hospitals, and others.¹³⁹ As a result, the ACA freezes payments to MA plans for 2011, causing a \$132 billion dollar reduction in payments to MA plans over ten years.¹⁴⁰ While this is seemingly cost effective, Medicare Advantage cuts could have long lasting effects by discouraging physicians from accepting Medicare beneficiaries.

III. ACCOUNTABLE CARE ORGANIZATIONS: A POTENTIAL SOLUTION TO ENCOURAGE PROVIDERS TO ACCEPT MEDICARE PATIENTS

A. Fragmented Care vs. Coordinated Care

A common criticism of United States health care is the fragmented nature of its payment and delivery system.¹⁴¹ This fragmentation is often due to no single group of participants (physician, hospitals, employers) being responsible for the patients' care.¹⁴² Many physicians who practice solo or in groups often do not coordinate care across specialty lines or with inpatient facilities, which makes providing care extraordinarily uncoordinated and episodic.¹⁴³ For example, there will often be multiple hospitals and health systems in the same city with no ability to communicate health information across systems, which perpetuates unnecessary duplication of services.¹⁴⁴ Medicare beneficiaries with multiple chronic conditions account for 93 percent of Medicare fee-for-service

¹³⁹ LANDMARK, *supra* note 53, at 119.

¹⁴⁰ Furrow et al., *supra* note 54, at 201.

¹⁴¹ Donald M. Berwick, *Launching Accountable Care Organizations – The Proposed Rule for the Medicare Shared Savings Program*, 364 NEW ENG. J. MED. 16 (2011), available at <http://www.nejm.org/doi/full/10.1056/NEJMp1103602>.

¹⁴² *Id.*

¹⁴³ Thomas L. Greaney, *Regulators as Market-Makers: Accountable Care Organizations and Competition Policy* 3 (working paper, 2012), available at http://papers.ssm.com/sol3/papers.cfm?abstract_id=2124097.

¹⁴⁴ See *History*, CAMDEN COALITION OF HEALTHCARE PROVIDERS, <http://www.camdenhealth.org/about/about-the-coalition/history/> (last visited July 2, 2013); *Accountable Care Organizations (ACOs): General Information*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://innovation.cms.gov/initiatives/ACO/> (last visited July 2, 2013).

expenditures.¹⁴⁵ Because these patients often receive care from multiple physicians due to their chronic condition, a failure to coordinate care can often lead to patients not getting the care they need and being subject to medical mistakes in the course of care.¹⁴⁶ One in five Medicare patients discharged from the hospital is readmitted within 30 days.¹⁴⁷ This alarming statistic illuminates the need for practitioners to position themselves to communicate treatment options with one another by having access to patient records and a shared financial interest in making health care work efficiently.¹⁴⁸ The fee-for-service payment structure also helps perpetuate fragmentation because care coordination within and outside of the practice, as well as information exchanges, are not rewarded.¹⁴⁹ Because fragmentation can lead to duplication and waste,¹⁵⁰ ACOs will aim to establish groups of service providers and suppliers who work together to manage and coordinate care for Medicare fee-for-service beneficiaries.¹⁵¹

Institutions and health care providers interested in forming an ACO will have considerable flexibility in the structure they assume because ACOs can be led by physicians in group practices,¹⁵² networks of individual practices, hospitals, or partnerships among these entities and other health care providers.¹⁵³ However, ACOs must have an established mechanism for

¹⁴⁵ CTNS. FOR MEDICARE & MEDICAID SERVS., *supra* note 56.

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ LANDMARK, *supra* note 53, at 141.

¹⁴⁹ See GREANEY *supra* note 143, at 5.

¹⁵⁰ Berwick, *supra* note 141.

¹⁵¹ Medicare Shared Savings Program, 42 U.S.C. §§ 1395 et seq. (2010).

¹⁵² A medical group practice is defined as three or more physicians engaged in the practice of medicine as a legal entity sharing business management, facilities, records, and personnel. Mary Pat Whaley, *How Does One Become a Medical Practice Manager*, MANAGE MY PRACTICE (Oct. 18, 2008), <http://www.managemypractice.com/how-does-one-become-a-medical-practice-manager/>. This includes single and multispecialty physician offices, ambulatory surgery and diagnostic imaging centers, and hospital-based practices. *Id.*

¹⁵³ See Robert Kocher, *Physicians Versus Hospitals as Leaders of Accountable Care Organizations*, NEW ENG. J. MED. (Dec. 2010), available at <http://www.nejm.org/doi/full>

joint decision-making.¹⁵⁴ To qualify, an ACO must agree to be accountable for the overall care of a group of at least 5,000 Medicare beneficiaries;¹⁵⁵ have sufficient participation of primary care physicians; have processes that promote evidence based medicine;¹⁵⁶ report on quality costs; and be capable of coordinating care among primary care providers, specialists, and hospitals.¹⁵⁷

B. ACO Payment Structure

If ACOs achieve a certain amount of savings under Medicare Parts A and B per beneficiary assigned to that ACO, then the ACO will qualify for an annual incentive bonus.¹⁵⁸ Medicare would pay a single bundled fee per patient and, in turn, ACOs would share in any savings that might accrue to Medicare as a result of not paying for every clinic visit, test, and procedure.¹⁵⁹ A bundled payment is a single payment for all services related to a treatment or condition that possibly spans multiple providers in multiple settings.¹⁶⁰ This is similar to the capitation method in Medicare Advantage, but there are safeguards in place to emphasize quality of care

/10.1056/NEJMp1011712#t=article.

¹⁵⁴ Furrow et al., *supra* note 54, at 212.

¹⁵⁵ Social Security Act, 42 U.S.C. § 1395jj(b)(2)(D) (2010) (requiring that “[a]t a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program”).

¹⁵⁶ Evidence based medicine is the conscientious and judicious use of current best evidence in making decisions about the care of individual patients. *Evidence Based Medicine Definitions*, NYU SCHOOL OF MEDICINE, <http://library.med.nyu.edu/library/instruction/handouts/pdf/ebmdefinitions.pdf> (last visited July 1, 2013). The practice of evidence based medicine means integrating individual, clinical expertise with the best available external clinical evidence from systemic research. *Id.*

¹⁵⁷ Furrow et al., *supra* note 54, at 211; *Affordable Care Act*, INFORMED MEDICAL DECISIONS FOUNDATION, <http://informedmedicaldecisions.org/shared-decision-making-policy/federal-legislation/affordable-care-act/> (last visited July 1, 2013).

¹⁵⁸ *Id.*

¹⁵⁹ LANDMARK, *supra* note 53, at 141.

¹⁶⁰ ANTONIO P. LINARES, ANTHEM, ACCOUNTABLE CARE ORGANIZATIONS: OVERVIEW AND ACO PILOTS 3, *available at* http://www.himss.org/files/HIMSSorg/content/files/ambulatorydocs/HIMSSAccountableCareOrganization_OverviewACOPilots.pdf.

and discourage corner cutting or denial of care.¹⁶¹ The bundled payment will be calculated by integrating Medicare payments for hospital inpatient and outpatient services, physician services, emergency room services, and post-acute care services.¹⁶² While the bundled payment model allows providers to retain any amount by which the actual cost of care was below the bundled payment for the episode, it simultaneously requires providers to assume financial risk for any amount by which the actual cost of care exceeds the bundled payment amount for the episode.¹⁶³ Medicare will, however, continue to pay individual providers and suppliers for specific items and services under the current Medicare fee-for-service payment system.¹⁶⁴

In light of this reality, CMS finalized both a one-sided model ACO and a two-sided model ACO.¹⁶⁵ Under the one-sided risk model, ACOs are eligible to share in the savings generated through care coordination but are not financially responsible for losses that result when the cost of care exceeds the benchmark level.¹⁶⁶ Alternatively, under the two-sided model,

¹⁶¹ See LANDMARK, *supra* note 53, at 131.

¹⁶² Peter Fise, *Accountable Care Organizations: 2012 Symposium Comments: Prognosis for Synergy Between Accountable Care Organizations and Bundled Payments in Medicare*, 28 J. CONTEMP. HEALTH L. & POL'Y 296, 299 (2012).

¹⁶³ *Id.* at 299–300.

¹⁶⁴ RTI INTERNATIONAL & TELLIGEN, ACCOUNTABLE CARE ORGANIZATION 2013: PROGRAM ANALYSIS 1 (2012). available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf>.

¹⁶⁵ Fise, *supra* note 162, at 297–98; 42 C.F.R. § 425.600 (2012). This amended 42 C.F.R. § 425 by adding § 425.200(b)(2) to establish that “for 2013 and all subsequent years, the term of the agreement is 3 years.” *Id.* In addition, by adding § 425.600 to require that during the first three-year agreement period, MSSP participating ACOs must elect to operate under either “Track 1,” which operates under a “one-sided model” that allows ACOs to share in savings generated without assuming risk for losses incurred when per-beneficiary expenditure levels exceed per-beneficiary benchmarks. *Id.* Alternatively, it could operate under “Track 2,” which requires the ACO to assume downside risk, but also offers ACOs a greater percentage share of savings generated. *Id.* New section 425.600(c) requires that in all subsequent three-year agreement periods—following the first three-year agreement period—an ACO must elect to operate under “Track 2.” *Id.*

¹⁶⁶ Fise, *supra* note 162, at 298.

ACOs must assume financial risk for a percentage of the losses that result when the expenditures for a given beneficiary exceed the benchmark level.¹⁶⁷ The CMS-developed benchmark is based off of estimates of what total expenditures for Medicare fee-for-service Parts A and B would have been without the ACO structure, and is updated/re-evaluated every year.¹⁶⁸ The two-sided model is designed to incentivize providers within the ACOs to limit excess use of fee-for-service reimbursements.¹⁶⁹

To reward ACOs for sharing in the losses, the law allows participants in the two-sided model to earn a higher percentage of the cost savings than the one-sided model.¹⁷⁰ Shared savings payments are determined by the ACOs aggregate quality performance score, which determines the "sharing rate" or percentage of shared savings the ACO is allowed to retain.¹⁷¹ ACOs must report on their performance of providing quality care based on 33 quality metrics established by CMS, which determines their quality performance score.¹⁷² The higher the score, the higher the sharing rate.¹⁷³ For a one-sided risk model ACO, the maximum sharing rate is 50 percent, which means the ACO may share in a maximum of 50 percent of the savings generated relative to the benchmark, while a two-sided risk model ACO has a sharing rate of 60 percent.¹⁷⁴ Shared savings, however, is limited to a percentage of the benchmark.¹⁷⁵ A one-sided risk model ACO shared savings are capped

¹⁶⁷ *Id.*

¹⁶⁸ CTRS. FOR MEDICARE & MEDICAID SERVS., FREQUENTLY ASKED QUESTIONS: MEDICARE SHARED SAVINGS PROGRAM 4, *available at* http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/sharesavingsprogram/downloads/MSSP_FAQs.pdf.

¹⁶⁹ Fise, *supra* note 162, at 298.

¹⁷⁰ *See id.* at 301.

¹⁷¹ *Id.*; 42 C.F.R. §§ 425.600-425.608, *et seq* (2012).

¹⁷² *Id.*

¹⁷³ *Id.*

¹⁷⁴ Sharing in 60 percent of the savings. *Id.* at 301-02.

¹⁷⁵ *Id.* at 303.

at 10 percent of the benchmark, and a two-sided risk model ACO shared savings are capped at 15 percent of the benchmark.¹⁷⁶

Because the two-sided risk model ACOs share in the loss if expenditures for a given beneficiary exceed the benchmark level, CMS established a “shared loss rate.”¹⁷⁷ This rate is the percentage of actual costs in excess of the benchmark that must be absorbed by the ACO and is equal to one minus the ACO’s shared savings rate.¹⁷⁸ For example, if a two-sided risk model ACO’s sharing rate is 45 percent, then its shared loss rate would be 55 percent, which means the ACO would be financially responsible for 55 percent of the excess costs above the benchmark, with the Medicare program paying for the remainder.¹⁷⁹ However, like shared savings, shared losses are also capped at certain percentages of the benchmark.¹⁸⁰ The maximum shared loss rate is 60 percent.¹⁸¹ In order to prevent shared savings being awarded for random variation¹⁸² in health care spending on Medicare beneficiaries as opposed to actual care coordination, ACOs must meet a minimum level of savings relative to the benchmarks before participating in shared savings known as the minimum savings rate.¹⁸³

C. Providing ACOs With a Platform: Repealing the Sustainable Growth Rate & Encouraging ACO Participation

As it stands, the current trajectory of Medicare spending is unsustainable, largely due to the SGR and low reimbursement rates.¹⁸⁴ Because the SGR

¹⁷⁶ *Id.*

¹⁷⁷ *Id.* at 302.

¹⁷⁸ *Id.*

¹⁷⁹ *Id.*

¹⁸⁰ *Id.* at 303.

¹⁸¹ *Id.* at 302.

¹⁸² See generally MEDPAC, REPORT TO THE CONGRESS: IMPROVING INCENTIVES IN THE MEDICARE PROGRAM 49, 50 (2009), available at http://www.medpac.gov/documents/jun09_EntireReport.pdf (discussing the connection between random variation as it pertains to health care spending).

¹⁸³ Fise, *supra* note 162, at 302–03.

¹⁸⁴ See MEDPAC, *supra* note 182, at 43; SCHWARTZ & HECK, *supra* note 59, at 1.

formula is used to calculate physician payments for providing services to Medicare beneficiaries, providers who are reimbursed on a fee-for-service basis are affected by the formula.¹⁸⁵ Low reimbursement rates affect the number of Medicare beneficiaries a primary care provider is able to take care of.¹⁸⁶ If payment rates are too low, then providers cannot afford to take care of Medicare beneficiaries. In light of this reality, access to primary care is becoming increasingly difficult for Medicare beneficiaries to obtain. The current payment approach penalizes physicians who control or reduce volume because they are unfairly subject to payment reductions in an effort to align with statutory targets.¹⁸⁷ Fee-for-service payments reward overutilization by encouraging clinicians to compensate for insufficient Medicare payments.¹⁸⁸ Because providers get paid a fee per service, the impetus to bill unnecessarily for services in order to recoup costs not covered by Medicare's low reimbursements is tempting. The current payment system perpetuates fragmentation and inefficiencies by not taking into account volume, complexity of services, or rewards for coordinating care.¹⁸⁹

Repealing the SGR formula would allow ACOs to become a viable alternative payment method to fee-for-service¹⁹⁰ and could encourage providers to continue accepting Medicare beneficiaries. Given the potential to share in the savings along with an underlying fee-for-service payment structure within, ACOs could encourage providers to voluntarily opt in. However, failing to repeal the SGR could cause providers to reluctantly participate in ACOs despite the cost sharing incentive. The SGR is a

¹⁸⁵ See MEDPAC, *supra* note 28; AM. MED. ASS'N., *supra* note 60, at 6.

¹⁸⁶ See AM. MED. ASS'N., *supra* note 28.

¹⁸⁷ SCHWARTZ & HECK, *supra* note 59.

¹⁸⁸ *Id.*

¹⁸⁹ See generally MEDPAC, MOVING FORWARD FROM THE SUSTAINABLE GROWTH RATE (SGR) SYSTEM 379 (2012), available at http://www.medpac.gov/chapters/Mar12_AppB.pdf; Greaney, *supra* note 143, at 5.

¹⁹⁰ See MEDPAC, *supra* note 182, at 381.

component in determining updates in the fee-for-service payment method. Because there is a fee-for-service component that underlies the ACO payment structure, the SGR could influence the Medicare reimbursement rates within the ACO fee-for-service payment structure. Because the SGR formula is designed to restrain payments if expenditures exceed a statutory target,¹⁹¹ the shared savings generated through cost containment efforts in the ACO could be off-set by the continued payment rate reductions. Therefore, instituting a new way to update physician payments that apply to the underlying fee-for-service payments within ACOs could make ACOs more successful in getting providers to participate. CMS is currently engaged in a number of initiatives to test new health care delivery and payment models intended to reduce costs while improving quality.¹⁹²

Until the SGR is repealed, ACOs could act to limit the perverse incentives that fee-for-service has developed as well as entice providers to participate in ACOs. Offering an underlying fee-for-service method could ease providers' concerns about not getting paid for their services under both a one-sided and two-sided ACO model. Additionally, economic and clinical autonomy that were enjoyed under a fee-for-service arrangement are encouraged under an ACO. Not only can providers establish their fees, but the law requires that 75 percent of the ACOs' governing body be held by ACO participants.¹⁹³ Having this structure is important because it prevents insurance companies from using payment mechanisms to influence how providers practice.¹⁹⁴ An ACO's physicians decide together, with

¹⁹¹ See Van de Water, *supra* note 92.

¹⁹² SCHWARTZ & HECK, *supra* note 59.

¹⁹³ Ezekiel J. Emanuel, MD, PhD, *Why Accountable Care Organizations Are Not 1990s Managed Care Redux*, 307 J. OF THE AM. MED. ASS'N 2263, 2012), available at <http://jama.jamanetwork.com/article.aspx?articleid=1172051>. The governing body should also include representation of Medicare beneficiaries as well. *Id.*; Affordable Care Act, 76 Fed. Reg. 67802(d) (Nov. 2, 2011).

¹⁹⁴ See Emanuel, *supra* note 193. In the managed care model of the 1990's, insurance companies would reduce payment for services in an effort to dictate changes. *Id.*

information on patient utilization and guidelines on physician performance, how best to manage their patients.¹⁹⁵

Collaboration within ACOs is key to sharing in the cost savings because the savings amount is based on a group quality performance score.¹⁹⁶ Unlike the sustainable growth rate which does not reward care coordination or quality, ACOs reward quality by cost sharing.¹⁹⁷ For those providers who are risk averse, having the option of the one-sided model in which ACOs only share in the gains could ease providers' hesitation to participate in an ACO. A one-sided model allows those ACOs with less experience in risk models to gain experience in management before sharing in the losses.¹⁹⁸

However, under the one-sided model there could be potential problems in overutilization because ACOs would not share in the losses, and thus not be held financially accountable for their choices.¹⁹⁹ An underlying fee-for-service method could frustrate the goal of containing volume because of the temptation to increase payments by billing per service.²⁰⁰ While it seems this same issue could arise under the two-sided model, it is less likely to happen because the ACO bears the responsibility of covering unnecessary costs.²⁰¹ Although an ACO is sharing in the losses, it is subject to a higher savings rate, which means it is eligible to earn more money for meeting quality metrics. Additionally, losses are capped at a certain percentage of the benchmark, which can help ACOs with its risk management.

Although financially incentivizing providers to curb costs has its benefits, it can have its drawbacks. Therefore, financial incentives should be used

¹⁹⁵ *Id.*

¹⁹⁶ *See* Fise, *supra* note 162, at 301.

¹⁹⁷ *See id.*

¹⁹⁸ RTI INTERNATIONAL, *supra* note 164, at 1–2.

¹⁹⁹ *See* FAMILIES USA, PUTTING THE ACCOUNTABILITY IN ACCOUNTABLE CARE ORGANIZATIONS: PAYMENT AND QUALITY MEASUREMENTS, 3 (2012), available at <http://familiesusa2.org/assets/pdfs/health-reform/ACOs-Payment-and-Quality-Measurements.pdf>.

²⁰⁰ *See id.*

²⁰¹ *See id.*

with care so as not to counteract the concerns of incentives undermining providers' professional ethos.²⁰² While financial incentives typically employ a mode of self-interest, implementing performance rankings that are openly discussed within group settings can be highly effective in counteracting self-interest.²⁰³ Counteracting self-interest within group settings works because it fosters a collaborative environment where colleagues can learn from each other—for example, when data on variation in health outcomes or utilization of resources causes physicians to reexamine their care.²⁰⁴ Although ACOs provide financial incentives, their structure fosters a collaborative environment in that the financial incentive is based off of a group quality performance score.²⁰⁵

This type of arrangement would not only hold providers accountable for their care decisions, but would also be better for the patients because they are receiving a holistic approach to their care. Collaboration on patient treatment would make designing a care plan for a patient better. Providers would be able to understand and review the interactions that the patient has had with other providers and analyze which treatments have worked and which have not. The ability of ACO participants to work toward the common goal of providing care²⁰⁶ and to reap the financial rewards outweigh the payment inequities perpetuated by the sustainable growth rate, with respect to primary care as opposed to specialists.²⁰⁷ The favorable

²⁰² Nikola Biller-Andorno, *Ethical Physician Incentives — From Carrots to Sticks to Shared Purpose*, 368 NEW ENGL. J. MED. 980, 980 (2013), available at <http://www.nejm.org/doi/full/10.1056/NEJMp1300373>.

²⁰³ *Id.*

²⁰⁴ *Id.*

²⁰⁵ Fise, *supra* note 162, at 301.

²⁰⁶ See *Accountable Care Organizations: A Collaborative Model for Improving Health Care Quality*, AETNA, <http://www.aetna.com/health-reform-connection/aetnasvision/accountable-care-organizations.html> (last visited June 27, 2013).

²⁰⁷ Letter from David L. Bronson, MD, FACP, President, American College of Physicians, to The Honorable David Camp, Chairman of U.S. House of Representative Committee on Ways and Means 1–2 (May 23, 2012), available at

payment structure within the ACO could encourage primary care providers to opt in and be financially capable of accepting Medicare beneficiaries.

While some providers and suppliers prefer Medicare Advantage for a risk-sharing model because of its predictable income,²⁰⁸ cost shifting to Medicare beneficiaries in the form of higher premiums is still a potential risk in adopting this model. If the bids are above the standard benchmark, then each enrollee pays a premium equal to the difference between the bid and the benchmark;²⁰⁹ if payments from Medicare are too low, providers can make up for the lack of payment in higher premiums. The propensity to cost-shift in order to make up for the lack of Medicare funds can have detrimental effects on Medicare beneficiaries. This is particularly concerning in light of how access to health care for seniors may be limited by increases to Medicare premiums.

The SGR also perpetuates cost-shifting in private Medicare Advantage Plans.²¹⁰ A key factor in determining the payment rate is Medicare Advantage's growth percentage, which is influenced by the sustainable growth rate.²¹¹ The benchmark that the Medicare Advantage plans base their bids off of incorporates the SGR formula.²¹² Because the plans are presumably attempting to stay under the benchmark to obtain more funding, provider payment can be negatively affected by the SGR.²¹³

http://www.acponline.org/advocacy/where_we_stand/assets/sustainable_growth_rate_response_2012.pdf.

²⁰⁸ Richard Jones, *Accountable Care Delivery and Payment Structures: Medicare Advantage with Physicians at Risk*, ACCOUNTABLE DELIVERY SYSTEM INSTITUTE (July, 13, 2012), <http://adsinstitute.org/2012/07/accountable-care-delivery-payment-structures-medicare-advantage-physicians-risk/>.

²⁰⁹ Furrow et al., *supra* note 54, at 202.

²¹⁰ See Chris Anderson, *CMS Changes Course, Will Raise 2014 Medicare Advantage Payments*, HEALTHCARE PAYER NEWS (Apr. 2, 2013), <http://healthcarepayernews.com/content/cms-changes-course-will-raise-2014-medicare-advantage-payments>.

²¹¹ See Alyene Senger, *Medicare Advantage Survives—for Now*, THE FOUNDRY (Apr. 3, 2013, 5:30 PM), <http://blog.heritage.org/2013/04/03/medicare-advantage-survives-for-now/>.

²¹² See generally *id.*; MEDPAC, *supra* note 28.

²¹³ See generally Senger, *supra* note 211; MEDPAC, *supra* note 182, at 312.

Given the perverse incentives that capitation can bring in an effort to save money, the sustainable growth rate reinforces this behavior because low payment rates encourage providers to withhold care to save money. The effects of the SGR are prevalent in both Medicare's private plan and traditional Medicare. Repealing the SGR would encourage primary care providers to look to new payment methods, like ACOs, so providers can afford to treat Medicare beneficiaries.

While repealing the SGR formula could counteract the impetus to cost shift in order to make up for low reimbursement, the perverse incentives of capitation still linger. Although the bundled payment method used in ACOs could be compared to capitation, stark differences remain.²¹⁴ Unlike straight capitation, where individual physicians take on the financial risk, ACOs are taking on the risk, which again reiterates the emphasis on a collaborative effort to drive down costs.²¹⁵ Furthermore, ACOs have quality metrics that could act to limit perverse incentives to withhold care in an effort to save money because ACOs must report and meet the quality standards to share in the savings.²¹⁶ Sharing in the cost savings would incentivize providers and suppliers to work together to achieve a high quality score by identifying new issues for improvement. For example, an ACO model, in which an insurance company and medical group are working together, have reduced the cost of caring for 40,000 members in the California Public Employees' retirement system by identifying and reducing overutilization of specific services (i.e. unnecessary tests or treatments) and hospital readmission rates.²¹⁷ After a year, this kind of collaboration saved them more than \$15 million. This type of structure allows physicians to decide together how best

²¹⁴ See LANDMARK, *supra* note 53, at 131.

²¹⁵ See Kyle Murphy, *What's the Difference Between ACOs and Capitation?*, EHR INTELLIGENCE (May 18, 2012), <http://ehrintelligence.com/2012/05/18/whats-the-difference-between-acos-and-capitation/>.

²¹⁶ See Affordable Care Act, 76 Fed. Reg. 67802(II)(B)(2) (Nov. 2, 2011) (payment for shared savings).

²¹⁷ Emanuel, *supra* note 193.

to implement guidelines and manage their patients.²¹⁸ The potential for cost savings and collaboration among providers not only holds providers accountable for their care, but also could encourage primary care physicians to accept Medicare beneficiaries because they would not have to worry about the threat of low reimbursement rates from the SGR because the savings from the cost sharing would be given. However, if the sustainable growth rate could negatively affect the underlying fee-for-service payments, it may disincentivize providers from participating in an ACO.

D. Moving From the SGR to ACOs: What New Problems Will There Be?

While there is much skepticism about ACOs, probably the most controversial aspect of ACOs is the potential to be anticompetitive.²¹⁹ Many health care economists fear the race to form ACOs could result in hospital mergers and provider consolidation.²²⁰ As hospitals position themselves to become integrated systems, many are working together and purchasing physician practices, leaving fewer independent hospitals and doctors.²²¹ Greater market share gives these health systems more leverage in negotiations with insurers, which can drive up health costs.²²² Providers enjoying market power can use their bargaining leverage to command substantial increases in reimbursement from private health insurers and insulate themselves from the pressures to accept change in payment.²²³ This raises a number of antitrust concerns, in particular that ACOs run the risk of price fixing if they engage in joint price negotiations, especially in rural

²¹⁸ *Id.*

²¹⁹ Greaney, *supra* note 143, at 3.

²²⁰ Jenny Gold, *ACO is the Hottest Three-Letter Word in Health Care*, KAISER HEALTH NEWS (Oct. 21, 2011), <http://www.kaiserhealthnews.org/stories/2011/january/13/aco-accountable-care-organization-faq.aspx>.

²²¹ *Id.*

²²² *Id.*

²²³ Greaney, *supra* note 143, at 17.

markets.²²⁴ There is also a risk that any reduction in Medicare expenditures will be shifted to payors in the private sector in order to recoup costs or qualify for the Medicare cost-reduction bonuses.²²⁵

While ACOs could accelerate consolidations, consolidating is already a powerful and pervasive trend.²²⁶ According to the consulting firm Accenture, 39 percent of doctors nationwide are independent, which is down from 57 percent in 2000.²²⁷ An array of new economic realities, from reduced Medicare reimbursements to higher technology costs, is driving consolidation in health care and transforming the practice of medicine.²²⁸ Because the sustainable growth rate can be attributed to low reimbursement rates, it suggests that the sustainable growth rate is playing a part in driving consolidation.²²⁹ As stated before, many providers can no longer afford to accept Medicare beneficiaries because of the low reimbursement rate, and teaming up with another practice may be a way for providers to still continue caring for Medicare beneficiaries.

While there are valid concerns about the potential of ACOs shifting costs to the private sector of health care, the low reimbursement rates suggest that the sustainable growth rate is also aiding in cost shifting. If payments are too low, providers could make up the difference by increasing prices to the private payers. While it is evident that the sustainable growth rate needs to be fixed, repealing it comes with the heavy price tag of \$138 billion

²²⁴ U.S. FED. TRADE COMM'N, ACCOUNTABLE CARE ORGANIZATIONS: WHAT EXACTLY ARE WE GETTING? (2011), available at <http://www.ftc.gov/speeches/rosch/111117fallforumspeech.pdf>.

²²⁵ *Id.* at 6; Greaney, *supra* note 144, at 14.

²²⁶ Gold, *supra* note 221; Julie Creswell & Reed Abelson, *A Hospital War Reflects a Bind for Doctors in the U.S.*, N.Y. TIMES, Dec. 1, 2012, at A1, available at http://www.nytimes.com/2012/12/01/business/a-hospital-war-reflects-a-tightening-bind-for-doctors-nationwide.html?pagewanted=all&_r=0.

²²⁷ Creswell & Abelson, *supra* note 226.

²²⁸ *Id.*

²²⁹ See Waldron, *supra* note 121.

according to the Congressional Budget Office (CBO).²³⁰ However, continuing to freeze payments and perpetuating the lack of access to primary care physicians for Medicare beneficiaries is going to be no less expensive or beneficial as time goes on.²³¹ Currently, a bipartisan bill²³² called the Medicare Physician Payment Innovation Act of 2013 proposed to repeal the sustainable growth rate²³³ and is forcing democrats and republicans to work together to come up with a way to pay for the repeal.²³⁴ The hope is that the savings generated from repealing the sustainable growth rate will help to offset (over time) the initial cost of repealing it.²³⁵ Repealing the sustainable growth rate could help to decrease cost shifting to the private sector and may also encourage providers to remain independent.

Many policy experts praise the shift away from independent practices because it makes health care less fragmented.²³⁶ Although this is true, it is also important to preserve independent and small group practices to avoid providers with too much market share controlling prices. Implementing adequate guidelines and maintaining transparency through interagency cooperation between CMS and antitrust agencies would help curb the anticompetitive effects that ACOs with dominant market power may have on the private market.²³⁷ In conjunction with the issuance of the final

²³⁰ See Press Release, Allyson Y. Schwartz, Schwartz and Heck Introduce Bipartisan Legislation to Repeal SGR and Reform Medicare Physician Payment System (Feb. 6, 2013), available at <http://schwartz.house.gov/press-release/schwartz-and-heck-introduce-bipartisan-legislation-repeal-sgr-and-reform-medicare-1#.UdDwP5z9WhE>.

²³¹ *Id.*; MEDPAC, *supra* note 182 at 379–80.

²³² Schwartz, *supra* note 230.

²³³ Medicare Physician Payment Innovation Act of 2013, H.R. 574, 113th Cong. § 1 (1st Sess. 2013), available at <http://www.govtrack.us/congress/bills/113/hr574/text>.

²³⁴ See ENERGY & COMMERCE COMMITTEE, ENERGY AND COMMERCE & WAYS AND MEANS OUTLINE COLLABORATIVE MEDICARE PHYSICIAN REFORM EFFORT (Feb. 7, 2013), available at <http://energycommerce.house.gov/press-release/energy-and-commerce-ways-and-means-outline-collaborative-medicare-physician-payment-reform-effort>.

²³⁵ *Id.*

²³⁶ Creswell & Abelson, *supra* note, 226.

²³⁷ See Greaney, *supra* note 143, at 15.

regulations for ACOs participating in the Medicare Shared Savings Plan, the Department of Justice and the Federal Trade Commission issued a joint statement of an antitrust enforcement policy regarding ACOs' participation in the plan.²³⁸ The Final Statement addresses the criteria ACOs qualifying for the Shared Savings Plan must meet to be considered sufficiently integrated²³⁹ to engage in joint price negotiations with commercial health plans without being liable for violations of the Sherman Act.²⁴⁰

Because the level of integration determines whether or not an ACO can engage in collective price negotiations,²⁴¹ it is important for both the antitrust agencies and CMS to work together to monitor ACO behavior. In an effort to reduce uncertainty and encourage ACO development, the antitrust agencies have elected to defer to CMS on issues concerning clinical integration.²⁴² While some commentators have criticized the agencies for ceding their responsibility for monitoring competition in private markets to CMS, in this instance it is appropriate given the uncertainty in evaluating different cases that may arise, and also to work

²³⁸ Press Release, U.S. Dep't of Justice, Department of Justice/Federal Trade Commission Issue Final Statement of Antitrust Policy Enforcement Regarding Accountable Care Organizations (Oct. 20, 2011), available at <http://www.justice.gov/opa/pr/2011/October/11-at-1384.html>.

²³⁹ The antitrust laws that prohibit independent competing physicians from engaging in collective price negotiations do not apply to those activities when undertaken by physicians who have formally merged, or otherwise fully integrated their practices into a single organization, such as a medical group practice. *Joint Contracting/Collective Bargaining*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/practice-management-center/claims-revenue-cycle/managed-carecontracting/evaluating-payment-options/contracting-and-bargaining.page>.

²⁴⁰ Robert E. Bloch & Scott P. Perlman, *Analysis of Policy Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations*, MAYER BROWN (2012), <http://www.mayerbrown.com/analysis-of-policy-statement-of-antitrust-enforcement-policy-regarding-accountable-care-organizations-04-01-2012/>. The Sherman Act aims to preserve free and unfettered competition as the rule of trade. *Antitrust Laws*, FED. TRADE COMM'N (last visited Mar. 7, 2014), <http://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/antitrust-laws>

²⁴¹ See AM. MED. ASS'N, *supra* note 239.

²⁴² See Greaney, *supra* note 143, at 19.

with CMS to encourage entry into ACOs.²⁴³ Although both agencies have different regulatory goals in that CMS is concerned with overseeing quality and performance of Medicare and the antitrust agencies are concerned with consumer protection in supervising dominant market participants,²⁴⁴ working together to deter anticompetitive effects helps encourage affordable care for everyone, not those solely in traditional Medicare. After all, Medicare Advantage is a private plan that still contracts with Medicare for services.²⁴⁵ Because greater market share can drive up health costs,²⁴⁶ it would be in CMS's interest to not enable ACOs to gain extensive market share because it would in turn cost more money to provide services to Medicare beneficiaries. Cost shifting is in no one's best interest because it prevents Medicare beneficiaries from receiving access to health care. Therefore, CMS should be proactive in helping the antitrust agencies monitor complaints about an ACO's formation or conduct.

Because ACO participation is voluntary, it is important to ensure antitrust laws are not so stringent as to discourage participation in ACOs; equally important is monitoring large consolidations and mergers that could lead to unequal bargaining power. One way that the Final Statement will monitor consolidations is by establishing a "safety zone" for certain ACOs.²⁴⁷ ACOs that fall within the safety zone are presumed to be "highly unlikely to raise significant competitive concerns."²⁴⁸ In order to fall within the safety zone, multiple participants of an ACO can provide no more than 30 percent

²⁴³ See *id.* at 19–20.

²⁴⁴ See *id.* at 30.

²⁴⁵ See Petigara & Anderson, *supra* note, 124.

²⁴⁶ Gold, *supra* note 220.

²⁴⁷ Press Release, U.S. Dep't of Justice, *supra* note 238, at 3.

²⁴⁸ FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, STATEMENT OF ANTITRUST ENFORCEMENT POLICY REGARDING ACCOUNTABLE CARE ORGANIZATIONS PARTICIPATING IN THE MEDICARE SHARED SAVINGS PROGRAM 67028 (Oct. 28, 2011) (summarizing policy statements of 76 Fed. Reg. 209), available at http://www.justice.gov/atr/public/health_care/279568.pdf.

of a health care service within the primary service area.²⁴⁹ Because an ACO that is outside the safety zone may be pro-competitive but also have the potential to have anticompetitive effects, the Final Statement describes certain types of conduct that an ACO should avoid to reduce the likelihood that it will be investigated and found to be anticompetitive.²⁵⁰ Additionally, the policy statement provides examples of conduct that may raise competitive concerns and advises ACOs to implement safeguards against conduct that may facilitate collusion among ACO participants in the sale of competing services outside of the ACO.²⁵¹ These guidelines will hopefully help maintain transparency and curtail anticompetitive behavior.

Another criticism is that ACOs have a negative assumption that “they can be successful without major changes in doctors’ behavior.”²⁵² For example, to achieve their cost savings goals providers will need to change some of their approaches to treating patients through evidence-based protocols,²⁵³ whether it be prescribing different medication or deciding whether certain kinds of surgery are necessary to determine optimal treatment.²⁵⁴ Critics go on to say, “[s]uch a profound behavioral shift would likely require re-education and training and even then the result would be uncertain...ACOs aren’t designed or equipped to transform physician behaviors on the scale that will be needed.”²⁵⁵ While the result may be uncertain, this assumption is flawed because ACOs are addressing the need for behavioral changes by structuring themselves to allow for a quality performance score based on

²⁴⁹ Press Release, U.S. Dep’t of Justice, *supra* note 238.

²⁵⁰ Bloch & Perlman, *supra* note 240.

²⁵¹ Press Release, U.S. Dep’t of Justice, *supra* note 238.

²⁵² Clayton Christensen et al., Op-Ed., *Christiansen, Flier and Vijayaraghavn: The Coming Failure of ‘Accountable Care’*, WALL ST. J., Feb. 19, 2013, at A15, available at <http://online.wsj.com/article/SB10001424127887324880504578296902005944398.html>.

²⁵³ Using evidence of research and treatment techniques to figure out how best to treat a patient. *See generally Evidence Based Medicine (EBM) Resources*, DARTMOUTH BIOMEDICAL LIBRARIES (2012), http://www.dartmouth.edu/~biomed/resources.html#guides/ebm_resources.shtml.

²⁵⁴ *See* Christensen et al., *supra* note 252.

²⁵⁵ *Id.*

quality metrics. Because behavioral changes in the way providers deliver care is likely to require training and more education, ACOs should implement some form of continuing education classes for providers and suppliers within ACOs so that they have clear expectations of how to meet quality metrics and also aid in fostering a collective accountable environment. Implicit in the quality metrics and emphasis on coordinated care is the positive assumption that providers must change their behavior by being more conscious about how they deliver care in order to share in the cost savings.

IV. CONCLUSION

Though not perfect, ACOs offer promising steps toward high quality efficient care for Medicare beneficiaries. While the amount of money ACOs will actually save is debatable, studies show that integrated delivery systems and multi-specialty care provide more preventative services and have, on average, better quality indicators.²⁵⁶ The SGR formula is having an effect on payment rates, which is perpetuating concerns as to whether Medicare will be financially sustained once baby boomers retire and whether they will have access to primary care physicians. As discussed before, primary care physicians have a positive effect on patient outcomes and can save money in the long run. But in order to encourage more individuals to choose primary care as a career, there needs to be financial incentives. The solution to this problem is repealing the sustainable growth rate and adopting alternative payment methods, like ACOs. ACOs encourage collaboration and also offer financial incentives for delivering high quality care. Despite the potential for ACOs to be anticompetitive, the guidelines in place act to curb some of the worries of ACOs having too much market share. Furthermore, there is room for interagency collaboration between CMS and the antitrust agencies to monitor complaints and ACO conduct. At the end,

²⁵⁶ Greaney, *supra* note 143, at 13.

it comes down to a collaborative effort from providers, suppliers, and agencies to address the Medicare dilemma and ensure that the more than 80 million projected to be on Medicare by 2030 receive high quality, efficient care.