The New Frontier of Healthcare: Accountable Care Organizations and the Changing Interplay Among Quality, Cost, and Peer Review

You know it seems the more we talk about it, it only makes it worse to live without it.
—The Beach Boys¹

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INTRODUCTION

Patients in the United States healthcare system are drowning. Drowning in costs. Drowning in overutilization. Drowning in a vast sea of choice, options, and conflicting opinion. Drowning simply because they do

¹. THE BEACH BOYS, Wouldn’t It Be Nice, on PET SOUNDS (Capitol Records 1966).
not know where to swim for safety. Accountable Care Organizations ("ACOs"), however, may be the staff of Moses that reveals the yellow brick road to a better healthcare system.

For many decades America’s prowess in business, technology, education, and healthcare was the envy of the world. In recent times, however, there has been a decline in America’s ability to deliver valuable healthcare. Employment-sponsored health insurance has buffered the effect of rising healthcare costs for some time, and the phenomenon of moral hazard contributes to unnecessary utilization.

The government’s role as a healthcare payor also contributes to increased access and utilization. Exponential increases in obesity, diabetes and other diseases, technology that provides for new testing, surgical procedures, pharmaceutics, fraud, waste, and malpractice all contribute to the rampant rising costs of healthcare. Instead of seeing improved health outcomes mirror the escalating costs, the opposite has occurred. Americans are paying higher costs for less quality. Consumers should get more for their money, not less. In the bastion of American capitalism, this makes little sense.

The healthcare system and its mechanisms are extremely fragmented, whereby “[h]ospitals and physicians occupy separate organizational universes, although the latter profoundly affect the fiscal fate of the former – and increasingly compete with it.” A lack of information technology ("IT") infrastructure, varying payment systems and coverage arrangements, and a lack of coordinated care all contribute to the murky waters a patient must navigate while using the U.S. healthcare system.

By enacting the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act (hereafter collectively referred to as “PPACA”) in March of 2010, the government and private providers are making a hard push toward improved coordination of care, IT infrastructure via electronic medical records, and incentive programs for improved quality of care and cost reduction through ACOs.

5. Id. at 22–24.
One of the purposes of ACOs is to mesh quality with efficiency and efficacy. Specifically, the American Health Lawyers Association states that the core principle of ACOs is to be a “group of medical and institutional providers and suppliers that accepts responsibility for providing or arranging for [a] group of patients under payment arrangement that allows for net profit payments to participants for achieving reduced costs and improved or enhanced quality of care.”

To achieve this goal, the government established a financial reward system to pay ACOs who perform under a benchmark cost curve. This reward system is called the Medicare Shared Savings Program (“MSSP”).

One may ask, what is the consequence for physicians in an ACO who frequently do not meet benchmark quality and cost objectives or are egregiously outside the benchmark? The answer comes from the Health Care Quality Improvement Act (“HCQIA”), which was designed to protect health care entities from damages when a peer review board brings an adverse action against a physician for not acting in the “furtherance of quality health care.”

This Note argues that while the HCQIA allows for immunity from damages for adverse peer review actions based on health care quality issues, the MSSP and other private ACOs need a mechanism to terminate physicians who do not comply with the cost reduction requirements of an ACO. Accordingly, the HCQIA should be amended to allow immunity from damages to ACOs, providers, and peer review boards from adverse privilege actions against physicians based on economic factors.

Part I discusses the systems and laws regulating healthcare quality and the increasing prevalence of decisions based on economic criteria. Part II expounds on the MSSP and ACOs under PPACA. Part III provides a discussion about ACOs formed before and/or outside the incentive and postulates that ACOs would better serve their purpose if the HCQIA was amended to grant ACOs and other providers immunity from taking action against physicians for economic purposes.

I. BACKGROUND

Although they operate in a fragmented system, physicians and hospitals rely on one another. Hospitals need physicians to send patients
Physicians need access to hospitals to perform procedures and “to perform diagnostic tests on their patients.” It is a symbiotic relationship that must function together to provide care, but whose externalities are profound and often unbecoming.

There are several ways in which physicians and hospitals engage. Physicians can be employed by a hospital, have a contractual relationship with a hospital, or be a member of a hospital’s medical staff and obtain privileges. Physicians who are members of the medical staff and have been granted privileges by the hospital are generally in the private practice of medicine and wish to admit and/or treat their patients at a particular hospital. Despite not being hospital employees, the physicians who are in a medical staff relationship with the hospital have a significant impact on the quality of care attributed to the hospital as well as the financial strength of the hospital. Specifically, the Joint Commission, a private accrediting body for hospitals that derives some authority from the Centers for Medicare and Medicaid (“CMS”), requires that the hospital’s medical staff be accountable to the hospital’s governing body for quality of healthcare, ethical and professional practices, and requirements for clinical privileges. In order to account for and take action based on quality concerns, physicians on the medical staff form committees and evaluate each other’s work. With the thrust of evidence-based medicine and the desire to merge quality and cost as a measure of performance, and as hospitals and physicians integrate into larger care delivery systems, peer review actions may take different forms and include efficiency and cost as components to be evaluated.

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12. Id.
13. Id.
14. Id. at 125.
15. Id. at 126.
16. Id.
18. BARRY R. FURROW ET AL., HEALTH LAW 193 (2008) (“Under the Medicare Statute, Joint Commission accredited hospitals are “deemed” to have met requirements for Medicare certification.”).
A. Peer Review

The mechanism seeking to maintain physician quality and address medical errors within the hospital setting is commonly called peer review.21 The supposition that gives credence to peer review is that physicians are the best at assessing, examining, and judging one another’s work because of their training and experience.22 Peer review committees or boards operate within a hospital system and are subject to an array of requirements and regulations. As such, peer review boards grant privileges and “consider[] action[s] involving existing privileges any time problems are identified.”23 The manual for hospitals provided by the Joint Commission states that there must be “mechanisms, including a fair hearing and appeal process, for addressing adverse decisions for existing medical staff members and other individuals holding clinical privileges for renewal, revocations, or revision of clinical privileges.”24 Although these requirements are spelled out, physicians organized within the medical staff are the ones responsible for acting on such requirements. Therefore, these medical staff physicians are charged, in part, with the self-governing of the profession.25 “[C]redentialing through peer review is the primary means of regulating physicians.”26 Accordingly, peer review is the instrument by which a hospital medical staff can restrict or revoke physician privileges based on poor performance or other factors.27

B. Economic Credentialing

A component of peer review, “economic credentialing” refers to the use of economic factors in determining credentialing and privilege decisions made by hospitals. The inclusion of the word credentialing in the term is misleading. Credentialing is generally the process where, prior to being granted privileges at a hospital, the professional record of a physician is reviewed to determine that the record complies with the hospital’s

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22. Id. (citing Newton II, supra note 20, at 723).
23. Dallon, supra note 19, at 611.
25. Id. at 60; see also Judith E. Orie, Comment, Economic Credentialing: Bottom-Line Medical Care, 36 DUQ. L. REV. 437, 446 (1998) (“A special peer review committee within the hospital reviews a physician’s request for privileges.”).
27. Moore et al., supra note 21, at 1178.
quality and competence standards. 28 Yet, the phrase economic credentialing encapsulates not only credentialing procedures, but also adverse action against physician practice groups with a hospital, 29 the restriction of physicians to perform certain services at a hospital, 30 and peer review actions. 31 The American Medical Association defines economic credentialing as “the use of economic criteria unrelated to the quality of care or professional competence in determining a physician’s qualifications for initial or continuing hospital medical staff membership or privileges.” 32 Most physicians, however, find hospitals’ use of a bottom line approach to credentialing, privilege, and peer review actions repugnant. 33 In the cases discussed below, quality and cost are often conjoined in the decision making process of the hospital.

In recent years hospitals increasingly find themselves making medical staff decisions based on economic criteria. 34 There are three main reasons for this. First, an increase in technology allows hospitals to more accurately capture the performance metrics and statistics of physicians. 35 Second, an increase in physician-owned specialty hospitals that compete with traditional hospitals has led to increased competition. 36 Finally, the increase in managed care fuels hospitals’ venture to control costs. 37

C. The Progeny of Economic Credentialing: Case Examples

The following cases demonstrate the various ways hospitals deal with economic concerns as a factor in medical staff credentialing, privileges, and/or peer review issues.

29. See infra Part I.C.1.
30. See infra Part I.C.3.
33. See Cohen, supra note 28, at 710 (internal citations omitted).
34. Id. at 711 (citing John D. Blum, The Evolution of Physician Credentialing into Managed Care Selective Contracting, 22 AM. J.L. & MED. 173, 180 (1996); Dallon, supra note 19, at 622–23).
35. Id. at 713–14 (citing John D. Blum, Economic Credentialing: A New Twist in Hospital Appraisal Processes, 12 J. LEGAL MED. 427, 430–31 (1991); Donovan Riley, Economic Credentialing Survey of University Teaching Hospitals, 47 HEALTHCARE FIN. MGMT. 42, 44 (1993)).
36. Id. at 713.
37. Id. at 714 (citing Blum, supra note 35, at 429–30); see also Orie, supra note 25, at 441 (“[T]he evolution of managed care led directly to the proliferation of economic credentialing.”).
1. Baptist Health v. Murphy

In Baptist Health v. Murphy, the Arkansas Supreme Court affirmed a permanent injunction against a hospital from denying physicians clinical privileges because they had ownership interests in a competing hospital. The hospital titled this policy the “Economic Conflict of Interest Policy.” The policy did not allow privileges to newly applying physicians or the renewal of privileges for current physicians if the physician “directly or indirectly acquires or holds an ownership or investment interest in a competing hospital.” Two physicians with staff privileges at the hospital had an ownership interest in a nearby competing hospital. When the physician privileges were to be renewed, the two physicians were denied renewal due to the Economic Conflict of Interest Policy. Subsequently, the physicians brought an action against the hospital and were ultimately granted a permanent injunction, enjoining the hospital from refusing to grant continuing privileges for the physicians.


In Mateo-Woodburn, poor quality and inefficiency from a hospital anesthesiology group prompted the hospital to move from an open to a closed medical staff system. The hospital notified the medical staff that the hospital would enter into an exclusive contract with an anesthesia provider. If the current anesthesiologists on staff did not enter into the contract, they would not be allowed to perform anesthesia services in the hospital. The court found the decision of the hospital board to be reasonable and maintained, “An important public interest exists in preserving a hospital’s ability to make managerial and policy determinations and to retain control over the general management of the hospital’s business.”


The South Dakota Supreme Court held that a hospital’s decision to bar its medical staff from engaging in certain specialties was permissible because the hospital acted in accordance with its corporate bylaws, to perpetuate its economic existence and to serve the needs of the public.

38. Baptist Health v. Murphy, 266 S.W.3d 800, 800–01 (Ark. 2006).
39. Id. at 805.
40. Id.
41. Id.
42. Id.
43. Id. at 804.
45. Id. at 899.
46. Id.
47. Id. at 902.
community. In Mahan, a group of local surgeons built a surgery center that performed some of the same procedures available to patients at the nearby hospital. The hospital realized the economic consequences of the private surgery center when several months after the surgery center opened, the hospital could not recruit a new neurosurgeon. The recruited neurosurgeon refused the position after learning an established spine surgery center existed in the area, and the hospital lost a significant amount of revenue because a decreasing amount of patients were utilizing the hospital for surgery. As a consequence, the hospital “preclude[d] any new physicians from applying for privileges to use hospital facilities for [certain] procedures.” When the private surgery center acquired a new surgeon, that surgeon was denied privileges at the hospital. In a suit against the hospital, the physician alleged that the hospital did not comply with its medical bylaws.

The court looked to the hospital’s corporate bylaws that governed business decisions like maintaining hospital viability by restricting physician use of the hospital for the performance of certain procedures. As a consequence, the court found that the hospital’s action denying physician privileges for certain procedures was justified in the hospital’s effort to remain viable and provide services to the community.


In Friedman, the court concluded that a physician’s privileges were properly revoked when the physician over-utilized certain procedures, used tools beyond the scope of their intended purpose, and failed to provide the necessary documentation demonstrating the need for such procedures. Some of the events that led to the review of Dr. Friedman’s privileges included his use of a “bronchoscope on a dead patient, use of the bronchoscope to perform a gastroscopy . . . and the belief that he was

49. Id. at 153.
50. Id. at 152.
51. Id.
52. Id. at 153.
53. Id.
54. Id.
55. Id.
56. Id. at 158.
57. Id. at 156 (“The Board responded to the effect the OSS hospital would have on the economic viability of ASL’s hospital and the healthcare needs for the entire Aberdeen community. These actions were within the power of the Board. It surely has the power to attempt to insure ASL’s economic survival.”).
performing excessive bronchoscopies.”59 During the peer review process, the hospital expressed concern that, given the history of the physician under scrutiny, the possibility of medical malpractice claims loomed should the physician continue to practice in the same manner.60 The court agreed with the hospital, asserting, “[A] physician who refuses to follow medical procedures established to protect patients from unnecessary surgical procedures is disruptive of hospital efficiency.”61 Moreover, the court stated that because Friedman was practicing “without adherence to reasonable, flexible medical precautions and indications” he was reducing the “hospital’s competitive position.”62

This spread of cases illustrates the economic quandaries hospitals face in their relationships with medical staff. Closed staff issues, brought on by a physician with privileges who has ownership interests in a competing specialty hospital, should be less prevalent in the coming days because PPACA bans the formation of specialty hospitals.63 The situation in Friedman is of particular interest post-PPACA because it may foreshadow an increase in this type of action. The Friedman case has particularly egregious facts whereas future cases may be based specifically on performance in terms of cost and efficiency. Currently, health care entities that make adverse physician privileges or credentialing decisions are granted immunity from damages under the Health Care Quality Improvement Act. This immunity, however, is only granted if the action is “in the furtherance of quality health care” and does not mention a cost or efficiency component.64

D. Health Care Quality Improvement Act

Enacted in 1986, the Health Care Quality Improvement Act (“HCQIA”) provides limited immunity from damages to those who institute a peer review action and establishes a reporting requirement for such actions.65 Introduced by Representative Ron Wyden of Oregon66 after a jury returned a substantial award for a physician whose privileges were

59. Id. at 183.
60. Id. at 186.
61. Id. at 190.
62. Id.
65. Id. §§ 11111(a)(1), 11133(a)(1), (3).
revoked by a peer review action, 67 the HCQIA seeks to “promote effective peer review.” 68

In *Patrick v. Burget*, the case that helped to propel the enactment of the HCQIA, a physician who turned down an offer to become a partner in a clinic and opened up his own independent practice was stripped of privileges at the clinic. 69 During the peer review process, plaintiff physician alleged that the proceedings did not occur in good faith, 70 and there was substantial evidence to support that contention. 71 The jury found for the plaintiff and awarded over two million dollars. 72 The news of the substantial jury award in *Patrick* swept through the medical community and inhibited effective peer review. 73

One of the main purposes of the HCQIA is to improve the quality of medical care by allowing for “effective professional peer review.” 74 To combat the chilling effect of *Patrick*, Congress enacted the HCQIA, finding that “[t]here is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.” 75 Inherent in Congress’s findings was the idea that by decreasing the fears of money damages and litigation, physicians will be more willing to be honest and effective in peer review decisions. The HCQIA only provides immunity from damages in a peer review action if certain standards are followed. 76 Specifically,

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67. *See* *Patrick v. Burget*, 800 F.2d 1498 (9th Cir. 1986), *rev’d*, 486 U.S. 94 (1988) (the Ninth Circuit opinion contains more details than the Supreme Court opinion on the background facts and jury award). In *Patrick*, a physician was awarded millions in damages after defendant physicians executed a bad faith peer review action against him. *Id.* at 1504–05. The jury found defendants to be in violation of state tort and federal antitrust laws. *Id.* The Ninth Circuit reversed the judgment on the Sherman Act claims, holding that the peer-review team conduct was exempt from antitrust liability under the state action doctrine. *Id.* at 1501–02. But ultimately, the Supreme Court reversed the decision of the Ninth Circuit, concluding that no state actor actively supervised the hospital peer-review decisions, so the state action doctrine did not protect them from federal antitrust laws. 486 U.S. at 105.


69. 800 F.2d at 1504.

70. *Id.* (“[T]he peer review process had treated his cases differently from analogous cases of other doctors.”).

71. *Id.* at 1507.

72. *Id.* at 1504–05.

73. Bierig & Portman, *supra* note 66, at 977 (internal citation omitted).


75. *Id.* § 11101(5); see also Bierig & Portman, *supra* note 66, at 982 (“The possibility of litigation deters physicians and hospitals from reporting incompetent or impaired physicians to state medical boards and discourages physicians from participating in peer review groups.”).

76. 42 U.S.C. § 11111(a)(1).
(1) in the reasonable belief that the action was in the furtherance of quality health care,
(2) after a reasonable effort to obtain the facts of the matter,
(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts . . .”77

The HCQIA further delineates notice requirements and the requirements for conducting a hearing.78 A professional peer review action will be presumed to meet the standards allowing immunity under the HCQIA “unless the presumption is rebutted by a preponderance of the evidence.”79 In other words, by insulating those who participate in peer review actions, the HCQIA provides a fair way for peer review bodies to evaluate medical malpractice claims and other physician problems that detract from the quality of medical care by insulating those who participate in peer review actions from damages.80

In addition to granting immunity for peer review actions, the HCQIA requires all Boards of Medical Examiners and health care entities to report certain actions taken against a physician to the Secretary of Health and Human Services.81 The HCQIA defines a “health care entity” as hospitals, entities that “provide[] health care services and that follow[] a formal peer review process for the purpose of furthering quality health care” and professional societies of physicians “that follow[] a formal peer review process.”82 The HCQIA requires that these entities report not only the physician’s name but also “a description of the acts or omissions or other reasons” that caused said physician to be subject to the report.83

To house these reports, an online database called the National Practitioner Data Bank was established.84 As a result, the HCQIA and subsequent databasing has made information sharing regarding adverse peer review actions against physicians readily and easily accessible. For example, if a physician were to apply for clinical privileges in a hospital cardiology department, the hospital has the authority to query the National Practitioner Data Bank and see if any adverse actions against the applicant

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77. Id. § 11112(a)(1)–(4).
78. See id. § 11112(b).
79. Id. § 11112(a).
80. The Health Care Quality Improvement Act does not provide immunity from injunctive relief, only immunity from liability in damages. Id. § 11111(a)(1).
81. Id. §§ 11132(a)(1), 11133(a)(1).
82. Id. § 11151(4).
83. Id. §§ 11132(a)(2), 11133(a)(2).
were reported.\textsuperscript{85} Further, the HCQIA provides little recourse for incompetent physicians because it both protects the hospitals and peer review bodies from suits for damages and reports physician wrongdoing so other hospitals can protect their patients from the same follies.

II. \textsc{Reform: An Attempt At Increasing Quality While Decreasing Costs}

A. \textit{Accountable Care Organizations}

Patients do not navigate the health care industry in a vacuum. Patient care is fragmented and unaccounted for by the various players across the system. For example, a patient may see a primary care physician who sends the patient to a cardiologist for evaluation. Next, the patient has surgery performed by a cardio-thoracic surgeon and has follow-up appointments with a different cardiologist. There is no central organization, no system to keep track of the patient outcome, and no way to harness the costs as patients float from one island to another in their quest for quality care. It is the hope of Congress that ACOs may be the answer to some of these problems.

The latest healthcare legislation, the Patient Protection and Affordable Care Act,\textsuperscript{86} establishes a pilot cost reduction and quality improvement program called the Medicare Shared Savings Program (“MSSP”).\textsuperscript{87} The MSSP requires the creation of a new type of health care delivery system called Accountable Care Organizations through the Centers for Medicare and Medicaid ("CMS").\textsuperscript{88} However, this is not the first time ACOs have been discussed as a mechanism of health reform. Broadly speaking, ACOs are “provider-led organization[s] whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population.”\textsuperscript{89} As umbrella organizations, ACOs are generally “a related set of providers, including at least primary care physicians, specialists, and hospitals, that can be held accountable for the cost and quality of care.”\textsuperscript{90} These organizations seek to improve quality while streamlining the patient experience and connecting many formerly

\begin{itemize}
\item \textsuperscript{85} Id.
\item \textsuperscript{87} Id. § 3022 (amending the Social Security Act, adding a new section at 42 U.S.C. § 1899(a)(1)).
\item \textsuperscript{88} Id. (ACO’s are mentioned in section 1899(a)(1)(A) of this amendment).
\item \textsuperscript{89} Diane R. Rittenhouse et al., \textit{Primary Care and Accountable Care – Two Essential Elements of Delivery-System Reform}, 361 NEW ENG. J. MED. 2301, 2302 (2009).
\item \textsuperscript{90} Kelly Devers & Robert Berenson, \textit{Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?}, \textsc{Urban Institute,} 1 (Oct. 2009), available at http://www.urban.org/publications/411975.html.
\end{itemize}
separate providers. In turn, Congress, through the PPACA, established ACO pilot programs and encourages their creation outside a statutory requirement.

**B. The Medicare Shared Savings Program: Hoisting the First ACO Flag**

Lured by hope’s siren call for higher-quality and lower-cost healthcare, Congress intends to test the effectiveness of ACOs through the MSSP. In order to receive any of the shared savings under the MSSP, an ACO must meet certain “quality performance standards.” Under the PPACA, any of the following may be eligible “to participate in the Shared Savings Program:

1. ACO professionals in group practice arrangements.
2. Networks of individual practices of ACO professionals.
3. Partnerships or joint venture arrangements between hospitals and ACO professionals.
4. Hospitals employing ACO professionals.

Such ACOs must have a minimum of 5,000 Medicare Part A and B beneficiaries. The ACOs must also have a formal legal structure, and be “accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO.” Additionally, the ACO must define ways to advance and implement evidence-based medicine as well

91. See Bruce Merlin Fried et al., *Accountable Care Organizations: Navigating the Legal Landscape of Shared Savings and Coordinated Care*, 4 J. HEALTH & LIFE SCI. L. 88, 88 (2010) (“In short, ACOs are intended to coordinate patient care and improve treatment outcomes by joining together networks of providers accountable for achieving the goal of collaborative, efficient, cost-effective care.”).

92. See Pub. L. No. 111-148, § 3022 (as discussed in the addition of §1899(a)(1) to the Social Security Act). In an interview with HHS Secretary Kathleen Sebelius, she remarked that, We think that the kind of accountable care organization — we’d like to see a lot of different models of innovation and care delivery. We think a number of them should be provider driven, not even connected to hospitals, and look forward to an opportunity. I think if some of these initiatives get under way, some of the myths will be dispelled about what people are speculating they are or are not going to be. Joyce Frieden & Emily Walker, *Exclusive Interview: HHS Secretary Discusses Budget, Health Reform, MEDPAGE TODAY* (Feb. 17, 2011), http://www.medpagetoday.com/Washington-Watch/Washington-Watch/24909.


94. *Id.* § 425.100(b).

95. *Id.* § 425.102(a).

96. *Id.* § 425.110(a)(1).

97. *Id.* § 425.104.

98. *Id.* § 425.204(a).

99. “Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best
as report quality and cost measures. In effect, these pilot ACOs will provide sweeping oversight for a new breed of healthcare delivery systems.

C. How Will the MSSP ACOs Incentivize Providers to Save Money?

ACOs that meet the appropriate requirements may reap the reward of shared savings. The savings are achieved because “[f]or each performance year, CMS determines whether the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for Parts A and B services are below the applicable updated benchmark.”

The benchmark uses per capita Medicare Part A and Part B expenditures and is computed by determining “fee-for-service expenditures for beneficiaries that would have been assigned to the ACO in any of the 3 most recent years prior to the agreement period using the ACO participants’ TINs [Tax Identification Numbers] identified at the start of the agreement period.”

Savings, in this sense, means a payment to the ACO of a percentage of the difference between the benchmark and actual expenditures while the remaining percentage will be retained by CMS.

The commentary provided by the government in the final rules states that they, in their capacity as the Centers for Medicare & Medicaid Services (“CMS”),

do not believe [they] have the legal authority to dictate how shared savings are distributed, however, [they] believe it would be consistent with the purpose and intent of the statute to require the ACO to indicate as part of its application how it plans to use potential shared savings to meet the goals of the program.

In other words, an ACO may choose to make distributions of its shared savings in a method that it pleases. An ACO could make shared savings distributions to a hospital, to an independent practice association, or to individual physicians.
As stated in the government commentary above, CMS will not expound on how distributions should be made, but only that they are made in relation to the purpose of an ACO – to enhance quality health care.\textsuperscript{106} The table that follows provides a visual of where shared savings are captured after a benchmark is set.

\begin{center}
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\end{center}

The MSSP is, in effect, a pilot program to determine whether providers can really reduce costs at the same time as improving quality. The MSSP requires the use of evidence-based medicine as part of the establishment of ACOs.\textsuperscript{108} Inherent in the definition of evidence-based medicine is restriction on futile tests, procedures, and prescriptions.\textsuperscript{109} The goal is to achieve healthy patient outcomes with as little healthcare utilization as possible. This sounds easy, but physicians like autonomy.\textsuperscript{110}

\begin{footnotesize}
\textsuperscript{106} Id. In the CMS Pioneer ACO Model application materials available to potential ACOs, CMS states ACOs are a mechanism for its tri-fold policy aim: “better care for individuals, better health for populations, and reduced expenditures for Medicare, Medicaid, and Children’s Health Insurance Program beneficiaries.” \textit{Pioneer Accountable Care Organization (ACO) Model Request for Application}, CTR. FOR MEDICARE AND MEDICAID SERVS. 1 (Jan. 8 2011, 8:20 PM), http://innovations.cms.gov/Files/x/Pioneer-ACO-Model-Request-For-Applications-document.pdf.

\textsuperscript{107} This graph provides a simplified visual of where the shared savings occur in relation to the benchmark. It by no means seeks to show drastic escalation in costs. It was created based upon my interpretation of the regulations.

\textsuperscript{108} 42 C.F.R. § 425.112(a)(1)(ii).

\textsuperscript{109} See Sackett et al., supra note 99, at 71 (“Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.”).

\end{footnotesize}
Many physicians do not like being subject to a business model. As healthcare in the United States engaged in a metamorphosis from hometown primary care doctors to modern large institutions with specialists, chief financial officers, and government regulations, physicians retained their autonomy and encountered little accountability for health outcomes. Physicians perform the services of the moment, but generally do not have a stake in patient outcomes or navigating a patient through a fragmented system. The MSSP is a trial to see whether ACOs can improve patient outcomes while reducing costs. The MSSP will undoubtedly place physicians under the lidless eye of the government. The scope of ACOs under the MSSP are far reaching. As noted above, under the MSSP, an ACO must have a minimum of 5,000 Medicare beneficiaries. Such a population seeks to supply the provider and ACO with a useful base to measure quality and costs.

III. MOVING FORWARD: THE MSSP, PRIVATE ACOS, AND AMENDING THE HCQIA

There is a sentiment among providers and policy makers that the healthcare system, as it stands, is unsustainable. This sentiment supports a growing need to reform healthcare delivery and payment systems. A key purpose of healthcare reform is to increase the quality of care provided to patients in the healthcare system. Another important purpose is to decrease costs while maintaining high quality. Physicians and hospitals are being drawn together for both of these reasons. First, the government, as one of the biggest payors of healthcare, is reducing its rates for many reimbursable services. It is both probable and possible that private insurers will follow suit. In order for physicians to save on both administrative costs and burdens, it is sometimes easier for physicians to be employees of a hospital instead of running their own smaller concern. A PricewaterhouseCoopers (PwC) study confirms, “63% of all cardiologists PwC surveyed said they’re interested in hospital employment.”

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112. See Pub. L. No. 111-148, § 3022, 124 Stat. 396 (2010) (“At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to become eligible to participate in the ACO program.”).
114. See From Courtship to Marriage, supra note 113, at 4.
115. Id. at 10.
116. Id. at 14.
administrative burdens have shifted drastically over the past several decades. Where a physician used to function with a nurse and paper records, those have been supplanted by costly medical equipment, computers, and a plethora of new regulations. These administrative burdens make it more difficult and more costly for a small-time physician to run their own shop. As in any business, a solution to this problem is to spread the costs through a larger organization. Accordingly, it is expected that more physicians and physician practices will integrate with hospitals.

In the modern world of technological connectivity, information sharing, and the Internet, it seems like the most effective change to the healthcare system is to take it from a fragmented system and integrate the pieces into a working Swiss clock. Some of the parts will need structural re-engineering, some wrenches will be thrown in, but the first step is bringing all the pieces together. Accountable Care Organizations seek to perform this task. Aside from the MSSP incentive to create ACOs, private ACOs are already popping up across the United States.

In the State of Michigan, Wayne State University Physician Group and Medical Network One, “a 750-member physician organization and provider of comprehensive health management support programs,” have entered into a contract to form an Organized System of Care (OSC) and ultimately a joint Accountable Care Organization. Meanwhile in Wisconsin, an ACO called ProHealth Solutions was formed, connecting the ProHealth Care hospital system and a local independent physician organization to service the needs of the community. In Virginia, AETNA and the Carilion Clinic recently announced their plan to create an ACO. Whether an ACO is part of a federal pilot program or is created

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117. Id.
118. Id.
119. Id. (“Nearly three-fourths (74%) of physicians surveyed said their professions will become more integrated with hospitals in the next five years.”).
123. AETNA and Carilion Clinic Announce Accountable Care Collaboration, CARILION CLINIC NEWSBLOG (March 10, 2011), http://newsblog.carilionclinic.org/2011/03/10/aetna-and-carilion-clinic-announce-accountable-care-collaboration/ (The Carilion Clinic is the largest provider in Southwest Virginia. The relationship between AETNA and Carilion, like the MSSP, offers shared costs savings if quality targets are met.).
by private providers, the overriding goals remain the same—reduce cost and heighten quality.

The goals of ACOs are vast. In essence, ACOs intend to be what their name suggests. They are accountable for patient care in a given population. The general tone is a “commit[ment] to enhancing healthcare quality by linking healthcare payment to quality and value.”124 Because ACOs seek to be “accountable for the entire continuum of care[,]”125 bringing physicians and hospitals together seems to be the most effective way to amass and correlate data. As a new form of an integrated delivery system, ACOs would “re[y] on a network of primary care physicians, one or more hospitals, and sub-specialists to provide care to a defined patient population.”126 By bringing all the players together into a larger institutional setting, it becomes easier to measure quality and cost.127 In turn, the hope is that ACOs “create a more coordinated approach to serving patient needs.”128 To adequately function, though, “ACOs must be comprised of selective, scalable, high-performing provider networks relying on evidence-based best practices, processes for continuous quality improvement, and clear action steps for addressing underperformance.”129

The use of peer review should be a viable option to root out physicians who do not comply with the quality and cost metrics required by an ACO. “ACOs will need to credential, discipline, and terminate physicians who do not meet quality and cost-effective care coordination standards.”130 The law currently provides immunity from damages to hospitals who meet the requirements of the HCQIA when hospitals terminate physicians based on quality issues. In keeping with the goals of ACOs and intentions of health reform in general, decreasing inefficiencies and reducing costs is tantamount. The law should make it easier to attain this goal.

124. Asyltene et al., supra note 101, at 1.
126. Asyltene et al., supra note 101, at 3.
127. From Courtship to Marriage, supra note 113, at 10 (“Physicians agree that they are major factors in efficiency improvements. Our survey revealed that 66% of physicians said hospitals are dependent on them to reduce costs and improve efficiency. To reduce costs, hospitals will have to work with doctors to successfully implement standard practice guidelines.”).
To adequately achieve desired cost savings and improved quality in the healthcare system, the HCQIA should be amended to grant immunity to ACOs, hospitals, and peer review bodies that terminate physician privileges for non-compliance with cost requirements delineated in their respective ACOs. Because the latest healthcare legislation is far from settled, it is time for Congress to implement strategic changes.

The adoption of two specific amendments to the HCQIA will grant immunity for hospital and peer review bodies when an adverse peer review takes action effecting a physician regarding quality and/or cost factors. Under the HCQIA, if a peer review action meets all the standards specified in section 11112(a), those involved in commencing and carrying out that decision shall not be liable in damages. The first standard of section 11112 is that a “review action must be taken in the reasonable belief that the action was in the furtherance of quality health care.” This section should be amended to read that the peer review action must be taken in the reasonable belief that the action was in the furtherance of quality health care including but not limited to quality, cost, and outcome measures as defined by an accountable care organization.

Amending the HCQIA definition of a health care entity is also important because the HCQIA requires that health care entities make reports of adverse peer review actions to the Board of Medical Examiners and the National Practitioner Data Bank. ACOs, like hospitals, should be required to report adverse peer review decisions via the National Practitioner Databank. Therefore, section 11151 (4)(A)(ii) should be amended to read:

[T]he term ‘health care entity’ means—an entity (including a health maintenance organization, accountable care organization, or group medical practice) that provides health care services and that follows a formal peer review process for the purpose of furthering quality health care (including but not limited to quality, cost, and outcome measures as defined by an accountable care organization).

These amendments grant providers and ACOs immunity from damages in an adverse peer review action. More importantly, these provisions allow for the “reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges” of a physician whose performance does not meet the quality and cost parameters as required by an ACO. In effect, implementing these changes or similar changes will provide ACOs and hospitals with a necessary tool to assist in navigating the new frontier of health reform and in achieving the overarching goals of health reform—to reduce healthcare costs and improve quality.

132. Id. § 11112(a)(1).
133. Id. § 11133(a)(1).
134. Id. § 11151(1).
Accountable Care Organizations are the lifeboats that the U.S. healthcare system, and their patients, await. Congress, however, must give strength to its latest healthcare overhaul and provide the lifeboat with oars, life preservers, and a compass. To do so means making sure the law mirrors policy intentions. In 1986, Congress took action by enacting the Health Care Quality Improvement Act giving health care entities immunity from damages in adverse peer review actions so long as the action was in the furtherance of quality health care. The challenges of today encompass not only quality but also unsustainable costs. Accountable Care Organizations and providers must have the tools to aptly control costs and promote quality. Expanding the Health Care Quality Improvement Act to extend immunity to peer review decisions based on ACO cost requirements gives the healthcare system true leverage in carrying out the policies of health reform.

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