

# Virtual Mentor

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## POLICY FORUM

### Ethics in Accountable Care Organizations

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Accountable care organizations (ACOs) are receiving significant attention as a policy initiative for achieving the “Triple Aim” [1] improved patient care experiences, better health for populations, and reduced per capita cost. This attention appears warranted. Although other initiatives exist (including pay for performance, the patient-centered medical home, value-based design, and global payment, among others), ACOs are forming rapidly in both the public and private sector.

Most of the attention paid to ACOs focuses on their structural features; less attention is paid to the ethical issues ACOs might raise or exacerbate. How health care is delivered and paid for, however, helps determine those issues. Traditional fee-for-service systems, for example, create an incentive for clinicians to perform more or unnecessary procedures, and capitated payment systems reward clinicians for doing less. Identifying and managing ethical problems will therefore be critical to the long-term success of ACOs. This essay examines some of the concerns ACOs—particularly hospital-based ACOs—confront.

#### Accountable Care Organizations: A Primer

The term “accountable care organization” was introduced relatively recently and is said to have originated with Elliot Fisher during a 2006 Medicare Payment Advisory Committee meeting and a subsequent publication [2]. The general concept is simple: by linking groups of providers and hospitals into a formal organizational structure and providing incentives based on specified health outcome measures and spending benchmarks, one is able to create shared accountability and coordination among all group members for achieving the Triple Aim. Shared accountability among all providers—as compared to traditional individual incentives (e.g., pay-for-performance)—is considered a novel feature of ACOs. By the time “ACO” entered the medical lexicon, pilot projects, such as Medicare’s Physician Group Practice Demonstration (PGPD) pilot project (2005-2010), involving its key features were already in operation [3].

The 2010 Patient Protection and Affordable Care Act [4] was a watershed moment for ACOs. Section 3022 directed the Secretary of the Department of Health and Human Services to create a “shared savings program,” i.e., ACOs, for Medicare. This legal framework was subsequently detailed by the Center for Medicare and Medicaid Services (CMS) as a final rule in November 2011 [5, 6]. Although a number of privately organized and successful accountable organizations exist [7], describing ACOs under Medicare outlines their basic structural features.

The Medicare Shared Savings Program allows any physician, hospital, physician network, and other health care provider group that cares for more than 5,000 Medicare fee-for-service beneficiaries to form an ACO and apply to participate. Agreements last at least 3 years. The incentive to participate is the “shared savings” that the organization can earn if Medicare expenditures for its beneficiaries are less than the CMS benchmark calculated for that ACO. This incentive should stimulate ACOs to provide better coordinated, higher-quality care while reducing expenses. Under a one-sided risk model, the ACO shares savings but suffers no loss if its expenditures are higher than the benchmark; under a two-sided risk model, the ACO can share a greater portion of the savings at the risk of having to pay back a portion of Medicare’s losses if its expenditures are higher than the benchmark. Both models require an ACO to report and meet 33 national quality measures. ACOs have significant freedom to adopt and create their own quality, efficiency, and patient care coordination interventions.

Data from the PGDP pilot suggest that ACOs may be effective at improving quality and reducing expenditures [8]. Participation is expanding rapidly. As of January 2013, more than 250 Medicare-related ACOs exist, covering nearly 4 million Medicare beneficiaries [9]. Two parallel initiatives are the advance payment model (which has provided upfront funds for infrastructure investment to small or rural ACOs), and the pioneer ACO model (which allows for higher levels of shared savings and risk for organizations with significant coordination experience). Of note, although the initial ACO concept centered on the acute-care hospital and its patient/physician area, having a hospital is not required in Medicare’s final rule, and some physician-only ACOs do exist [10].

### **Ethical Issues in ACOs**

Hospitals and hospital-based systems, however, will undoubtedly head some if not most ACOs, and they will also contract with physician-only ACOs. This section introduces a few of the ethical concerns hospitals and their leadership might face.

*Patient autonomy and cost savings.* To protect patient autonomy, hospitals that lead ACOs assume responsibility for informing patients of their membership in the ACO, what an ACO is, and how it might affect their care. Within Medicare’s Shared Savings Program, for example, ACOs must inform patients either in writing or in person about their clinicians’ participation. Unlike health maintenance organizations, ACOs claim to allow patient choice of doctors (especially under Medicare’s rules), but evidence suggests that cost savings might depend on the ACO’s control over referral patterns [11]. How should hospitals balance control over referral patterns with physician and patient preferences, or might a constraint on autonomy be ethically justified [12]?

*Unintended financial effects.* ACOs face a certain financial tension. Excellent outpatient care, for example, might reduce admissions for “ambulatory-sensitive conditions,” such as chronic obstructive pulmonary disease; can hospitals put the overall ACO savings and patient well-being above the fees they would receive from

more admissions? Hospitals and other ACO leaders have an ethical obligation not to engage in behaviors that are inconsistent with the intent of the signed agreement, namely, to reduce or limit overall health expenditures. But there is the possibility that hospitals will engage in unethical fiscal behaviors, including cost shifting and escalation. For example, hospitals might shift patients from costly therapeutics paid for under Medicare part A to outpatient therapeutics paid for under Medicare part D, because the latter is not part of the benchmark calculation [13]. Others worry that powerful hospitals might use substantial market power obtained through participation in a large, well-integrated ACO to raise prices [14]. A hospital or health system, for example, could use its large size to negotiate higher payments from private insurers, thereby gaining additional revenue or offsetting any reduction in revenue, were it to occur as a result of reduced Medicare payments. For patients with private insurance, this could result in higher premiums that effectively supplement or subsidize the shared savings. Payers (such as CMS) will undoubtedly watch for such scenarios, and legal rules (such as antitrust law) might place certain constraints on them.

*Benefit sharing.* Successful ACOs will share in the savings accrued with the payer, which means that hospitals will need to determine how to use these savings. In the case of the Medicare Shared Savings Programs, the savings must be shared with ACO participants or used for purposes consistent with those of the program. How can a hospital use and distribute these savings fairly? Should savings be shared equally among ACO members, or awarded to departments or clinicians according to a formula based on performance? If ACO savings result mainly from reduced hospital readmissions, for example, should those savings go to the hospital unit responsible for the discharge—or the outpatient clinicians’ efforts to follow up and keep patients at home? Finally, should patients in an ACO share some portion of the savings?

*Focus.* ACOs will need to determine which of many quality metrics to focus on. In the CMS program, for example, among the 33 quality measures, specific attention is given to “at-risk” patient populations (e.g., patients with diabetes, hypertension, coronary artery disease, and heart failure). Time and resources are limited, so ACOs must decide how to spend limited quality-improvement resources fairly. Acute-care hospital leaders might have experience with certain measures (e.g., medicine reconciliation at discharge), lack of experience with others (e.g., preventive health, such as mammography), and lack of control over still others (e.g., ambulatory care). Deciding how to prioritize goals will require careful balancing of ethical values. Should an ACO focus, for example, on improving quality measures that are furthest from the target, those nearest, or those most easily achieved? Because quality measures will likely be associated with specific patient populations, this choice will be analogous to choosing between those “most in need” and those “most likely to benefit”—a classic issue of distributive justice.

*Relationships with physicians.* From ACOs’ beginnings, the historically strained relationships between hospitals and providers was seen as a potential “cultural”

barrier [2], and this tension continues [15]. The appropriate relationship between hospitals and providers is an ethical concern, not just cultural or financial. Ethical values of concern to the profession, such as professional autonomy, might be affected when hospitals decide upon and implement initiatives for achieving ACOs' aims [16]. If physicians or other providers resist or sense a loss of professional autonomy, this could impact their willingness to adopt new initiatives and thereby affect their patients' care. Hospitals within ACOs will need to recognize this historical context and develop strategies for appropriately managing relationships with physicians.

*Board governance.* Finally, ACO leadership will play a key role in determining how an ACO behaves. Determining an appropriate governance structure is therefore important. The Medicare Shared Savings program rules require governing boards to include a Medicare beneficiary but otherwise allow significant latitude in composition and procedures. Including a beneficiary should add critical accountability, legitimacy, and patient-centered input, but questions will remain regarding the beneficiary's role and ability to remain an independent and powerful voice.

### **Conclusion**

As ACOs proliferate, their long-term success depends in part upon identifying and addressing the ethical issues that, while not entirely new to hospitals, are relatively unique to this structure. Some behavioral economists caution that undue focus on financial incentives erodes intrinsic motivation and altruism [17]. Whether this will change or compromise a hospital's mission and organizational behaviors over time requires ongoing study. To the extent that certain issues (e.g., cost shifting) require empirical identification, verification, or testing, future empirical research will be necessary. To the extent that other issues, such as fair sharing of ACO savings with patients, require conceptual clarity, further thought will be necessary.

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