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Emerald Article: Consideration of social values in the establishment of accountable care organizations in the USA

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Consideration of social values in the establishment of accountable care organizations in the USA

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Abstract

Purpose – The purpose of this paper is to introduce the new US health organizations called accountable care organizations (ACOs) which are expected to improve the quality and reduce the cost of healthcare for Medicare enrolees. It assesses the importance of ACOs, defining and articulating the values that will underpin their strategic and clinical decision making.

Design/methodology/approach – This paper uses a social values framework developed by Clark and Weale to consider the values relevant to ACOs.

Findings – It is likely that social values could be made more explicit in a US setting than they have ever been before, via the new ACOs. Social values could start to form part of a local health economy's marketing strategy.

Originality/value – ACOs are very new. This paper identifies that they will need to be very explicit about the values relevant to them. The development of ACOs and the articulation of social values therein may even form the basis of a meaningful dialogue on the importance of assessing value for money or cost-effectiveness in the wider US health policy environment.

Keywords United States of America, Health care, Social values, Accountable care organisations, Medicare, Cost-effectiveness

Paper type General review

Background

In 2010 the US spent approximately $2.6 trillion on healthcare, which translates into $8,400 per capita (Centers for Medicare and Medicaid Services, 2011) – about twice the amount spent per capita on healthcare in the UK. The rate of growth in US healthcare spending has slowed in the last few years, but continues to grow faster than national income, and in 2010 accounted for 17.9 percent of the nation's gross domestic product (Centers for Medicare and Medicaid Services, 2011), several percentage points higher than its European counterparts. Whilst healthcare financing in the US has been built around private (mainly employer-sponsored) health insurance, in 2010 only 34 percent of the $2.2 trillion in personal healthcare expenditures was paid for by private insurance. A much larger proportion (44 percent) was paid for by government-sponsored health insurance (Centers for Medicare and Medicaid Services, 2011), mainly Medicare, which covers the elderly and people with

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disabilities, and Medicaid, which provides coverage to low-income families and children. The marked growth in healthcare costs has had a profound effect on the finances of both the public and private sector, significantly straining federal and state government budgets, and forcing private corporations to curtail employer sponsored health insurance benefits in order to remain profitable (State Health Access Data Assistance Center, 2011).

The 2010 Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148, 2010) was introduced to expand access to high quality healthcare and provide healthcare delivery and financing reform to address spiraling healthcare costs in the US. One key feature of the PPACA is the establishment of accountable care organizations (ACOs) as a means of improving the quality and reducing the cost of healthcare for Medicare enrolees, as well as children insured through Medicaid. ACOs are collaborations of physicians, hospitals, and other providers that agree to coordinate care for a defined population of patients and receive shared savings bonuses if they are able to achieve specific quality targets and demonstrate reductions in overall healthcare spending (Fisher *et al.*, 2009). They can take on a variety of provider configurations and payer participants but all include payment incentives in the form of shared savings within a fee-for-service model and/or varying degrees of capitation arrangements with quality bonuses (Shortell *et al.*, 2010; McClellan *et al.*, 2010).

Much has been written about the financial, legal, and technical challenges of establishing ACOs (Congressional Research Service, 2010; Commonwealth Fund, 2011; Berwick, 2011) but there has been little discussion about the raft of ethical issues raised when considering a transition from a one patient/one provider fee-for-service payment model to one in which a group of providers share accountability for the quality and cost of care for a panel of patients, with the opportunity for financial gain if healthcare savings are achieved. This transition will require ACOs to make decisions about healthcare priorities, and therefore to consider the social values of the populations that they serve. In February 2011, a multi-national group of clinicians, ethicists, and health policy experts participated in a National Institute of Health and Clinical Excellence (NICE) sponsored workshop to develop a framework for thinking about social values and priority setting in health. We use that framework (Clark and Weale, 2011) to outline the social values that must be considered in the establishment and operation of ACOs, and how those values may in fact become distinguishing features in the future marketplace of American healthcare.

Social values can be divided into process and content values. Process values concern the rules that guide a decision making process, while content values deal with considerations taken into account in making the decisions. We discuss several of these values that will be relevant to priority setting in ACOs.

Process values

Transparency

Decisions about which health services will be provided in an ACO may be controversial, mainly because providers of different backgrounds (primary care vs specialist) often disagree about best practices, but also because patients and payers may have their own opinions about which interventions should be made available.

Thus, transparency in the decision making process for determining appropriateness of health services will be paramount. ACOs will want to base decisions on locally developed or nationally endorsed evidence based guidelines. Publicly available quality measures that will be used to determine whether ACOs are meeting quality benchmarks will help to ensure transparency of outcomes. Given the potential for financial gain in shared savings arrangements, ACOs should inform their patients that their providers are part of an ACO and what that means as far as the coordination, quality, and quantity of care that they will receive. ACOs should also publicly report their annual proportion of shared savings bonuses and case-mix of enrolled patients to allay fears that they are skimping on needed care or avoiding sicker patients in order to enhance profits.

Accountability

ACOs will be accountable to several stakeholders, including patients, payers, and providers. Current measurement approaches and infrastructure may not satisfy stakeholder needs, but advances in improvement science, quality measurement, and health information technology infrastructure should make it possible for stakeholders to have the comprehensive and valid information about quality and cost to ensure accountability (Fisher and Shortell, 2010). To avoid real or perceived conflicts of interest in provider decisions relating to care of individual patients, providers should be rewarded collectively, not individually, which should also foster collective accountability for quality and cost savings.

Participation

Providers and payers will need to collaborate in the establishment of practice guidelines, quality and cost benchmarks, and shared savings arrangements. The AHRQ Effective Health Care Program will be an important partner in the process of identifying best practices. ACOs should consider including member patients in their governance boards as well as guideline development groups in order to ensure that their preferences are represented in practice policies.

Content values

Clinical effectiveness

If care is to meet quality benchmarks, ACOs will need to implement best practices from evidence based guidelines and comparative effectiveness research findings. However, difficult decisions will remain about effectiveness thresholds that must be exceeded before utilization of particular practices are recommended. ACOs will also need to develop processes for dealing with situations in which there is little or conflicting evidence.

Cost-effectiveness

ACOs seek to realign financial incentives so that high value, coordinated, and preventive care is promoted, and unnecessary, duplicative and poorly coordinated care is avoided. However, the extent to which cost-effectiveness is considered in the provision of health services will probably depend on the specific payment models in

place. Efforts to maximize shared savings will certainly promote consideration of cost-effectiveness in priority setting, but only some form of capitation will force more extensive and formal consideration of cost-effectiveness in the allocation of health resources in an ACO.

Justice/equity

Ensuring justice and equity in decision making will be a major concern for ACOs who agree to provide comprehensive care for a diverse panel of patients. Decision makers will need to consider socioeconomic, racial, and ethnic disparities, as well as intergenerational issues (Keren *et al.*, 2004) in both the organization and content of care provided to their panels. Establishment of ACOs may actually serve to reduce disparities if they are encouraged to adopt metrics that measure them and payers agree to provide payment bonuses for reducing them. Regulations will also be needed to prevent gaming of payment arrangements, such that ACOs are assembled in a way that cherry picks the healthiest patients or takes advantage of risk adjustment schemata.

Autonomy

ACOs should seek to maintain patient autonomy and avoid the patient and media backlash seen in the 1990s with HMOs that insisted on strict gate keeping and penalized patients for seeking care outside of network. However, it must be recognized that patient autonomy has the potential to undermine the aims (more coordinated, high quality, lower cost care) and incentives (shared savings) of keeping care within the ACO. Thus, ACOs will need to effectively communicate to patients the importance and effectiveness of keeping care within the ACO.

Conclusion

ACOs face significant financial, legal, and technical hurdles to widespread adoption, but early demonstration projects (Centers for Medicare and Medicaid Services, 2010) suggest that their successful implementation holds great promise for reducing cost and improving the quality of care. Their acceptance by payers, providers and the public is likely to be enhanced if ACOs are explicit about the process (what values they uphold in how they make decisions) and content (what values they consider in making decisions) of their social values. Indeed, one can imagine a future in which patients and payers actively consider an ACO's stated (and evident) values in deciding whether to seek care at or contract with an ACO, and ACOs, in turn, advertise their social values, in addition to information about their success meeting quality and cost targets, to compete for those patients and payer contracts in the healthcare marketplace, in effect creating a market place for social values. If that happens, the formation of ACO's, which were originally conceived to address issues of quality and cost, could trigger broader discussions about the appropriate utilization and distribution of our healthcare resources, issues that in many ways lie at the heart of the US healthcare dilemma.

References

Berwick, D.M. (2011), "Launching accountable care organizations: the proposed rule for the Medicare Shared Savings Program", *New England Journal of Medicine*, Vol. 364 No. 16, p. e32.

Centers for Medicare & Medicaid Services (2010), "Medicare physician group practice demonstration: physician groups continue to improve quality and generate savings under Medicare physician pay-for-performance demonstration", available at: www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf

Centers for Medicare and Medicaid Services (2011), "National Health Expenditure Tables for Selected Calendar 1960-2010", CMS, Washington, DC, available at: www.cms.gov/NationalHealthExpendData/downloads/tables.pdf

Clark, S. and Weale, A. (2011), "Social Values in Health Priority Setting, NICE Workshop on Social Values and Health Priority Setting", London, available at: www.ucl.ac.uk/spp/../Social_Values_and_Priority_setting_in_health.pdf

(The) Commonwealth Fund (2011), "Final rule for the Medicare shared savings program", available at: www.commonwealthfund.org/Publications/Other/2011/Proposed-Rules-for-ACOs.aspx

Congressional Research Service (2010), "Accountable care organizations and the Medicare shared savings program", available at: assets.opencrs.com/rpts/R41474_20101104.pdf

Fisher, E.S. and Shortell, S.M. (2010), "Accountable care organizations: accountable for what, to whom, and how", *Journal of the American Medical Association*, Vol. 304 No. 15, pp. 1715-6.

Fisher, E.S., McClellan, M.B., Bertko, J., Lieberman, S.M., Lee, J.J., Lewis, J.L. and Skinner, J.S. (2009), "Fostering accountable health care: moving forward in Medicare", *Health Affairs (Millwood)*, Vol. 28 No. 2, pp. 219-31.

Keren, R., Pati, S. and Feudtner, C. (2004), "The generation gap: differences between children and adults pertinent to economic evaluations of health interventions", *Pharmacoeconomics*, Vol. 22 No. 2, pp. 71-81.

McClellan, M., McKethan, A.N., Lewis, J.L., Roski, J. and Fisher, E.S. (2010), "A national strategy to put accountable care into practice", *Health Affairs (Millwood)*, Vol. 29 No. 5, pp. 982-90.

Public Law 111-148 (2010), "Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152)", enacted March 23, 2010, available at: http://docs.house.gov/energycommerce/ppacacon.pdf

Shortell, S.M., Casalino, L.P. and Fisher, E.S. (2010), "How the Center for Medicare & Medicaid Innovation should test accountable care organizations", *Health Affairs (Millwood)*, Vol. 29 No. 7, pp. 1293-8.

State Health Access Data Assistance Center (SHADAC) (2011), "State-level trends in employer-sponsored health insurance", Robert Wood Johnson Foundation, available at: www.rwjf.org/coverage/product.jsp?id=72528

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