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The Accountable Care Paradigm Shift: New Ethical Considerations

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Midstate Internal Medicine is an LLC (limited liability company) of 12 physician equity partners, each with equal ownership of physical assets and equal share of overhead expenses in a leased building. Serving an area of about 120,000, their urban and suburban practice has been financially solvent for the last ten years.

Since the passage of the Patient Protection and Accountable Care Act of 2010, Midstate physicians had been considering collaborating with a local hospital and other practices to form an accountable care organization (ACO) because of concerns about the future economic viability of their standalone practice. They were stalled at the point of creating a payment scheme and accountability structure for the ACO's many physicians.

At this juncture, Midstate received an unsolicited offer from Roosevelt Hospital, the largest hospital system in the state. Roosevelt wanted to buy the entire practice (physical assets, accounts receivable, and goodwill), an arrangement that would, Roosevelt's senior management explained, solve Midstate's concerns about forming an ACO, inasmuch as Roosevelt had purchased several physician practices in recent years and functioned as an extended ACO itself. In the long run, Roosevelt's executives explained, the consolidation would lower costs to patients and insurers as continuity of care was enhanced, fewer unnecessary tests were performed, and complications and hospital stays were reduced through the integration of hospital and physician services.

When Midstate Medical Group physicians met to consider the offer, all 12 acknowledged that they had seen a decline in patient visits as Roosevelt acquired local practices and kept its referrals within its system, a trend that was likely to continue. However, they had been their own bosses for more than 25 years and were skeptical about life as salaried employees. Stories were already circulating at specialty meetings that physicians in the Roosevelt system had to meet admissions quotas, for example.

Response

Thomas Kuhn, in his landmark book *The Structure of Scientific Revolutions*, challenged the idea that scientific progress is composed of the progressive accumulation of facts and theories that march toward a greater understanding of the natural world. Rather, he argued that science advances episodically during periods of "revolutionary," accelerated

progress. These reset the prevailing worldview, establishing a new paradigm upon which “normal” science resumes. He defined “paradigms” as achievements that are “sufficiently unprecedented to attract an enduring group of adherents” away from the status quo and as “open-ended,” with plenty of problems for the “redefined group of practitioners to resolve” [1].

This is an apropos description of what the 2010 Patient Protection and Affordable Care Act (ACA) produced with the creation of accountable care organizations (ACOs). This law defined an ACO as an alliance of hospitals, physicians, and other health care professionals who collaborate for the purpose of being accountable for the cost and quality of health care delivered to a set of at least 5,000 Medicare patients [2]. The ACO model represents a radical upheaval in the way health care is delivered. The core bioethical principles of beneficence, nonmaleficence, justice, and respect for autonomy are all central to the goals of providing access to quality, evidence-based care while at the same time containing costs. In this paper I will examine each of the principles in relation to ACOs and provide examples of ethical issues that may arise for the Midstate Medical Group in their decision to join a hospital-based ACO.

Beneficence

Central to the ACO model is the effort to promote beneficence—to “do good” by providing evidence-based care and to be held accountable for that good. Patients have traditionally trusted their physicians to be intellectually competent and morally unquestionable. The ACO model brings about a paradigm shift, supplementing fee-for-service payment with payment incentives that are tied to the quality of care. ACOs receive a portion of their cost savings as incentive payments from Medicare for meeting quality care measures. This demands a new type of fiduciary responsibility, which becomes part of a physician’s moral responsibility to “do good.” Fiduciary responsibility encompasses the physician’s role in asset and cost management for individual patients as well as the larger society of patients [3]. This represents a drastic departure from traditional medical practice, wherein cost of care was immaterial and the emphasis on thoroughness required the exploration of every diagnostic and treatment possibility. It will be imperative that the Midstate group be cognizant of this change in physicians’ fiduciary responsibility in making their decision to join an ACO.

In order to quantify physicians’ skills and outcomes, the Centers for Medicare and Medicaid Services (CMS) has identified 33 measures of patient care that will be monitored. These include the domains of patient and caregiver experience, care coordination and patient safety (e.g., performing medication reconciliation after discharge), preventive health (e.g., tobacco cessation intervention, cancer screening) and specific issues in at-risk populations (e.g., aspirin use in diabetics and beta-blocker therapy for left ventricular dysfunction) [4]. Reporting quality measures requires an infrastructure dedicated to peer review and quality assurance.

In addition to infrastructure, an enormous culture change extending beyond the moral obligations of the physician has to be in place in order for an ACO to be successful. Health care delivery must make the switch from being *reactive* to being *proactive*. Currently, patients are treated when they have acute episodes, for example asthma exacerbations, cardiac arrests, and diabetic comas. Although such acute treatments will still be necessary, the focus will shift toward preventive measures such as smoking cessation, weight reduction, and diabetes education. The attitudes of administrators must change and permeate the workplace to affect those of ancillary staff.

Effective communication is crucial. In a study evaluating communication between primary care physicians (PCPs) and hospital-based physicians (HPs) in six academic centers treating 2,336 patients, Bell et al. found that PCPs for 77 percent of patients were aware that their patients had been admitted to the hospital, but direct communication between these PCPs and HPs occurred for only 23 percent of patients. A discharge summary was available within two weeks of discharge for 42 percent of patients [5]. These cultural issues all contribute to how much *good* is ultimately performed for the patient. The Midstate group would need to consider communication among professionals as part of their decision to join the Roosevelt system.

Nonmaleficence

The Hippocratic concept of “*primum non nocere*” permeates medical culture. While communication between physicians in an ACO takes determined follow-through, ACOs do foster collaboration between physicians and hospitals to decrease harm to patients by penalizing “never” events such as development of venous thromboembolism and wound infections in hospitalized patients. Hospital policies, if carefully crafted, may strike a balance between respecting physician autonomy and avoiding patient harm, such as automated display of antibiotic guidelines in the electronic medical record (EMR), which, in one study, decreased vancomycin usage by 32 percent and reduced costs [6]. There are numerous other reports of EMR use improving care quality and coordination [7-10]. ACOs also promote decreasing readmissions, minimizing lengths of stay, and curtailing duplicative costs. There is an inherent tension, however, between the hospital’s need to “fill beds” and the ACO’s obligation to avoid unnecessary hospitalizations. Regarding duplicative costs, specialist physicians may face pressure to rely on tests previously performed outside the ACO system. These may vary widely in quality, which is particularly true for imaging studies, and may pose a safety and liability risk for the patient and the clinician. There may also be variability in quality when less costly devices and implants are used. The Roosevelt health network should have a robust system of checks and balances that includes an EMR system to prevent both unnecessary duplication of testing and reliance on previously performed, poor-quality tests.

Also important is the issue of referral sources. ACOs function best as closed systems, within which cost-containing and quality-improving measures can be implemented by the full complement of medical services and specialists. Does the Roosevelt system have all the necessary referral options for its patients' needs? An obvious problem arises if an in-house referral is not in the patient's best medical interest or if a medically necessitated referral to an outside source is denied or delayed.

Justice

Some would argue that the sorts of decisions I've been discussing constitute health care rationing, a term that has the negative connotations associated with inequalities in care and has engendered fear of health care reform in many Americans. Many authors argue that rationing has existed in our health care system for years, based on price, ability to pay, and several cost-containment policies such as certificate-of-need regulations and lower Medicaid payment rates to clinicians [11, 12]. Even such decisions as whether to order daily lab draws or how soon to schedule a new referral in a busy clinic fundamentally constitute rationing. In the microcosm of an ACO, some form of rationing needs to be present for the model to remain solvent [13]. The question then becomes, should there be explicit rationing policies, or should implicit rationing occur at the bedside? Some would argue for rationing by policy, to prevent individual physician bias that would introduce many discrepancies [14], but do such policies erode the autonomy of the physician in the practice of medicine? This ethical conundrum needs to be addressed by the Midstate group with strong adherence to evidence-based data.

The principle of justice also encompasses respect for morally germane laws. Three such laws—the anti-kickback statute [15], the “Stark” physician self-referral law [16], and the Gainsharing civil monetary penalty (CMP) statute [17] apply to ACOs and have ethical implications. In sum, these laws make it illegal to knowingly pay or be paid for the referral of patients for any service reimbursed under Medicare/Medicaid, prohibit physicians from making referrals to any entity with which they or immediate family members have a financial relationship, and prevent hospitals from disbursing payments to physicians to reduce medically necessary services to Medicare and Medicaid patients. These laws were all created with the goal of preventing financial incentives from interfering with just and appropriate patient care.

A problem arises with these statutes in the context of ACOs, however. The ACO model requires group collaboration within a health care system that would violate the above-mentioned laws. CMS and the Office of Inspector General have established waivers to protect ACOs from penalties related to these laws as long as the ACO remains in good standing with the Medicare Shared Savings Program and to protect certain start-up activities related to ACO formation [18]. The Midstate group would be wise to assure that these protections would apply to the group as it incorporates into a larger ACO system and that there is complete transparency during the process.

Special mention should be made of socially disadvantaged and clinically vulnerable patient populations. When these populations overlap, those in the middle—members of ethnic minority groups with complex chronic illnesses who live in impoverished neighborhoods—are particularly susceptible to inadequate care. This could arise if physicians “dump” patients by referring them or otherwise avoiding their care [19]. A 2002 Institute of Medicine report found that members of racial and ethnic minorities often receive lower-quality care than patients of European descent—differences not explained by insurance coverage, access to care, income, education, or patient preferences [19, 20]. Does the Roosevelt system have safeguards in place to avoid these injustices?

Respect for Autonomy

The bioethics principle of respect for individual autonomy encompasses two often competing interests—the autonomy of the patient and that of the physician. With the increasing complexity of medical treatment and controversies over end-of-life decisions, preserving patient autonomy in medical decision making has become a key interest [21-23]. Americans demand freedom of choice in health care [24, 25].

Certain ethically justifiable limits must be placed on patient autonomy, however, for the ACO to be viable. The patient can no longer be considered a mere consumer of health care, but also has an ethical obligation to be a responsible co-manager of health care resources who makes decisions based on sound, evidence-based data. The physician’s role is to present that data and to educate and guide the patient and surrogates toward medically appropriate care that avoids overtreatment, undertreatment, and mistreatment. This role is especially important during end-of-life discussions, when the temptation to “do everything” in the face of a truly terminal disease process should be avoided. Zhang et al. showed that health care costs for patients with advanced cancer in the last week of life were 35.7 percent lower when end-of-life discussions occurred than when they did not. Lower costs were correlated with a better quality of death, and there were no survival differences between the groups [26]. Physicians should maintain patient trust while staying steadfast in their dedication to limit care to that which is medically sound and evidence-based. The ACO is ethically justified in upholding those limits. The Midstate group should confirm that the Roosevelt system would be unwavering in its support for the physicians in this endeavor.

The ACA provides ACOs with the means to reward patients who stay engaged in their health by offering premium reductions for participation in wellness programs or for meeting body mass index (BMI) targets. Education is key. Patients may at first be skeptical of doctors and hospitals profiting from what patients may perceive as providing *less* care. But patients, too, may benefit from the savings derived from receiving what is actually *effective* and *appropriate* care. Overcoming patients’ skepticism will involve

educating patients throughout their health care surveillance and health care delivery. The patient, as well as the physician, has an ethical responsibility to control costs since the collective decisions of both impact the resources subsequently available for others.

Summary

The current state of our health care system is analogous to the status of science that Kuhn describes as “a proliferation of compelling articulations, the willingness to try anything, the expression of explicit discontent, the recourse to philosophy and to debate over fundamentals” [27]. ACOs represent a paradigm shift in the way health care is delivered. As with any dramatic public policy change, ethical issues will arise. These are surmountable challenges, and with open communication, physicians such as the Midstate group can partner effectively with hospital systems to ensure the delivery of quality, evidence-based care while at the same reorienting the culture to be attentive to its fiduciary responsibilities.

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