Accountable Care Organizations — The Fork in the Road

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Despite the uncertainty and controversy it has generated, the Patient Protection and Affordable Care Act (ACA) has sown the seeds for a major reorganization of the U.S. health care delivery system. In almost every region of the country, hospitals and physicians are forming (or talking about forming) accountable care organizations (ACOs) and entering into other arrangements designed to integrate care, manage chronic conditions, and enable evidence-based practices.

Critical to the achievement of these ends are the regulations and guidance soon to be issued by the Centers for Medicare and Medicaid Services (CMS) and the Federal Trade Commission (FTC). One of the most important judgments these agencies will be called on to make entails determining how best to ensure that ACOs foster, not hinder, competition in health care markets.

Although not precisely defined by the new law or the theorists who proposed the concept, ACOs are best understood as affiliations of health care providers that are held jointly accountable for achieving improvements in the quality of care and reductions in spending. ACOs may take a variety of organizational forms, including integrated delivery systems, primary care or multispecialty medical groups, hospital-based systems, and even contractual or virtual networks of physicians, such as independent practice associations.

In designing an organizational framework, providers and regulators will have to contend with trade-offs involving such factors as control and governance of the organization, the extent of integration among providers, allocation of risk and rewards, and exclusivity of membership.

It appears likely that the regulations will allow for considerable variation in the form of ACO that providers adopt but will nudge them toward greater integration and more interdependent relationships. And well they should. Economic analyses of the current state of U.S. health care markets suggest that they are plagued by both fragmentation and concentration. ACOs offer a much-needed vehicle for integrating health care delivery and reducing the well-documented shortcomings of the system that are attributable to payment and organizational features that reward high volume rather than low cost or high quality.

At the same time, ACOs do little to address the problem of...
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market concentration. Indeed, the ACO phenomenon may well encourage some mergers, joint ventures, and alliances that will exacerbate this considerable problem. Anecdotal evidence suggests that health care reform legislation has already prompted a number of mergers among health care providers. Furthermore, a substantial body of economic evidence indicates that market concentration has been a major factor spurring escalation in the cost of health insurance. Studies show that hospital consolidation in the 1990s raised overall inpatient prices by at least 5%, and by 40% or more when merging hospitals were located close to one another. Similarly, a recent empirical study by the attorney general of Massachusetts linked that state’s inflation in health insurance premiums to “provider leverage” — the ability of dominant hospitals and specialty physician practices to obtain high levels of reimbursement that were not attributable to differences in quality, case mix, or demographic factors. Dominant providers have used their market power for more than seeking higher reimbursements. As reported by Blue Shield of California, there have been instances in which they have also restricted the ability of employers and health plans to obtain and use cost and quality data that would enable them to shop more effectively.

Certification of ACOs for participation in the ACA’s Shared Savings Program for Medicare beneficiaries therefore poses a challenge for regulators. Because most Medicare ACOs are likely to serve private insurers as well, those that exacerbate or entrench provider dominance are likely to raise costs in the private sector, including the commercial and self-insured markets, and may also adversely affect competition among Medicare Advantage plans. The delicate task facing the agencies (the CMS in its role as ACO gatekeeper and the FTC as enforcer of antitrust law) will be to strike a balance that encourages the efficient integration of providers while preventing the formation of anticompetitive monopolies or oligopolies.

Although it is impossible to unscramble consummated mergers facilitated by lax enforcement of antitrust laws or to reverse several dubious federal court decisions made during the past decade, the CMS, working with the FTC (which has announced that it will closely monitor the formation and operation of ACOs under the Shared Savings Program), can take a number of steps to reduce the risk of anticompetitive effects. First, the agencies must be acutely sensitive to the risks posed by “overinclusive” ACOs — those composed of an unduly large proportion of the hospitals or physicians in their markets. To the extent feasible, the CMS should not certify ACOs that are likely to inhibit the development of competing ACOs or that will otherwise impede competition in the private insurance market. In most regions of the country, this approach would constrain large hospitals from forming ACOs with rival hospitals and from locking up key specialty physician groups with exclusive contracts.

Second, the CMS should insist that ACOs provide transparent and accessible cost and quality information regarding their hospitals and physicians. Allowing private plans and their customers to monitor, share, and publicize such data can improve competition even when providers possess market power. In addition, the CMS should restrict ACOs from adopting “most favored nation” clauses in their contracts with insurers. As illustrated by a case recently filed by the Justice Department, dominant hospitals and dominant insurers making use of such contracts can undermine their rivals’ ability to compete.

Finally, in places where the creation of competitive ACOs is simply not feasible because of previous merger activity among providers, the CMS and state insurance regulators may have to take more draconian measures, such as directly capping premium increases, when providers’ costs exceed benchmarks established in competitive markets.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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This article (10.1056/NEJMp1013404) was published on December 22, 2010, at NEJM.org.


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