

**RURAL ROADS TO ACOs:
INTER-COMMUNITY COLLABORATION IS KEY TO RURAL
ACCOUNTABLE CARE ORGANIZATIONS' SUCCESS UNDER
MEDICARE'S SHARED SAVINGS PROGRAM**

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I. INTRODUCTION

Only a few years ago, health professionals compared accountable care organizations to mythical unicorns: They all wanted to believe in them, but none of them had seen one.¹ Today, unicorns are real. In May 2012, hospitals in forty-five states conducted accountable care organization activities.² In December 2012, approximately 330 accountable care organizations (“ACOs”) operated in the United States.³ By February 2013, 428 ACOs were operating in forty-nine states and had more than doubled in number since 2011.⁴ While the ACO movement began and continues to grow in the private sector,⁵ the Centers for Medicare and Medicaid’s Shared Savings Program is expected to account for a large increase in ACO numbers in 2013.⁶ Health care’s unicorn has shown its face, and it plans to stick around for a while.⁷ So, why did we want to believe in unicorns in the first place?

¹ Ken Perez, *The Inexorable March Toward Accountable Care*, HEALTHCARE FIN. MGMT., Oct. 2012, at 42, 42.

² DAVID MUHLESTEIN ET AL., GROWTH AND DISPERSION OF ACCOUNTABLE CARE ORGANIZATIONS: JUNE 2012 UPDATE 7 (2012), available at <http://leavittpartners.com/wp-content/uploads/2012/06/Growth-and-Dispersion-of-ACOs-June-2012-Update.pdf> (listing Delaware, Idaho, Rhode Island, South Dakota, and West Virginia as the only five states that “do not have an ACO-affiliated hospital within their boundaries”).

³ Victoria Stagg Elliott, *ACOs, Already Surging, Poised for Even More Growth*, AM. MED. NEWS (Dec. 10, 2012), <http://www.ama-assn.org/amednews/2012/12/10/bisc1210.htm>.

⁴ *Accountable Care Organizations Have More Than Doubled Since 2011*, LEAVITT PARTNERS (Feb. 20, 2013), <http://leavittpartners.com/2013/02/accountable-care-organizations-have-more-than-doubled-since-2011/> [hereinafter LEAVITT PARTNERS].

⁵ See SHARON SILOW-CARROLL & JENNIFER N. EDWARDS, THE COMMONWEALTH FUND, EARLY ADOPTERS OF THE ACCOUNTABLE CARE MODEL: A FIELD REPORT ON IMPROVEMENTS IN HEALTH CARE DELIVERY 9 (2013), available at http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Mar/1673_SilowCarroll_early_adopters_ACO_model.pdf (noting that ACOs were “initially a private-sector innovation”); see also David Muhlestein, *Continued Growth of Public and Private Accountable Care Organizations*, HEALTH AFFAIRS BLOG (Feb. 19, 2013), <http://healthaffairs.org/blog/2013/02/19/continued-growth-of-public-and-private-accountable-care-organizations/> (comparing public-sector and private-sector ACOs).

⁶ See Muhlestein, *supra* note 5; Press Release, U.S. Dep’t of Health & Human Servs., More Doctors, Hospitals Partner to Coordinate Care for People with Medicare (Jan. 10, 2013), available at <http://www.hhs.gov/news/press/2013pres/01/20130110a.html>.

⁷ See Elliot, *supra* note 3 (“The folks who were hoping that the ACO would go away are not going to get what they want.” (internal quotations omitted)); see also Erin McCann, *More Health Professionals in PCMHs/ACOs*, HEALTHCARE FIN. NEWS (June 20, 2013), <http://www.healthcarefinancenews.com/news/more-health-professionals-pcmhsacos> (“More than half of physicians and other industry professionals are participating in nontraditional care delivery models such as accountable care organizations (ACOs) and patient centered medical homes (PCMHs).” Among those who aren’t participating yet, “approximately one-third anticipate their organization joining an ACO, PCMH or shared-savings plan in the next three years.”).

The state of American health care has something to do with it. The current payment structure in the American system has nurtured fragmented health care and driven health care costs to an unsustainably high level.⁸ This is not by choice, but by design. Fee-for-service, currently the dominant payment structure,⁹ reimburses health care providers based on the number and types of procedures performed.¹⁰ This structure often fosters performance of unnecessary and repetitive procedures because more procedures mean more money in reimbursements.¹¹ Because the current payment structure does not promote efficiency in health care delivery, it needs a change. The Centers for Medicare & Medicaid Services (“CMS”) has recently implemented a program to address this need: the Shared Savings Program.

CMS implemented the Shared Savings Program to promote accountable care organizations as a vehicle to drive needed changes in health care delivery. Instead of being reimbursed strictly based on the number of procedures performed, ACOs under the program are rewarded for maximizing health outcomes while minimizing expenditures—a value-based system.¹² ACOs reward providers for high quality care at low costs.¹³

From the start, ACOs through Medicare seemed out of reach for rural providers.¹⁴ In response, CMS attempted to encourage rural provider participation in the Shared Savings Program through several rural accommodations in its final rule.¹⁵ Most of the rural accommodations fell short primarily because they did not address the steep start-up costs of ACOs, but CMS appears to have hit its mark with the Advance Payment Model. This Note argues that if rural

⁸ See Doriann Cain, *Accountable Care Organizations: Providing Quality Healthcare in an Integrated System*, 20 ANNALS HEALTH L. ADVANCE DIRECTIVE 1, 9 (2010), available at <http://luc.edu/media/lucedu/law/centers/healthlaw/pdfs/advancedirective/pdfs/issue5/cain.pdf>.

⁹ *Id.*

¹⁰ *See id.*

¹¹ *Id.* at 9–10 (The fee-for-service payment structure “encourages the overutilization of services since a physician is reimbursed for each procedure performed.”).

¹² See A. Clinton MacKinney et al., *The March to Accountable Care Organizations—How Will Rural Fare?*, 27 J. RURAL HEALTH 131, 133–34 (2011), available at <http://www.health.state.mn.us/divs/orhpc/conf/2011/presentations/mackinney2.pdf> (describing an ACO as “a health care delivery system organized to improve health care quality and control costs through care coordination and provider collaboration, and then is held accountable for its performance”).

¹³ *See id.*

¹⁴ See Medicare Shared Savings Programs: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,814 (Nov. 2, 2011). For example, commenters “recommended that CMS should continue to work with providers and patients practicing in and living in rural underserved to . . . meet the unique healthcare delivery challenges facing rural underserved areas.” *Id.*

¹⁵ See generally *id.* Medicare’s final rule implemented Medicare’s Shared Savings Program, which “promotes accountability for a patient population, coordinates items and services under Medicare parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient services.” 42 C.F.R. § 425.10 (2013).

health care providers enroll in the Advance Payment Model to establish an ACO and utilize the Shared Savings Program's rural accommodations to their advantage in their operations, ACOs under these programs are a viable option for rural communities.

Part II of this Note examines the theoretical foundations of ACOs, their development from earlier constructs, and their potential to deliver the efficient and coordinated care our health care system currently lacks. This Part will also explain how accountable care organizations reward better results rather than more procedures and why this distinction is important to reigning in health care costs, despite ACOs' initial financial costs and demands on resources.

Next, Part II explores the health care policy evolution that led to the ACO concept, why it has been a topic of tension between policymakers' and physicians' interests,¹⁶ and how this tension may have partially accounted for Health Maintenance Organizations' ("HMOs'") lackluster advances in coordinated care and efficiency.¹⁷ Finally, this Part discusses vital differences between HMOs and ACOs that are likely to lead to ACO success where HMOs failed.¹⁸

Part III begins with an overview of the Patient Protection and Affordable Care Act ("PPACA") and Medicare's Shared Savings Plan ("MSSP"). Next, this Part will focus on MSSP provisions that specifically purport to help rural providers form ACOs under the program. Then, this Part addresses the Advance Payment Model, which was developed to further aid rural providers participate in the MSSP. Finally, this Part identifies the unique challenges rural health care faces in its transition to coordinated care under an ACO structure.

Part IV evaluates several of the MSSP final rule's rural accommodations and analyzes whether they are sufficient to enable rural participation in the program. This Part also assesses any additional impact the Advance Payment Model may have to help rural ACO participation. While Part IV analyzes the possibility of rural ACOs, Part V argues the importance of establishing them in rural communities and suggests potential actions that can be taken by rural communities and policymakers to support rural ACO development. Finally, Part V proposes a path for rural providers to follow in developing an ACO.

In sum, this Note argues that ACOs are a promising method to reduce costs and improve care for the entire American health care system. This is especially true for rural communities. By collaborating across communities, enrolling in the Advance Payment Model to establish an ACO, and implementing

¹⁶ MARSHA GOLD, ACCOUNTABLE CARE ORGANIZATIONS: WILL THEY DELIVER? 4 (2010), available at http://www.mathematica-mpr.com/publications/PDFs/health/account_care_orgs_brief.pdf.

¹⁷ *Id.* at 5–6.

¹⁸ *See id.* at 6 (noting that HMOs were "based more on managing costs than care," and "[p]roviders were not necessarily organized to manage such risk and pushed back").

the MSSP rural accommodations in its operations, rural communities can form ACOs under Medicare's Shared Savings Program.

II. ACCOUNTABLE CARE ORGANIZATIONS

This Part explores the theoretical underpinnings of accountable care organizations ("ACOs"). First, Section A explains why the ACO model has recently gained support among providers and policymakers. It also recognizes challenges to their widespread implementation. Section B traces the historical development of ACOs and their evolution from earlier constructs. But, before anything else, we must understand what ACOs are.

A. *Accountable Care Organizations: The Concept*

The accountable care organization ("ACO") delivery model was developed to achieve high-value, effective, and efficient health care through quality-based incentives.¹⁹ For this reason, the Affordable Care Act promotes ACOs as a way to address deficiencies in the current fee-for-service system.²⁰ ACOs are "voluntary groups of physicians, hospitals, and other health care providers that are willing to assume responsibility for the care of a clearly defined population of [patients] attributed to them on the basis of patients' use of primary care services."²¹ In this model, a health care provider is generally reimbursed based on the quality of health outcomes rather than the number of health procedures performed.²² An ACO's focus on coordinated care and value-based medicine discourages fragmented care and repetitive procedures common under a strict fee-for-service model.²³ This is because ACOs reward better outcomes, which necessitate better coordination among providers.²⁴

¹⁹ See David J. Ballard, *The Potential of Medicare Accountable Care Organizations to Transform the American Health Care Marketplace: Rhetoric and Reality*, 87 MAYO CLIN. PROC. 707, 707 (2012); see also Francis J. Crosson, *The Accountable Care Organization: Whatever Its Growing Pains, the Concept Is Too Vitally Important to Fail*, 30 HEALTH AFF. 1250, 1254 (2011) ("It is in our common interest to see that accountable care organizations succeed and that they deliver the long-awaited promise of a high-value, effective, and efficient health care system for our country.").

²⁰ Mark C. Shields et al., *A Model for Integrating Independent Physicians Into Accountable Care Organizations*, 30 HEALTH AFF. 1, 1 (2011).

²¹ Paul Barr, *Bumpy Road Ahead: Rural Hospitals Confront the Challenges of Establishing ACOs and Medical Homes with Limited Resources and Thinner Margins*, MODERNHEALTHCARE.COM (May 2, 2011, 12:01 AM), <http://www.modernhealthcare.com/article/20110502/MAGAZINE/110429983>.

²² Cain, *supra* note 8, at 2.

²³ Jane Sherwin, *Contemporary Topics in Health Care: Accountable Care Organizations*, PT IN MOTION, Feb. 2012 at 28, 28.

²⁴ See GOLD, *supra* note 16, at 2 (explaining that ACOs "provid[e] financial incentives for broad cost containment and quality performance across multiple sites of care").

1. From Quantity to Quality: A Step Away from Fee-for-Service

Fee-for-service is currently the dominant payment structure in American health care.²⁵ In a fee-for-service arrangement, providers are reimbursed a discrete monetary value for each procedure performed—more procedures mean more payments.²⁶ Because physicians and hospitals are reimbursed based upon the quantity of tests performed, they lack incentive to tightly control the number of procedures performed.²⁷ As a result, physicians often perform many, sometimes unnecessary, procedures.²⁸ In order to reign in fee-for-service's tendency toward excess, ACOs have been proposed to focus payments on the quality of results rather than the quantity of procedures.

In contrast to the strict fee-for-service payment model, ACOs base physician reimbursement on the quality of health outcomes.²⁹ Payment structures vary among ACOs, but a common thread remains: ACOs place a greater emphasis on quality of outcomes than quantity of procedures.³⁰ In ACOs under the MSSP, providers continue to bill according to fee-for-service calculations.³¹ However, CMS provides additional payments, in the form of shared savings, when providers treat patients more efficiently by maintaining or improving health outcomes while reducing the number of procedures performed.

2. ACOs Present Challenges

While potentially cost-effective and efficient, the ACO model presents several challenges. Primarily, critics have focused on four general barriers: “complexities and costs of reporting requirements; internal coordination; and

²⁵ Stephen M. Shortell, *Key to Health Care Reform: Changing How Care is Delivered*, 25 NOTRE DAME J.L. ETHICS & PUB. POL'Y 399, 401 (2011).

²⁶ *Id.* (“Simply put, physicians make more money for more services, tests, visits, treatments, and drugs prescribed.”).

²⁷ *Id.*

²⁸ *Id.*

²⁹ Under the MSSP, providers will continue to be reimbursed on a fee-for-service basis; providers will only share in monetary savings if the total in fee-for-service billings “demonstrates that [the provider] has achieved savings against a benchmark of expected average per capita Medicare FFS expenditures.” Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,904 (Nov. 2, 2011).

³⁰ See Paul R. DeMuro, *Accountable Care*, 24 HEALTH LAWYER 1, 8–12 (2012). Forms of reimbursement in an ACO include episode-based performance measurement and payment, payment for quality, payment for improved efficiency, and payment for chronic disease state management. *Id.*

³¹ Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,802 (explaining that “providers of services and suppliers can continue to receive traditional Medicare fee-for-service (FFS) payments . . . and be eligible for additional payments if they meet specified quality and savings requirements”).

the external impact ACOs may have on the healthcare market and whether ACOs can actually deliver on the promise of a reformed system.”³² Others have suggested that today’s emphasis on ACOs is yet another American fad in its search for the “Holy Grail” of health care policy and delivery.³³ Practically, start-up costs present one of the most daunting challenges. It is the first one any ACO faces, and this Note primarily addresses this obstacle.

Costs present the most substantial barrier to widespread ACO implementation. The American Hospital Association has estimated that start-up costs can range from five to twelve million dollars.³⁴ These initial costs often present rural providers with an insurmountable hurdle to implementation, which prevents them from realizing cost efficiencies and quality care associated with ACOs.³⁵ In some cases, however, rural providers have already taken a step toward integrated care that can ease their transition into a full ACO.³⁶ For example, many rural providers have adopted integrated care through patient-centered medical homes.

3. Patient-Centered Medical Homes

Patient-centered medical homes (“PCMHs”) share many qualities with ACOs and may serve as their foundation.³⁷ In PCMHs, “each patient in the practice is assigned to a team of health care professionals who are responsible for that patient’s ongoing care.”³⁸ PCMHs provide comprehensive care to a person across the entire spectrum of health care, from primary to specialty care, and throughout all stages of life.³⁹ This sounds familiar. Like ACOs, PCMHs

³² For an in-depth discussion of these criticisms, see Wasif Ali Khan, *Accountable Care Organizations: A Response to Critical Voices*, 14 DEPAUL J. HEALTH CARE L. 309, 324 (2012).

³³ Theodore Marmor & Jonathan Oberlander, *From HMOs to ACOs: The Quest for the Holy Grail in U.S. Health Policy*, 27 J. GEN. INTERNAL MED. 1215, 1215–16 (2012) (“Fads in American health policy come and go so quickly that there is too little reflection about their origins, effects, and whether any are actually effective approaches to controlling health care spending. Why do American analysts keep searching for the Holy Grail in health policy and what impact has that quest had on our medical care?”).

³⁴ AM. HOSP. ASS’N, THE WORK AHEAD: ACTIVITIES AND COSTS TO DEVELOP AN ACCOUNTABLE CARE ORGANIZATION 13–16 (Apr. 2011), available at <http://www.aha.org/content/11/aco-white-paper-cost-dev-aco.pdf>.

³⁵ *Id.*; see also Khan, *supra* note 32, at 324–25; DeMuro, *supra* note 30, at 11 (discussing how rural providers will likely need to “collaborat[e] with larger, urban and suburban health systems” in order implement successful ACO programs).

³⁶ DeMuro, *supra* note 30, at 3.

³⁷ Shortell, *supra* note 25, at 407.

³⁸ Gwendolyn Roberts Majette, *From Concierge Medicine to Patient-Centered Medical Homes: International Lessons & the Search for a Better Way to Deliver Primary Health Care in the U.S.*, 35 AM. J.L. & MED. 585, 593 (2009).

³⁹ *Id.*

focus on coordinated care and evidence-based medicine.⁴⁰ Unlike ACOs, however, PCMHs primarily operate on a smaller scale—usually including only one primary care facility and a network of specialists.⁴¹ Because of the similarities between the models, PCMHs can serve as a head start toward establishing an ACO.⁴²

For example, consider Community Care of North Carolina, a medical home-centric ACO. While it began as a group of patient-centered medical homes dispersed over several regions in North Carolina, it has since become a state-wide collaborative effort among PCMHs to provide integrated, collaborative care.⁴³ The program's website describes its program as follows:

So through our public-private partnership, we have brought together regional networks of physicians, nurses, pharmacists, hospitals, health departments, social service agencies and other community organizations. These professionals work together to provide cooperative, coordinated care through the Medical Home model. This approach matches each patient with a primary care physician who leads a health care team that addresses the patient's health needs.⁴⁴

As demonstrated in this case, a group of PCMHs can join to form a larger entity premised on providing accountable care: an ACO.

This Section of the Note shows that ACOs can provide better-coordinated and more efficient care by rewarding positive health outcomes, factors lacking in the current system. In theory, the ACO model has wide appeal to health care providers; however, practical barriers to its implementation have prevented many providers, especially rural, from adopting it. In an attempt to overcome these practical barriers, CMS implemented its final rule for Accountable Care Organizations and Shared Savings Program as part of the PPACA.⁴⁵ But in order to understand why integrated health care is important to

⁴⁰ *Id.*

⁴¹ See Jane N. Bolin et al., *Patient-Centered Medical Homes: Will Health Care Reform Provide New Options for Rural Communities and Providers?*, 34 *FAM. & COMMUNITY HEALTH* 93, 94 (2011) (“The key components of a PCMH include care that is led by a primary care provider, with processes in place that make care better coordinated . . . and linked to community services.”).

⁴² See DeMuro, *supra* note 30, at 3.

⁴³ Community Care of North Carolina, *The Community Care Story: Why a Community-Based System Really Works*, COMMUNITYCARENC.ORG (2013), <https://www.communitycarenc.org/about-us/>.

⁴⁴ *Id.*

⁴⁵ Edward Correia, *Afterword: The Final ACO Rule*, 28 *J. CONTEMP. HEALTH L. & POL'Y* 260, 262 (2012) (describing that the final rule eliminated or modified many provisions in the original rule to enhance attractiveness of the ACO program).

the future of health care delivery, we must understand its history and persistence in health care policy. The next Section traces this history.

B. From HMOs to ACOs: A Historical Perspective

The benefits of integrated medical care have been recognized almost as long as the medical profession has existed.⁴⁶ Physician opposition to integration has existed equally as long.⁴⁷ For example, the “Report of the Committee on the Costs of Medical Care,” issued in 1932, recommended the “group practice of medicine, preferably around a hospital” and “enhanced coordination between medical and community services” in health care delivery.⁴⁸ However, physicians interpreted these recommendations as a threat to their professional autonomy and “individual entrepreneurship.”⁴⁹ The tension between physicians’ professional autonomy and policies for integration persists today, and it may play a factor in today’s continued fragmentation.⁵⁰ As discussed *infra*, this tension may be reduced in ACOs.

Health maintenance organizations (“HMOs”) are the most recognizable ACO precursors.⁵¹ An HMO is a health insurance model in which “an organization . . . provides comprehensive health care to voluntarily enrolled individuals and families in a particular geographic area . . . that is financed by fixed periodic payments determined in advance.”⁵² In effect, HMOs pay a physician a negotiated price per patient for a specified period of time.⁵³ For example, a physician would be paid a set fee each month to treat a patient, regardless of the number of procedures or office visits. HMOs focus on the modification of reimbursement only.⁵⁴ ACOs, on the other hand, address modification of both delivery structure and reimbursement.⁵⁵ Despite this important distinction, some have suggested that ACOs are but a reincarnation of the HMO: They are doomed to repeat the HMO’s failed attempts at health care reform in the

⁴⁶ GOLD, *supra* note 16, at 4 (observing that “[t]he tension over whether medical practice should be controlled by an autonomous set of individual practitioners or assume a more organized structure dates back to the early development of the medical profession” and has undermined health care delivery reform).

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *See id.*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² HMO, MERRIAM-WEBSTER ONLINE, <http://www.merriam-webster.com/dictionary/hmo> (last visited Sept. 8, 2013).

⁵³ *See* GOLD, *supra* note 16, at 7 (noting that this method was primarily reserved for primary care physicians, while specialists were usually paid on a fee-for-service basis).

⁵⁴ *See id.* at 5.

⁵⁵ *Id.*

1990s.⁵⁶ Understanding the rise of HMOs illustrates why ACOs are not simply repackaged HMOs.

The federal HMO Act was passed in 1973 as “a market-based response to concerns over cost containment in health care.”⁵⁷ Capitation, paying a physician a negotiated amount per patient per month, introduced a dramatic change to physician reimbursement.⁵⁸ Physicians opposed this change.⁵⁹ Congress responded to the backlash by allowing less restrictive ways for physicians to participate in HMOs, such as individual practice associations (“IPAs”).⁶⁰ Under an IPA structure, physicians could elect to reduce the proportion of patients paid under the capitation method in favor of the “status quo”—fee-for-service payments.⁶¹ This compromise increased physician participation in HMOs in the 1990s, but diluted HMOs’ impact on health care integration and management by allowing physicians to continue receiving fee-for-service payments for a significant portion of their patients.⁶²

The effectiveness of HMOs was further blunted because health care providers may not have been prepared for the rise of HMOs. Many did not have the sometimes-sophisticated infrastructure required to support integrated care among several physicians and locations.⁶³ The HMO was premised on the concept that if insurance companies were to reimburse based on the number of patients treated rather than procedures performed, providers would respond by organizing and delivering care more efficiently.⁶⁴ However, many providers entered into HMO arrangements without the proper infrastructure to foster integrated care or properly manage the risk imposed by such plans.⁶⁵ Without integration, an HMO is a sinking ship before leaving the dock.

⁵⁶ See Mark V. Pauly, *Patient Protection and Affordable Care Act Cost-Containment Choices: The Case for Incentive-Based Approaches*, 36 J. HEALTH POL. POL’Y & L. 591, 594 (2011) (noting that ACOs “appear[] similar to the integrated delivery systems that flourished briefly but then largely collapsed after the period of high HMO growth in the mid-1990s”); see also Joseph Burns, *Herzlinger Predicts ACOs, PCMHs Will Fail*, 21 MANAGED CARE 29, 29 (Apr. 2012), available at http://www.managedcaremag.com/archives/1204/1204.healthplan2020_herzlinger.html (“ACO’s will implode just as capitated HMOs imploded in the 1990s.”).

⁵⁷ GOLD, *supra* note 16, at 4–5.

⁵⁸ *Id.* at 5.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ *Id.* (“Experience with the HMO Act and other policy initiatives, as well as various theories of human and organizational behavior, illustrate the preference providers, like people in general, have for the status quo. Providers will push policies to be less restrictive.”).

⁶² *Id.* at 11 (“As history shows, fewer requirements enhance participation but could also undercut the potential for performance improvements.”).

⁶³ *Id.* at 6 (remarking that physicians “were not necessarily organized” to take on the risk imposed by HMOs).

⁶⁴ *Id.* at 5.

⁶⁵ *Id.* at 6.

Understandably, health care providers did not wish to be forced into a situation for which they did not have time to prepare.⁶⁶ As a result, instead of focusing on integrating care, hospital-physician alliances concentrated their efforts on increasing their bargaining power with insurance companies to defeat capitated payments.⁶⁷ This resistance diverted attention from delivery reforms expected from HMOs.⁶⁸

Recently, things have changed. Physicians are now widely recognized as some of the greatest ACO advocates.⁶⁹ Between 2012 and 2013, the number of physicians participating in ACOs rose dramatically,⁷⁰ and the trend is expected to continue.⁷¹ While some claim ACOs carry stronger appeal to physicians than HMOs due to their greater allowance for physician leadership,⁷² others claim physicians are simply being pressured into ACOs because “if they don’t get into them, they may get shut out of a potential patient pool.”⁷³ Regardless of motivation, physician participation is centrally important to ACO success because each will be “a quarterback of sorts” in managing the medical

⁶⁶ *Id.*

⁶⁷ *See id.* (discussing that the focus on bargaining power had the effect that “the growth of managed care was based more on managing costs than care, with savings based substantially on price discounting”).

⁶⁸ *Id.* (noting that “many provider entities organized defensively to gain negotiating strength with managed care and showed little evidence of clinical integration that might lead to improvements in care delivery”).

⁶⁹ LEAVITT PARTNERS, *supra* note 4; *see also* Charles Fiegl, *Medicare Pioneer ACOs Save Money But Lose Physicians*, AM. MED. NEWS (July 29, 2013), <http://www.amednews.com/article/20130729/government/130729933/1/> (“The American Medical Association supported ACO programs that have allowed physicians practicing in groups of various sizes to participate in new care models.”).

⁷⁰ *See* LEAVITT PARTNERS, *supra* note 4 (claiming that accountable care organizations have more than doubled since 2011); *see also* Bruce Japsen, *Doctors Rush to Obamacare’s Accountable Care Approach*, FORBES (Apr. 27, 2013), <http://www.forbes.com/sites/brucejapsen/2013/04/27/doctors-rush-to-obamacares-accountable-care-approach/> (reporting that physician participation in ACOs has tripled since 2012).

⁷¹ *See* LEAVITT PARTNERS, *supra* note 4 (“[I]f ACOs meet their quality and cost benchmarks, the ACO model may become the dominant form of health care in the United States over the next decade.”) (internal quotation marks omitted).

⁷² *See* J. Ortiz et al., *Accountable Care Organizations: Benefits and Barriers as Perceived by Rural Health Clinic Management*, RURAL AND REMOTE HEALTH 3 (June 28, 2013), http://www.rrh.org.au/publishedarticles/article_print_2417.pdf (“Whereas the managed care model was dominated by insurance companies, the ACO model allows its physicians to decide how to best care for their patients.”).

⁷³ *See* Japsen, *supra* note 70.

care of patient populations.⁷⁴ Especially in rural areas, allowing physicians to maintain their leadership role is likely to ease transition into an ACO model.⁷⁵

ACOs differ from HMOs. ACOs are structured around efficient health care delivery while HMOs expect it as a result of capitated payments.⁷⁶ Placing an emphasis on restructured care encourages providers to make the necessary infrastructural changes before assuming an ACO model. As an example, CMS's Shared Savings Program requires providers to take specific steps toward restructured care before participating in the program. The next Part of this Note addresses many of the program's specific requirements.

III. THE ACA AND MEDICARE'S SHARED SAVINGS PROGRAM

Section A of this Part introduces Medicare's Shared Savings Program ("MSSP"), which was implemented as part of the Affordable Care Act. This Section also discusses the requirements to participate in the MSSP and emphasizes its role in the widespread implementation of ACOs as a way to control health care costs and reform its delivery. Section B discusses why rural health care is unique. Then, it describes factors that may frustrate rural efforts to participate in the MSSP. Finally, Section B explains why ACOs can be especially beneficial to rural health care. Section C highlights changes that CMS made in the MSSP final rule to promote rural participation. This Section also introduces the Advance Payment Model, which is designed to help small and rural providers overcome a burden that the MSSP does not otherwise address—start-up costs.

A. *Accountable Care Organizations and the ACA*

In March of 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 were enacted, which are collectively known as the Affordable Care Act ("ACA").⁷⁷ The ACA includes provisions to "support innovation and the establishment of new payment

⁷⁴ See *id.*

⁷⁵ See J. Ortiz et al., *supra* note 72, at 3 (emphasizing the importance of physicians in rural ACOs because "physicians make up approximately half of the professional staff" in these areas).

⁷⁶ Christine Vestal, *Accountable Care Explained: An Experiment in State Health Policy*, KAISER HEALTH NEWS (Oct. 18, 2012), <http://www.kaiserhealthnews.org/stories/2012/october/18/aco-accountable-care-organization-states-medicare.aspx> (Clarifying the difference between HMOs and ACOs: "[W]hen HMOs first appeared on the scene in the 1970s, quality control mechanisms to monitor the ongoing health of patients had not been widely developed. Under ACOs, treatment quality and success rate measurement are at the center of the effort.").

⁷⁷ Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,803 (Nov. 2, 2011).

models” in the form of value-based purchasing programs.⁷⁸ CMS’s Shared Savings Program was designed to implement these provisions.

Effective January 3, 2012, Medicare’s Shared Savings Program (“MSSP”)⁷⁹ established “a shared savings program . . . that promotes accountability for a patient population and coordinates items and services . . . and [that] encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.”⁸⁰ The program has three primary goals: (1) better care for individuals, (2) better health for populations, and (3) lower growth in expenditures.⁸¹

Participants become eligible to receive benefits, in the form of monetary payments, by forming ACOs that meet quality performance standards set forth in the program.⁸² If providers reduce the overall cost to treat their Medicare beneficiaries, the providers will share these savings with CMS.⁸³ Shared savings payments are calculated based on the difference between historical benchmark⁸⁴ expenditures and the cost to treat patients under the ACO model.⁸⁵

The historical benchmark reflects the amount of money that an ACO’s participants spent to treat each patient before forming an ACO.⁸⁶ This serves as a baseline. Then, the baseline is compared to what an ACO spends per patient under the MSSP.⁸⁷ The difference between the baseline and current spending reflects the shared savings under the MSSP.⁸⁸ If a provider achieves similar health outcomes by spending less money per patient under the ACO model than

⁷⁸ *Id.*

⁷⁹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Title III, § 3022, Title X, § 1037, 124 Stat. 395, 940 (to be codified at 42 U.S.C. § 1395jjj).

⁸⁰ *Id.*

⁸¹ Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,802.

⁸² Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Title III, § 3022, Title X, § 1037, 124 Stat. 395, 940 (to be codified at 42 U.S.C. § 1395jjj).

⁸³ Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,802.

⁸⁴ 42 C.F.R. § 425.602 (2013) (calculating the historical benchmark as “adjusted for historical growth and beneficiary characteristics, including health status” determined by “the per capita Parts A and B 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.”).

⁸⁵ *Id.* While more simplistic than the actual calculations, the following example illustrates this general concept: Before joining an ACO, a physician treats his patients for one year at an average cost of 5,000 dollars per patient per year. After joining an ACO, the same physician treats his patients for a lower cost of 4,000 dollars per patient per year. The difference in cost before and after joining an ACO, 1,000 dollars, is the shared savings.

⁸⁶ *See id.* The historical benchmark is based on the past three years’ expenditures. *Id.*

⁸⁷ *See id.*

⁸⁸ *See id.*

it did in the past, the provider shares these savings with CMS.⁸⁹ The historical benchmark is independently calculated for each ACO's patient population, which helps calculate a fair representation of savings for each ACO.⁹⁰ If the provider reduces its per-capita treatment costs below that of the benchmark by a margin greater than the minimum savings rate,⁹¹ CMS will share these savings with the providers.⁹² Therefore, providers are rewarded for providing equal—or better—quality care at lower costs. This change of focus discourages a multitude of medical procedures and instead creates an incentive to provide “the most cost-effective care based on current knowledge and best judgment.”⁹³

But here is the catch. Physicians are still reimbursed on a fee-for-service basis.⁹⁴ The shared savings are payments in addition to fee-for-service reimbursements and are designed to reward providers for treating patients with fewer and less costly procedures.⁹⁵ By rewarding lower per-capita costs, the MSSP indirectly rewards reductions in fee-for-service payments.⁹⁶ Further, providers only share in the savings if they meet the program's extensive list of quality standards.⁹⁷ In addition to these requirements, other formalities must be met before a provider can participate in the MSSP.

To receive payments, ACO participants must form a group of professionals that the MSSP recognizes as an ACO. Generally, the MSSP recognizes four combinations of health providers as ACOs: ACO professionals in group practice arrangements; networks of individual practices of ACO professionals; partnerships or joint venture arrangements between hospitals and ACO professionals; hospitals employing ACO professionals and other groups deemed appropriate by the Secretary of the Department of Health and Human Resources (“the Secretary”).⁹⁸ CMS's final rule explicitly adds to this list Federally Qualified Health Centers (“FQHCs”), Rural Health Clinics (“RHCs”), Critical Access Hospitals (“CAHs”), long-term care hospitals, Skilled Nursing Facilities,

⁸⁹ *See id.*

⁹⁰ *Id.*

⁹¹ *Id.*; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,910 (Nov. 2, 2011). The minimum savings rate is “the percentage that expenditures must be below the applicable benchmark ‘to account for normal variation in expenditures . . . based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.’” *Id.*

⁹² 42 C.F.R. § 425.604(c) (2013).

⁹³ Shortell, *supra* note 25, at 402.

⁹⁴ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Title III, § 3022, Title X, § 1037, 124 Stat. 395, 940 (to be codified at 42 U.S.C. § 1395jjj).

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.* The MSSP reserves a great deal of discretion for the Secretary to acknowledge other arrangements. *Id.*

and nursing homes.⁹⁹ These facilities were added in the final rule to widen the appeal of ACOs to smaller markets.¹⁰⁰ An ACO under the MSSP must meet more than organizational requirements, however.

ACOs must satisfy an extensive list of resource-intensive obligations to participate in and reap the benefits of the MSSP. ACOs must be a legal entity recognized by State, Federal, or Tribal law; enter into a three-year agreement with the Secretary; have a sufficient number of members to provide care to a minimum of 5,000 Medicare patients; form a leadership and management structure that includes clinical administrative systems; and formulate processes for reporting evaluations to determine the payment for shared savings, promote evidence-based medicine, and coordinate care.¹⁰¹

Quality and coordination of care are primarily measured by three variables. First, quality and coordination of care are measured by evaluating clinical processes and outcomes.¹⁰² Second, ACO professionals collect patients' ratings and experience of care through evaluation forms.¹⁰³ Third, ACO professionals determine utilization rates of services.¹⁰⁴

Electronic health records and other technologies are effective tools to measure quality of care and coordination variables.¹⁰⁵ While electronic health records are highly emphasized in the ACA and MSSP, they are no longer required in the final rule.¹⁰⁶ They play a key role in coordinated care by promoting effective communication among network providers and, as a result, avoiding redundancy of procedures.¹⁰⁷

In sum, The MSSP presents a demanding list of requirements for both urban and rural providers. Rural health care is especially burdened by the more resource-intensive requirements. The next Section of this Note explains why rural health care faces these unique burdens.

⁹⁹ 42 C.F.R. § 425.102 (2013).

¹⁰⁰ *Id.*

¹⁰¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Title III, § 3022, Title X, § 1037, 124 Stat. 395, 940 (to be codified at 42 U.S.C. § 1395jjj).

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ *Id.* (suggesting examples of rates, such as “rates of hospital admissions for ambulatory care sensitive conditions”).

¹⁰⁵ 42 C.F.R. § 425.506 (2013); see DeMuro, *supra* note 30, at 13.

¹⁰⁶ 42 C.F.R. § 425.506 (“ACOs, ACO participants, and ACO providers/suppliers are *encouraged* to develop a robust EHR infrastructure.” (emphasis added)); see DeMuro, *supra* note 30, at 13.

¹⁰⁷ Paul R. DeMuro, *Community Physicians Participating in Accountable Care Organizations Through Clinical Integration*, 22 HEALTH LAW. 13, 15 (2010) (“Without substantial implementation of technology and biomedical informatics, the requisite clinical integration necessary to implement healthcare reform will be difficult, if not impossible, to achieve.”).

B. Rural Health Care

Rural health care is different than urban health care. Rural populations are generally sicker, less likely to have private health insurance, and more likely to experience a shortage of health care providers.¹⁰⁸ While the second factor is certainly important in considering the viability of ACOs in rural communities, the greatest attention will be paid to the other two factors—rural community members are generally sicker and rural communities suffer from a shortage of health care providers.

A statistical representation of health care in rural communities underscores their unique challenges. For purposes of the MSSP, CMS defines the term “rural” as a county with fewer than 50,000 individuals.¹⁰⁹ Within these scarcely populated areas, rural communities have about half the number of primary care physicians as their urban counterparts, an overall older physician population, and a declining rate of physician recruitment due to lifestyle preferences of younger physicians.¹¹⁰ Only about 3% of recent medical students plan to practice in rural communities, while these communities represent approximately 20% of the U.S. population.¹¹¹ Rural hospitals are also generally smaller than urban hospitals and display a trend of shrinking, closing, or being perpetually understaffed.¹¹² Many hospitals in rural areas necessarily cut expenditures by downsizing, which precludes these facilities from investing capital to overhaul their care delivery model.¹¹³ Rural populations face these challenges amidst suffering poorer health than their urban counterparts.

Generally, rural patients suffer from a higher prevalence of chronic conditions than urban patients.¹¹⁴ Key to effectively managing chronic illnesses, such as diabetes, is “collaborative, cooperative efforts” among all health care providers.¹¹⁵ Because rural populations suffer from a high prevalence of chronic diseases, they have a special need for the coordinated care associated with the ACO model. Also, managing chronic conditions through preventative

¹⁰⁸ Sidney D. Watson, *Mending the Fabric of Small Town America: Health Reform & Rural Economies*, 113 W. VA. L. REV. 1, 5 (2010).

¹⁰⁹ MEDICARE PAYMENT ADVISORY COMM’N, MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM 125 (2012), available at www.medpac.gov/documents/Jun12_EntireReport.pdf.

¹¹⁰ Watson, *supra* note 108, at 8–9.

¹¹¹ *Id.* at 4, 9.

¹¹² *Id.*

¹¹³ See Asa B. Wilson et al., *Financial Performance Monitoring of the Technical Efficiency of Critical Access Hospitals: A Data Envelopment Analysis and Logistic Regression Modeling Approach*, 57 J. HEALTHCARE MGMT. 200, 201 (2012).

¹¹⁴ Kathryn E. Artnak et al., *Health Care Accessibility for Chronic Illness Management and End-Of-Life Care: A View from Rural America*, 39 J.L. MED. & ETHICS 140, 143 (2011) (noting that “nearly one in three adults living in rural America is in poor to fair health and nearly half of those have at least one chronic illness”).

¹¹⁵ *Id.* at 152.

and coordinated care can simultaneously maintain health and avoid costly medical procedures in the future.¹¹⁶ Coordinated care can even provide rural communities with benefits beyond cost savings.

But health care coordination is a challenge for rural communities. It is especially challenging because rural health care providers are geographically dispersed¹¹⁷:

Providers often practice independently, even within the same community or when caring for the same patient. Fragmentation tends to be even more pronounced in rural America where practices are smaller and care often requires distant providers. Although provider independence does not necessarily equate with poor care coordination, patients are mystified and frustrated when critical health information does not follow them from one provider to another.¹¹⁸

In addition to geographical dispersion, rural physician practices are also typically smaller than urban practices;¹¹⁹ many rural physicians are even solo practitioners.¹²⁰ As a result, rural providers “are likely to be particularly disadvantaged in a system [such as an ACO] that requires practice redesign, care coordination, and provider collaboration.”¹²¹ That the ACO model has been almost exclusively developed in urban—and not rural—health care systems is reflective of this disadvantage.¹²² However, ACO advocates recognize these challenges as an opportunity for rural providers to develop “partnerships with hospitals, arrangements with insurance plans, and . . . information systems funded by and distributed within local communities.”¹²³ While ACOs show

¹¹⁶ See Astrid G. Meghrijian, *Retaining Independence While Embracing Accountability: Care Coordination and Integration Strategies for Small Physician Practices*, in ACOS AND OTHER OPTIONS: A “HOW-TO” MANUAL FOR PHYSICIANS NAVIGATING A POST-HEALTH REFORM WORLD 1, 20 (AM. MED. ASS’N 4th ed. 2010–2013), available at <http://www.ama-assn.org/resources/doc/psa/physician-how-to-manual.pdf>.

¹¹⁷ A. CLINTON MACKINNEY ET AL., RURAL POLICY RESEARCH INST., PURSUING HIGH PERFORMANCE IN RURAL HEALTH CARE 17 (Jan. 2012), available at http://www.rupri.org/Forms/FuturesLab_Health_Jan2012.pdf (“The autonomous and independent ‘cottage industry’ historically typical of especially rural health care providers is not conducive to consistent and efficient health care.”).

¹¹⁸ *Id.* at 8.

¹¹⁹ MacKinney et al., *supra* note 12, at 133 (explaining that rural practices are smaller “due to lower population density and greater geographic isolation”).

¹²⁰ *Id.* at 134.

¹²¹ *Id.* at 133 (alteration in original).

¹²² *Id.* (citing case studies from the Commonwealth Fund Commission on a high-performance health system).

¹²³ Crosson, *supra* note 19, at 1252.

great potential to connect distant rural practice groups while improving the population's health,¹²⁴ rural communities have high hurdles to clear.¹²⁵

Despite rural health care's unique challenges, it must find the resources to supply start-up costs, implement innovative and integrated delivery structures, meet the 5,000 Medicare beneficiary threshold, and develop evaluation and reporting procedures that the MSSP requires. In its final rule, CMS altered several of the MSSP's requirements to address these challenges. The next Section discusses some of the changes.

C. *Federal Concessions for Rural ACOs*

After publication of the Medicare Shared Savings Plan proposed rule,¹²⁶ CMS received approximately 1,300 public comments from a variety of professionals.¹²⁷ Many comments revealed aspects of the proposed rule that were especially burdensome for rural providers.¹²⁸ In response, CMS modified many requirements in the final rule hoping to encourage rural participation in the MSSP.¹²⁹ This Section discusses some of the modifications.

1. The Medicare Beneficiary Minimum

The 5,000 Medicare beneficiary minimum stirred debate among commenters. While some recommended that the number be increased to as many as 20,000 beneficiaries, others suggested a lower threshold and emphasized that the existing 5,000 beneficiary threshold already placed a substantial burden on rural providers.¹³⁰ CMS finalized the 5,000 beneficiary threshold because it was important "with respect to both eligibility of the ACO to participate in the program and the statistical stability for purposes of calculating per capita expenditures and assessing quality performance."¹³¹ Allowing ACOs to participate with fewer than 5,000 members risked jeopardizing the success and practicality of

¹²⁴ See Senator Craig Thomas, *Understanding Rural Health Care Needs and Challenges: Why Access Matters to Rural Americans*, 43 HARV. J. ON LEGIS. 253, 260–61 (2006).

¹²⁵ See *id.*

¹²⁶ Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 19,528 (proposed Apr. 7, 2011).

¹²⁷ Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,804 (Nov. 2, 2011).

¹²⁸ See *id.*

¹²⁹ *Id.*

¹³⁰ *Id.* at 67,807–08 (emphasizing that some "commenters believed that the 5,000 beneficiary threshold will preclude smaller and rural entities from participating in the Shared Savings Program").

¹³¹ *Id.* at 67,807.

the program.¹³² Fewer beneficiaries could not only thwart efforts to accurately calculate savings but could also fail to provide the patient volume necessary to realize savings.¹³³ While the minimum beneficiary threshold remained unchanged from the proposed to the final rule, other important factors did not.

2. Federally Qualified Health Centers and Rural Health Clinics Explicitly Recognized

Under the proposed rule, neither a Federally Qualified Health Center (“FQHC”)¹³⁴ nor a Rural Health Clinic (“RHC”)¹³⁵ was explicitly authorized to form an independent ACO.¹³⁶ After public comment, CMS decided, “[I]t is highly desirable to allow for FQHCs and RHCs to participate independently and to determine a way to include their beneficiaries in assignment.”¹³⁷ In order to do this, CMS modified the proposed rule’s assignment process in its final rule to recognize a wider array of services and coding formats, specifically those formats frequently used by FQHCs and RHCs to measure primary care services.¹³⁸ By including these new coding formats, more FQHC and RHC health care services are recognized by the MSSP. Recognizing more services results in recognizing more Medicare beneficiaries, which helps FQHCs and RHCs meet the 5,000 Medicare beneficiary minimum.¹³⁹ The next rural accommodation, the rural exception to the antitrust “safety zone,” is also designed to aid rural ACOs reach the Medicare beneficiary minimum.

¹³² *Id.* at 67,808.

¹³³ *See id.*

¹³⁴ Federally Qualified Health Centers are “‘safety net’ providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless.” CTRS. FOR MEDICARE & MEDICAID SERVS., DEP’T OF HEALTH & HUMAN SERVS., FEDERALLY QUALIFIED HEALTH CENTER: RURAL HEALTH FACT SHEET SERIES 1 (Jan. 2013), *available at* <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf>.

¹³⁵ Rural Health Clinics address the “inadequate supply of physicians serving . . . patients in rural areas and . . . increase the utilization of non-physician practitioners such as nurse practitioners (NP) and physician assistants (PA) in rural areas.” CTRS. FOR MEDICARE & MEDICAID SERVS., DEP’T OF HEALTH AND HUMAN SERVS., RURAL HEALTH CLINIC: RURAL HEALTH FACT SHEET SERIES 1 (Jan. 2013), *available at* <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfactsht.pdf>.

¹³⁶ Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,812 (Nov. 2, 2011) (explaining that CAHs, FQHCs, and RHCs were specifically considered for inclusion as recognized facilities because “these entities play a critical role in the nation’s health care delivery system, serving as safety net providers of primary care and other health care and social services”).

¹³⁷ *See id.*

¹³⁸ 42 C.F.R. § 425.404 (2013).

¹³⁹ *See id.*

3. The Rural Exception to the Antitrust Safety Zone

The MSSP addresses heightened antitrust risks associated with rural ACOs. The Federal Trade Commission and Department of Justice issued a statement in conjunction with Medicare's Shared Savings Plan to manage these risks.¹⁴⁰ The statement introduced the concept of antitrust "safety zones."¹⁴¹ Safety zones are designed to address "ACOs that are highly unlikely to raise significant competitive concerns and, therefore, will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances."¹⁴² Justified from a policy standpoint, the threat of anticompetitive behavior in these zones is outweighed by the interest to promote the overall health of the population through integrated health care.¹⁴³

The safety zone's applicability begins when two or more providers in an ACO offer the same service.¹⁴⁴ If they do, then their combined services cannot exceed 30% of the total services of that kind offered in the Primary Service Area.¹⁴⁵ For example, suppose two podiatrists are in the same ACO. If those two podiatrists provide less than 30% of all podiatry services offered in the Primary Service Area, the ACO falls within the safety zone. Rural providers are given a bit more leeway.

Rurally-based ACOs can be excused from the 30% market share limit if they qualify for the rural exception.¹⁴⁶ An ACO fits the rural exception as long as there is only one "physician or physician group practice per specialty" in each county that contains at least one "isolated rural" or "other small rural" zip code, even if this results in a Primary Service Area market share greater than 30%.¹⁴⁷ For example, rural ACOs can have multiples of particular specialists in an ACO, regardless of market share, as long as there is only one per rural area. Additionally, these physicians must be non-exclusive to an ACO, meaning they must also provide care to patients who are not members of the ACO.¹⁴⁸

¹⁴⁰ Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (Oct. 28, 2011).

¹⁴¹ *Id.* at 67,028–29.

¹⁴² *Id.* at 67,028.

¹⁴³ See Shields et al., *supra* note 20, at 162 (allowing for negotiating between and among physicians because they are "improving quality, patient safety, patient experience, and efficiency, and therefore to be producing benefits to the public through financial or clinical integration").

¹⁴⁴ Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. at 67,028.

¹⁴⁵ *Id.* ("The PSA for each participant is defined as 'the lowest number of postal zip codes from which the [ACO participant] draws at least 75 percent of its [patients].'" (alterations in original)).

¹⁴⁶ *Id.* at 67,029.

¹⁴⁷ *Id.*

¹⁴⁸ *Id.* (noting that the physicians must be non-exclusive to the ACO).

Finally, the exception allows a rural ACO to include rural hospitals and health clinics regardless of their effect on market share.¹⁴⁹

As a result, rural providers are less restricted as to what services ACO professionals can provide and where they can provide them. So far in this discussion, the rural accommodations have been designed to help rural providers reach the beneficiary minimum. The next accommodation is designed to help rural providers adjust to MSSP's risk sharing structure.

4. The One-Sided Savings Approach

The MSSP's final rule adopted two shared savings payment methods, one of which allows new ACOs to avoid some risks of financial loss. Under Track One, the "one-sided savings approach," an ACO is not responsible for shared losses for the initial three-year agreement period.¹⁵⁰ The ACO only shares in savings. Under Track Two, the "two-sided savings approach," an ACO shares a greater percentage of the savings, but also shares the risk of loss.¹⁵¹ Commenters suggested that CMS increase the duration of the "one-sided savings approach" from two years to include the entire initial three-year agreement period.¹⁵² CMS complied. This extension aims to increase "broad participation" of those new to the accountable care model, particularly "small, rural, safety net, and physician-only ACOs."¹⁵³

But the "one-sided savings approach" is only meant to aid transition.¹⁵⁴ The two-sided approach allows for "more meaningful changes" to coordinated care, efficiency, and savings.¹⁵⁵ Therefore, while extended in the final rule, one-sided savings will not be offered beyond the first three-year agreement period.¹⁵⁶ In addition to allowing newer and smaller ACOs to minimize risk by sharing in savings only, CMS has made significant efforts to remedy the oppressive impact of start-up costs.

¹⁴⁹ *Id.*

¹⁵⁰ Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,904 (Nov. 2, 2011).

¹⁵¹ *Id.* at 67,904.

¹⁵² *Id.*

¹⁵³ *Id.* at 67,907 (claiming that "this modification will increase interest in the Shared Savings Program by providing a gentler 'on ramp'").

¹⁵⁴ *See id.*

¹⁵⁵ *See id.*

¹⁵⁶ *See id.*

5. A Response to Start-Up Costs: The Advance Payment Model

ACO start-up costs can range from five to twelve million dollars.¹⁵⁷ Public comments to the proposed rule indicated that primary care and rural providers needed financial assistance with these costs.¹⁵⁸ CMS acknowledged that “a real commitment to improving care processes for Medicare beneficiaries will require financial investment,” but the MSSP is only “designed to provide an incentive for ACOs demonstrating high quality and improved efficiencies.”¹⁵⁹ In short, the MSSP is designed to reward efficiency—not fund it. Regardless, CMS recommended an advance payment model to its Innovation Center.¹⁶⁰ In response, the Innovation Center developed the Advance Payment Model for ACOs.¹⁶¹

The Advance Payment Model was created as part of the MSSP to “help entities such as smaller practices and rural providers with less access to capital participate in the Shared Savings Program.”¹⁶² It is designed to test two effects.¹⁶³ First, it tests whether advance payments will increase participation in the MSSP.¹⁶⁴ Second, it tests whether advance payment will improve care, generate quicker savings, and increase Medicare savings.¹⁶⁵ In the Advance Payment Model, CMS immediately issues payments to help new ACOs finance their start-up costs.¹⁶⁶ Once an ACO begins to earn shared savings payments, that ACO uses the savings to repay CMS for its initial advance payments.¹⁶⁷ Although relinquishing shared savings to CMS is expected to be the primary method of repayment, each ACO will negotiate the repayment schedule by con-

¹⁵⁷ AM. HOSP. ASS’N, *supra* note 34.

¹⁵⁸ Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,834–35.

¹⁵⁹ *Id.* at 67,835.

¹⁶⁰ “The Innovation Center was created by the Affordable Care Act to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care.” CTRS. FOR MEDICARE & MEDICAID SERVS., DEP’T OF HEALTH AND HUMAN SERVS., ADVANCE PAYMENT ACCOUNTABLE CARE ORGANIZATION (ACO) MODEL 2 (Jan. 10, 2013), available at <http://innovation.cms.gov/Files/fact-sheet/Advanced-Payment-ACO-Model-Fact-Sheet.pdf>.

¹⁶¹ Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,835.

¹⁶² See CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 160.

¹⁶³ *Id.*

¹⁶⁴ *Id.*

¹⁶⁵ *Id.*

¹⁶⁶ *Id.* Participating ACOs receive three types of payments: an upfront, fixed payment; payment based on the number of its preliminary prospectively-assigned beneficiaries; and monthly payments based on the number of the beneficiaries. *Id.*

¹⁶⁷ *Id.*

tract with CMS.¹⁶⁸ The Advance Payment Model provides financial support to meet ACO costs, a primary concern for prospective rural ACOs. While the Advance Payment Model is a promising option, only eligible ACOs may participate.

An ACO must satisfy two primary requirements to participate in the Advance Payment Model. First, an ACO must be accepted to the MSSP.¹⁶⁹ Second, an ACO's participants must meet one of two categories.¹⁷⁰ The first category includes ACOs that do not include inpatient facilities *and* have less than fifty million dollars in total annual revenue.¹⁷¹ The second category includes ACOs in which the only inpatient facilities are critical access hospitals or rural hospitals *and* have less than eighty million dollars in total annual revenue.¹⁷² These criteria reflect the program's preference for rural providers.¹⁷³

This Section of the Note explained many ways in which CMS is attempting to accommodate rural communities' unique health care needs in order to ease their transition into the MSSP. It has recognized FQHCs and RHCs in the list of qualified entities to form an ACO, created a rural exception to anti-trust violations, allowed for a more forgiving "one-sided savings approach" to lessen the financial risk to newly formed ACOs, and developed the Advance Payment Model to subsidize a portion of rural or physician-led ACOs' start-up costs. But this Part also raised two questions: First, are these changes enough to actually increase rural participation in the MSSP? Second, if they are enough, how do rural communities take advantage of them to participate in the MSSP? The next Part of this Note analyzes these two questions.

IV. EVALUATING THE EFFICACY OF RURAL ACCOMMODATIONS

The previous Part of this Note addressed several rural accommodations CMS included in its MSSP final rule. This Part evaluates the likely impact these accommodations will have on rural communities' ability to form ACOs. Section A of this Part argues that the 5,000 Medicare beneficiary minimum is burdensome, but necessary. This Section also argues that the rural exception to the antitrust "safety zone" and CMS's recognition of larger rural health care fa-

¹⁶⁸ *Id.*

¹⁶⁹ See *supra* Part III.A; see also CTR. FOR MEDICARE & MEDICAID INNOVATION, DEP'T OF HEALTH AND HUMAN SERVS., ADVANCE PAYMENT SOLICITATION, available at <http://innovation.cms.gov/Files/x/Advance-Payment-Model-ACO-solicitation-doc.pdf> (last visited Oct. 19, 2013).

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ *Id.* ("The eligibility and selection criteria . . . are designed to target Advance Payments to those ACOs with the least access to capital, particularly those that are physician-based . . . and located in rural areas.").

ilities helps rural providers reach the 5,000 Medicare beneficiary minimum. Section B argues that the “one-sided savings approach” aids rural communities in the early stages of ACO operation, but it cannot be effective unless CMS adds provisions to the MSSP that will help rural providers with start-up costs. Section C argues that the Advance Payment Model softens the blow of start-up costs and allows rural providers to overcome their first and most significant barrier. By applying several of CMS’s accommodations throughout its establishment and operations, rural ACOs are possible. This Part explains why. First, this Part addresses the question: Why is the 5,000 Medicare beneficiary minimum a *necessary* burden?

A. *The 5,000 Medicare Beneficiary Minimum: A Necessary Burden*

Few rural providers will be able to form independent ACOs under the MSSP because they lack the patient volume required to meet the 5,000 Medicare beneficiary minimum. CMS categorizes all counties with fewer than 50,000 people as rural.¹⁷⁴ In rural populations, Medicare beneficiaries constitute approximately 23% of all fee-for-service beneficiaries.¹⁷⁵ Assuming that all Medicare beneficiaries—23% of all fee-for-service beneficiaries—participate in a rural area’s ACO, an ACO would need to serve a population of at least 21,740 to meet the minimum. Based on these numbers, the 5,000 Medicare beneficiary minimum drastically reduces many rural communities’ ability to participate in the MSSP. As a result, rural providers are likely unable to form ACOs within their own communities simply because the numbers do not add up. So why not lower the minimum?

Accountable Care Organizations require a large patient base. While the 5,000 beneficiary minimum poses a significant challenge to rural providers, ACOs with fewer beneficiaries may not survive under the MSSP.¹⁷⁶ An ACO may not create appreciable shared savings if its patient volume is too low.¹⁷⁷ As a result, lowering the minimum might doom an ACO for failure.¹⁷⁸ Regardless of the hardships it places on rural providers, the minimum is necessary to maintain the integrity of the MSSP.¹⁷⁹ ACOs thrive as patient volume increases,¹⁸⁰

¹⁷⁴ MEDICARE PAYMENT ADVISORY COMM’N, *supra* note 109.

¹⁷⁵ *Id.*

¹⁷⁶ See Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,808 (Nov. 2, 2011) (“Some commenters recommended that the minimum threshold of beneficiaries be increased to as high as 20,000 beneficiaries to reduce uncertainties in achieving program goals.”).

¹⁷⁷ MacKinney et al., *supra* note 12, at 134.

¹⁷⁸ See Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,808 (explaining that these numbers are necessary “with respect to both the eligibility of the ACO to participate in the program and to the statistical stability for purposes of calculating per capita expenditures and assessing quality performance”).

¹⁷⁹ See *id.*

and rural providers should not expect to circumvent this hurdle through further changes to the MSSP; rather, they should address it head-on.

Rural communities can utilize two of the previously discussed rural accommodations to meet the minimum: the rural exception to the antitrust “safety zone”¹⁸¹ and the recognition of rural health facilities.¹⁸² Both exceptions allow a rural ACO to add health care providers—and as a result, add Medicare beneficiaries—where an urban ACO cannot.¹⁸³ Part V of this Note more specifically addresses how rural ACOs can capitalize on these accommodations.¹⁸⁴ After an ACO meets the beneficiary threshold, it can take part in the “one-sided savings approach.”

B. *The One-Sided Savings Approach*

While the “one-sided savings approach” prevents rural providers from experiencing any losses throughout the first term of the Shared Savings Program, it does little to help them finance the overwhelming initial costs.¹⁸⁵ Even though this approach allows ACOs new to the risk-sharing structure to avoid “downside performance risk” and attract “smaller group participation,”¹⁸⁶ an ACO sees no shared savings until well after a year of operation.¹⁸⁷ As a result, this approach will not benefit rural providers until the start-up costs are overcome, which is where most rural providers have trouble.

Many rural providers do not have the necessary ACO start-up funds due to low patient volume, marginal profits, and lack of technological infrastructure.¹⁸⁸ Rural providers have historically, and necessarily, managed expenses meticulously to remain economically viable;¹⁸⁹ therefore, they are not well positioned to make additional—and substantial—financial investments to

¹⁸⁰ See MacKinney et al., *supra* note 12, at 135 (“[I]ncreased volume decreases cost per unit service, and consequently increases profit.”).

¹⁸¹ See *supra* Part III.C.3.

¹⁸² See *supra* Part III.C.2.

¹⁸³ See *supra* Part III.C.2; see also *supra* Part III.C.3.

¹⁸⁴ See *infra* Part V.

¹⁸⁵ Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,904 (Nov. 2, 2011).

¹⁸⁶ *Id.*

¹⁸⁷ *Id.* (“Under [the ‘one-sided’ approach], shared savings would be reconciled annually.”).

¹⁸⁸ See MacKinney et al., *supra* note 12, at 134; see also Shields et al., *supra* note 20, at 162 (“Solo practitioners and small groups rarely have the capital to invest in the kind of information technology (IT) or quality improvement training for staff that is necessary to achieve ACO status.”).

¹⁸⁹ MacKinney et al., *supra* note 12, at 133.

establish an ACO.¹⁹⁰ To invest five to twelve million dollars for start-up costs is especially out of reach.¹⁹¹ However, rural providers' historical operational efficiencies will likely help them attain shared savings once operations begin.¹⁹² If rural communities cannot afford to start an ACO, the "one-sided savings approach" does not help them. Rural ACOs need help with start-up costs first. The next Section addresses why the Advance Payment Model effectively addresses this problem.

C. *The Advance Payment Model*

The Advance Payment Model substantially aids rural providers because it addresses ACO start-up costs. Health professionals' comments to the MSSP proposed rule indicated that shared savings do not address the initial financial burden.¹⁹³ Many commenters stated, "[A]dvance payments would make program participation more attractive to many ACOs, particularly those comprised of networks of smaller practices, providers that operate on small margins, or hospitals in specific regions of the country."¹⁹⁴ In response, CMS relayed the advanced payment concept to its Center for Medicare and Medicaid Innovation Center ("Innovation Center").¹⁹⁵

The Innovation Center developed the Advance Payment Model as part of the MSSP in order to help offset start-up costs associated with ACO formation.¹⁹⁶ The Advance Payment Model immediately issues ACOs monetary advances, which the ACOs repay once shared savings are realized; this is opposed to sharing savings only after they are earned.¹⁹⁷ The initial payments are both fixed and variable, the latter of which depends on the number of participants.¹⁹⁸ These upfront payments are considered an investment because CMS expects ACOs to invest them into infrastructure and redesigned delivery processes, which will provide the necessary resources for efficient care.¹⁹⁹ Then, ACOs will be able to reimburse CMS for the advance payments once opera-

¹⁹⁰ Watson, *supra* note 108, at 9 ("Rural hospitals are also aging, shrinking, and in short supply. Rural America lost almost 10% of its hospitals in the 1980s and 1990s. Today, 17% of rural communities are at risk of losing their hospital.").

¹⁹¹ AM. HOSP. ASS'N, *supra* note 34.

¹⁹² Wilson et al., *supra* note 113, at 201.

¹⁹³ Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,904 (Nov. 2, 2011).

¹⁹⁴ *Id.* at 67,834.

¹⁹⁵ *Id.* at 67,835.

¹⁹⁶ See CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 160, at 3.

¹⁹⁷ *Id.* at 1.

¹⁹⁸ *Id.* at 2.

¹⁹⁹ *Id.* at 3.

tions have commenced and shared savings are earned.²⁰⁰ Generally, CMS will collect its reimbursement by withholding an ACO's share of savings once they are earned.²⁰¹

The Advance Payment Model is currently the most promising option for rural providers to form an ACO under Medicare because it offers a solution to start-up costs.²⁰² Previous accommodations—such as the “one-sided savings approach,” the antitrust “safety net” exception for rural providers, and FQHC and RHC ACOs—were only beneficial to rural ACOs *after* they had been established. Conversely, the Advance Payment Model provides support from the get-go and is tailored to the needs of rural and physician-led ACOs.²⁰³ The model's real-life success has yet to unfold but has steadily gained momentum.

On April 1, 2012, CMS announced its first five ACO participants in the Advance Payment Model.²⁰⁴ These ACOs serve a range of 6,000 to 11,000 Medicare beneficiaries and operate in many states.²⁰⁵ They are primarily made of physician practices, primary care clinics, community health centers, and FQHCs.²⁰⁶ Fifteen additional ACOs were announced for the performance period that began July 1, 2012.²⁰⁷ Then, on January 10, 2013, fifteen more ACOs joined the Advance Payment Model, for a total of thirty-five ACOs participating in the program—all of which are rural.²⁰⁸

Close attention should be paid to these fledgling ACOs participating in the Advance Payment Model because they are representative of rural ACOs'

²⁰⁰ *Id.* (“ACOs selected to receive advance payments will enter into an agreement with CMS that details the obligation to repay advance payments.”).

²⁰¹ *Id.* (“If the ACO does not generate sufficient savings to repay the advance payments as of the first settlement for the Shared Savings Program, CMS will continue to offset shared savings in subsequent performance years and any future agreement periods, or pursue recoupment where appropriate.”).

²⁰² Charles Fiegl, *Advance Pay ACOs: A Down Payment on Medicare's Future*, AM. MED. NEWS (July 29, 2013), <http://www.amednews.com/article/20130729/government/130729938/4/> (speaking of ACOs in rural communities, “If not for the startup money, none of us would have the margin to do something like this.”) (internal quotation marks omitted).

²⁰³ Gregg Masters, *Is the Advanced ACO Payment Model an Unlikely Source of Innovation?*, MEDCITY NEWS (Aug. 2, 2012, 8:24 AM), <http://medcitynews.com/2012/08/is-the-advanced-aco-payment-model-an-unlikely-source-of-innovation/> (noting that the Advance Payment Model “addresses core issues of two principal provider classes including: ‘rural’ and ‘physician led’ ACOs”).

²⁰⁴ Ctr. for Medicaid & Medicare Innovation, *Advance Payment ACO Model*, CMS.GOV, <http://innovation.cms.gov/initiatives/Advance-Payment-ACO-Model> (last visited Oct. 6, 2013).

²⁰⁵ *Id.* For example, ACOs have been formed under the Advance Payment Model in Florida, Rhode Island, Tennessee, California, Massachusetts, Maryland, Mississippi, Connecticut, Texas, Kentucky, North Carolina, New Hampshire, Indiana, Arkansas, Missouri, Ohio, and Nebraska.

Id.

²⁰⁶ *Id.*

²⁰⁷ *Id.*

²⁰⁸ *Id.*

future success or failure. Even now, rural providers who wish to develop an ACO should look to them for guidance as to how to take their first step toward coordinated, efficient care. CMS has made many concessions to rural providers in its final rule and the Advance Payment Model. As a result, rural ACOs can be a reality under Medicare. The next Part of this Note argues why this is important and how rural health care providers can form ACOs.

V. RURAL ROADS TO ACOS

Section A of this Part of the Note argues that community involvement and local efforts are essential to support rural ACOs. Also, this Section analyzes how rural communities' unique characteristics expose a dire need for the integrated and preventative care that ACOs provide. Section B proposes a path to establish ACOs in rural communities. Before discussing how rural communities can form ACOs under Medicare, the importance of rural ACOs must be established.

A. *Keeping Rural Health Care Rural: The Need for ACOs*

In order to keep rural health care locally accessible, rural providers should begin to enact local policies and involve community members to support integrated health care.²⁰⁹ Since the passage of the Affordable Care Act, over 250 Accountable Care Organizations have been established, serving over four million Medicare beneficiaries.²¹⁰ As ACOs continue to grow in number, rural providers may become susceptible to losing their client base due to expansion of surrounding urban ACOs into the rural market.²¹¹ Urban health care systems' use of "financial strength, leadership experience, market dominance, and policy clout" could initiate an exodus of rural patients to urban health centers, forcing rural providers to reduce their already limited services.²¹² Reducing

²⁰⁹ KEITH J. MUELLER ET AL., RURAL POLICY RESEARCH INST., THE HIGH PERFORMANCE RURAL HEALTH CARE SYSTEM OF THE FUTURE 2 (Sept. 2011) ("A high performance rural health care system includes care integration and coordination based in primary care, the cornerstone of health care delivery."), available at http://www.rupri.org/Forms/HealthPanel_FutureSystem_October2011.pdf.

²¹⁰ Press Release, Ctrs. for Medicare & Medicaid Servs., More Doctors, Hospitals Partner to Coordinate Care for People with Medicare: Providers Form 106 New Accountable Care Organizations (Jan. 10, 2013), available at <http://www.cms.gov/apps/media/press/release.asp?Counter=4501&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>.

²¹¹ See MacKinney et al., *supra* note 12.

²¹² *Id.* (finding that "[u]rban predation will shift patients (and hence payment) out of rural areas," leaving rural hospital services to "degrade, and the previously unmerited 'Band-aid station' label will become a reality").

services diminishes rural populations' access to local quality care,²¹³ which could negatively impact the overall health of rural individuals.²¹⁴ Keeping in mind that the rural population accounts for approximately 20% of Americans,²¹⁵ there is a need to address a possible urban annexation of rural health care before it occurs. By adopting policies that reinforce integrated care, rural communities can do more than keep health care locally available: They can attract more physicians.

Integrated health care under an ACO structure can attract more physicians to rural areas²¹⁶ despite historically suffering from a shortage of physicians.²¹⁷ Without intervention, however, this problem is expected to increase due to the combination of an aging physician population in rural areas and a failure to recruit recent medical school graduates,²¹⁸ which is at least partially due to professional isolation.²¹⁹ Integrated health care can provide even geographically isolated physicians with professional camaraderie through telecommunications, electronic health information, and collaborative treatment of patients, all while working to maintain the health of a rural population.²²⁰ Rural populations need ACOS because they provide integrated health care,²²¹ and some rural providers have already taken a step toward integration through patient-centered medical homes.²²²

Rural providers have begun this move toward more coordinated care through the patient-centered medical home ("PCMH") model. Policy makers advocate increased use of PCMHs, especially for treatment of chronic diseases, which rural populations suffer at a higher rate than their urban counterparts.²²³

²¹³ *Id.* at 132.

²¹⁴ *Id.*

²¹⁵ U.S. Dep't of Health and Human Servs., *Defining the Rural Population*, HRSA.GOV, http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html (last visited Oct. 6, 2013).

²¹⁶ See Steven Crane, *Redesigning the Rural Health Center: High Tech, High Touch, and Low Overhead*, 72 N.C. MED. J. 212, 212 (2011) ("To attract new physicians to rural primary care, new models of care are needed that are more effective, sustainable, and that can be replicated in smaller communities."); see also Scott Lindstrom, *Health Care Reform and Rural America: The Effect of the Patient Protection and Affordable Care Act on the Rural Economy and Rural Health*, 47 IDAHO L. REV. 639, 665 (2011).

²¹⁷ Lindstrom, *supra* note 216 ("Rural counties have on average 1.2 active doctors for every 1,000 residents, compared to 3 active doctors for every 1,000 residents in urban counties.").

²¹⁸ *Id.* at 665–66.

²¹⁹ Thomas, *supra* note 124, at 260–61.

²²⁰ *Id.*

²²¹ Sherwin, *supra* note 23, at 28.

²²² A. CLINTON MACKINNEY ET AL., RURAL POLICY RESEARCH INST., PATIENT-CENTERED MEDICAL HOME SERVICES IN 29 RURAL PRIMARY CARE PRACTICES: A WORK IN PROGRESS 1 (Sept. 2011), available at http://www.public-health.uiowa.edu/rupri/publications/policybriefs/2011/09082011_PCMH_Survey_Brief_082311_FINAL.pdf.

²²³ See Bolin et al., *supra* note 41, at 93.

A PCMH promotes coordination of care, focuses on quality and safety, increases access to care, and bases payments on quality of care management.²²⁴ Similarly, the MSSP promotes high quality care, redesigned care processes, and accountability for a patient population.²²⁵ Because of these similarities, providers already practicing in a PCMH are well positioned to transition to an ACO under the MSSP and the Advance Payment Model. Integrating care through ACOs will likely result in recruiting more physicians and positively impact the overall health of rural communities.²²⁶ Until integration occurs, however, “rural health clinics will continue to face challenges in providing the interdisciplinary and integrated care anticipated by the PPACA.”²²⁷ The MSSP’s three-part aim reflects this anticipated interdisciplinary and integrated care.

The three-part aim of the MSSP is complementary to the needs of rural health care: better care for individuals, better health for populations, and lower growth in expenditures.²²⁸ First, individuals in rural populations generally suffer from poorer health than those in urban populations.²²⁹ Rural communities need better care for individuals.²³⁰ Second, better care for rural individuals will result in better overall health for rural populations.²³¹ Third, rural communities need lower growth in expenditures.²³² Rural providers experience rising health care costs, largely due to “a rapidly aging population, high chronic illness, decreasing access to providers, transportation issues, and low patient volumes.”²³³ Better-coordinated care will limit, and potentially reduce, these high costs.²³⁴

In sum, rural communities are in need of what the MSSP provides. They are ideal candidates. For this reason, CMS should continue to modify the MSSP to further aid rural participation. While rural communities are ideal candidates for ACOs in many respects, they must also promote healthy lifestyles through new policies and programs.

Engaging community members will help ensure success for rural ACOs.²³⁵ Understanding community members’ needs is critical to providing

²²⁴ *Id.*

²²⁵ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Title III, § 3022, Title X, § 1037, 124 Stat. 395, 940 (to be codified at 42 U.S.C. § 1395jjj).

²²⁶ Bolin et al., *supra* note 41, at 100.

²²⁷ *Id.*

²²⁸ Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,803 (Nov. 2, 2011).

²²⁹ *See* Watson, *supra* note 108, at 5–6.

²³⁰ *Id.*

²³¹ *Id.*

²³² Thomas, *supra* note 124, at 259.

²³³ *Id.*

²³⁴ *Id.* at 261.

²³⁵ *See* MacKinney et al., *supra* note 12, at 133–34. (“To effectively improve quality and control costs, ACOs must work in partnership with patients and communities.”).

effective, efficient, and coordinated health care.²³⁶ ACO professionals should engage community resources and social supports, such as community health workers, who can “play a critical role in providing peer-based support and helping people integrate disease prevention and management regimens into their daily situation.”²³⁷

In addition, rural ACOs should engage local agencies and local government to develop school, workplace, and community-wide health education programs; promote healthy lifestyles through policy initiatives, such as creating recreational areas; and develop support groups for individuals with chronic conditions in order to fully benefit from an ACO.²³⁸ These measures actively involve patients in their own care, which is another important aspect of the ACO model specifically, and health care generally.²³⁹ While community collaboration is important to rural ACOs, collaboration must surpass its own community to form a viable ACO. Region-wide efforts might best reach the population.

This Section emphasized the need for ACOs in rural communities and the importance of community involvement in their realization. An ACO, like health care in general, requires a group effort. The next Section of this Note proposes one way that health care providers can form an ACO in a rural community.

B. Rural Providers Must Collaborate to Form ACOs Under the MSSP

Now that the need for ACOs in rural communities has been established, the next question becomes: How can rural health care providers successfully form ACOs? Drawing from rural accommodations included in the MSSP and characteristics of ACOs participating in the Advance Payment Model, this Section of the Note provides one possible route. Throughout this analysis, an overwhelming theme emerges—collaboration. Collaboration across communities is key to rural ACO success. Organizing providers across regions will provide rural ACOs with the numbers, resources, and integration needed to max-

²³⁶ See TRICIA MCGINNIS & DAVID MARC SMALL, CTR. FOR HEALTH CARE STRATEGIES, INC., ACCOUNTABLE CARE ORGANIZATIONS IN MEDICAID: EMERGING PRACTICES TO GUIDE PROGRAM DESIGN 3–4 (Feb. 2012), available at http://www.chcs.org/usr_doc/Creating_ACOs_in_Medicaid.pdf.

²³⁷ TRICIA MCGINNIS & NIKKI HIGHSMITH, ACCOUNTABLE CARE ORGANIZATIONS: CREATING A WORKABLE APPROACH FOR MEDICAID 3 (June 2011), available at http://www.chcs.org/usr_doc/Medicaid_ACO_Issue_Brief_-_FINAL.pdf.

²³⁸ See MCGINNIS & SMALL, *supra* note 236 (highlighting the importance of “behavioral health, social services, and community stakeholders . . . to incorporate valuable expertise and lay[] the groundwork for critical partnerships once the ACO is operational”).

²³⁹ CMS determined preventative health care to be a performance measure domain to assess an ACO’s quality of care. See 42 C.F.R. § 425.502(d)(iii) (2013).

imize shared savings offered by the programs.²⁴⁰ The first collaboration is among physicians: They will lead the charge.²⁴¹

1. Physicians as Foundations

The first step in forming a rural ACO is to organize physician practices across communities and counties. This step is critical primarily due to three factors: collaboration reduces professional isolation,²⁴² the rural safety zone allows for collaboration across counties,²⁴³ and groups of physicians have greater appeal to larger rural or urban health care centers as ACO partners.²⁴⁴ Because rural health care is highly dependent on solo or small group physician practices,²⁴⁵ physicians will serve as a rural ACO's foundation.²⁴⁶ The foundation can then be complemented by rural hospitals, critical access hospitals, or community health centers to provide well-rounded care.²⁴⁷ But first things first: How does physician collaboration reduce professional isolation?

Physician collaboration reduces professional isolation because they must band together to provide the coordinated care required by the MSSP.²⁴⁸

²⁴⁰ See CTR. FOR MEDICARE & MEDICAID INNOVATION, *supra* note 169 (noting that ACOs may need the advance payments to “invest in data warehouses and generate patient registries”).

²⁴¹ See MacKinney et al., *supra* note 12, at 135–36 (noting that physicians will serve as leaders in rural ACOs and “are particularly essential to foster physician engagement in practice redesign and collaboration building”).

²⁴² See *id.* (“Rural providers must begin to acknowledge that strict independence is no longer a success strategy.”); see also Artnak et al., *supra* note 114, at 143 (remarking that even “hospitals increasingly become outpatient delivery centers in the rural continuum of care”).

²⁴³ Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026, 67,028 (Oct. 28, 2011).

²⁴⁴ MacKinney et al., *supra* note 12, at 134.

²⁴⁵ *Id.*

²⁴⁶ Rob Lazerow, *Medicare's Advance Payment Model: Details and Implications for Independent Medical Groups*, THE ADVISORY BOARD Co. (Dec. 22, 2011), <http://www.advisory.com/Research/Health-Care-Advisory-Board/Blogs/Toward-Accountable-Payment/2011/12/Medicare-Advanced-Payment-Model> (noting that ACOs under the Advance Payment Model can be “composed primarily—if not exclusively—of physicians”).

²⁴⁷ Elias N. Matsakis, *Partnering with Hospitals to Create an Accountable Care Organization*, in ACOS AND OTHER OPTIONS: A “HOW-TO” MANUAL FOR PHYSICIANS NAVIGATING A POST-HEALTH REFORM WORLD 1 (AM. MED. ASS'N 4TH ed. 2010–2013), available at <http://www.ama-assn.org/resources/doc/psa/physician-how-to-manual.pdf> (“There are many opportunities for physicians and hospitals to affiliate and clinically integrate so as to enable both parties to improve their service delivery and positively impact their financial viability.”).

²⁴⁸ See MacKinney et al., *supra* note 12 at 133–34 (“Rural provider practices, already frequently smaller than urban practices due to lower population density and greater geographic separation, are likely to be particularly disadvantaged in a system that requires practice redesign, care coordination, and provider collaboration. Rural providers must begin to acknowledge that *strict independence is no longer a success strategy.*” (emphasis added)).

Physicians will likely join forces more readily under ACOs—as opposed to the HMOs of the 1990s—primarily because ACOs allow physicians to maintain much of the control and autonomy to which they have grown accustomed.²⁴⁹ Rural physicians have been autonomous largely because they experience geographical isolation from their colleagues.²⁵⁰ By forming an ACO around a group of geographically dispersed physicians, increased communication among them is likely to naturally result from their joint responsibility for an ACO's patient population. Heightened communication will also “identify and disseminate best practices that promote efficiency, improve quality, and reduce cost.”²⁵¹ In addition to better patient outcomes, better communication among professionals may help attract new physicians to rural areas.²⁵²

So what do we do with these newly recruited physicians? They can likely join an ACO because of the rural exception to the antitrust “safety zone.”²⁵³ By collaborating with other physicians in neighboring counties, a rural ACO can increase its beneficiary numbers while avoiding anticompetitive concerns, thanks to the rural exception to the antitrust “safety zone.”²⁵⁴ Here, an ACO would not need to fear redundancy of specialties as long as there is only one such specialist for every “rural area.”²⁵⁵ Therefore, each “rural area” can have its own set of specialties, regardless of market share. Adding larger health care facilities is the next step.

Once the physicians are recruited, they can attract rural hospitals, community health centers, critical access hospitals, or urban tertiary care centers to participate in an ACO.²⁵⁶ Partnerships between physicians and a larger, more resource-intensive entity will increase the number of ACO beneficiaries, provide access to more specialized medicine, and fill any gaps in care that phy-

²⁴⁹ Japsen, *supra* note 70.

²⁵⁰ MacKinney et al., *supra* note 12, at 133–34.

²⁵¹ *Id.* at 134.

²⁵² See Watson, *supra* note 108, at 9 (“Only about 3% of recent medical graduates plan to practice in small towns and rural areas.”); see also Thomas, *supra* note 124, at 260–61. (“One reason for the lack of health care professionals willing to work full time in rural areas . . . is the isolation that many rural physicians face.”).

²⁵³ See Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (Oct. 28, 2011).

²⁵⁴ *Id.*

²⁵⁵ See *id.* at 67,029 n.32 (“For the purposes of the Policy Statement, a ‘rural area’ means any county containing at least one zip code that has been classified as ‘isolated rural,’ or ‘other small rural,’ according to the WWAMI Rural Health Research Center of the University of Washington’s seven category classification.”).

²⁵⁶ See Matsakis, *supra* note 247, at 6 (“Creating a group of physician providers . . . to serve as natural leaders is the first step [to ACO formation].”). But see Lazerow, *supra* note 246 (noting that an ACO in the Advance Payment Model may be composed exclusively of physicians).

sicians otherwise would not be able to fill.²⁵⁷ However, not all hospital-physician arrangements are created equal.²⁵⁸ The inequalities are numerous and include financial strength, patient loads, service offerings, and technological infrastructure.²⁵⁹

Fledgling ACOs must take these inequalities into consideration. When partnering with an urban tertiary care center, it is important to remember that it may not fall under the rural exception to the antitrust “safety zone.”²⁶⁰ Therefore, a rural ACO should consider the various levels of antitrust protections allowed among the different partnership possibilities.²⁶¹ While rural hospitals can be added without considering their effect on an ACO’s anticompetitive behaviors, urban health centers can greatly implicate anticompetitive concerns.²⁶² Also, urban tertiary care centers are likely ineligible to participate in the Advance Payment Model,²⁶³ which is the next step to form rural ACOs.

2. Participating in the Advance Payment Model

In an ACO, there is power in numbers.²⁶⁴ Even to reach the minimum numbers, rural providers will need to collaborate across counties—or even regions—and then likely unite with a larger health care facility.²⁶⁵ Even after the numbers are attained, rural providers will likely struggle to finance their first step—start-up costs. They will need help.²⁶⁶ The Advance Payment Model

²⁵⁷ See Matsakis, *supra* note 247, at 6 (explaining that “[h]ospitals generally have a superior set of financial and administrative resources”); see also DeMuro, *supra* note 30, at 11 (suggesting that “[r]ural provider participation most probably will require coordination and collaboration with larger, urban and suburban health systems”).

²⁵⁸ See Matsakis, *supra* note 247, at 6.

²⁵⁹ See *id.* (observing that hospitals “vary significantly in their financial strength, market position, medical staff composition, compliance programs, payer mix, service offerings, technology investments, management quality and style, information technology, and technological infrastructure—and perhaps most importantly, their willingness and effectiveness in partnering with their physicians”) (emphasis omitted).

²⁶⁰ See Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (Oct. 28, 2011).

²⁶¹ See *id.*

²⁶² See *id.*

²⁶³ See *supra* Part IV.C.

²⁶⁴ See MacKinney et al., *supra* note 12, at 135.

²⁶⁵ Alternatively, a group exclusively composed of physicians may form an ACO under the Advance Payment Model. See *supra* Part IV.C.

²⁶⁶ GUTERMAN ET AL., HIGH PERFORMANCE ACCOUNTABLE CARE: BUILDING ON SUCCESS AND LEARNING FROM EXPERIENCE 29 (Apr. 2011), available at http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2011/Apr/1494_Guterman_high_performance_accountable_care_v3.pdf.

[U]pfront investments often are necessary to make the changes that will produce savings. Making those investments has required both financial stability

meets this need by supplying rural providers with a portion of the start-up costs to invest in areas such as infrastructure and technology.²⁶⁷ These advance payments help rural ACOs clear the often insurmountable first hurdle.²⁶⁸ Once a rural ACO is established through the Advance Payment Model, rural providers can take advantage of the “one-sided savings approach.” The ACO will be protected from sharing in the losses that may result from early inefficiencies.²⁶⁹ This will allow them to work out the kinks associated with major infrastructural changes and new care delivery model. Once the initial shift is overcome, rural providers should begin to achieve savings, as well as enjoy better-managed chronic conditions and increased rural population health.²⁷⁰

While many accommodations made in the MSSP final rule help a rural ACO manage itself once it is up and running, they do not address the key hurdle—start-up costs. The Advance Payment Model alleviates this barrier. Rural providers should track the success or failure of those ACOs already involved in the Advance Payment Model as a guide for their own future actions.²⁷¹ Recent reports suggest that savings and quality care are already being realized through the MSSP.²⁷² Thirty-five ACOs have been created through the Advance Payment Model alone—and there are more to come.²⁷³

This Section offered one road that a rural ACO can follow to participate in the MSSP. Regardless of uncertainties, rural providers should make a move toward integrated care either by forming an independent ACO or collaborating with surrounding providers. If these options do not appear viable, they may wish to consider joining an existing ACO, which would alleviate many of the barriers associated with forming an ACO from the ground up. Integrated

and a leap of faith that the investments will pay off. Even if methods are adopted that make payment of shared savings more timely, some mechanism for upfront funding (which could be counted against any realized savings) may enable more potential ACOs to make the investments necessary to participate in the program. This funding could be targeted to providers that face particular challenges in accessing capital or that serve certain (vulnerable) populations or certain (rural, low-income, or underserved) areas, by restricting it to those groups of providers or by offering them more favorable terms.

Id.

²⁶⁷ See CTR. FOR MEDICARE & MEDICAID INNOVATION, *supra* note 169.

²⁶⁸ See Khan, *supra* note 32, at 324–25; see also DeMuro, *supra* note 30, at 11 (discussing how rural providers will likely need to “collaborate with larger, urban and suburban health systems” in order implement successful ACO programs).

²⁶⁹ Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,904 (Nov. 2, 2011).

²⁷⁰ See Meghrihan, *supra* note 116, at 19.

²⁷¹ See, e.g., Ctr. for Medicaid & Medicare Innovation, *supra* note 204.

²⁷² Alex Wayne, *Obamacare Shows Hospital Savings as Patients Make Gains*, BLOOMBERG.COM (June 12, 2013, 4:35 PM), <http://www.bloomberg.com/news/2013-06-12/obamacare-shows-hospital-savings-as-patients-make-gains.html> (noting that “hospitals are improving care and saving millions of dollars with [Medicare’s Shared Savings Program]”).

²⁷³ Ctr. for Medicaid & Medicare Innovation, *supra* note 204.

care is key to managing the health of rural populations, and the potential positive impact of ACOs on rural health care should not be overlooked.

VI. CONCLUSION

Today, America's health care costs are rising to an unsustainably high level.²⁷⁴ Medicare's Shared Savings Program responds to the rising costs by emphasizing integration and coordination of care via ACOs.²⁷⁵ Although MSSP requirements initially presented rural communities with insurmountable hurdles, the Advance Payment Model, in concert with CMS's changes to the MSSP final rule, finally allows rural providers and communities to share in the program's benefits.

Health care policymakers have valued integrated health care almost as long as the medical profession has existed.²⁷⁶ Integrated care improves population health and reduces costs by rewarding preventative care and management of health conditions, which can avoid costly and unnecessary medical procedures.²⁷⁷ If rural providers collaborate across counties and communities, rural ACOs are a viable option under Medicare because the Advance Payment Model addresses the initial financial burdens associated with establishing ACOs, while Medicare's Shared Savings Program addresses and attenuates many of the issues rural providers will face as they transition into a fully operational ACO.

Rural communities can also benefit most from an ACO's integrated care. Rural communities often suffer worse overall health than urban communities, experience a shortage of physicians, and, partly because of the physician shortage, travel long distances to receive medical care.²⁷⁸ Not only do rural communities generally suffer worse overall health, but they are also specifically affected by chronic conditions that require continuous management and coordination of care across multiple providers.²⁷⁹ ACOs can provide the integrated, coordinated, and continuous care rural populations need.

²⁷⁴ Cain, *supra* note 8, at 9.

²⁷⁵ Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,803 (Nov. 2, 2011).

²⁷⁶ GOLD, *supra* note 16, at 4.

²⁷⁷ See MACKINNEY ET AL., *supra* note 117.

²⁷⁸ See *supra* Part III.B.

²⁷⁹ Watson, *supra* note 108, at 3 ("Rural Americans tend to . . . suffer from more chronic illnesses and disabilities than urban Americans."); Bolin et al., *supra* note 41, at 93 (stating, "chronic diseases and conditions requir[e] frequent monitoring of health status").

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American health care is moving toward integration. Integrated care can greatly improve rural communities' health, and Medicare's Shared Savings Plan provides an opportunity for rural communities to realize such integration. Today, unicorns are real. It is time for them to roam the countryside.

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