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**KEEPING OUR EYES ON THE PRIZE: EXAMINING
MINNESOTA AS A MEANS FOR ASSURING ACHIEVEMENT
OF THE “TRIPLE AIM” UNDER THE ACA**

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“At the end of the day, if the only successful ACOs are those from Geisinger, [Rochester, Minn.-based] Mayo Clinic and Kaiser Permanente, what has society gained? These organizations were already operating at the highest levels of confidence in respect to the triple aim.”

-Marc Bard, MD, *ACOs: The Least Agreed-Upon Concept in Healthcare?* via Becker’s Hospital Review (May, 2013)

I. INTRODUCTION

A little more than four years after enactment of the Patient Protection and Affordable Care Act of 2010 (“ACA”),¹ daily headlines still abound on

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newspapers and websites across the country highlighting both successes and failures of the ACA. Much of the public debate thus far has focused on those aspects of the ACA that address insurance reform,² such as the constitutionality of the individual mandate,³ the launching of the healthcare exchanges,⁴ and enrollment of previously uninsured individuals into new insurance plans.⁵ While insurance reform is important and essential to

¹ The Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148 (2010) (codified as amended in scattered sections of 42 U.S.C., 29 U.S.C., 26 U.S.C., 25 U.S.C., 21 U.S.C.).

² See Jean Card, *Trust Your Gut on Obamacare*, U.S. NEWS & WORLD REP., (May 22, 2014), <http://www.usnews.com/opinion/blogs/opinion-blog/2014/05/22/americans-are-right-to-trust-their-gut-on-obamacare> (stating “The Affordable Care Act was not healthcare reform, it was health insurance reform. And why would anyone understand that, when we generally don’t understand health insurance anyway?”).

³ While the United States Supreme Court affirmed the constitutionality of the “individual mandate,” which is that aspect of the ACA that requires individuals to purchase health insurance or otherwise face a tax penalty, there continues to be litigation surrounding this determination. See *Sissel v. Dept. of Health and Human Svcs.*, 951 F.Supp.2d 159 (D.C. Cir. 2014) (arguing that the ACA is unconstitutional because, to the extent that the requirement that individuals purchase health insurance is actually a tax, the bill that eventually became the ACA originated in the United States Senate in violation of the Origination Clause of the Constitution, which requires that all bills for raising revenue originate in the United States House of Representatives).

⁴ Paul Demko, *More Than Half of Companies Considering Private Exchanges, Survey Finds*, MOD. HEALTHCARE (July 8, 2014), <http://www.modernhealthcare.com/article/20140707/BLOG/307079997> (finding that more than 50% of surveyed companies are considering sending employees to private insurance exchanges, and 23% of employers are likely to eliminate healthcare coverage altogether and instead direct their employees to the public exchange); David Blumenthal, M.D., M.P.P. & Sara R. Collins, Ph.D., *Health Care Coverage under the Affordable Care Act—A Progress Report*, NEW ENG. J. MED. (July 2, 2014), available at http://www.commonwealthfund.org/~media/files/publications/in-the-literature/2014/jul/1759_blumenthal_coverage_under_aca_progress_report_nejm_07_02_2014_itl.pdf (estimating that twenty million individuals are now covered by insurance because of provisions under the ACA, consisting of one million individuals between the ages of 19–26 who went on a parent’s policy, eight million individuals who purchased insurance off a federal or state insurance exchange, five million individuals who purchased insurance directly from an insurer, and six million individuals who enrolled in Medicaid or CHIP under expansion in certain states).

⁵ There is debate as to whether the estimated eight million Americans who enrolled in private health coverage under the ACA in the first year of enrollment are those who were previously uninsured or those who opted for new insurance coverage on the exchanges. See Amit Bhardwaj et al., *Individual Market Enrollment: Updated View*, MCKINSEY & CO. (Mar., 2014), <http://healthcare.mckinsey.com/individual-market-enrollment-updated-view> (exhibit three shows that as of March 31, 2014, an estimated 27% of respondents who purchased insurance on the health insurance exchange were previously uninsured, up from an estimated 11% of respondents being previously uninsured); but see Liz Hamel et al., *Survey Of Non-Group Health Insurance Enrollees*, KAISER FAMILY FOUND., (June 19, 2014), <http://kff.org/health-reform/report/survey-of-non-group-health-insurance-enrollees/> (finding that 57% of individuals who did not have group coverage who have purchased insurance on a state or national insurance exchange under the ACA were uninsured prior to purchasing their current plan). Irrespective of this dispute, about eight million Americans purchased insurance coverage from either state or federal exchanges set up under

understand (both as employers and for purposes of their own financial statements), for providers, suppliers, and other participants in the healthcare industry much of the dialogue and energy has been focused instead on those aspects of the ACA that address other types of reform of the healthcare system; specifically, the manner in which care is provided to patients and at what cost such care is provided.⁶

In analyzing the stated goals of the ACA in its proposed reform of the healthcare delivery system, many such goals have their origins in a premise first proposed by Dr. Donald M. Berwick and the Institute for Healthcare Improvement (“IHI”) in 2006 referred to as the “Triple Aim.”⁷ The Triple Aim is a framework for healthcare that, at its origin, was intended to “optimize population health, care experience, and cost.”⁸ Much of the impetus for this framework came about originally, and has managed to gain traction since its origin, in response to the fact that the healthcare system in the United States was then and continues to be today the most costly system in the world.⁹ Yet, many patient outcomes and patient satisfaction scores in the United States are nevertheless worse than in other developed nations.¹⁰ Thus, recognizing key challenges unique to the U.S. healthcare system,¹¹ IHI

the ACA in the first year of enrollment. *See Enrollment in the Health Insurance Marketplace totals over 8 Million People*, HHS.GOV (May 1, 2014) html [hereinafter *HHS Press Release I*], <http://www.hhs.gov/news/press/2014pres/05/20140501a.html>.

⁶ See William M. Sage, *Putting Insurance Reform in the ACA’s Rear-View Mirror*, 51 HOUS. L. REV. 1081, 1082 (2014).

⁷ See *A History of IHI (“IHI”)*, INST. FOR HEALTHCARE IMPROVEMENT, <http://www.ihl.org/about/Documents/IHITimeline2013.pdf> (last visited Jan. 27, 2015); see also Donald M. Berwick et al., *The Triple Aim: Care, Health, And Cost*, 27 HEALTH AFFAIRS 759 (2008).

⁸ See Berwick, *supra* note 7.

⁹ Cathy Schoen, et al., *Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System*, COMMONWEALTH FUND (Jan. 10, 2013), <http://www.commonwealthfund.org/publications/fund-reports/2013/jan/confronting-costs>; see *National Healthcare Expenditure Projections, 2012–2022*, CMS.GOV, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/proj2012.pdf> (last visited Jan. 27, 2015).

¹⁰ See Berwick, *supra* note 7, at 759 (noting that despite spending the highest in the world on healthcare expenses relative to other developed countries, the U.S. ranks 31st on life expectancy, 36th on infant mortality, 28th on male healthy life expectancy, and 29th on female life expectancy (citing World Health Organization, *World Health Statistics of 2006*). Note that some statistics have only worsened since the time of Berwick’s article. According to the World Health Organization, *World Health Statistics of 2014*, the U.S. now ranks thirty-fifth in female life expectancy, thirty-fifth in male life expectancy, and thirty-second in overall life expectancy. WORLD HEALTH ORGANIZATION, WORLD HEALTH STATISTICS 2014 60–66, available at http://apps.who.int/iris/bitstream/10665/112738/1/9789240692671_eng.pdf?ua=1; see also Karen Davis, *Mirror, Mirror on the Wall*, COMMONWEALTH FUND (June 2014), http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf.

¹¹ The findings of IHI regarding the need for the Triple Aim is based on the assumption that the U.S. does not currently and will not under current reforms have a single payor system. See Berwick, *supra* note 7 at 767 (“[W]ith some risk, we note that the simplest way to establish many of these environmental conditions is a single-payer system, hiring

established a framework that is intended to optimize health system performance by focusing on the following three goals: (1) improving the patient experience of care (including quality and satisfaction); (2) improving the health of populations; and (3) reducing the per capita cost of healthcare.¹² Utilizing knowledge of the perceived failures of the managed care movement of the 1980s and 1990s,¹³ lawmakers and policy makers focused their reforms on the concept of the “Triple Aim,” which appears different from managed care reforms of the past because of its focus on achieving all three of its stated goals simultaneously, only one of which is cost containment.¹⁴

While not specifically referenced as the “Triple Aim” in the actual text of the ACA, the themes and goals of the Triple Aim were prominent aspects of the dialogue and debate in both the U.S. Congress and at the Centers for Medicare and Medicaid Services (“CMS”) in connection with the proposed reforms and process improvements under the ACA.¹⁵ For example, the ACA initiated the formation of the CMS Innovation Center, which stated goal is the “testing [of] various payment and service delivery models that aim to achieve better care for patients, better health for our communities, and lower costs through improvement for our healthcare system.”¹⁶ Probably the

integrators with prospective, global budgets to take care of the health needs of a defined population, without permission to exclude any member of the population.”).

¹² See *The IHI Triple Aim*, INST. FOR HEALTHCARE IMPROVEMENT, <http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx> (last visited July 28, 2014).

¹³ When health maintenance organizations (“HMOs”) initially emerged in the 1980s, there was a proliferation of these types of organizations due in large part to the success that was being demonstrated regarding cost containment. HMOs then fell out of favor by the 1990s, for various reasons, including concerns that insurers and providers sacrificed quality of care in order to achieve cost containment goals. David Muhlestein et al., *The Accountable Care Paradigm: More than Just Managed Care 2.0*, CTR. FOR ACCOUNTABLE CARE INTELLIGENCE 8 (2013) [hereinafter Muhlestein, *The Accountable Care Paradigm*], available at <http://leavittpartners.com/wp-content/uploads/2013/03/Accountable-Care-Paradigm.pdf>.

¹⁴ *Id.*

¹⁵ Patient Protection and Affordable Care Act 42 U.S.C. §229b (2014) (stating that entities who may be eligible for awards from the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality will be judged by certain criteria including the provision of better care at a lower cost); *id.* § 1315a (2014) (establishing the Center for Medicare and Medicaid Innovation and stating that some of the testing models will provide assistance to other healthcare institutions on how best to employ such best practices and proven care methods to improve healthcare quality and lower costs). See also PRESIDENT BARACK OBAMA, REMARKS BY THE PRESIDENT IN AN ONLINE TOWN HALL ON HEALTH CARE (July 1, 2009) [hereinafter OBAMA REMARKS], available at <https://www.whitehouse.gov/the-press-office/remarks-president-online-town-hall-health-care-reform>.

¹⁶ See *CMS Innovation Center*, CMS.GOV <http://www.innovation.cms.gov> (last visited Mar. 27, 2015). In addition to the CMS Innovation Center, the ACA proposed various pilot programs and grant awards also with the goal of developing new systems that will achieve the Triple Aim, such as the Medicare Shared Savings Program (to be discussed at length in the remainder of this article), value-based purchasing programs, bundled payment programs, patient-centered medical home models, etc. See 42 U.S.C. § 1395ww (hospital

most direct and obvious example in the ACA of a system process change that is focused on achieving the goals of the Triple Aim and emulating integrated delivery systems seemingly already achieving this balance is the formation and creation of accountable care organizations (“ACOs”) under the Medicare Shared Savings Program (“MSSP”).¹⁷ The ACA states that the MSSP is intended to “promote[] accountability for a patient population and coordinate[] items and services under [Medicare] parts A and B, and encourage[] investment in infrastructure and redesigned care processes for high quality and efficient service delivery.”¹⁸ Many scholars have praised ACOs and ACO-like organizations¹⁹ as the best means for improving the quality and efficiency of healthcare in a manner that fulfills the Triple Aim because ACOs enable hospitals and physicians, as opposed to insurers, to “join forces” and work together to better coordinate the care of patients in the most cost effective and quality-driven manner.²⁰

One of the most common examples of efficiency and quality utilized during the debates leading up to enactment of the ACA was the world-renowned Mayo Clinic in Rochester, Minnesota.²¹ Promoted as a model of the Triple Aim and exemplar for how ACOs should function, the Mayo Clinic was frequently cited by President Barack Obama as one of the institutions to which all other providers should look when considering reform of the U.S. healthcare delivery system.²² The Mayo Clinic is ranked first on

value-based purchasing program); *id.* § 256a-1 (2014) (establishing community health teams to support the patient-centered medical home.

¹⁷ 42 U.S.C. § 1395jjj; *see also* Frank Pasquale, *Accountable Care Organizations in the Affordable Care Act*, 42 SETON HALL L. REV. 1372, 1374–75 (2012).

¹⁸ 42 U.S.C. § 1395jjj.

¹⁹ There are many organizations, sometimes referred to as clinically integrated networks, that have been established since the enactment of the ACA or pre-dating the ACA that have many of the same elements of an ACO, but do not meet the precise definition of an ACO as established by the Department of Health and Human Services (“DHS”) in enactment of regulations for the MSSP and thus are not participating in the MSSP. While many of the arguments made in this article regarding ACOs apply equally to ACOs and clinically integrated networks, this article will focus primarily on the structure that has been set up under the ACA for establishment of ACOs under the MSSP.

²⁰ *See* Pasquale, *supra* note 17 at 1374; Mark Morrell & Alex Krouse, *Accountability Partners: Legislated Collaboration for Health Reform*, 11 IND. HEALTH L. REV. 225 (2014).

²¹ A search of the White House Press Office website reveals over 18 references to instances in which the President or other White House officials mentioned the Mayo Clinic in connection with healthcare or healthcare reform. *See generally* WHITE HOUSE PRESS OFFICE, <http://search.whitehouse.gov/search/news?utf8=%E2%9C%93&sc=0&query=%22mayo+clinic%22&locale=en&m=&channel=6&affiliate=wh&commit=Search> (last visited July 10, 2014).

²² *See* OBAMA REMARKS, *supra* note 15 (“We have long known that some places, including Minnesota, offer high-quality care at costs below average. (Applause) Look at what the Mayo Clinic is able to do. It’s got the best quality and the lowest cost of just about any system in the country. (Applause) So what we want to do is we want to help the whole country learn from what Mayo is doing.”); Letter from President Obama to Chairmen Edward M. Kennedy and Max Baucus (June 2, 2009), *available at* <http://www.whitehouse.gov/t>

the U.S. News and World Report Honor Roll for hospitals, and was listed as one of the top three hospitals in the country for nearly all of the specialties in which the publication ranks hospitals, including cancer; cardiology and heart surgery; diabetes and endocrinology; ear, nose, and throat; gastroenterology and GI surgery; geriatrics; gynecology; nephrology; neurology and neurosurgery; orthopaedics; pulmonology; and urology.²³ Even as a top provider of healthcare in the nation (and, indeed, the world), the Mayo Clinic has also been lauded as being able to provide high-quality care without corresponding high spending.²⁴

To determine whether these assumptions regarding the Mayo Clinic and its role as a model for ACOs are true, it is necessary to examine the structure and regulations established for ACOs. ACOs are considered one of the primary means by which legislators and regulators intended for the U.S. healthcare system to move towards the Triple Aim,²⁵ or said another way, look more like the Mayo Clinic. If the formation and adoption of ACOs is intended to make other hospitals, physicians, and other providers resemble those integrated systems promoted in 2009, and thus realize the Triple Aim, it is critical that the ACO regulations create a structure that is accessible and achievable for all types of providers across the delivery spectrum. As ACOs begin in earnest, and industry leaders also start the process of developing and

he_press_office/Letter-from-President-Obama-to-Chairmen-Edward-M-Kennedy-and-Max-Baucus ("We should ask why places like the Mayo Clinic in Minnesota, the Cleveland Clinic in Ohio, and other institutions can offer the highest quality care at costs well below the national norm. We need to learn from their successes and replicate those best practices across our country. That's how we can achieve reform that preserves and strengthens what's best about our healthcare system, while fixing what is broken."); PRESIDENT BARACK OBAMA, REMARKS BY THE PRESIDENT MEETING WITH SENATE DEMOCRATS TO DISCUSS HEALTH CARE (June 2, 2009), available at <http://www.whitehouse.gov/the-press-office/remarks-president-meeting-with-senate-democrats-discuss-health-care> ("So we've got to reform the underlying system. And this means promoting best practices, not just the most expensive practices. And one of the things I'm going to be discussing with the health and the finance committees is how can we change incentive structures so that, for example, places like Mayo Clinic in Minnesota are able to provide some of the best healthcare services in the country at half or sometimes even less of the costs than some other areas where the quality is not as good.").

²³ In addition to being in the top three of each of these specialties, Mayo Clinic is the top hospital in pulmonology; neurology and neurosurgery; nephrology; gynecology; geriatrics; gastroenterology and GI surgery; ear, nose, and throat; and diabetes and endocrinology. See *U.S. News Best Hospitals 2014–15*, U.S. NEWS & WORLD REP. [hereinafter *Best Hospitals 2014–15*], <http://health.usnews.com/best-hospitals/rankings> (last visited July 22, 2014).

²⁴ See Atul Gawande, *The Cost Conundrum*, NEW YORKER (June 1, 2009), <http://www.newyorker.com/magazine/2009/06/01/the-cost-conundrum>; see also *Medicare Spending Per Enrollee, By State*, KAISER FAMILY FOUND., <http://kff.org/medicare/state-indicator/per-enrollee-spending-by-residence/> (last visited July 10, 2014) (citing Montana as the lowest cost per enrollee at \$7,576 per enrollee, with Minnesota averaging \$8,941 per enrollee, and New Jersey as the highest cost per enrollee at \$11,903).

²⁵ See generally DAVID NEWMAN, CONG. RESEARCH SERV., ACCOUNTABLE CARE ORGANIZATIONS AND THE MEDICARE SHARED SAVINGS PROGRAM 9 (Nov. 4, 2010), available at http://assets.opencrs.com/rpts/R41474_20101104.pdf.

establishing national standards, it is becoming increasingly apparent that the U.S. health system cannot simply replicate the Mayo Clinic and Kaiser Permanente²⁶ through the ACO models that have been enacted. While the goals of ACOs are consistent with the goals of the Triple Aim, the process of actually creating a system that is more integrated and coordinated like the Mayo Clinic and less like most other current (more fragmented and expensive) systems will require continued thoughtful analysis.²⁷ Such analysis must consider the ACO structure established under current regulations, which structure must continue to evolve if the U.S. healthcare system is ever to realize the Triple Aim.

This article argues that in order to maintain the focus applied during the drafting and ultimate enactment of the ACA, and ensure that healthcare is provided in furtherance of the Triple Aim, the current ACO structure requires attention, direction, development, and ultimately amendment because it currently lacks applicability to those integrated systems that were intended to be leaders towards healthcare reform, such as the Mayo Clinic. Part II of this Article will describe the basis of the Triple Aim and the intended embodiment of the Triple Aim in the development of ACOs under the ACA. Part III will examine the Mayo Clinic and other integrated delivery systems to consider whether or not such systems, which have long been touted as beacons of quality and cost effectiveness, are already achieving the Triple Aim and further consider how these integrated delivery systems have responded to the ACO movement and their impact on participation or lack of participation in such movement. Part IV will examine some of the challenges of the current ACO structure as it exists today, focusing on Minnesota and the Mayo Clinic as a case study. It will further offer some recommendations for amendments to the ACO structure that will ensure that the healthcare delivery system that ultimately arises out of the ACO movement does not lose sight of the original goals of the Triple Aim, which can only be accomplished and achieved if the ACO structure is open and accessible to all providers, including academic medical centers (“AMCs”) and other integrated delivery systems.²⁸ Finally, this Article will conclude in Part V by

²⁶ Reed Abelson, *The Face of Future Health Care*, N.Y. TIMES (Mar. 20, 2013), http://www.nytimes.com/2013/03/21/business/kaiser-permanente-is-seen-as-face-of-future-health-care.html?_r=1& (Kaiser Permanente is a similarly touted system in California that is seen as a model of integrated care, which is able to maintain quality services, but without experiencing run-away healthcare spending).

²⁷ See Gawande, *supra* note 24 (comparing the Mayo Clinic and the high quality, low cost care that it is able to provide to its patients to the fragmented and highly expensive healthcare structure operating in McAllen, Texas).

²⁸ See generally John A. Kastor, *Accountable Care Organizations at Academic Medical Centers*, 364 NEW ENG. J. MED. 7 (Feb. 17, 2011); Melanie Evans, *Beyond ACOs*, MODERN HEALTHCARE (June 22, 2013) [hereinafter Evans, *Beyond ACOs*]; Justin Kearns, *Rural Roads to ACOs: Inter-Community Collaboration is Key to Rural Accountable Care Organizations' Success Under Medicare Shared Savings Program*, 116 W. VA. L. REV. 425 (2013).

noting that an ACO system that does not provide accessibility to all providers will ultimately be unsuccessful in achieving the Triple Aim envisioned under the ACA.

II. THE TRIPLE AIM AND THE ACA

The Triple Aim is a concept that pre-dates the ACA and was developed in 2006 through the IHI.²⁹ In response to consistently poor “scorecards” for the U.S. healthcare system,³⁰ Berwick and the IHI believed there was a need to shift the paradigm of the delivery of healthcare in the United States in an effort to address the fact that the U.S. healthcare system “lacks the capacity to integrate its work over time and across sites of care.”³¹ The Triple Aim focuses on meeting, simultaneously, three goals in the delivery of healthcare: “improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations.”³² As one can note from the continued use of the word “population,” the IHI emphasizes the need for this framework to be applied for all individuals receiving healthcare in the U.S.³³ While each of the goals of the Triple Aim are important aspects of healthcare reform processes, Berwick believes that “the promise of equity” should be the most important policy consideration; that is, each of the aims must be pursued on parallel tracks³⁴ and achieving the Triple Aim cannot mean providing improved outcomes to only a small subpopulation at the expense of another, but must contemplate better population health for all.³⁵

Much of Berwick’s premises and ultimate recommendations for reform are seeded by current ills of the U.S. healthcare system.³⁶ Certainly, for some populations in the U.S., the healthcare system here is better than any other in the world, the Mayo Clinic being a prime example given its

²⁹ See Berwick, *supra* note 7, at 760.

³⁰ See *id.* (citing Commonwealth Fund Commission on High Performance Health System in which U.S. scored an overall score of sixty six out of 100). Note that the U.S. scorecard from the Commonwealth Fund Commission on High Performance System has not improved with the U.S. scoring an overall score of 64 out of 100. See *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2011*, COMMONWEALTH FUND, <http://www.commonwealthfund.org/publications/fund-reports/2011/oct/why-not-the-best-2011> (last visited Mar. 27, 2015). Note, however, that the report is based on data from 2007–2009, as an update from that last most recent data, and “does not fully reflect the effects of the recent economic recession on access to and use of care.” *Id.* It also fails to include whether any improvements have been made since the enactment of the ACA. *Id.*

³¹ See Berwick, *supra* note 7, at 759.

³² *Id.* at 760.

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.* Berwick has called pursuit of the Triple Aim as “an exercise in balance [to be] subject to specified policy constraints, such as decisions about how much to spend on healthcare or what coverage to provide and to whom.” *Id.*

³⁶ See Berwick, *supra* note 7, at 760.

international reputation for excellent care.³⁷ As is demonstrated by the findings of the Commonwealth Fund, however, for others in this country the care that is provided, or at least the outcomes resulting from the care or lack of care to certain vulnerable populations, is worse than other developed or developing countries.³⁸ In addition to the health disparities among certain subpopulations, certain models of care that have been utilized in the U.S., such as the managed care model, have focused on cost containment to the detriment of patient satisfaction.³⁹ Thus, from Berwick's perspective, it is not enough to succeed on one or two of the aims and it is also not enough for certain subpopulations of a few individuals to succeed in all three of the aims. For the Triple Aim to realize the change the IHI is proposing, the healthcare delivery system must achieve all three aims together in a manner that results in better care for all.⁴⁰

In defining and describing the Triple Aim, Berwick identified certain "preconditions" for pursuit of the Triple Aim, which are required because of specific "design constraints" inherent in the U.S. system.⁴¹ More specifically, Berwick asserts that to accomplish the Triple Aim, the following preconditions must be established: (a) create a definition of "population" under the Triple Aim that relates to enrollment and ability to track and monitor a patient, as opposed to a geographic population;⁴² (b) create policy constraints that will balance each of the aims in order to achieve all, as

³⁷ The Mayo Clinic has an international reputation and sections of its website are dedicated to its international medicine practice, which "serves patients who come from outside the United States seeking medical care at Mayo Clinic." Mayo Clinic Staff, *International Medicine Practice*, MAYO CLINIC, <http://www.mayoclinic.org/departments-centers/general-internal-medicine/minnesota/overview/specialty-groups/international-medicine-practice> (last visited July 28, 2014). Services include consultative care for international patients, coordinate of international patient care, preventative screening services for health maintenance, and collaborative care of patients with chronic medical illnesses. *Id.* See also *Patients Beyond Borders*, MAYO CLINIC, <http://www.patientsbeyondborders.com/hospital/mayo-clinic> (last visited July 28, 2014) ("Each year more than 8,000 international patients from 140 countries travel to one of Mayo's locations.").

³⁸ See Davis, *supra* note 10, at 8.

³⁹ See generally Berwick, *supra* note 7; see also generally Ezekiel J. Emanuel, *Why Accountable Care Organizations are Not 1990s Managed Care Redux*, 21 J. AM. MED. ASS'N. 307 (June 6, 2012).

⁴⁰ Berwick refers to "universal coverage" as "The Holy Grail" and thus views a system in which we have the effects of a single-payor system, but without the obligation of the government to provide it, as the ultimate goal of healthcare in the United States. See Berwick, *supra* note 7, at 761.

⁴¹ *Id.* at 762–63.

⁴² *Id.* Berwick states that for purposes of accomplishing the aims for a "population" it is not necessary to think about populations in terms of where they live, but a group of people for who certain care goals can be achieved. An example might be a definition such as, "all of the diabetics in Massachusetts" or "members of Group Health Cooperative of Puget Sound." *Id.* Berwick believes that this definition is essential because only when we can define a specific population can we start to consider what that population's experiences are relative to healthcare, health status, and the costs related to caring for such a population. *Id.*

opposed to simply one, aim; and (c) identify an “integrator.”⁴³ The authors define this “integrator” as a single entity that accepts responsibility for implementation of the Triple Aim across its “population” (however such “population” has been defined).⁴⁴

While all preconditions are critical, Berwick believes that identification of an integrator is a key component of pursuit of the Triple Aim, as it is critical to have an entity that links healthcare organizations together in order to overlap the “spectrum of delivery.”⁴⁵ One example of an integrator could be Kaiser Permanente, but Berwick notes that effective integrators are really any entities that can link healthcare organizations “whose missions overlap across the spectrum of delivery.”⁴⁶ As Berwick states, “[t]he important function of linking organizations across the continuum requires that the integrator be a single organization (not just a market dynamic) that can induce coordinative behavior among health service suppliers to work as a system for the defined population.”⁴⁷ Under the ACA, this function could be filled by the management of the ACO, but the definition is not limited only to ACOs and could be filled by various entities.⁴⁸

A. Distinctions Between the Triple Aim and Managed Care

The general concepts espoused through the Triple Aim perhaps seem obvious, self-evident, or even familiar health policy. Indeed, Berwick and his colleagues at IHI acknowledge that the general theme is not entirely new and, in fact, is already being implemented to some extent in different programs across the country.⁴⁹ Berwick further acknowledges that the goals of the Triple Aim are not unlike the goals of the managed care movement of the 1980s and 1990s and the emergence of HMOs, as he has stated, “As conceived by their greatest champion, Paul Ellwood, HMOs were, or were intended to be, integrators exactly as we propose, in pursuit of the Triple Aim.”⁵⁰

If IHI is correct and managed care and HMOs have been aspiring to the same goals as the Triple Aim for years, what then is different about the

⁴³ *Id.* at 762–63.

⁴⁴ *See* Berwick, *supra* note 7, at 762–63.

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*; Patient Protection and Affordable Care Act 42 U.S.C. § 1395j.

⁴⁹ *See* Berwick, *supra* note 7, at 766 (noting that the Veterans Health Administration, the Indian Health Service, and the Military Health Command are all examples of integrated systems within government and that classic HMOs and systems like Kaiser Permanente, HealthPartners, and Group Health Cooperative of Puget Sound (combinations of the provision of services and insurance) as examples in the commercial system).

⁵⁰ *Id.* at 766 (citing P.M. Ellwood et al., *Health Maintenance Strategy*, 9 MED. CARE 291 (1971)).

Triple Aim and the ACO movement today, and why does IHI believe the Triple Aim can accomplish what HMOs could not? Much has been written since the emergence of ACOs regarding this exact question; that is, are ACOs really all that different from HMOs?⁵¹ Berwick's response is that while HMOs appeared to hold the same goals as the Triple Aim, HMOs were not, in fact, applying the Triple Aim as he and others conceived it:

The HMO movement was eventually defined by its organizational structure rather than its aims and performance. The experience of people enrolled in HMOs was not sufficiently improved to overcome the restriction of choice of providers or the perceived barriers to access to specialists that became part of the HMO model. Because they restricted care, HMOs were vulnerable to competitive retaliation by indemnity insurers and others, which began offering products called "HMO" or "managed care" that merely managed money, not care.⁵²

Essentially, argues Berwick, HMOs failed to fulfill that aspect of the Triple Aim that improves the patient experience of care, allowing instead cost containment to become the sole driver.⁵³ This can be seen by example in many of the state laws that were enacted in response to the rise of HMOs in the 1990s.⁵⁴ The Minnesota legislature, for example, amended Chapter 62D of the Insurance Title to address concerns regarding the operations and practices of health maintenance organizations.⁵⁵ Minnesota's § 62D.12 lists the "prohibited practices" of managed care companies, which prohibitions include, *inter alia*, denying or limiting coverage of a service that the enrollee has already received solely on the basis of lack of prior authorization or second opinion if the service would have otherwise been covered absent that authorization process.⁵⁶ While denials and prior authorizations were viewed negatively from a consumer protection perspective (and thus many other states' enacted laws that echoed Minnesota's law), such approaches were

⁵¹ See Emanuel, *supra* note 39, at 2263; see generally Muhlestein, *The Accountable Care Paradigm*, *supra* note 13.

⁵² Berwick, *supra* note 7, at 766.

⁵³ See generally Berwick, *supra* note 7; see also Anna Wilde Mathews, *Can Accountable-Care Organizations Improve Health Care While Reducing Costs?*, WALL ST. J. (Jan. 23, 2012), <http://www.wsj.com/articles/SB10001424052970204720204577128901714576054> (noting a comment by Donald Berwick, stating: "[HMOs] required patients to stay within their own networks, but, for many patients, the trade-off between loss of choice and improved care was worth it. By the 1970s, however, mutant forms of managed care emerged that kept the restrictions but not the care improvements. Doctors and patients sensed the game and didn't like it. By the 1980s, HMOs had a bad name.").

⁵⁴ See MINN. STAT. §§ 62D.01–62D.24 (2014); TENN. CODE ANN. §§ 56-32-101–56-32-138 (2014) (Health Maintenance Organization Act of 1986); WIS. STAT. § 609.10 (2014); KY. REV. STAT. ANN. § 304.38-010 (West 2014); IOWA CODE §§ 514b.1–514b.33 (2014).

⁵⁵ See MINN. STAT. §§ 62D.01–62D.24.

⁵⁶ MINN. STAT. § 62D.12, subd. 19 (coverage of service); see also TENN. CODE ANN. § 56-32-129.

nevertheless successful cost containment measures for HMOs.⁵⁷ Others have arrived at similar conclusions as Berwick regarding some of the failings of HMOs, finding that the limitations and restrictions that were implemented for purposes of cost savings resulted in poor patient satisfaction, which ultimately resulted in the consequent rejections of such plans by consumers.⁵⁸

B. Development of ACOs under the ACA

It is with the backdrop of both the benefits and the downfall of the managed care movement of the 1980s and 1990s that the Obama administration and legislators considered new delivery models under the ACA.⁵⁹ While there were many complaints and frustrations with the financial drivers and data points that HMOs used to measure success (as opposed to health outcomes), one thing that is difficult to argue with regarding the managed care movement is that it saved money.⁶⁰ Thus, when considering how to reform the healthcare system and the spiraling healthcare costs that have developed since the managed care movement was curbed through consumer protection laws, legislators and policy experts were keenly aware that certain aspects of the managed care movement needed to be a part of the new system of reform.⁶¹ But, they were also keenly aware that simply creating a new statutory scheme of HMOs with a new name would also not be effective change.⁶² This is where the Triple Aim and the development of accountable care organizations (“ACOs”) came into play: ACOs share many of the same goals of the managed care movement, but are intended to bring the focus away from solely cost containment.⁶³ That change in focus is highlighted by two key differences between ACOs and HMOs: (1) ACOs manage care through providers (as opposed to insurers), utilizing outcome-

⁵⁷ Morrell, *supra* note 20, at 242.

⁵⁸ See Muhlestein, *The Accountable Care Paradigm*, *supra* note 13, at 3 (stating “MCOs, though, came to be seen as limiting patient choice and potentially rationing necessary healthcare services to increase profits through limited networks of providers, stiff gatekeeping requirements and utilization review, resulting in insurer-based ‘death panels’ where anonymous underwriters determined who received care”); Morrell, *supra* note 20, at 242; Martin Markovich, *The Rise of HMOs*, RAND CORP. (2003), available at http://www.rand.org/content/dam/rand/pubs/rgs_dissertations/RGSD172/RGSD172.ch1.pdf (last visited Sept. 2, 2014).

⁵⁹ See Pasquale, *supra* note 17, at 1373.

⁶⁰ See Markovich, *supra* note 58, at 13 (“The effectiveness of HMOs in controlling costs has been the subject of a tremendous volume of research and analysis. . . . The balance of the evidence indicates that HMOs have reduced overall healthcare costs through several mechanisms and substantially contributed to the cost de-escalation of the 1990s. This de-escalation has caused costs to recede as an issue in the consciousness of the public, the press, and elected officials.”).

⁶¹ *Id.*; see Morrell, *supra* note 20, at 242–43.

⁶² See Morrell, *supra* note 20, at 243; Muhlestein, *The Accountable Care Paradigm*, *supra* note 13, at 7.

⁶³ See Berwick, *supra* note 7, at 760.

driven data and quality metrics, as opposed to financial measures, and (2) ACOs have access to technological advancements in patient tracking and monitoring, enabling a new and improved approach to healthcare delivery.⁶⁴

ACOs, as defined under the ACA, are legal entities organized as groups of providers of services and suppliers who work together to manage and coordinate care for Medicare fee-for-service beneficiaries through accountability for quality, cost, and overall care⁶⁵ through the MSSP.⁶⁶ In an effort to incentivize this coordination of care, the MSSP program attempts to align participating providers/suppliers with one another (particularly hospitals and physicians) by agreeing to share with the ACO any savings that the Medicare program might realize from healthcare expenditures for the same Medicare beneficiaries in previous years.⁶⁷

At its heart, the MSSP program is much like a gainsharing program.⁶⁸ Gainsharing arrangements have been the subject of much analysis, research, and discussion since the 1990s, which the Centers for Medicare and Medicaid Services (“CMS”) has addressed in several advisory opinions.⁶⁹ As recognized by CMS and the requestors in these advisory

⁶⁴ See Muhlestein, *The Accountable Care Paradigm*, *supra* note 13, at 4.

⁶⁵ Patient Protection and Affordable Care Act 42 U.S.C. 1395jjj.

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ See Newman, *supra* note 25, at 9; see also generally Nicole Martingano-Reinhart, *Gainsharing and the Patient Protection and Affordable Care Act*, 43 SETON HALL L. REV. 1325, 1348 (2013).

⁶⁹ OIG Advisory Opinion No. 01-1, 2001 WL 36190940 (Jan. 11, 2001), available at <https://oig.hhs.gov/fraud/docs/advisoryopinions/2001/ao01-01.pdf>; OIG Advisory Opinion No. 05-01, 2005 WL 6289864 (Feb. 10, 2005), available at <https://oig.hhs.gov/fraud/docs/advisoryopinions/2005/ao0501.pdf>; OIG Advisory Opinion No. 05-02, 2005 WL 6289865 (Feb. 10, 2005), available at <https://oig.hhs.gov/fraud/docs/advisoryopinions/2005/ao0502.pdf>; OIG Advisory Opinion No. 05-03, 2005 WL 6289866 (Feb. 10, 2005), available at <https://oig.hhs.gov/fraud/docs/advisoryopinions/2005/ao0503.pdf>; OIG Advisory Opinion No. 05-04, 2005 WL 6289867 (Feb. 10, 2005), available at <https://oig.hhs.gov/fraud/docs/advisoryopinions/2005/ao0504.pdf>; OIG Advisory Opinion No. 05-05, 2005 WL 6289868 (Feb. 18, 2005), available at <https://oig.hhs.gov/fraud/docs/advisoryopinions/2005/ao0505.pdf>; OIG Advisory Opinion No. 05-06, 2005 WL 6289869 (Feb. 18, 2005), available at <https://oig.hhs.gov/fraud/docs/advisoryopinions/2005/ao0506.pdf>; OIG Advisory Opinion No. 06-22, 2006 WL 6252293 (Nov. 9, 2006), available at <https://oig.hhs.gov/fraud/docs/advisoryopinions/2006/AdvOpn06-22NewA.pdf>; OIG Advisory Opinion No. 07-21, 2007 WL 6400848 (Dec. 28, 2007), available at <https://oig.hhs.gov/fraud/docs/advisoryopinions/2007/AdvOpn07-21A.pdf>; OIG Advisory Opinion No. 07-22, 2007 WL 6400849 (Dec. 28, 2007), available at <https://oig.hhs.gov/fraud/docs/advisoryopinions/2007/AdvOpn07-22A.pdf>; OIG Advisory Opinion No. 08-09, 2008 WL 6067519 (July 31, 2008), available at <https://oig.hhs.gov/fraud/docs/advisoryopinions/2008/AdvOpn08-09B.pdf>; OIG Advisory Opinion No. 08-15, 2008 WL 6067525 (Oct. 06, 2008), available at <https://oig.hhs.gov/fraud/docs/advisoryopinions/2008/AdvOpn08-15.pdf>; OIG Advisory Opinion No. 08-21, (Nov. 25, 2008), available at <https://oig.hhs.gov/fraud/docs/advisoryopinions/2008/AdvOpn08-21.2.pdf>; OIG Advisory Opinion No. 09-06, 2009 WL 2371264 (June 23, 2009), available at <https://oig.hhs.gov/fraud/docs/advisoryopinions/2009/AdvOpn09-06.pdf>; OIG Advisory Opinion No. 12-22, 2012 WL 7148098 (Dec. 31, 2012), available at <https://oig.hhs.gov/fraud/docs/advisoryopinions/2012/AdvOpn12-22.pdf>.

opinions, gainsharing arrangements were first proposed in order to align the actions of a hospital's medical staff with that of the hospital itself.⁷⁰ While CMS has lauded the perceived benefits of gainsharing, approved certain limited gainsharing proposals, and funded several pilot programs,⁷¹ it has consistently held the opinion that gainsharing programs are not permissible under the Anti-kickback Statute⁷² and the Civil Monetary Penalties Act⁷³ due to the concern that gainsharing will ultimately drive providers (physicians and hospitals alike) to reduce the amount of care or lower the quality of care that is provided to beneficiaries.⁷⁴ Despite the concerns expressed by CMS in various advisory opinions, the concept of shared savings programs and their system of using such provider collaborations for purposes of improving the healthcare delivery system eventually made an impact on Congress, resulting in the development of the ACO model and the MSSP under the ACA.⁷⁵

ACOs, as they have come to be known, have their origins with Elliot Fisher and the Dartmouth Atlas Project, who first described an ACO as: "provider collaborations that integrate groups of physicians, hospitals, and other providers around the ability to receive shared-savings bonuses by achieving measured quality targets and demonstrating real reductions in overall spending growth for a defined population of patients."⁷⁶ The ideas expressed by Fisher, Dartmouth Atlas Project, and others started to gain

⁷⁰ See *supra* note 70 and accompanying text. The need for these incentives arises out of the differences between the manner in which hospitals are paid versus physicians under the Medicare program. Hospitals are paid based on a diagnosis related group (DRG), which is a flat fee payment based on a particular condition of the patient. For a detailed description of DRGs, see BARRY R. FURROW ET AL., HEALTH LAW CASES, MATERIALS, AND PROBLEMS 785–88 (7th ed., 2013). In contrast to this, physicians participating in the Medicare program are paid on a fee-for-service basis for each procedure, exam, or other service performed. *Id.* This distinction in payment structure creates a system in which the hospital would like to encourage the physician to provide fewer services, given that the hospital will only receive the amount as is appropriate for the patient's designated diagnosis code, whereas the physician is motivated from a revenue generation perspective to order as many tests as can be supported as medically necessary. *Id.*

⁷¹ See note 69 and accompanying text. CMS funded the Medicare Physician Group Practice Demonstration, which demonstrated project tested forms of gainsharing. See generally JOHN KAUTTER ET AL., EVALUATION OF THE MEDICARE PHYSICIAN GROUP PRACTICE DEMONSTRATION, FINAL REPORT (2012), available at <http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/PhysicianGroupPracticeFinalReport.pdf>.

⁷² Patient Protection and Affordable Care Act 42 U.S.C. § 1320a-7b (2014).

⁷³ *Id.* § 1320a-7a (2014).

⁷⁴ See *id.* §§ 1320a-7b, 1320a-7a.; see 73 Fed. Reg. 38502, 38550 (July 7, 2008) (noting five concerns regarding gainsharing including stinting).

⁷⁵ 42 U.S.C. § 1395jjj.

⁷⁶ Aaron McKethan & Mark McClellan, *Moving from Volume-Driven Medicine Toward Accountable Care*, Health Affairs Blog (Aug. 20, 2009); see generally Elliot Fisher et al., *Creating Accountable Care Organizations: The Extended Medical Staff*, 26 HEALTH AFFAIRS (2007), available at <http://content.healthaffairs.org/content/26/1/w44.full>.

widespread attention⁷⁷ and eventually made its way to MedPac in 2009. MedPac issued a report to Congress, one section of which was titled *Why Medicare May Want Accountable Care Organizations*.⁷⁸ MedPac's support for ACOs in the report stemmed in large part from its observations that Medicare was on an unsustainable trajectory regarding spending and proposed ACOs as a new mechanism for potentially curbing the trajectory.⁷⁹ The report made specific mention of certain gainsharing models that were already being tested under then-current Physician Group Practice ("PGP") demonstration and provided examples for how the concept might be expanded to a larger scale.⁸⁰ As the concept of the ACO and shared savings began to move through Congress, the underpinnings of the Triple Aim and the ascent of the ACO started to work in concert, resulting in an ACO-definition that focused not only on cost savings, but promotion of accountability for an entire patient population, and also the redesign of care processes for high quality and efficient service delivery.⁸¹

III. CONSIDERING THE MAYO CLINIC AND ACOS UNDER THE ACA

Themes of the Triple Aim are present in the language of the ACA, and the focus on integration in the ACO regulations moves many providers closer to the idea of achieving the Triple Aim more than ever before.⁸² In fact, Berwick himself sees ACOs as a step in the right direction, stating, "Taken together, [the changes to the final regulations for ACOs] create a more feasible and attractive on-ramp for a diverse set of providers and organizations to participate as ACOs. . . . We believe that today's ACO rule is the next step in our shared commitment to a better, more lasting healthcare system."⁸³ While the revised regulations may be moving some providers closer towards achieving the goals of the Triple Aim, those entities lauded as models of accountable care and for purposes of developing the ACO structure are, for the most part, not participating in an ACO or the MSSP.⁸⁴

⁷⁷ See Barry R. Furrow, *Regulating Patient Safety: The Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1727, 1760 (2011).

⁷⁸ MEDPAC, REPORT TO THE CONGRESS: IMPROVING INCENTIVES IN THE MEDICARE PROGRAM, 39 (2009), available at http://www.medpac.gov/documents/reports/Jun09_EntireReport.pdf?sfvrsn=0.

⁷⁹ *Id.* at 43.

⁸⁰ *Id.* at 40.

⁸¹ Patient Protection and Affordable Care Act § 42 U.S.C. § 1395jij.

⁸² See Donald M. Berwick, M.D., *Making Good on ACOs' Promise—The Final Rules for the Medicare Shared Savings Program*, 19 NEW ENG. J. MED. 1753 (2011) [hereinafter Berwick, *Making Good on ACOs' Promise*].

⁸³ *Id.* at 1755–56.

⁸⁴ See *Medicare Shared Savings Programs Accountable Care Organizations*, DATA.CMS.GOV, <https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-Opfam-u3vp> (last visited Mar. 28, 2015); see generally *Pioneer ACO Model*, CMS.GOV, <http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/> (last visited Oct. 16, 2014).

This disconnect between those healthcare systems intended to be emulated for purposes of healthcare delivery because of their ability to achieve the Triple Aim, like the Mayo Clinic, and their lack of participation in the ACO structure under the ACA calls into question whether the ACO regulations, as drafted, are in fact accomplishing the goals they were set out to establish. In order to understand this disconnect, it is necessary to examine first whether the Mayo Clinic and other similarly integrated systems are not participating as ACOs in either the MSSP or the Pioneer ACO Program.⁸⁵

A. Integrated Delivery Systems and ACO Participation

As President Obama toured the United States in 2009 promoting the ACA, he frequently referred to Geisinger Health System, Intermountain Health System, Mayo Clinic, and other integrated delivery models as systems that he believed already served as models of how healthcare should be provided to all U.S. citizens.⁸⁶ It is certainly true that many of these integrated delivery systems seem to have figured out how to provide quality care, without excess spending on a per capita basis under the Medicare program.⁸⁷ In an article that was considered required reading for the Obama

⁸⁵ The ACA established the MSSP in connection with formation of an ACO under § 3022 of the ACA. Patient Protection and Affordable Care Act 42 U.S.C. § 1395jjj. In 2012, the CMS Innovation Center, established under Section 1115A of the ACA, launched a second program known as the Pioneer ACO Program, working in concert with the MSSP, which was intended for those entities who had previously participated in Physicians Group Practice demonstration projects. See *Accountable Care Organization Model: General Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Sept. 12, 2012) available at <http://innovation.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf>. There were initially 32 entities that were selected to participate in the Pioneer ACO Program. *Id.* Unlike the Pioneer ACO Program, which requires that participants be at-risk for the shared savings and losses from the beginning of the program, the MSSP offers a sort of “phase in” for two-sided risk in which the ACO can either be responsible for both a share of the losses and the savings, in exchange for a higher share of the savings, or only take part in the savings. 76 Fed. Reg. 67802 (Nov. 2, 2011) (codified at 42 C.F.R. § 425). Under the final rule, no ACO participating in the MSSP can stay on a one-sided risk model forever, as all ACOs must transition to two-sided risk by the end of three years. *Id.* Note that proposed rules were published on December 8, 2014, which rules contemplate permitting ACOs to remain in a one-sided risk-model for an additional period of time. 79 Fed. Reg. 72760, 72869 (Dec. 8, 2014) (amending 42 C.F.R. § 425.600(b)).

⁸⁶ *On the President's Radar Screen*, GEISINGER ACADEMIC AFFAIRS, http://www.geisinger.edu/med-ed/clin_camp/pages/president.html (last visited Mar. 28, 2015); Bernie Monegain, *Intermountain, Geisinger get Spotlight in Obama Speech*, HEALTHCARE IT NEWS (July 1, 2009), <http://www.healthcareitnews.com/news/intermountain-geisinger-get-spotlight-obama-speech>; John Daly, *Obama Singles Out Intermountain Healthcare as a Model System*, KSL NEWS 5 (Sept. 10, 2009), <http://www.ksl.com/?sid=7873613> (last visited Oct. 16, 2014); OBAMA REMARKS, *supra* note 15.

⁸⁷ See AM. HOSP. ASS'N, GEOGRAPHIC VARIATION IN HEALTH CARE SPENDING: A CLOSER LOOK (2009) [hereinafter AHA], available at <file:///C:/Users/Jon/Downloads/twnov09geovariation.pdf>.

administration during the period leading up to enactment of the ACA,⁸⁸ Atul Gawande explored the cost of healthcare spending relative to its outcomes in *The Cost Conundrum* in THE NEW YORKER.⁸⁹ Gawande highlighted the Mayo Clinic for its high quality and cost containment successes, stating:

Americans like to believe that, with most things, more is better. But research suggests that where medicine is concerned it may actually be worse. For example, Rochester, Minnesota, where the Mayo Clinic dominates the scene, has fantastically high levels of technological capability and quality, but its Medicare spending is in the lowest fifteen percent of the country - \$6,688 per enrollee in 2006, which is eight thousand dollars less than the figure for McAllen[, Texas].⁹⁰

Much of Gawande's findings were based on a study published by The Dartmouth Institute for Health Policy & Clinic Practice, which study explored care provided to patients with severe chronic illness.⁹¹ In one chapter of the Dartmouth Institute's study, the authors examine America's "best hospitals" regarding their management of chronic illness, and find that despite possessing superior clinical scientific knowledge, academic medical centers vary greatly in how they manage chronic illnesses.⁹² After an examination of the various practices of academic medical centers in general, the authors established the Mayo Clinic as a model academic medical center due to its "strong national reputation for quality, while simultaneously [being able to keep] utilization and costs relatively low."⁹³ The authors further suggested using the Mayo Clinic as a benchmark for "a strategy to reduce overuse of the acute care sector in managing chronic illness."⁹⁴ In

⁸⁸ Robert Pear, *Health Care Spending Disparities Stir a Fight*, N.Y. TIMES (June 8, 2009), http://www.nytimes.com/2009/06/09/us/politics/09health.html?ref=todayspaper&_r=1& ("President Obama recently summoned aides to the Oval Office to discuss a magazine article investigating why the border town of McAllen, Tex., was the country's most expensive place for healthcare. The article became required reading in the White house, with Mr. Obama even citing it at a meeting last week with two dozen Democratic senators.").

⁸⁹ See Gawande, *supra* note 24.

⁹⁰ *Id.* The author examined the city of McAllen, Texas, which according to statistics in 2009 had the highest spending per Medicare enrollee of any city in the country.

⁹¹ JOHN E. WENNBURG ET AL., THE DARTMOUTH INST. FOR HEALTH POLICY AND CLINICAL PRACTICE, TRACKING THE CARE OF PATIENTS WITH SEVERE CHRONIC ILLNESS: THE DARTMOUTH ATLAS OF HEALTH CARE 2008 (2008), available at http://www.dartmouthatlas.org/downloads/atlas/2008_Chronic_Care_Atlas.pdf.

⁹² *Id.* at 39 (noting that "academic medical centers vary widely on all three measures – resources, utilization, and spending—a finding that raises a serious challenge to the assumption that clinical science plays a dominant role in determining the patterns of medical practice at these prestigious hospitals").

⁹³ *Id.* at 40.

⁹⁴ *Id.* But see Peter J. Nelson, *The Mayo Clinic: High Quality Yes, but Low Cost?*, CENTER OF THE AMERICAN EXPERIMENT (Sept. 8, 2009), <http://www.americanexperiment>

considering this information and its delivery of care in light of the goals of the Triple Aim, the Mayo Clinic appears to embody all prongs of the Triple Aim: namely, quality care for the patient, quality care for populations, and cost-effective care.⁹⁵ The question remains, then: if the Mayo Clinic is achieving the Triple Aim, why is it, or other systems like it, not forming an ACO or participating in the MSSP, which is supposed to be the embodiment of the Triple Aim?

Ironically, the Mayo Clinic's lack of participation is not unique; indeed, many of the systems that were promoted as models for development of an ACO structure have not formed ACOs and are not participating in the MSSP.⁹⁶ The reasons that wide-spread adoption of the ACO structure by integrated delivery systems such as the Mayo Clinic are varied. One of the primary reasons is existing challenges for many of these organizations to make a profit, or break-even, on Medicare patients, thus making achievement of any shared savings a near impossibility.⁹⁷ As Gawande noted, data indicates that Mayo Clinic spending on its Medicare patients is lower on average than other institutions; however, such successes do not necessarily indicate that the Mayo Clinic is realizing increased revenues or "profits" from these patients.⁹⁸

In considering Gawande's observations of the Mayo Clinic, author Peter Nelson noted that while the Mayo Clinic has demonstrated success on

.org/publications/policy-in-detail/the-mayo-clinic-high-quality-yes-but-low-cost (finding that "when it comes to understanding *value*-the intersection between cost and quality-the Dartmouth research is limited by the fact that it covers only Medicare patients. In Medicare, the government sets prices and, as a result, the prices in the Dartmouth data reflect national Medicare policies and do not reflect the price of healthcare services negotiated between private health plans and providers more generally. . . . Evidence shows that the Mayo Clinic is actually a high cost provider when compared to other Minnesota providers.").

⁹⁵ See Berwick, *supra* note 7, at 760.

⁹⁶ As of the middle of 2014, while there were 366 ACOs registered in the MSSP, less than 15 of these ACOs were large academic medical centers. See *Medicare Shared Savings Program*, CMS.GOV, <https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/ay8x-m5k6> (last visited June 27, 2014). Neither Mayo Clinic, Kaiser Permanente, nor Intermountain have registered as ACOs under the MSSP or under the Pioneer ACO program.

⁹⁷ It was reported that the Mayo Clinic lost \$840 million on Medicare patients in 2009 and due to similar circumstances in their Arizona facilities have begun to require a \$2,000 retainer fee with a \$250 administrative fee for Medicare patients, as all Mayo Clinic facilities are non-participating in the Medicare program because they do not accept Medicare Part B. See also *Medicare and the Mayo*, WALL ST. J. (Jan. 8, 2010), <http://www.wsj.com/articles/SB10001424052748703436504574640711655886136>. See Tony Brayer, *Why the Mayo Clinic is Refusing to See Medicare Patients*, KEVINMD (Jan. 25, 2010), <http://www.kevinmd.com/blog/2010/01/mayo-clinic-refusing-medicare-patients.html>.

⁹⁸ See Gawande, *supra* note 24; see also *Total Medicare Reimbursements per Enrollee, by Adjustment Type* (Year: 2010), THE DARTMOUTH ATLAS OF HEALTH CARE, <http://www.dartmouthatlas.org/data/topic/topic.aspx?cat=21> (last visited, Mar. 28, 2015) (noting that Minnesota has an average Medicare spending rate of between \$6,911 and \$8,100 with Rochester, Minnesota with a spending rate of \$7,229, which is among the lowest in the United States).

its Medicare spending for Medicare beneficiaries, such lower spending may be offset by what appears to be higher than average reimbursement on services from third party commercial payors.⁹⁹ In fact, research from Dartmouth Medical School supports a finding that Medicare patients at the Mayo Clinic consistently pay far less than, and have superior outcomes relative to, other systems across the country.¹⁰⁰ Such research also finds, however, that spending for Medicare patients is different relative to the average of overall spending for all patients in the state of Minnesota.¹⁰¹ Nelson believes that such distinctions exist because the study is limited to only a study of Medicare patients and does not reflect the price that private individuals pay through commercial insurance.¹⁰² Thus, Nelson argues, while it appears that Mayo Clinic's Medicare costs per beneficiary demonstrate greater efficiency, the Mayo Clinic currently offsets such shortfalls by being one of the highest priced providers in the Minnesota market when it comes to commercial insurance.¹⁰³

Nelson's observations regarding the high cost of care at the Mayo Clinic for patients with private insurance is not only evidenced in historic data regarding the difference in average spending on Medicare beneficiaries and overall spending,¹⁰⁴ but has also been evidenced through the insurance market and, most recently, the health insurance exchanges in Minnesota.¹⁰⁵ Although Minnesota as a state spends at or below average for Medicare patients,¹⁰⁶ average commercial insurance premiums for family coverage are above average, with Minnesota as one of the highest ten states in the nation.¹⁰⁷ More precisely, Minnesotans who live in the southeastern part of the state who attempted to purchase insurance on Minnesota's health insurance exchange, MNSure, experienced higher premiums on average than in other parts of the state and fewer options for providers than in other areas

⁹⁹ See Nelson, *supra* note 94.

¹⁰⁰ *Id.*

¹⁰¹ See AHA, *supra* note 87, at 14.

¹⁰² *Id.* at 10, 13.

¹⁰³ *Id.*

¹⁰⁴ See generally *id.*

¹⁰⁵ See Associated Press, *Mayo's Dominance Skews Health Insurance Exchange in SE Minnesota*, PIONEER PRESS (Oct. 28, 2013) [hereinafter *Mayo's Dominance*], http://www.twincities.com/localnews/ci_24405205/mayos-dominance-skews-health-insurance-exchange-southeastern-minnesota.

¹⁰⁶ See AHA, *supra* note 87, at 4 (noting that Minnesota has below average unadjusted spending per beneficiary and an average spending per beneficiary when adjusted for wages, health status, graduate medical education, indirect medical education, and disproportionate share hospital payments).

¹⁰⁷ See *id.*; Cathy Schoen et al., *Paying the Price: How Health Insurance Premiums Are Eating Up Middle Class Incomes*, THE COMMONWEALTH FUND 8 (2009), http://www.commonwealthfund.org/~media/files/publications/data-brief/2009/aug/1313_schoen_paying_the_price_db_v3_resorted_tables.pdf (noting that Minnesota families' average commercial insurance premiums for family coverage is in excess of \$13,001 per family, which is higher than the national average of \$12,298).

of the state.¹⁰⁸ Experts believe that the reason for this skewed effect in this region is due to the presence of the Mayo Clinic in southeast Minnesota and the higher costs that insurers have to pay for services at the facility.¹⁰⁹

The effect of this high-cost is likely evident in the fact that the Mayo Clinic is currently only available as an in-network provider in one plan available on the health insurance exchange in Minnesota, although there are other insurers in the state who are in talks with the Mayo Clinic to include them in other networks in the future.¹¹⁰ Note, however, that the Mayo Clinic is not alone in this phenomenon.¹¹¹ Of the top 18 institutions nationally ranked by U.S. News and World Report, six institutions accept only one insurance plan on the exchange (including, without limitation, Cleveland Clinic and UCSF Medical Center) and five accept only two insurance plans on the exchange (including, without limitation, UCLA Medical Center and Northwestern Memorial Hospital).¹¹²

For some insurers, regardless of the cost, there is no option but to contract with certain academic medical centers for services, as some AMCs, especially those that provide specialty pediatric care, are considered “essential community providers” under the ACA and thus are required to be

¹⁰⁸ *Mayo's Dominance*, *supra* note 105 (noting that Sandra Toogood checked her options in October of 2013 and found only one plan that included the Mayo Clinic, the main provider in her area, and as a 55 year old with no available subsidies her monthly premium was \$594 for a mid-level plan, which compared to \$268 per month in St. Paul/Minneapolis, Minnesota).

¹⁰⁹ *Mayo's Dominance*, *supra* note 105.

¹¹⁰ Patrick Howley, *Hospital Cited by Obama as Health-Reform Model for the Nation Accepts only One Kind of Insurance Plan under Obamacare*, DAILY CALLER (Feb. 23, 2014), <http://dailycaller.com/2014/02/23/hospital-cited-by-obama-as-health-reform-model-for-the-nation-accepts-only-one-kind-of-insurance-plan-under-obamacare/> (noting that the only insurance exchange offering that is accepted at the Mayo Clinic is the Blue Cross Blue Shield silver plans); *see also Mayo's Dominance*, *supra* note 105 (stating that “Officials with Medica, another major Minnesota provider, said they’re working with regulators to offer individual and small group plans in Rochester on the exchange as early as next year. The company currently offers plans in the rest of Olmstead County, but not in the two Rochester ZIP codes.”).

¹¹¹ *See Mayo's Dominance*, *supra* note 105 (finding that the insurance premiums being higher are not uncommon in other parts of the country where there is a single, dominant provider).

¹¹² *See* Tori Richards, *Top Hospitals Opt Out of Obamacare*, U.S. NEWS & WORLD REP. (Oct. 30, 2013), <http://health.usnews.com/health-news/hospital-of-tomorrow/articles/2013/10/30/top-hospitals-opt-out-of-obamacare>; *see also Which Hospitals Take Your Health Insurance Under Obamacare?*, U.S. NEWS & WORLD REP. (Oct. 30, 2013), <http://health.usnews.com/health-news/hospital-of-tomorrow/articles/2013/10/30/which-top-hospitals-take-your-health-insurance-under-obamacare>. Regarding the remainder, three accept only three insurance plans on the exchange (including, without limitation, New York-Presbyterian University Hospital of Columbia and Cornell and University of Pittsburgh Medical Center) and three of the four remaining hospitals accept all insurance offerings on the exchange, pursuant to requirements under state law, including top-ranked Johns Hopkins. Note that the data is based on the 2013–2014 rankings for U.S. News and World Report, but since the date of the article U.S. News and World Report has released the 2014–2015 rankings. *See Best Hospitals 2014–15*, *supra* note 23.

included in all health insurance options.¹¹³ For those insurers who have options, however, they are more reticent, or at least very concerned, regarding the inclusion of high-cost providers in their networks.¹¹⁴ Prior to the ACA, paying certain providers, such as AMCs, higher rates for services was less of a cause for concern for insurers because insurers could simply raise premiums on their insureds based on certain rating factors.¹¹⁵ For example, if an insurance company received an application from an individual in his or her 50s who smokes, has a previous history of heart disease, and a family history of cancer, the insurance company could either refuse to insure the individual or require the individual to pay an extremely high premium, based on the fact that the insurer is likely to end up spending more on this individual than others due to pre-existing conditions and family history. Under the ACA, insurance companies are prevented from denying individuals insurance coverage based on pre-existing conditions and limited in their ability to rate individuals based on anything other than age and tobacco use.¹¹⁶ Additionally, for those insurers who are participating in the exchanges, the insurers have no idea what sort of a population “mix” they will receive in their new exchange plans.¹¹⁷ It is possible that an insurer offering insurance on the exchange might end up insuring a population of individuals who are all older and sicker than average individuals. Ensuring

¹¹³ Patient Protection and Affordable Care Act 42 U.S.C. §§ 18021 (2014), 18031(c)(1)(C) (2014); 45 C.F.R. § 156.235 (defining “essential community providers” as “providers that serve predominantly low-income, medically underserved individuals, including providers that [are eligible to receive § 340B(a)(4) funding under the Public Health Services Act or are defined under Section 1927(c)(1)(D)(i)(iv) of the ACA.]”). *But see* Steve Davis, *Narrow Network Lawsuit Takes Odd Turn; Premera Seeks to Dismiss Judge’s Decisions*, HEALTH BUS. DAILY (July 7, 2014), <http://aishealth.com/archive/nblu0714-01> (noting that Seattle Children’s Hospital filed a lawsuit against the insurance commissioner in connection with its exclusion from certain exchange plan offerings on the Washington state exchange, Healthplanfinder) and Joe Carlson, *Exchange Exclusion Suit*, MODERN HEALTHCARE (Oct. 12, 2013), *available at* <http://www.modernhealthcare.com/article/20130817/MAGAZINE/308179921>.

¹¹⁴ Due to restrictions under the ACA regarding the ability of insurers to deny coverage for or rate certain individuals, insurers have less ability to manage risk through selection of beneficiaries and therefore are looking towards other means to ensure cost savings. *See* M.P. McQueen, *Less Choice, Lower Premiums, Many Exchange Plans Will Offer Narrow Networks*, MOD. HEALTHCARE (Aug. 17, 2013), <http://www.modernhealthcare.com/article/20130817/MAGAZINE/308179921>.

¹¹⁵ *See* David Orentlicher, *The Future of the Affordable Care Act: Protecting Economic Health More Than Physical Health*, 51 HOUS. L. REV. 1057, 1059 (2014) (“Before the ACA’s reform of the individual market, high premiums caused by preexisting conditions created a substantial obstacle to job mobility.”).

¹¹⁶ 42 U.S.C. § 300gg.

¹¹⁷ *See* Sara R. Collins et al., *Covering Young Adults Under the Affordable Care Act: The Importance of Outreach and Medicaid Expansion*, COMMONWEALTH FUND 1 (2013), *available at* http://www.commonwealthfund.org/~media/files/publications/issue-brief/2013/aug/1701_collins_covering_young_adults_tracking_brief_final_v4.pdf (“Young adults’ participation in the nation’s new insurance marketplaces is essential: as a healthier-than-average population, it allows for comprehensive plans to be offered at affordable prices to all enrollees over time.”).

enrollment of young and healthy individuals on the exchanges was a key focus for insurers, as healthy under-utilizers of services whose premiums are in excess of claims are necessary to offset higher spending on older, sicker individuals whose claims far exceed premium payments.¹¹⁸ Thus, given these new market dynamics, insurers are suddenly less willing to contract with historically higher-cost providers like AMCs.¹¹⁹

If the ACA and the MSSP are focused on Medicare beneficiaries, and entities like the Mayo Clinic are performing well relative to spending on Medicare beneficiaries, do premiums on the commercial side matter at all? Indeed, the fact that the Mayo Clinic and other top-ranked institutions may be reimbursed at a higher rate by commercial insurers does not indicate that the individuals receiving care at those institutions are not provided with the highest level of care.¹²⁰ This is also not to say that the quality of services provided to Medicare patients differs from those that are provided to commercial pay patients or that the Mayo Clinic, based on its financial incentives, does not actually provide more efficient care than other systems.

If the Mayo Clinic is equally efficient in the provision of its care to its patients, why then are the costs from commercial insurance so much higher? Kathleen Harrington, government relations chair of the Mayo Clinic, states a similar argument to most other AMCs across the nation, which is that the Mayo Clinic treats patients with very complex illnesses and supports the cost of research and education, the costs of which are not borne by all hospitals.¹²¹ Ms. Harrington states, “We’re not a community-based hospital. This is an academic medical center that does research, education, and top-of-the-pyramid care for the sickest of the sick. The cost is naturally higher.”¹²² These comments are not unique to the Mayo Clinic, as other AMCs and research institutions experience similar issues: “The supervision and teaching of trainees, whether in the hospital or in an outpatient clinic, take time, and time costs money. Reducing the cost of training will require fundamental changes in the way [that the mission of an AMC] is pursued.”¹²³ Thus, while it may be true that Mayo Clinic provides efficient and effective care for all of its patients, certain aspects of what makes the Mayo Clinic a leader in its field is due in part to the research, innovation, and training that are only possible, to some extent, due to high reimbursement Mayo Clinic receives from commercial insurers. In considering this reality in the context of ACOs and the Triple Aim, it is evident that achieving the balance and equity that Berwick contemplated in providing quality care that is available and

¹¹⁸ *Id.* at 1–2.

¹¹⁹ *See Mayo’s Dominance*, *supra* note 105.

¹²⁰ *See Best Hospitals 2014–15*, *supra* note 23.

¹²¹ *See Mayo’s Dominance*, *supra* note 105.

¹²² *Id.*

¹²³ Kastor, *supra* note 28.

accessible to all is challenging, even at our most efficient and renowned quality institutions.¹²⁴

Despite the intentions of legislators and regulators at CMS, the Mayo Clinic and other providers that many thought would lead the country through healthcare reform are opting instead for care delivery alternatives.¹²⁵ In addition to the challenges regarding Medicare payments cited above, a few other themes have emerged from these healthcare leaders regarding their respective decisions not to participate in either the MSSP or the Pioneer ACO programs.¹²⁶ Two of the primary issues for these providers relate to reimbursement under Medicare and the manner in which the ACOs were structured under the regulations.¹²⁷ For example, in an interview given in 2011, George Halvorson, chair and CEO of Kaiser Permanente's hospitals and health plans, commented that part of the reason that they did not have any plans to participate in the MSSP was due, in large part, to reimbursement and also the complexity of the regulations:

Private care delivery can [provide integrated care now]. The problem is they're not paid for it. At [Kaiser Permanente] we do six things for seniors that help keep bones from breaking, and three of the six do not appear on a Blue Cross or Medicare or Medicaid fee schedule....For Medicare, it means that even though (the program isn't) going to pay for what the pharmacist and nurse do, if as a result of this you save money on broken bones providers get half the savings. Right now the caregivers who do that work get absolutely no

¹²⁴ See Nelson, *supra* note 94, at 4 (stating “The evidence that Mayo is a high-cost provider in Minnesota suggests that high-quality medical care does come at a higher price when providers are free to negotiate, just like high-quality services in any other industry. Consequently, in a Medicare system that pays Mayo for the true value that it provides, the average patient will likely cost more than \$53,432.”).

¹²⁵ Chris Anderson, *CMS Taps 32 Health Systems for Pioneer ACO Program*, HEALTHCARE FIN. NEWS (Dec. 20, 2011), <http://www.healthcarefinancenews.com/news/cms-taps-32-health-systems-pioneer-aco-program?single-page=true> (“Those systems, the Mayo Clinic, the Cleveland Clinic, Geisinger Health System and Intermountain Healthcare, are often touted among the ‘poster boys’ for care quality and cost controls many want to see in a revamped national healthcare system.”).

¹²⁶ See Jenny Gold, *‘Poster Boys’ Take a Pass On Pioneer ACO Program*, KAISER HEALTH NEWS (Sep. 14, 2011), <http://www.kaiserhealthnews.org/stories/2011/september/14/aco-pioneers-medicare-hospitals.aspx>. One entity that stands in contrast to some of the other large integrated delivery systems is Geisinger Health, which is participating in the Keystone ACO. See generally KEYSTONE ACO, available at <http://www.keystoneaco.org/> (last visited July 1, 2014) (listing Geisinger Medical Center, Geisinger-Wyoming Valley Medical Center, Geisinger-Community Medical Center, and Geisinger-Bloomsburg Hospital as participating hospitals in the ACO).

¹²⁷ Joanne Silberner, *Head of Major HMO Sees Openings for Accountable Care Organizations—the KHN Interview*, Kaiser Health News (July 25, 2011), <http://www.kaiserhealthnews.org/stories/2011/july/25/halvorson-q-and-a-kaiser-permanente-accountable-care-organizations.aspx>.

reward and actually lose revenue. But the version of ACOs that was written into the law for Medicare is complex and the law wasn't as well drafted as it could have been.¹²⁸

Halvorson's comments regarding complexity have been echoed by others. In a study released by Medical Group Management Association ("MGMA") in 2011, it communicated to CMS that, by MGMA's estimate, up to 90% of its members would likely not be participating in the MSSP due to the complexity of the regulations and the expectations regarding the reporting requirements.¹²⁹ CMS attempted to address some of these concerns with changes to the final ACO regulations¹³⁰ and with the creation of the Pioneer ACO Program; which was a coordinated effort to offer greater incentives and greater simplification to encourage industry leaders such as the Mayo Clinic to participate. The Pioneer ACO Program did attract some AMCs and other integrated institutions, such as Dartmouth-Hitchcock Health Pioneer ACO and Partners Healthcare, but the initial participation of AMCs remained relatively low.¹³¹ While Halvorson was somewhat critical of the ACO regulations, he was more positive and encouraged by the possibilities of other aspects of the ACA stating, "Medicare is creating some pilot programs with ACOs, and I think there are going to be a few dozen of these that are going to figure out ways of dealing with the patient population more directly."¹³²

Intermountain cited similar frustrations with the ACO regulations, but more so with aspects of the regulations that imposed little obligations on

¹²⁸ See Silberner, *supra* note 128. Note that from the date of this interview, the ACO regulations were revised somewhat, but as of the date of this article, Kaiser Permanente is still not participating in any type of ACO program. Melanie Evans, *Providers See Little Enthusiasm to Join Pioneer ACOs*, MODERN HEALTHCARE (Sept. 2, 2014) [hereinafter Evans, *Providers See Little Enthusiasm to Join Pioneer ACOs*], <http://www.modernhealthcare.com/article/20140901/NEWS/309019991/providers-see-little-enthusiasm-to-join-pioneer-acos>. See Silberner, *supra* note 127.

¹²⁹ See Anderson, *supra* note 125.

¹³⁰ For example, one of the primary complaints is related to the reporting of quality metrics. The initial regulations required the reporting of 65 different measures. 76 Fed. Reg. 19528 (proposed Apr. 7, 2011) (to be codified at 42 C.F.R. pt. 425). The final regulations were amended to require the reporting of only 33 metrics. 76 Fed. Reg. 67802 (codified at 42 C.F.R. pt. 425); see *Pioneer ACO Model*, *supra* note 84.

¹³¹ Partners Healthcare is a non-profit healthcare system that is a teaching affiliate of Harvard Medical School and provides physician services at Brigham and Women's Hospital, Massachusetts General Hospital, and other hospitals in and around the Boston area. See *About Partners HealthCare*, PARTNERS HEALTHCARE, <http://www.partners.org/About/Default.aspx?id=1> (last visited June 30, 2014); Jessica Zigmond, *CMS Names ACOs Leaving Pioneer Program*, MODERN HEALTHCARE (July 16, 2013), <http://www.modernhealthcare.com/article/20130716/NEWS/307169945/cms-names-acos-leaving-pioneer-program>.

¹³² Joanne Silberner, *Head of Major HMO Sees Openings for Accountable Care Organizations—The KHN Interview*, KAISER HEALTH NEWS (July 25, 2011), <http://kaiserhealthnews.org/news/halvorson-q-and-a-kaiser-permanente-accountable-care-organizations/>.

the part of Medicare beneficiaries, “Since Medicare’s accountable care program does not require patients to actively select an ACO—or even, once enrolled, seek care from that ACO—Intermountain is instead developing what officials call a shared accountability organization.”¹³³ In the formation of its own accountable care focused organization, Intermountain seems to be retaining the goals of the Triple Aim, as Intermountain states that the approach of the shared accountability organization is to provide better care, better health, and better care management.¹³⁴

As the data from Leavitt Partners has demonstrated, Intermountain Health is not alone in its attempts to accomplish some reforms in the system outside the structure of the ACO.¹³⁵ Due to dissatisfaction with the regulations, a lack of confidence or success in the MSSP program, or for various other reasons, many providers are opting to form their own ACO-like organizations intended to accomplish similar goals.¹³⁶ In fact, of the 626 entities Leavitt Partners identified as practicing accountable care, 210 of those entities were not participating in any sort of government program.¹³⁷ The Mayo Clinic is one such organization that is trying alternative system reform models. The Mayo Clinic has formed the Mayo Clinic Care Network, which it describes as:

[A] network of like-minded organizations which share a common commitment to improving the delivery of health care in their communities through high-quality, data-driven, evidence-based medical care. The network recognizes that people prefer to get their health care close to home. The main goal of the network is to help people gain the benefits of Mayo Clinic expertise without having to travel to a Mayo Clinic facility.¹³⁸

The “network” essentially supplies providers otherwise unaffiliated with the Mayo Clinic with access to physicians from the Mayo Clinic for consultations, protocols, and other tools and expertise (primarily electronic)

¹³³ Evans, *Beyond ACOs*, *supra* note 28. Some key features of Intermountain’s accountability organization involved placing up to 25% of doctors’ compensation at risk for performance on quality and cost targets and incorporating the use of shared decision-making and benefit design that would hold patients accountable for their care. *Id.*

¹³⁴ See *Shared Accountability*, INTERMOUNTAIN HEALTHCARE, <http://intermountainhealthcare.org/about/overview/trustees/for-trustees/healthcare-initiatives/shared-accountability/Pages/home.aspx> (last visited Mar. 28, 2015).

¹³⁵ See Muhlestein, *The Accountable Care Paradigm*, *supra* note 13, at 6.

¹³⁶ *Id.*

¹³⁷ See Matthew Petersen et al., *Growth and Dispersion of Accountable Care Organizations: August 2013 Update*, CTR. FOR ACCOUNTABLE CARE INTELLIGENCE (2014), available at http://www.cap.org/apps/docs/advocacy/aco/aco_growth_dispersion.pdf.

¹³⁸ See *Mayo Clinic Care Network*, MAYO CLINIC, <http://www.mayoclinic.org/about-mayo-clinic/care-network> (last visited Mar. 28, 2015).

and periodic monitoring from a Mayo Clinic physician.¹³⁹ Providers participating in this program can utilize the Mayo Clinic Care Network name for purposes of marketing in exchange for a fee that paid to the Mayo Clinic for the services and use of the name.¹⁴⁰ While the network hospitals do not have any joint ownership or joint contracting at this point, features and programs in the network, especially the use of electronic systems and shared data, may enable the network, in the future, to financially integrate in a more formal manner that could provide care for patients in a similar manner across the country.¹⁴¹ Despite the goal of the ACA to organize large numbers of providers into similar organizations, what has evolved is a system in which providers, suppliers, and insurers are continuing to explore various healthcare delivery systems (with some common themes to ACOs) on a contract by contract basis for certain discrete services.¹⁴² Similarly, AMCs and integrated delivery systems like the Mayo Clinic are opting out of ACOs entirely, and instead are charting their own paths towards the provision of accountable care outside the MSSP context.¹⁴³

IV. CURRENT STATUS OF ACOS UNDER THE ACA?

If ACOs were intended to serve as the mechanism by which the U.S. healthcare system could realize, or at least move closer towards, the Triple Aim, and those institutions that were thought to be role models in that movement are not participating as ACOs, what does that mean for purposes

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ One of the biggest challenges under the current healthcare system with forming a multistate system that would be truly integrated from a financial perspective relates to the system of reimbursement. Due to various insurance regulations and the structure of health insurance reimbursement, negotiating payor contracts that could apply to various entities that are located in various states across the country could be challenging. For example, the Blue Cross Blue Shield systems have a sort of national umbrella organization, but there are 37 insurance companies that are incorporated in various states and negotiate contracts with providers in those specific states. BLUE CROSS BLUE SHIELD, www.bcbs.com (last visited Oct. 21, 2014).

¹⁴² See David Muhlestein et al., *Geographic Distribution of ACO Covered Lives*, LEAVITT PARTNERS (Dec. 1, 2013) [hereinafter Muhlestein, *Geographic Distribution of ACO Covered Lives*], <http://leavittpartners.com/2013/12/geographic-distribution-of-aco-covered-lives/>.

¹⁴³ In addition to larger academic medical centers and large integrated delivery systems, many rural hospitals found themselves opting out of participation in ACOs. Justin Kearns, *Rural Roads to ACOs: Inter-Community Collaboration is Key to Rural Accountable Care Organizations' Success Under Medicare Shared Savings Program*, 116 W. VA. L. REV. 425 (2013). In response to the preliminary regulations for ACOs, CMS made many adjustments that were intended to assist rural providers in being able to meet necessary hurdles for purposes of participating in the MSSP. See 42 C.F.R. § 425.404. For example, federally qualified health centers ("FQHCs") and rural health clinics ("RHCs") were permitted to form independent ACOs. *Id.* Additionally, there are exceptions for rurally-based ACOs in connection with the antitrust safety zones that would excuse rural ACOs from the 30% market share limits. *Id.*

of the success of ACOs fulfilling their goals and purposes? Are ACOs, as structured under the ACA, able to provide that success for all kinds and type of providers across the country, including leaders in healthcare like the Mayo Clinic? Do AMCs and other integrated delivery systems need to participate in the MSSP and/or Pioneer ACO Program to realize the Triple Aim?

A. ACO Successes

In order to answer the above questions, it first seems necessary to consider how current ACOs are faring and analyze their successes and challenges. The phrase “accountable care organization” first made its appearance into healthcare vernacular in 2007, and has since exploded into the industry due to the use of these ACOs under the MSSP.¹⁴⁴ Industry experts have defined the generic concept of an ACO as an entity that consists of “providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth.”¹⁴⁵ As noted above, there are likely far more organizations that are practicing accountable care or functioning as accountable care organizations, but the term ACO and entities utilizing the ACO moniker are most predominantly entities participating in the MSSP.¹⁴⁶ Initial indications from ACOs under the MSSP are that many entities participating in the program have been

¹⁴⁴ See generally Fisher, *supra* note 76.

¹⁴⁵ Mark McClellan et al., *A National Strategy to Put Accountable Care Into Practice*, 29 HEALTH AFFAIRS 982 (2010), available at <http://content.healthaffairs.org/content/29/5/982.full>.

¹⁴⁶ See Muhlestein, *The Accountable Care Paradigm*, *supra* note 13, at 4. Muhlestein and his colleagues conducted a study of accountable care organizations in an effort to compare such organizations to HMOs to understand the distinctions and similarities between the two entity types. In defining which entities were included as part of the study, the authors did not limit their study group to those entities that are participating in the MSSP. Rather, Muhlestein noted:

In any effort to define accountable care, a distinction must be drawn between the accountable care movement and Medicare Shared Savings Program (MSSP). An MSSP ACO is a payment model established by statute and regulation with a defined structure and specific objectives. The MSSP, however, is only one model of accountable care. Due to the intense focus on MSSP ACOs, many definitions are limited to explanations of the MSSP, but this is insufficient to define the movement as a whole given the intense activity occurring by non-Medicare players, including private and state-level Medicaid efforts.

Id. at 6 (internal citations omitted). As mentioned above, the intention of this Article is to focus on the specific provisions of the ACA to determine whether the existing structure as drafted in the ACA will enable the industry to function in fulfillment of the goals of the Triple Aim. Therefore, ACOs are examined through the lens and definition set forth under the ACA, although the authors acknowledge that there are many organizations that are practicing accountable care in different manners.

successful in cost savings and quality improvements.¹⁴⁷ In examining preliminary data from the Medicare ACOs and the Pioneer ACOs, HHS reported that savings from both programs in 2014 generated over \$372 million in total savings for the Medicare program, and generated shared savings payments of \$445 million.¹⁴⁸ HHS reported that ACOs in their second performance year improved on quality scores and patient experience measures.¹⁴⁹ This comes on the heels of reports that were released in the middle of 2014, stating that in the MSSP program over the first 12 months “...nearly half (54 out of 114) of the ACOs that started the program operations in 2012 already had lower expenditures than projected. Of the 54 ACOs that exceed their benchmarks in the first 12 months, 29 generated savings totaling more than \$126 million”¹⁵⁰ The Pioneer ACO program has also demonstrated high quality scores, with a mean quality score of 85.2% and an estimated total savings of over \$96 million with shared savings payments of \$68 million.¹⁵¹

Although there have been some successes, there have also been some growing pains. In the two years since the program’s beginning, nine of the Pioneer ACOs dropped out of the program in the first year¹⁵² and an additional four dropped out of the Program in the second year, leaving the grand total of participants at 19.¹⁵³ Granted, the ACO numbers from the MSSP (and to some extent the Pioneer ACOs) are still preliminary and the program is in its infancy, there are at least preliminary indications that entities participating in the program are achieving savings and are performing well on quality metrics.¹⁵⁴

¹⁴⁷ *Medicare’s Delivery System Reform Initiatives Achieve Significant Savings and Quality Improvements—Off to a Strong Start*, HHS.GOV (Jan. 30, 2014), <http://www.hhs.gov/news/press/2014pres/01/20140130a.html>.

¹⁴⁸ See *Facts Sheets: Medicare ACOs Continue to Succeed in Improving Care, Lowering Cost Growth*, CMS.GOV (Sept. 16, 2014) [hereinafter CMS, *Facts Sheets*], <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-09-16.html>.

¹⁴⁹ *Id.*

¹⁵⁰ See *Medicare’s Delivery System Reform Initiatives*, *supra* note 147.

¹⁵¹ See CMS, *Facts Sheets*, *supra* note 148.

¹⁵² Molly Gamble and Heather Punke, *100 Accountable Care Organizations to Know*, BECKER’S HOSP. REV. (Aug. 14, 2013), <http://www.beckershospitalreview.com/lists/100-accountable-care-organizations-to-know.html>. It should be noted that seven of the nine that dropped out of Pioneer ACO Program transitioned into the MSSP. *Id.*

¹⁵³ Melanie Evans, *Medicare’s Pioneer Program Down to 19 ACOs after Three More Exit*, MODERN HEALTHCARE (Sept. 25, 2014) [hereinafter Evans, *Medicare’s Pioneer Program Down to 19 ACOs*], http://www.modernhealthcare.com/article/20140925/NEWS/309259938&utm_source=AltURL&utm_medium=email&utm_campaign=am&AllowView=VXQ0UnpwZTVBL2FiL1lzSkUvSHRIRU9naIvRZEErVIY=?mh.

¹⁵⁴ *Id.*; see also 42 C.F.R. § 425 subd. F. Note that under the MSSP, achieving quality goals is built into the payment structure such that an entity that is not performing well on quality metrics will not achieve a maximum level of savings. Prior to the payment of any savings under the program, CMS assesses a score for the ACO on the established 33 quality metrics. The percentage of “success” on quality metrics is applied to the savings. For example,

In fact, there are three systems in the Minneapolis-St. Paul, Minnesota area that are participating in the MSSP and one of the systems, Allina Health, performed the best overall on diabetes measures according to data released by CMS regarding five of the 33 measures upon which CMS reported in the beginning of 2014.¹⁵⁵ Reporting of the metrics, however, has been one of the biggest challenges for the program.¹⁵⁶ Although the reporting of public data from CMS has been somewhat limited, those reporting the data have stated that the process of reporting the data to CMS has “accelerated improvement efforts and strengthened care, most notably in areas not previously tracked by providers and in areas of weak performance.”¹⁵⁷ Although Allina Health stated on its website that it did not earn any shared savings for the first quarter,¹⁵⁸ others have found that, at least according to the results that have been reported publicly by CMS, there appears to be a correlation between strong quality performance and cost savings.¹⁵⁹ While the reporting requirements, and the lack of publicly available information, have been criticized, it does seem that the requirements to begin the process of tracking and reporting these quality metrics has made systems and hospitals more aware of where their attention needs to be focused in terms of quality.¹⁶⁰

While ACOs are on the rise and appear to be making an impact on the market, at least as related to savings, the percentage of ACO covered lives remains low relative to total population.¹⁶¹ As of December 23, 2013,

if the entity scores 100% on the quality metrics, the ACO may be paid the entirety of the savings that are owed to the ACO based on the formula set forth in the ACO. If the entity instead scores only 40% on the quality metrics, the entity could only be paid 40% of the available savings that are owed to the ACO based on the same formula.

¹⁵⁵ See Jordan Rau, *Medicare Data Show Wide Differences in ACOs' Patient Care*, KAISER HEALTH NEWS (Feb. 21, 2014), <http://www.kaiserhealthnews.org/Stories/2014/February/21/Medicare-Data-Shows-Wide-Differences-In-ACOs-Patient-Care.aspx>. Kaiser Health News reported that 88% of Allina Health's diabetes patients kept their blood pressure under the target set by Medicare of 140/90 mmHg. Note, however, that it appears that there were some challenges in gathering and reporting of data. John Muir Health Medicare ACO in San Francisco scored poorly, as the report stating that only 9% of its patients had their blood pressure below the rate set by Medicare. John Muir, however, stated a reporting error in which 534 of the 616 patients did not have blood pressure readings due to a computing error. John Muir Health Medicare ACO claims that of the 73 patients whose blood pressure was reported, 71% met the Medicare rate. *Id.*

¹⁵⁶ Melanie Evans, *Limited Medicare ACO Quality Data Show Sharp Variation in Performance*, MODERN HEALTHCARE (May 3, 2014) [hereinafter Evans, *Limited Medicare ACO Quality Data*], <http://www.modernhealthcare.com/article/20140503/MAGAZINE/305039990> (noting that “CMS has released results for only five of 22 quality measures it has responsibility for publishing.”).

¹⁵⁷ *Id.*

¹⁵⁸ See *Medicare Accountable Care Organization (ACO)*, ALLINA HEALTH, <http://www.allinahealth.org/ahs/medicalservices.nsf/page/aco> (last visited June 30, 2014).

¹⁵⁹ See Evans, *Limited Medicare ACO Quality Data*, *supra* note 156.

¹⁶⁰ See *id.*

¹⁶¹ See Muhlestein, *Geographic Distribution of ACO Covered Lives*, *supra* note 142, at 3–4.

CMS reported that there were a total of 366 ACOs participating in either the MSSP or the Pioneer ACO program.¹⁶² Leavitt Partners published a study last updated in June, 2014 in which it examined 626 entities that it considered to be ACOs,¹⁶³ consisting of 329 entities that had government contracts (and are thus participating in either the MSSP or the Pioneer ACO program), 210 entities had commercial contracts, and 74 entities that had both kinds of contracts.¹⁶⁴ Due to the establishment of ACOs in the ACA, Leavitt Partners reported that at least some ACO activity is seen to some degree in all 50 states.¹⁶⁵ While activity is increasing, and is seen nationwide, the percentage of ACO covered lives remains relatively low, with a penetration of between just three and 10% of total covered lives in most states.¹⁶⁶ There are two states that have reported greater than 15% of their covered lives in the state are participating in ACOs, with Oregon reporting the highest rate at 25%.¹⁶⁷ The study concluded that, based on current trends and penetration, the best chance for success of ACOs is in markets (a) that already have a strong history of managed care (such as the Geisinger Health System in Pennsylvania, the Kaiser Permanente system in California, and the

¹⁶² *More Partnerships Between Doctors and Hospitals Strengthen Coordinated Care for Medicare Beneficiaries*, CMS.GOV (Dec. 23, 2013) [hereinafter CMS Press Release, *More Partnerships*], <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2013-Press-releases-items/2013-12-23.html>; David Muhlestein, *Accountable Care Growth In 2014: A Look Ahead*, HEALTH AFFAIRS BLOG (Jan. 29, 2014) [hereinafter Muhlestein, *Accountable Care Growth*], <http://healthaffairs.org/blog/2014/01/29/accountable-care-growth-in-2014-a-look-ahead/>.

¹⁶³ Muhlestein, *Geographic Distribution of ACO Covered Lives*, *supra* note 142, at 1–2 (clarifying that the study tracked entities that are practicing “accountable care” and not just those entities that are considered ACOs under the MSSP program).

¹⁶⁴ Petersen, *supra* note 137, at 1. The study noted that they are tracking 13 other ACOs, but such entities have not yet released specific information regarding the activities, even though they have reported their intentions to “practice accountable care.”); *see also* Muhlestein, *Geographic Distribution of ACO Covered Lives*, *supra* note 142 at 1–2. Since the date of the published study, CMS published its report regarding the fourth round of MSSP participants and the third round of Pioneer ACO organizations. *Accountable Care Organization 2014 Program Analysis Quality Performance Standards Narrative Measure Specifications*, CMS.GOV (Aug. 15, 2014), available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf>.

¹⁶⁵ Muhlestein, *Geographic Distribution of ACO Covered Lives*, *supra* note 142, at 3. (noting that Alabama does not have an ACO that is headquartered in its state, but there are residents of the state of Alabama who are participating in ACOs that are headquartered in other states). *Id.* at 4; Petersen, *supra* note 137, at 4.

¹⁶⁶ Peterson, *supra* note 137, at 5.

¹⁶⁷ Muhlestein, *Geographic Distribution of ACO Covered Lives*, *supra* note 142 at 4–5 (arguing that Oregon’s success is due in large part to the fact that Oregon’s Medicaid Program implemented a system in August of 2012 in which it utilizes Coordinated Care Organizations (“CCOs”) for delivering care to its Medicaid population). *Id.* at 4. This program was implemented with funding from CMS, which provided Oregon with \$1.9 billion to implement the program, which is expected to reduce per capita healthcare spending in its Medicaid population by two percentage points by 2014. *Id.* Similar programs are also active in Colorado and Utah and are being planned in Alabama, Illinois, and Iowa. *Id.*

Intermountain Health system in Utah), (b) where there are dominant payors and/or providers that have already been practicing accountable care (e.g., commercial insurers who are already operating pay for performance programs or gainsharing programs), or (c) where state legislation has amended its Medicaid program to operate through ACOs or ACO-like organizations.¹⁶⁸

B. ACO Challenges

While there has been some demonstration of success for ACOs, some challenges remain. In considering whether the ACO structure enables providers to function more like entities such as the Mayo Clinic, it must be acknowledged that the Mayo Clinic and others function quite differently from most healthcare delivery systems across the nation, and the ACO structure has not accounted for all of those distinctions.¹⁶⁹ As Gawande points out in *The Cost Conundrum*, the relationship between the physicians and the other healthcare professionals vis-à-vis the Mayo Clinic is quite distinct from the relationship between physicians, professionals, and the hospitals in McAllen, Texas:

The core tenet of the Mayo Clinic is “The needs of the patient come first”—not the convenience of the doctors, not their revenues. The doctors and nurses, and even the janitors, sat in meetings almost weekly, working on ideas to make the service and the care better, not to get more money out of patients. I asked [the Chief Executive Officer of the Mayo Clinic] how the Mayo Clinic made this possible. “It’s not easy,” he said. But decades ago Mayo recognized that the first thing it needed to do was eliminate the financial barriers. It pooled all the money the doctors and the hospital system received and began paying everyone a salary, so that the doctors’ goal in patient care couldn’t be increasing their

¹⁶⁸ *Id.* at 4.

¹⁶⁹ Kaiser Permanente is the largest nonprofit health plan in the United States and is known for its integrated approach to care in that it closely coordinates primary, secondary, and hospital care. See *What Health Systems Can Learn from Kaiser Permanente: An Interview with Hal Wolf*, MCKINSEY & CO. (July 2009), http://www.mckinsey.com/insights/health_systems_and_services/what_health_systems_can_learn_from_kaiser_permanente_an_interview_with_hal_wolf. Kaiser Permanente is the largest nonprofit health plan in the United States and is known for its integrated approach to care in that it closely coordinates primary, secondary, and hospital care. All those patients who receive care at Kaiser Permanente are enrollees of their health plan. This is unlike other systems that accept multiple types of insurance products. Similarly, Intermountain Healthcare also has an associated health plan and a connected medical group. See INTERMOUNTAIN HEALTHCARE, <http://intermountainhealthcare.org/Pages/home.aspx> (last visited Jan. 30, 2015) (“Intermountain Healthcare is an internationally recognized, nonprofit system of 22 hospitals, a Medical Group with more than 185 physician clinics, and an affiliated health insurance company, SelectHealth.”).

income. Mayo promoted leaders who focused first on what was best for patients, and then on how to make this financially possible.¹⁷⁰

While ACOs have incorporated the concept of gainsharing through the MSSP, which is intended to eliminate some of the financial barriers the Mayo Clinic CEO was referencing, gainsharing does not generate the same effect as hospitals employing or contracting with physicians and then paying the physicians a salary or flat-fee, thus eliminating the incentive for over-utilization.¹⁷¹ Implementing structural change such as the structure of the Mayo Clinic, however, is far easier said than done.¹⁷²

The majority of all hospitals in the country have no financial relationship with physicians on their medical staffs, and little money to undertake such structural changes that would alter that fact.¹⁷³ In fact, according to a recent survey from the American Medical Association (“AMA”), 60% of physicians work in private practices owned by physicians (either as owners or employees of the practice), with only 23% working in practices owned in whole or in part by a hospital or hospital system, and only slightly over 5% of physicians are employed directly by a hospital or hospital system.¹⁷⁴ The AMA has itself acknowledged that the current manner in which physicians interact and are engaged with hospitals may prove an issue: “While some physicians will easily be able to adapt to and engage in Accountable Care Organizations or other health delivery structures that emphasize greater integration and care coordination, for others it will prove more of a challenge.”¹⁷⁵

Given the structure of most hospital systems, implementing even a gainsharing structure (much less an employed or contracted physician structure) that endeavors to create this alignment presents substantial

¹⁷⁰ See Gawande, *supra* note 24, at 12.

¹⁷¹ While the number of employed physicians is increasing, a report from the American Medical Association found that only about 212,000 physicians are employed by hospitals, which includes a small number of dentists and medical residents. Carol K. Kane & David W. Emmons, *New Data on Physician Practice Arrangements: Private Practice Remains Strong Despite Shifts Toward Hospital Employment*, AM. MED. ASS’N. 2 (2013), available at http://www.mmms.org/sites/default/files/images/2013_9_23_ama_survey_prp-physician-practice-arrangements.pdf. As of 2012, about 60% of physicians worked in a private practice as either employees or owners. The fact remains that the many physicians in the country have medical staff privileges to perform services at hospitals, but all or the majority of the revenue that they receive for such services is generated from billing payors (including Medicare and Medicaid) on a fee-for-service basis.

¹⁷² See *id.* at 6.

¹⁷³ See generally *id.*

¹⁷⁴ *Id.* Of those individuals who are directly employed by hospitals or hospital systems, data indicates an increase in primary care physicians, which is done with the intention of maintaining a strong referral base to the hospital’s specialty physicians. *Id.* at 8. The two more often reported employed physicians were internal medicine and family practice physicians. *Id.*

¹⁷⁵ Kane & Emmons, *supra* note 171, at 8.

challenges to hospitals.¹⁷⁶ IHI has emphasized that improving patient experience, managing population health, and lowering the per capita cost of healthcare (achieving the Triple Aim) in many instances may mean providing less costly care or simply less care.¹⁷⁷ For many hospitals, however, the provision of less costly care or less care in the current environment is likely to have a large impact on the bottom line that may not be offset by potential savings to a specified Medicare population.¹⁷⁸ Thus, trying to convince providers to shift the paradigm towards an ACO model seeking to achieve the Triple Aim is actually a greater task than it would first appear.

An example of this challenge can be seen in the following scenario: assume that a patient goes to see an orthopaedic physician due to a wrist injury. Upon examination, the wrist appears to be broken in two places. The physician notes that the nature of the break is such that it would likely have a very successful outcome if the patient has surgery and a metal rod inserted. Surgery will require admission to the hospital, as the surgery must be done on an inpatient basis. Alternatively, the break is relatively clean and it is possible that it will heal nicely on its own with a splint and cast, and proper monitoring and follow-up. In the current fee-for-service driven system, both the hospital and the physician will generate the highest revenue if the physician recommends that the patient have surgery.¹⁷⁹ From the patient perspective, surgery is likely to drive up fees in the form of co-pays, co-insurance, and deductibles, and will likely mean time off work or school. Attempting to splint and cast the arm first, however, will be more cost efficient and less invasive for the patient. From a Triple Aim perspective, the surgical option, unless absolutely warranted from a medical perspective, potentially fails two “aims” in that it is more costly for the payor and the patient, and does not provide quality services that are consistent with patient satisfaction.¹⁸⁰ That said, the non-surgical option provides the least amount

¹⁷⁶ *Id.* at 4. See also Susan Kreimer, *ACOs: Multi-Year Transition Requires an Overhaul to Healthcare Delivery*, MED. ECON. (June 24, 2014), <http://medicaleconomics.modernmedicine.com/medical-economics/news/acos-multi-year-transition-requires-overhaul-healthcare-delivery?page=full>; see also Gawande, *supra* note 24, at 15.

¹⁷⁷ See Berwick, *supra* note 7, at 720.

¹⁷⁸ See Kreimer, *supra* note 176, at 2.

¹⁷⁹ Both the hospital and the physician will be paid if the physician chooses to perform surgery (the hospital in the form of the technical fee and the physician in the form of the professional fee). To the extent that the physician opts for the “wait and see” approach, the hospital will not bill for any services and the physician will only bill for the associated office visit.

¹⁸⁰ It should be acknowledge that patient satisfaction is often times a subjective standard. While the splint and cast option will be less costly to the patient and will not involve a hospital stay, it is possible that a patient would choose the surgical option in order to ensure that the break is fixed right the first time and it avoids having to sit around and see if the non-surgical option works. To the extent that the patient ends up having to have surgery regardless, it is arguable that the patient could claim more satisfaction if the surgical option had been chosen from the beginning.

of revenue for the physician and the hospital. If the physician and hospital are participating in an ACO under the MSSP, choosing the non-surgical option will be less costly, and may lead to the ability to share in overall savings, assuming quality metrics are met.¹⁸¹ In making this decision, however, both the hospital and physician are forced to consider whether the potential savings that may be achieved will be offset by services provided to other patients.

Mayo Clinic and other integrated delivery systems have noted the challenges that are presented by a new reality that providing more efficient care might mean providing less care in connection with their hesitancy in participating in the MSSP or Pioneer ACO Program, which reality has been echoed by hospitals that are currently participating in ACOs.¹⁸² As the example above demonstrates, the paradigm shift away from fee-for-service reimbursement towards efficient and more cost-effective care also moves the focus away from a hospital's average daily census, which has been the historical bellwether for hospitals in ensuring sufficient revenues.¹⁸³ Margaret O'Kane, President of the National Committee for Quality Assurance explained:

Learning to function "180 degrees differently" will require a lot of innovation in a leaner environment. . . . "The business incentive for a hospital usually is to have heads in beds, and if you're an ACO, you're trying to keep people out of the hospital and healthy[.] It could take down the whole organization if your hospital beds are empty, so it's a complicated transition for a hospital."¹⁸⁴

One provider that seems to have guarded against this is MissionPoint Health Partners in Nashville, Tennessee, for which the ACO is currently only available for employees of Saint Thomas Health, and for which health insurance is self-funded.¹⁸⁵ St. Thomas Health was successful in decreasing overall costs from 2012 to 2013, some of which was attributed to savings through a reduction in admissions to the hospital and emergency room

¹⁸¹ See Kreimer, *supra* note 176, at 1.

¹⁸² Gold, *supra* note 126; see Kreimer, *supra* note 176, at 2 (noting that hospital-based ACOs are experiencing more challenges and difficulties than provider-based ACOs).

¹⁸³ Kreimer, *supra* note 176, at 2. An "average daily census" is defined as the "The average number of inpatients present each day for a given time period. This figure is derived by dividing the sum of patient days for a period by the number of days in the same period." *Education Module for Health Record Practice*, available at http://www.unc.edu/~murrell/Health_Care_Statistics_class/Health_Care_Statistics.html (last visited Mar. 28, 2015).

¹⁸⁴ *Id.* Kreimer, *supra* note 176.

¹⁸⁵ See generally MISSION POINT, <http://www.missionpointhealth.org/about/> (last visited Oct. 23, 2014).

visits.¹⁸⁶ Such reductions in a fee-for-service system necessarily means less revenue for the hospital related to such services. In the case of St. Thomas Health, however, reduction of those volumes was offset by cost savings realized through its employees' healthcare expenses.¹⁸⁷ While successful for St. Thomas Health and MissionPoint Health Partners, not all hospitals can experience these same savings on the employee side to offset losses in revenue on the hospital-side.

C. Does the Current ACO Structure Fulfill the Triple Aim?

It appears, then, that there is conflicting information about whether or not ACOs can be successful as a means for fulfilling the Triple Aim. Based on preliminary data, ACOs that seem to function well, or are at least able to generate some savings and meet quality standards in the MSSP, are located in urban settings and consist of large multi-specialty groups of providers that do not have a heavy focus on research or teaching, and were not previously operating in an integrated system.¹⁸⁸ Perhaps some of the successes are due to the fact that these organizations likely could have practiced better care coordination and realized efficiencies years earlier, but were not willing to attempt such changes without financial incentives.¹⁸⁹ Perhaps this is because larger systems involved in research and teaching have been sustaining their operations through margins realized on reimbursement from commercial payors, but such systems are not (yet) able to achieve any savings on Medicare patients, despite providing efficient and effective care.¹⁹⁰

Regardless of the reason behind it, the fact that success under the MSSP, a key part of the United States healthcare industry, especially for AMCs and other integrated delivery systems, remains elusive indicates that the ACO scheme currently established under regulations does not appear to be achieving the Triple Aim. Evidence supports a finding that the current ACO structure may improve patient experience of care, the health of certain Medicare beneficiaries, and may reduce the per capita cost of healthcare for the Medicare program and certain of its beneficiaries. Such a structure does not, however, enable successes at the country's top AMCs. Absent such

¹⁸⁶ Kreimer, *supra* note 176, at 2–3.

¹⁸⁷ *Id.*

¹⁸⁸ *Id.* at 2.

¹⁸⁹ One of the reasons provided by ACOs that dropped out of the Pioneer ACO Program for departure from the program was that fact that the systems were already operating at maximum efficiencies, and thus, achievement of additional savings were likely elusive because of an inability to reduce additional expenses. Debra Ness & William Kramer, *The First-Year Pioneer ACO Results: Predictable Bumps in the Road*, HEALTH AFFAIRS (July 25, 2013), <http://healthaffairs.org/blog/2013/07/25/the-first-year-pioneer-aco-results-predictable-bumps-in-the-road/>.

¹⁹⁰ See *supra* notes 139–144 and accompanying text (discussing the Mayo Clinic and its Mayo Clinic Care Network).

inclusion, the ACO structure is unable to achieve the equity balance that is so critical to the Triple Aim.¹⁹¹

If the U.S. is to realize the goals of the ACA through adoption of the Triple Aim, legislators and regulators must adapt the current ACO regulations in a way that will encourage participation of AMCs in ACOs and associated care delivery models. A system in which AMCs are unable or unwilling to participate in ACOs is likely to result in one of two eventualities: (1) AMCs will be squeezed out of any new service delivery models, such as ACOs, potentially reducing or eliminating institutions that are leading the country in innovation, teaching, efficiency, and quality; or (2) ACOs and other evolving healthcare delivery models will falter because industry leaders, such as the Mayo Clinic, are not participating in the reform movement, which will result in maintenance of the status quo of healthcare in the United States. A U.S. healthcare system without providers such as the Mayo Clinic would lack in innovation, cutting-edge research, and meaningful advancement of evidenced-based research.¹⁹² These losses would fail to attain the goals of the Triple Aim of achieving better patient care and better population health in furtherance of the Triple Aim¹⁹³ How does the healthcare industry avoid this eventuality without putting the country in a situation where, either, providers simply opt out of providing services to government beneficiaries entirely or AMCs cease to exist as they are known today, along with some of the care they provide?

D. Recommendations

Marc Bard was correct to say that it really is not enough for purposes of actually reforming the healthcare delivery system in the United States if, at the end of the day, the only result is that the entities that were performing

¹⁹¹ See generally Berwick, *supra* note 7, at 760.

¹⁹² Regulations that also encourage support of rural providers is also essential in the system, as assuring access to care in local communities that provides convenience and accessibility for patients in rural settings is equally essential for ensuring that healthcare that is available to all segments of the population. For purposes of this article, the focus will be on the importance of AMCs in the system, but rural providers are also a critical provider that has thus far struggled with participating in ACOs. Beth Kutscher, *Nine Rural Providers Test Out ACO Initiative*, MOD. HEALTHCARE (Jan. 28, 2014) <http://www.modernhealthcare.com/article/20140128/NEWS/301289912#>; see DEPT. OF HEALTH & HUMAN SERVS., MEDICARE SHARED SAVINGS PROGRAM AND RURAL PROVIDERS (2014), available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Rural_Factsheet_ICN907408.pdf; see also A. CLINTON MACKINNEY ET. AL., RUPRI CTR. FOR RURAL HEALTH POLICY ANALYSIS, ACCOUNTABLE CARE ORGANIZATIONS IN RURAL AMERICA (2013) available at <http://cph.uiowa.edu/rupri/publications/policybriefs/2013/Accountable%20Care%20Organizations%20in%20Rural%20America.pdf>; A. Clinton MacKinney et. al., *The March to Accountable Care Organizations—How Will Rural Fare?*, J. RURAL HEALTH 131 (2011).

¹⁹³ *Id.*

at maximum efficiency continue to perform at maximum efficiency.¹⁹⁴ Further, if the U.S. healthcare delivery system is to achieve the Triple Aim, which this article argues is a desired and perhaps necessary goal in order to truly reform the way in which healthcare is delivered in the U.S., it is not enough that a few large urban providers afford greater integrative care for a percentage of the U.S.'s Medicare beneficiaries.¹⁹⁵ Underlying all of the insurance reform, coverage mandates, and quality metrics in the ACA is the concept that what the ACA is attempting to accomplish is better care for patients, better health for our communities, and lower costs through improvement for our healthcare system.¹⁹⁶ While the current ACO structure is a step in the right direction towards trying to accomplish all of those goals, it seems to be falling short of such goals in its current state. Although some ACOs may be providing "better care,"¹⁹⁷ such care is limited to those individuals who happen to live in areas in which ACOs are participating, which in large part seem to be centered in urban areas, many with providers that were already operating integrated systems.¹⁹⁸ Without more widespread adoption of the MSSP or Pioneer ACO Program,¹⁹⁹ current ACOs will continue to provide care to a limited portion of Medicare beneficiaries.²⁰⁰ Additionally, certain providers, such as the Mayo Clinic and Intermountain Health System, may be unavailable for individuals who cannot afford their services, depending on their insurance coverage.²⁰¹ Finally, from a cost containment perspective, while preliminary data indicates that many providers participating in the ACO program have been able to achieve savings in the first few years of the MSSP or Pioneer ACO Program, as the case may be,²⁰² such savings appear limited to only a small portion of urban, multispecialty groups that needed financial incentives to realize efficiencies that perhaps could have been achieved years earlier.²⁰³ Thus, in considering

¹⁹⁴ Molly Gamble, *ACOs: The Least Agreed-Upon Concept in Healthcare?* Becker's Hosp. Rev. (May 6, 2013), <http://www.beckershospitalreview.com/accountable-care-organizations/acos-the-least-agreed-upon-concept-in-healthcare.html>.

¹⁹⁵ See generally Berwick, *supra* note 7.

¹⁹⁶ See *CMS Innovation Center*, *supra* note 16.

¹⁹⁷ See Kreimer, *supra* note 176, at 2.

¹⁹⁸ See Muhlestein, *Geographic Distribution of ACO Covered Lives*, *supra* note 142, at 3–4.

¹⁹⁹ Indeed, there are systems that are providing "accountable care" even if not participating in ACOs through the MSSP or Pioneer ACO Program. This article argues, however, that without more widespread adoption of ACOs through a national program like Medicare that the delivery systems that are providing care across the U.S. will continue to do so in a disjointed and uncoordinated manner, just as the system is currently functioning. Thus, participation in these programs is essential for trying to establish some uniformity for how accountable care is delivered across populations.

²⁰⁰ See generally Muhlestein, *Geographic Distribution of ACO Covered Lives*, *supra* note 142; see also Petersen, *supra* note 137.

²⁰¹ See generally Nelson, *supra* note 94.

²⁰² See *Medicare's Delivery Reform Initiatives*, *supra* note 147; see also CMS, *Facts Sheets*, *supra* note 148.

²⁰³ See Kreimer, *supra* note 176, at 2–3.

aspects of the Triple Aim: (a) achieving better health for our communities remains elusive to the extent that the same quality and level of care varies based on where one lives or where one seeks care; and (b) providing better population health at a lower cost per patient also proves challenging because for those entities, like the Mayo Clinic, that do not or cannot generate revenues based on Medicare reimbursement, even if costs can be lowered for some Medicare beneficiaries, costs cannot be lowered for all patients.²⁰⁴

These challenges should not be taken to suggest that the ACO concept or structure needs to be scrapped entirely. It seems clear that, despite certain reservations with the ACO regulations, the MSSP, and Pioneer ACO Programs, providers in the United States are largely in agreement that the United States does need to reform the healthcare delivery system in a way that provides for more integrated and more coordinated care.²⁰⁵ Given growing support for the concept of accountable care, despite somewhat slowly evolving participation in the MSSP or Pioneer ACO Program,²⁰⁶ it seems that the best hope for achieving the Triple Aim and working towards those goals envisioned with enactment of the ACA, is to work towards revising the ACO structure in such a way that all providers, especially AMCs, but also rural hospitals as well as those systems that are already finding some successes in the current programs, can participate.²⁰⁷ This article proposes three primary changes to the ACO structure that, ideally, will adequately encourage participation by a wider percentage of providers, including leaders in quality and effective care like the Mayo Clinic.

First, the ACO structure needs to include comprehensive payment reform that eliminates, or greatly reduces, reliance on a fee-for-service structure. Granted, there are ongoing pilot projects testing various payment

²⁰⁴ See generally Nelson, *supra* note 94; see also Mayo's Dominance, *supra* note 105.

²⁰⁵ As pointed out in the Leavitt study regarding ACO penetration discussed in Part IV above, there are a number of providers that are participating in organizations providing accountable care, even if such organizations are not participating in any Medicare programs. See Muhlestein, *Geographic Distribution of ACO Covered Lives*, *supra* note 142, at 2. Clinically integrated networks have become increasingly common both among providers and among providers in combination with insurers. Jason Goldwater et. al., *Considerations for Clinical Integration*, TRUVEN HEALTH ANALYTICS 4 (2011), available at http://truvenhealth.com/portals/0/assets/HOSP_11363_0712_ClinicalIntegration_WP_Web_7662; see also *Why Should You Clinically Integrate?*, THE CAMDEN GROUP (2014) <http://www.thecamden.org/thought-leadership/blog/why-should-you-clinically-integrate/> (last visited Jan. 27, 2015). Not wanting to be left behind, many physicians are joining these organizations or participating in certain insurance networks or becoming employees of hospital systems due to the belief (or, for many, fear) that the healthcare delivery system will move in a direction of more integrated and coordinated care away from a fee-for-service model. Abby Goodnough, *New Law's Demands on Doctors Have Many Seeking a Network*, N.Y. TIMES (Mar. 2, 2014), http://www.nytimes.com/2014/03/03/us/new-laws-demands-on-doctors-have-many-seeking-a-network.html?_r=0.

²⁰⁶ See Muhlestein, *Geographic Distribution of ACO Covered Lives*, *supra* note 142, at 2–4.

²⁰⁷ *Id.*

systems,²⁰⁸ but the MSSP and Pioneer ACO program that promotes gainsharing while retaining a fee-for-service payment system will be unable to evolve to a point where other providers are encouraged to enter.²⁰⁹ If such a lack of participation continues for too long, the ACO structure will wither and die before any payment reforms can be implemented. In examining why systems like the Mayo Clinic have been successful with providing more efficient care, observers (and even the Mayo Clinic itself) credit this success, in part, to the compensation structure of the Mayo Clinic's physicians.²¹⁰ Unlike private practice physicians who are compensated only when they perform services, the physicians at Mayo Clinic have no pressure or need to ensure a certain volume of patients or number of procedures in order to sustain a practice or make a living.²¹¹

While gainsharing programs such as the MSSP provide some physician-hospital alignment, such programs are not sustainable on a long term basis as the sole means assuring integration and coordination.²¹² This is true for three primary reasons: (a) at some point, the physicians and hospital will be operating at maximum efficiency and further savings and incentives will be impossible without the potential for impacting patient care;²¹³ (b) shared savings programs like the MSSP alone do not address or control the actions of the physicians outside of the hospital setting, which may be used to offset losses in fee-for-service revenues at the hospital;²¹⁴ and (c) if hospitals are realizing success in meeting quality metrics and lowering costs through gainsharing, such success likely means fewer patients who are

²⁰⁸ For an extensive list of current pilot programs testing various payment models see CTRS. MEDICARE & MEDICAID SERVS., *Innovation Models*, (2014), available at <http://innovation.cms.gov/initiatives/index.html#views=models>.

²⁰⁹ Between the drafting of this article and publication, the CMS Innovation Center proposed a new pilot program called the "Next Generation ACO Model." The goal of the program is to "test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures for Original fee-for-service (FFS) beneficiaries." *CMS Innovation Center, Next Generation ACO Model*, CMS.GOV, <http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/> (last visited Apr. 14, 2015). The program is looking to attract 15–20 providers and contemplates a graduation from FFS reimbursement to capitation. See *CMS Innovation Center, Next Generation ACO Model: Frequently Asked Questions*, CMS.GOV (Apr. 13, 2015), available at <http://innovation.cms.gov/Files/x/nextgenacofaq.pdf>.

²¹⁰ See Gawande, *supra* note 24, at 12; MAYO CLINIC, *The Mayo Effect*, (Jan. 14, 2011), <http://www.mayoclinic.org/documents/mayo-effect-10-things-pdf/doc-20079459>; Douglas McCarthy et. al., *Mayo Clinic: Multidisciplinary Teamwork, Physician-Led Governance, and patient-Centered Culture Drive World-Class Health Care*, COMMONWEALTH FUND (Aug. 2009), http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2009/Aug/1306_McCarthy_Mayo_case%20study.pdf.

²¹¹ *Id.*

²¹² See generally Kautter, *supra* note 71.

²¹³ See Kreimer, *supra* note 176, at 2–3.

²¹⁴ See *Id.*

seeking services at the hospital,²¹⁵ which means less revenue based on the current payment system.²¹⁶ To the extent that the Medicare system continues to lack comprehensive payment reform, such as bundled payments or value-based purchasing, which should be implemented in conjunction with shared savings incentives, it will be challenging to reform the current system in a way that actually emulates the quality and efficiency that is demonstrated by providers like the Mayo Clinic.

Granted, there are ongoing pilot programs for many payment reform mechanisms²¹⁷ and it is important to take the time to ensure that whatever payment system is implemented in the future will be successful in accomplishing desired goals. It is critical to keep these payment reform initiatives a top priority, however, because achieving the goals of the Triple Aim and experiencing true cost containment for all populations is unlikely to occur so long as the fee-for-service system is still in place.²¹⁸ So long as the fee-for-service system remains, many providers, including a disproportionate number of AMCs and other integrated delivery systems, will be either unable or unwilling to participate in the MSSP or Pioneer ACO Program on the basis that achieving savings under these programs, based on their costs in providing services, is exceedingly challenging.²¹⁹ Without wider adoption of the MSSP and Pioneer ACO Programs by AMCs and similar research institutions, the balance that Berwick avers is so critical for pursuit of the Triple Aim is unachievable, because the healthcare system will remain fractured as providers pursue their own paths towards healthcare reform without coordination and cooperation.²²⁰ A system in which various providers are pursuing their own goals and aims is not unlike the system that

²¹⁵ For example, lower hospital readmissions after a hospital stay, especially avoiding readmission for at least 30 days post discharge, is considered better quality care for the patient and is a defined quality metric by CMS. Patient Protection and Affordable Care Act 42 U.S.C. § 1395ww (2014); *Quality Measures and Performance Standards*, CMS.GOV, <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-Shared-Savings-Program-Quality-Measures.pdf> (last visited Nov. 4, 2014) (noting that metric #8 on Table 33 is Risk Standardization, All Condition Readmissions). Avoiding readmissions is clearly better for the patient, but to the extent that the hospitals are successful in avoiding such admissions, it means that patients are coming to the hospital less.

²¹⁶ See Kreimer, *supra* note 176, at 2.

²¹⁷ See *Innovation Models*, CMS.GOV, <http://innovation.cms.gov/initiatives/index.html#views=models> (last visited Mar. 28, 2015) (providing an extensive list of current pilot programs testing various payment models); see also *supra* note 209 and accompanying text.

²¹⁸ Glen Cheng, *The National Residency Exchange: A proposal to Restore Primary Care in an Age of Microspecialization*, 38 AM. J.L. & MED. 158, 171 (2012) (noting the negative effects of the fee-for-service system on the healthcare market during recent reform initiatives); see also Ashley Craig, *You Can't Go Home Again – Difficulties of Medical Home Implementation within Health Reform*, 21 ANNALS HEALTH L. ADVANCE DIRECTIVE 60, 64 (2011) (explaining how the fee-for-service system will continue to be an enormous financial burden on the United States' healthcare market).

²¹⁹ See Kastor, *supra* note 28.

²²⁰ See Berwick, *supra* note 7, at 768.

was in effect in the United States prior to adoption of the ACA. That is, the Mayo Clinic, Kaiser Permanente, Intermountain Health and other similar systems have been pursuing alternative delivery systems and coordination of care for years, but without comprehensive payment reform that has forced other providers to consider modeling these systems, the systems have remained silos in their respective areas with little impact on changing the way that other systems function.²²¹

The second recommendation for amendments to the ACO structure is to consider carefully the establishment of the metrics and tracking of outcomes data in connection with ACOs and the manner in which such quality markers are utilized for purposes of reimbursement.²²² In examining the Mayo Clinic, even with its successes regarding patient outcomes and efficient care delivery (as demonstrated by lower than average Medicare spending), it has also been clear that supporting the quality of care that is provided at the Mayo Clinic cannot be sustained by the Mayo Clinic or other providers based on the current Medicare payment structure.²²³ As leadership at the Mayo Clinic has recognized, as well as other leaders of AMCs, the quality care received at the Mayo Clinic is attainable because the Mayo Clinic and other AMCs are innovators in their respective fields and conduct a large amount of research that ensures that some of the sickest patients are receiving care supported by evidenced-based medicine.²²⁴ The research and innovation that takes place at AMCs across the country is not inexpensive and cannot be fully sustained based on Medicare's current reimbursement system, or even such reimbursement system in combination with shared savings.²²⁵ It is not in furtherance of the Triple Aim, however, to continue a system in which such research and innovation is only sustainable to the extent that commercial insurers continue to pay more than government payors to a group of select providers.²²⁶

In addition to the challenges of funding related to research and innovation, the current ACO structure does not recognize distinctions in

²²¹ See Gamble, *supra* note 194.

²²² Patient Protection and Affordable Care Act 42 U.S.C. § 280j (2014) (establishing a National Strategy for Quality Improvement in healthcare, including to comparative effectiveness research (CER) designed to make available to physicians scientific information, evidence-based tools, recommend clinical practices, and other guidelines to promote patient safety and optimize patient outcomes). *Strategic Goal 1: Strengthen Health Care*, HHS.GOV, http://www.hhs.gov/strategic-plan/goal1.html#obj_b (last visited Nov. 4, 2014).

²²³ See generally Nelson, *supra* 94; Kastor, *supra* note 28.

²²⁴ See Kastor, *supra* note 28.

²²⁵ *Id.*

²²⁶ See Joe Robertson, *Health Care Reform - The Impact on Academic Medical Centers: An Academic Health Center Executive's Perspective*, WILLAMETTE MGMT. ASSOCS., http://www.willamette.com/insights_journal/10/spring_2010_1.pdf (noting that the "prevailing model for funding [academic health centers], in which the clinical system significantly cross-subsidizes the education, research and community outreach missions, is increasingly under duress").

patient population for purposes of its shared savings.²²⁷ AMCs, as specialty institutions, tend to have more complex patients with multiple comorbidities.²²⁸ As a result, keeping these patients out of the hospital and complying with some of the 33 quality metrics may be more challenging given that the patients are not being treated for only one condition.²²⁹ The incentives and payment structure of the current ACO system provides for exceedingly limited exceptions or allowances for these factors that are unique to AMCs.²³⁰ Therefore, as providers consider establishing an ACO and those other entities with which they would want to associate, AMCs are not necessarily an attractive partner, as it is possible that such association will actually hinder the ability to achieve shared savings and desired quality scores.²³¹ Such issues are especially inherent at an AMC because of the high expense structure at AMCs due to the teaching and training aspects of these institutions,²³² which cannot simply be reduced to the same extent that a hospital could save costs related to better coordination of supply chain management, for example.²³³

In order to address this issue, the ACO structure needs to be adapted to account for or allow for some of the inherent challenges of working with AMCs. Some of these adjustments can be remedied through payment reform that eliminates the fee-for-service payment and provides for compensation that is paid across a continuum, encouraging transfer for specialty services as

²²⁷ As noted above, all funding for teaching, research, and other graduate medical education and other expenses are reimbursed separately through other mechanisms, but there is not differentiation among ACOs that would provide a different level of reimbursement to AMCs or other research institutions. See Patient Protection and Affordable Care Act 42 U.S.C. § 1395jjj; *Graduate Medical Education*, ASS'N OF AMERICAN MED. COLLS., <https://www.aamc.org/advocacy/gme/> (last visited Mar. 28, 2015) (providing a brief explanation of how GME payments are made).

²²⁸ See Kastor, *supra* note 28.

²²⁹ See Val Jones, *Why an Elite Academic Medical Center May Not Provide the Best Care*, KEVINMD.COM (May 7, 2014), <http://www.kevinmd.com/blog/2014/05/elited-academic-medical-center-provide-care.html>.

²³⁰ See 42 U.S.C. § 1395jjj; 42 C.F.R. § 425.

²³¹ It is true that AMCs are not in fact paid “the same” as other hospitals, as there is a complex reimbursement structure that has been established that reimburses AMCs for many of their costs related to teaching, research, and the provision of care to uninsured patients. *Direct Graduate Medical Education (DGME)*, CMS.GOV (last updated Dec. 31, 2014), <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html>. Despite these “extras,” many of which were substantially reduced through various provisions in the ACA, such expenses often far exceed the cost of the AMC in providing such services. See Robertson, *supra* note 226, at 6.

²³² *Id.* Kastor, *supra* note 28 (“The traditional method of training students, house staff, and clinical fellows is expensive and inefficient. Since junior trainees are particularly inexperienced, they take longer to work up their patients, and they order more tests than an experienced physician might think necessary. House officers and students, eager to answer correctly any questions posed by their attending physician during morning rounds, order whatever tests and procedures are necessary to rule out every relevant diagnosis and treat every possible disease.”).

²³³ See *Id.*

soon as possible, or in the alternative, transfer from a specialty hospital to a lower level of care.²³⁴ Current fee-for-service structure, despite the possibility of shared savings, retains challenges for hospitals in maintaining revenues based on lower volumes. Elimination of fee-for-service will shift the focus away from the issues related to ensuring a sufficient volume.²³⁵ Additionally, and in the interim, the quality metrics need to be weighted or adjusted based on the condition of the patient similar to other systems. While classifying how “sick” a patient is can be challenging, the quality metrics need to be fluid and flexible enough to have at least some allowances for comorbidities or patients who are at a higher complexity, and thus cannot be compared from an outcomes perspective with healthier patients. Allowing this flexibility will provide a greater likelihood of the possibility of shared savings in the current system, despite some variance in outcomes data. Maintaining a structure that promotes inclusion of AMCs in ACOs might enable the costs of teaching and research to be better spread across a multitude of providers, ultimately enabling systems to work together to reduce costs as a whole. This coordination should result in a structure that more closely resembles the Triple Aim, as it means better care for patients and a population across a continuum in settings that should be the most cost effective based on patient needs. Such coordination will not take place, however, unless AMCs are seen as assets and contributors to the ACO structure, as opposed to hindrances.

Finally, although perhaps the most challenging politically, ACOs need to more fully incorporate the concepts promoted by Intermountain Health System and others;²³⁶ namely, Medicare beneficiaries and commercial beneficiaries alike need to be participants in their care in a way that makes both providers *and patients* accountable for a patient’s care.²³⁷ One of the reasons that HMOs were successful from a cost containment perspective in the 1970s and 1980s related to the fact that beneficiaries were limited in their movement among providers.²³⁸ Cost containment proved successful to the

²³⁴ Arguably, patients who have less complex conditions may actually be cared for more efficiently in a low cost setting that handles similar conditions on a daily basis. See Jones, *supra* note 229 (“Academic medical centers specialize in caring for those who are often too sick or too complicated to be cared for elsewhere. If you happen to be on a medical floor with complicated neighbors, expect to see less of your doctors and nurses.”).

²³⁵ See Kreimer, *supra* note 176, at 2.

²³⁶ CMS Releases Mixed Results for First Year Pioneer ACO Program, ADVANTEDGE, <http://ahsrcm.com/medical-billing-news/cms-releases-mixed-results-for-first-year-pioneer-aco-program/> (last visited Nov. 4, 2014).

²³⁷ See Evans, *Providers See Little Enthusiasm to Join ACOs*, *supra* note 128.

²³⁸ While limitations within a network did control costs, patients were often times also limited by specific procedures. Many HMOs and other managed care organizations also implemented pre-authorization requirements in which certain procedures or treatment plans required authorization by a medical director or other reviewer who worked for the insurer. Thus, simply the presence of a narrow network was not the only complaints from consumers and managed care began its descent in the 1980s and 1990s. Gerard Wedig, *The Value of*

extent that insurers could require patients to seek care from specific providers with whom the insurer had already negotiated low rates.²³⁹ While a lack of flexibility in this area ultimately became one of the key downfalls of HMOs long-term, completely ignoring the fact that some level of patient involvement and accountability is necessary for cost containment and coordination of care disregards some of the lessons that should have been learned from the managed care movement. Indeed, one of the biggest criticisms of the current ACO structure is that it is challenging for providers to control costs if beneficiaries are permitted to seek care from other providers outside an established network as well as within the network.²⁴⁰

From the perspective of the Triple Aim, Berwick himself has promoted the flexibility of Medicare beneficiaries to seek care from any provider as an aspect of ACOs that is in furtherance of the Triple Aim because it enhances the care experience.²⁴¹ Berwick has stated in recent interviews:

[A]bout 1 in 4 Medicare beneficiaries chooses to be in a private health plan through Medicare Advantage, also known as Part C Medicare. They accept the restrictions on choice of provider in return for better-coordinated care. . . . Seventy-five percent of Medicare beneficiaries don't want restricted choices. Do they have to forgo the benefits of good managed care? Many experts would say, "Yes." They think that care management is incompatible with patient choice. The ACO premise is different. Beneficiaries don't join an ACO; providers of care do. . . . It will work because it is set up to reward the right combination of goals for our time: transparency, coordination, consumer power and intolerance of waste.²⁴²

In contrast, Jeff Goldsmith stated in response, "The biggest problem with the ACO, however, isn't the faulty business proposition, but the patient's role. . . . Patients need to be active agents in their own health, and in

Consumer Choice and the Decline in HMO Enrollments, ECON. 51 INQUIRY 1066, 1068 (2012).

²³⁹ *Id.*; see also Berwick, *supra* note 7, at 767.

²⁴⁰ See Evans, *Providers see Little Enthusiasm to Join ACOs*, *supra* note 128. This is one of the primary complaints of Intermountain regarding the ACO regulations and that is the fact that accountable care is not just about accountability of the providers, but providers working with patients who are themselves also accountable for their care.

²⁴¹ Donald M. Berwick, *Making Good on ACOs' Promise—The Final Rule for the Medicare Shared Savings Program*, NEW ENG. J. MED. 1753, 1755 (2011) [hereinafter Berwick, *Making Good on ACOs' Promise*], available at <http://www.nejm.org/doi/pdf/10.1056/NEJMp1111671>.

²⁴² See Mathews, *supra* note 53.

an effective care system. They need to choose to participate and be rewarded for healthy behavior.”²⁴³

Granted, Berwick’s caution in this area is well-placed in that creating an ACO system that ignores some of the key components of HMOs that ultimately gave rise to the failure of such HMOs would simply be repeating history. That said, does the current system that enables patients to receive care from any provider, even though the providers themselves are restricted in terms of their patients, truly achieve the Triple Aim? Can you still achieve the aim of patient experience if ultimately the patient ends up receiving (and paying for) the same test three times due to a lack of coordination among the patient’s various providers, for example? Recall the dilemma discussed earlier involving the patient who has a broken wrist.²⁴⁴ Suppose that the physician does in fact recommend splinting and casting the arm to see if it heals on its own, in lieu of surgery. Suppose also, however, that the patient is busy and does not want to have to be in a splint and then cast for the next eight weeks because the patient is planning on taking a trip to the beach in five weeks. Under the current MSSP and Pioneer ACO Program, the patient is permitted to seek care from another provider, who may decide to perform the surgery. If the plurality of the care is still provided by the original physician who recommended the splint and cast, the physician’s ACO will still be assessed the cost of the surgery and related expenses for purpose of its shared savings calculation, even though such costs were not incurred at the recommendation of the original physician.²⁴⁵ Thus, physicians within an ACO have greater difficulty in providing the kind of efficient and accountable care for which such physicians will be judged, on the basis that the ACO physicians cannot prevent the beneficiary from seeking care outside the ACO.²⁴⁶ To the extent that the patient is prohibited from going to the other physician without first discussing it with his first physician, might that force (even if initially uncomfortable) a conversation between the patient and physician where the patient talks about the trip to the beach and what the alternatives might be? It could be argued that the latter scenario will provide the patient with ultimately increased patient experience because the patient will feel involved and a part of the care process and decision, and ultimately (ideally) feel fulfilled about the medical decision that the patient and physician arrived at collectively.

It seems that it is necessary to arrive at some sort of middle ground with respect to the role of the patient within the ACO structure that more meaningfully incorporates the involvement and accountability of the patient, without restricting care in a way that does not fulfill the Triple Aim.²⁴⁷ Interestingly, there has already been evidence of the resurgence of the

²⁴³ *Id.*

²⁴⁴ *See supra* Part IV.

²⁴⁵ 42 C.F.R. § 425.402.

²⁴⁶ *Id.*

²⁴⁷ *See Berwick, Making Good on ACOs’ Promise, supra* note 245.

narrow network as insurance products have rolled out onto the various exchanges across the country.²⁴⁸ Insurers, unsure about the potential costs of newly insured individuals whom the insurance companies are now unable to rate in advance,²⁴⁹ want to create networks that can be tightly held and controlled with incentives for the providers to provide cost effective and efficient care as well as disincentives for the patients to seek care outside the narrow network.²⁵⁰ While these narrow networks have not been viewed positively by all consumers,²⁵¹ there are many consumers on the exchanges who are electing narrow network options because of the lower premiums associated with these plans.²⁵² As Berwick himself has pointed out, many consumers abandoned managed care when restrictions that restricted quality care were hoisted upon them with little choice in the matter and little flexibility.²⁵³ To the extent that Medicare beneficiaries are offered both choice and incentives, similar to the choice that they can make today to participate in traditional Medicare or Medicare Advantage, would they be willing to participate in an ACO structure in which they committed to a particular set of providers for at least some period of time? Perhaps the problem with HMOs was not so much the restrictions, but a lack of ability to choose whether to agree to such restrictions at a lesser cost or based on certain incentives.

While it is outside the scope of this article to suggest a specific mechanism for implementing this choice, at a minimum, the ACO regulations need to incorporate provisions that commit Medicare beneficiaries to ACOs for some period of time so that the patients can be more actively engaged participants in their care. To the extent that CMS will make providers in an ACO responsible for cost containment and will pay based on outcome-driven data, CMS needs to provide assurances to these providers that the beneficiaries will work with the providers as participants in their own care.²⁵⁴ While quality metrics will encourage and incentivize

²⁴⁸ Noam Bauman et al., *Hospital Networks: Updated national View of Configurations on the Exchanges*, MCKINSEY & CO., (June 2014), available at http://healthcare.mckinsey.com/sites/default/files/McK%20Reform%20Center%20-%20Hospital%20networks%20national%20update%20%28June%202014%29_0.pdf.

²⁴⁹ Patient Protection and Affordable Care Act 42 U.S.C. § 18012 (2014).

²⁵⁰ *Id.*

²⁵¹ Sandhya Somashekhar & Ariana Eunjung Cha, *Insurers Restricting Choice of Doctors and Hospitals to Keep Costs Down*, WASH. POST (Nov. 10, 2013), http://www.washingtonpost.com/national/health-science/insurers-restricting-choice-of-doctors-and-hospitals-to-keep-costs-down/2013/11/20/98c84e20-4bb4-11e3-ac54-aa84301ced81_story.html.

²⁵² Sarah Kliff, *Obamacare's Narrow Networks Are Going To Make People Furious—But They Might Control Costs*, WASH. POST (Jan. 13, 2014), <http://www.washingtonpost.com/blogs/wonkblog/wp/2014/01/13/obamacares-narrow-networks-are-going-to-make-people-furious-but-they-might-control-costs/>.

²⁵³ See Mathews, *supra* note 53.

²⁵⁴ See Shared Accountability, *supra* note 134; see also Mathews, *supra* note 53 (noting comments from Jeff Goldsmith).

providers to encourage (and perhaps cajole) their patients to comply with medication regimens, stop smoking, eat better, etc., to be able to be successful as to outcomes with those patients and cost containment, the patient him or herself needs to be included in this process and work with providers towards those goals.

Although Berwick is cautious about imposing restrictions on beneficiaries, incorporating some level of patient involvement that commits the patient to certain providers into the ACO structure would push the ACO scheme towards the Triple Aim, because it will enable providers to work more closely with the patient on achieving better care outcomes. Additionally, so long as the patients feel as if they are choosing to participate in such coordination, it will also improve the patient experience of care necessary under the Triple Aim. Likewise, if such a structure is successful, it should make lowering the per capita cost of healthcare under the ACO structure more feasible.²⁵⁵

V. CONCLUSION

Over the last four years, many have claimed that, at its heart, the ACA is simply insurance reform.²⁵⁶ Behind the obvious insurance aspects of the law, however, the ACA is also attempting to reform the U.S. healthcare system to move towards providing better patient experience, delivering better healthcare for the entire population, and lowering the per patient cost of providing such care²⁵⁷; that is the Triple Aim.²⁵⁸ When this reform movement began (in fact, when the concept of the Triple Aim was first launched in 2006), the greatest attention and focus rested on integrated systems such as the Mayo Clinic that were already operating efficiently and effectively.²⁵⁹ In attempting to recreate or model those structures, the ACA and its enacting agency, the Department of Health and Human Services, created ACOs, which are attempting to fulfill this Triple Aim by creating necessary financial incentives and disincentives that are designed to help hospitals and physicians work together in a manner that will enable them to function more like the Mayo Clinic.²⁶⁰ What is clear, however, is that while the ACO structure is creating alignment for some providers, it remains elusive and inaccessible for the very providers and systems that it was trying to emulate.

²⁵⁵ See Berwick, *Making Good on ACOs' Promise*, *supra* note 241

²⁵⁶ See Sage, *supra* note 6.

²⁵⁷ By way of example, the CMS Innovation Center, created under § 1115A of the ACA (codified at 42 U.S.C. § 1315a), has a stated goal of providing better care for patients, better health for our communities, and lower costs.

²⁵⁸ See Berwick, *supra* note 7, at 760.

²⁵⁹ See OBAMA REMARKS, *supra* note 15.

²⁶⁰ As discussed above, the MSSP and Pioneer ACO program attempt to align physicians and hospitals financially by allowing them to share savings to the extent that they can work together to reduce amounts paid by CMS on Medicare beneficiaries. See *supra* Part I (discussing the MSSP and Pioneer program).

Such inaccessibility indicates that the ACO structure is not achieving the goals of the Triple Aim that it set out to accomplish given that it perpetuates and solidifies the current fractured delivery system.

Rather than a system that seems to be excluding leaders in care delivery such as the Mayo Clinic, Intermountain Health System, and Kaiser Permanente, the United States needs such systems to be leading the reform of the healthcare delivery system. Such leadership cannot exist only in the commercial sector, but needs to involve the use and participation of government programs such as Medicare. This is true because not only will doing so fulfill the balance necessary to achieve the Triple Aim, but also because government programs are the only programs that cross state borders. Unlike commercial insurance, which is most often limited to use by residents in the particular state of incorporation due to licensure laws, nearly every hospital in the country is a Medicare provider.²⁶¹ Various systems across the country are stating that they are practicing accountable care and/or entering into alternative reimbursement contracts such as shared savings with insurance companies, even if not part of the MSSP or Pioneer ACO Program.²⁶² With these sorts of trends, healthcare delivery reform movements will continue to be fractured and varied unless and until there is a system within the Medicare program that provides some consistency and is able to achieve that balance and better health management for an entire population as envisioned by Berwick and the IHI.²⁶³ For this reason, if the U.S. is to achieve the Triple Aim, focus must be paid to the ACO structure and to making that structure accessible to all.

In order to create an ACO structure that is accessible and available to all, the structure must be revised in a way that will assure that it can attract and include all health systems, including academic medical centers and integrated delivery systems like the Mayo Clinic. Such reforms may not come easily, but it is critical to keep the process of development of ACOs and the ACO structure dynamic. This includes: adoption of more comprehensive payment reform systems, development and enactment of national quality standards that are attainable and realistic for all to achieve and that help spread the related costs of the teaching and research that often accompany high quality and innovation, and inclusion of Medicare beneficiaries in their care that will hold such beneficiaries accountable for their care along with their providers. The Triple Aim is still an attainable goal, but in order to keep moving towards that goal, much more needs to be

²⁶¹ AM. HOSP. ASS'N, UNDERPAYMENT BY MEDICARE AND MEDICAID FACT SHEET (2015), available at file:///C:/Users/Jon/Downloads/medicaremedicaidunderpmt.PDF (“[A]s a condition for receiving federal tax exemption for providing healthcare to the community, not for profit hospitals are required to care for Medicare and Medicaid beneficiaries. Also, Medicare and Medicaid account for 58% of all care provided by hospitals. Consequently, very few hospitals can elect not to participate in Medicare and Medicaid.”).

²⁶² See Petersen, *supra* note 137, at 1.

²⁶³ See Berwick, *supra* note 7, at 768.

done with respect to the ACO structure that keeps the focus on the Triple Aim.