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REVIEWS

Ethical Challenges for Accountable Care Organizations: A Structured Review

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BACKGROUND: Accountable care organizations (ACOs) are proliferating as a solution to the cost crisis in American health care, and already involve as many as 31 million patients. ACOs hold clinicians, group practices, and in many circumstances hospitals financially accountable for reducing expenditures and improving their patients' health outcomes. The structure of health care affects the ethical issues arising in the practice of medicine; therefore, like all health care organizational structures, ACOs will experience ethical challenges. No framework exists to assist key ACO stakeholders in identifying or managing these challenges.

METHODS: We conducted a structured review of the medical ACO literature using qualitative content analysis to inform identification of ethical challenges for ACOs.

RESULTS: Our analysis found infrequent discussion of ethics as an explicit concern for ACOs. Nonetheless, we identified nine critical ethical challenges, often described in other terms, for ACO stakeholders. Leaders could face challenges regarding fair resource allocation (e.g., about fairly using ACOs' shared savings), protection of professionals' ethical obligations (especially related to the design of financial incentives), and development of fair decision processes (e.g., ensuring that beneficiary representatives on the ACO board truly represent the ACO's patients). Clinicians could perceive threats to their professional autonomy (e.g., through cost control measures), a sense of dual or conflicted responsibility to their patients and the ACO, or competition with other clinicians. For patients, critical ethical challenges will include protecting their autonomy, ensuring privacy and confidentiality, and effectively engaging them with the ACO.

DISCUSSION: ACOs are not inherently more or less "ethical" than other health care payment models, such as fee-for-service or pure capitation. ACOs' nascent development and flexibility in design, how-

ever, present a time-sensitive opportunity to ensure their ethical operation, promote their success, and refine their design and implementation by identifying, managing, and conducting research into the ethical issues they might face.

KEY WORDS: accountable care organizations; ethics; health reform; physician-patient relationship.

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INTRODUCTION

Accountable care organizations (ACOs) are a new approach to organizing medical care and financing to achieve the "triple aim" of higher quality care, decreased costs, and improved population health.¹ In ACOs, health care providers and in many circumstances hospitals share accountability for the health outcomes and expenditures of their patients.² Through contracts with payers, an ACO can share in the savings accrued if it spends less than a defined benchmark while meeting specified quality metrics. These shared savings encourage ACOs to improve quality and reduce cost, especially through improved care coordination.

ACOs have formed rapidly in the public and private sectors, covering as many as 31 million patients.³ In the public sector, the Medicare Shared Savings Program (MSSP) is illustrative.^{4,5} The MSSP allows clinicians (including physicians, nurse practitioners, clinical nurse specialists, and physician assistants), hospitals, and federally qualified and rural health centers to form ACOs. MSSP ACOs must contract for 3 years, cover more than 5,000 Medicare beneficiaries, and meet 33 quality measures while holding Medicare expenditures below a benchmark defined by the Centers for Medicare and Medicaid Services (CMS). If successful, the ACO shares in the cost savings.⁶ In less than 2 years, more than 360 Medicare ACOs already

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involve more than 5 million beneficiaries in the MSSP and two related ACO programs.⁷

ACOs have been called necessary for health reform,⁸ an elusive “holy grail,”⁹ or even a “wolf in sheep’s clothing,” the wolf being managed care in disguise.¹⁰ Public comments on the CMS draft rule raised concern about inappropriately withholding care, and the potential for a perceived threat to professional autonomy was recognized in ACOs’ original conception.² ACOs, like all health care financing and organizational structures, present the risk of unintended consequences, misaligned incentives, and other challenges to ethical behavior at the clinician and organizational levels.¹¹ Whether or how ACOs raise such issues—and whether they on balance represent improvement—is unknown, in part because no framework exists to help identify ethical challenges within ACOs. Identifying these at ACOs’ early developmental stage could help policymakers and ACO participants avoid unintended harms, promote ACOs’ success, and prevent the risk of backlash (e.g., patient distrust) observed during 1990s managed care.¹² In this paper, we use an innovative approach to identify the critical ethical challenges that ACO leaders, clinicians, and patients might face.

METHODS

We conducted a structured review of the ACO literature in PubMed using qualitative content analysis.¹³ This allowed us to examine hypothesized ethical content and to discover unexpected yet important content. It also ensured that the ethical challenges identified represented real practical concerns in ACO implementation. The novelty of ACOs (which began under CMS regulations in 2012), the nature of our subject matter (ethical content), and the scarcity of explicit attention given to ACOs’ ethical issues all supported this qualitative, narrative approach.

Our primary objective was to use the content analysis to inform identification of the critical ethical challenges for ACOs. Thus, although we used the content analysis *directly* as a means to examine, discover, and quantify the frequency of ethical content in the literature, more importantly, we used the analytic process *indirectly* as a means to facilitate identification of ethical challenges, iteratively and by consensus. This qualitative process recognizes that infrequent or unexpected content could nonetheless warrant inclusion as critical ethical challenges.

To accomplish this, we developed a PubMed search using keywords and the medical subject heading (MeSH) “Accountable Care Organization” (introduced in 2012). Our search was limited to English language publications after 1 January 2006 (“accountable care organization” originated at a Medicare Payment Adviso-

ry Committee in late 2006). The full search, last performed 1 July 2012, is in the [online appendix](#).

In parallel, we used a modified Delphi method to create a data abstraction strategy. In round one, we elaborated objective article data and hypothesized major ethical themes that might occur in the literature. This was based on the authors’ prior experience. We also decided to examine whether the article used explicit ethics terms [“ethic(s), ethical, moral, morality, professional(ism)”] in reference to normative standards; we excluded descriptive uses, e.g., “the medical profession.” Initially hypothesized themes included, for example, “patient autonomy” within the ACO and “dual responsibility” of clinicians to their patients and the ACO. In round two, the facilitator (MD) compiled an abstraction form, upon which the rest of the team provided written feedback. In the final round, we agreed upon a final form via teleconference. (The form and all originally hypothesized themes are available in the [online appendix](#).)

We reviewed the full-text of all articles independently and in duplicate, first by one co-author (MD) and a second time by another co-author. Full-text review eliminated 68 articles; the most common reason for elimination was if either reviewer determined use of “ACO” was tangential (e.g., a single reference within an otherwise unrelated article). Figure 1 displays a flow diagram of article identification. Citations of the 300 articles in our final analysis are in the [online appendix](#).

Our conceptual framework was informed by systems views of professionalism.¹⁴ It recognizes that the structure of health care both determines, and is determined by, how patients, clinicians, and organizational leaders experience issues of ethics and professionalism. This framework is applied to ACOs in Fig. 2. In addition, we defined ethical themes broadly, recognizing that even ACOs’ fundamental goals (“quality” and “cost”) can involve ethics; pursuing quality can require tradeoffs between efficiency and equity,

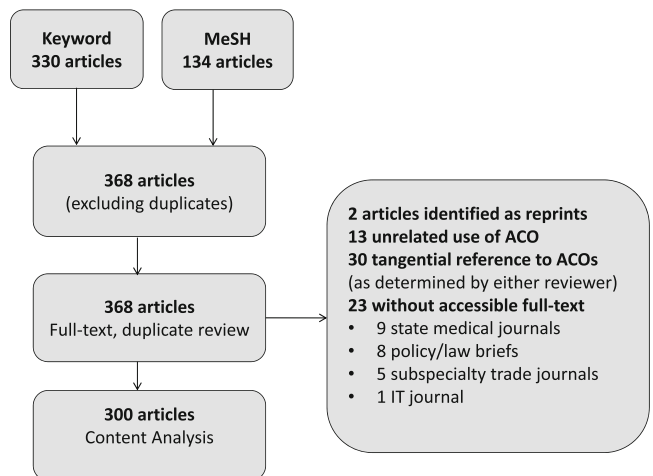


Figure 1. Flow diagram of articles identified.

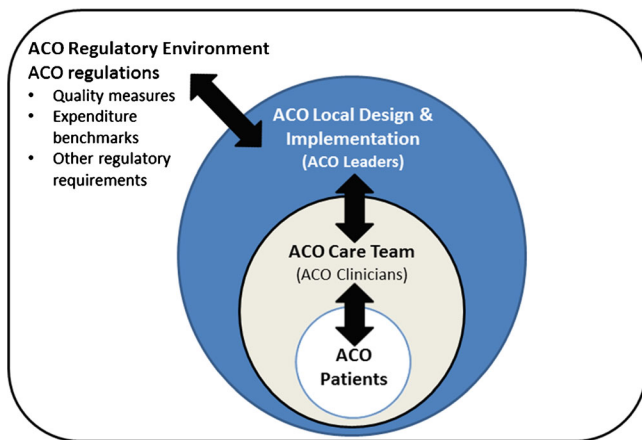


Figure 2. Conceptual framework, informed by Lesser et al.¹⁴ Bidirectional arrows represent how—within a background regulatory context—decisions or actions taken by each stakeholder group both determine, and are determined by, the ethical issues they experience. (ACO = accountable care organization).

and reducing costs might not affect all patients equally. Finally, we included themes, such as “healthcare information technology (IT),” that are not classically “ethics,” but might entail them (e.g., IT and privacy).

RESULTS

Several findings emerged. First, use of explicit ethical terms was infrequent, occurring in 16/300 articles reviewed (5%). Of these, 13 used the terms < 3 times; one 5 times; one 14 times; and one 87 times (in an article addressing ACO leaders’ ethical obligations¹⁵). For 14/16 articles, explicit ethics terms appeared only in the full text.

Second, despite infrequent explicit discussion of ethics, in 299/300 articles reviewers agreed upon at least one of our ethical themes. The average number of themes agreed upon per article was 3.9 (SD 1.8). In 122/300 articles (41%), reviewers agreed that a theme was “primary” for that article. Our qualitative method and the low prevalence of many of the identified themes limited the usefulness of the kappa statistic.¹⁶ Overall agreement was moderate to high (67–97%) for all themes; we considered a theme present only if both reviewers agreed.

Third, during the review we agreed upon and added eight themes: patient accountability to the ACO, patient engagement, competitive tension between physicians and hospitals, the role of academic medical centers (AMCs) as appropriate leaders of ACOs, the imperative of team communication, whether ACOs should improve public health beyond their patient population, appropriate performance measurement, and leaders’ “cofiduciary” obligations to patients and broader societal interests.

Figure 3 displays the frequency of themes identified. Among all articles, cost, quality, and care coordination were dominant and present in over half of articles; this was not surprising, given the centrality of these to ACOs. This was not true among the “primary” themes identified; instead, the effect of ACOs on particular (sub)specialties and disciplines (e.g., gastroenterology and radiology, among others) was the most frequently identified “primary” theme. Finally, among articles using explicit ethics terms, several themes were particularly evident, including patient choice and dual responsibilities of clinicians (Fig. 3).

CRITICAL ETHICAL CHALLENGES FOR ACCOUNTABLE CARE

We used our content analysis to identify critical ethical challenges facing ACO leaders, clinicians, and patients (see Table 1). Consistent with a qualitative approach, this was done by reorganizing related thematic content. For example, the patient themes “informed consent,” “patient autonomy,” and “patient choice” were grouped into one challenge, Patient Autonomy and Choice. Through this process, we identified nine critical challenges by consensus. Although issues affect multiple stakeholders, we placed each within its primary stakeholder of decision-making import. The discussion that follows represents our interpretation of key ethical challenges for ACOs, informed by our qualitative review. Citations refer to articles from our search, unless otherwise noted. Where possible, we suggest potential management strategies, recognizing that limited practical experience with ACOs makes fully elaborating these premature.

Leaders

Appropriate leadership was the subject of the article with the highest frequency of explicit ethics terms, which focused on the “cofiduciary” obligations of leaders to patients and to society.¹⁵ More specifically, ethical challenges for leaders include:

1. Resource Allocation

ACO leaders will face decisions about how to allocate resources. For example, assuming all quality metrics cannot receive equal attention, focusing on one condition (e.g., diabetes) at the exclusion of others—whether within or outside the ACO’s requirements—involves tradeoffs among different patients. This is an issue of distributive justice, i.e., choices about the “good of the many” (for prevalent diseases) versus the “good of the few” (for rarer ones) and/or “those most in need” (for the worst-performing measures) versus “those most

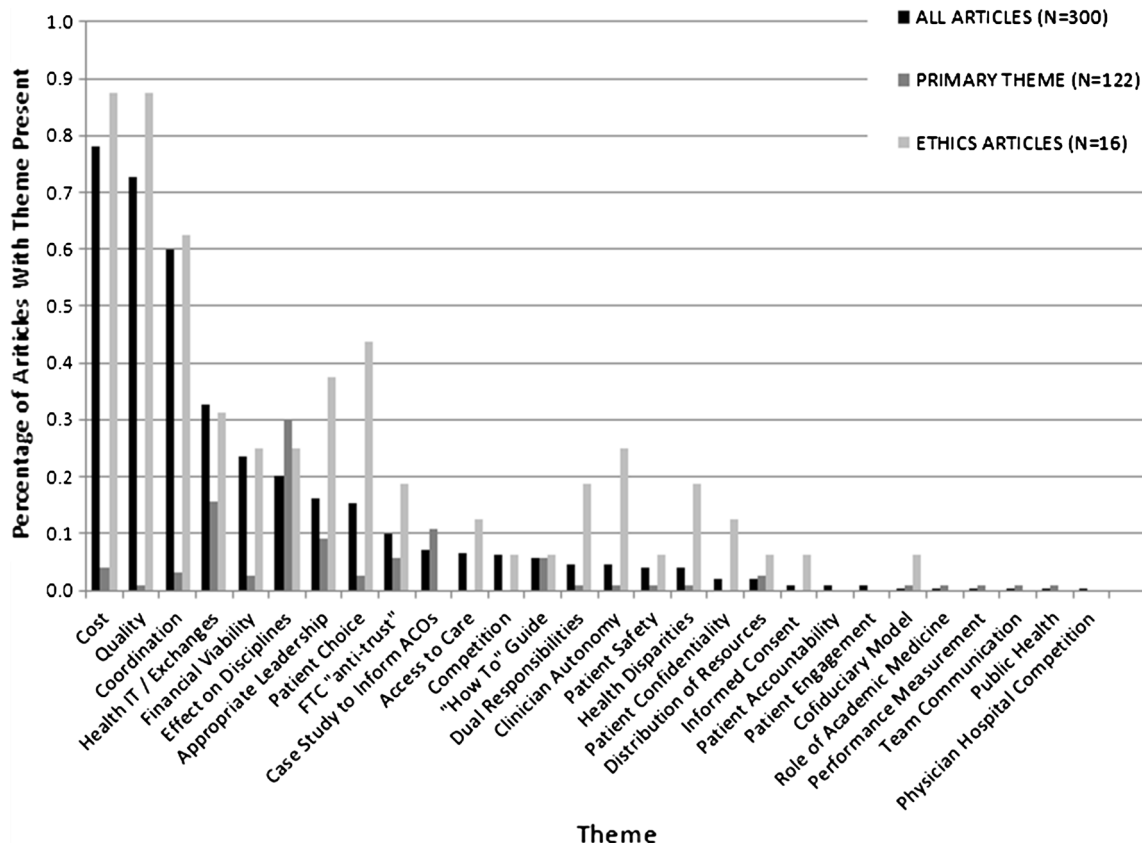


Figure 3. Frequency of themes identified among all articles, among articles with a primary theme, and among ethics articles.

likely to benefit/generate savings” (for measures just at the threshold of required performance).

ACO leaders will also need to decide how to distribute shared savings fairly. In the MSSP, ACOs have flexibility, so long as use is consistent with ACOs’ overall mission. Should savings be used solely for quality improvement? Alternatively, with estimates suggesting average potential bonuses of about \$2000–\$6000 per clinician,^{17,18} should savings be shared with clinicians? Equally, or based on performance? Should patients somehow share financial savings, perhaps based on how well they achieve particular metrics?¹⁹ If so, ACOs should inform patient incentive programs with recent work on their ethical design, including the avoidance of coercively large incentives.²⁰

2. Protecting Professionals’ Ethical Obligations

ACO leaders will have to develop cost-control and quality improvement strategies aligned with clinicians’ existing ethical obligations, such as beneficence. For example, if an ACO is trying to reduce the cost of diabetic care by reducing referrals to podiatry, it might ask physicians to “reduce referrals by 25 %,” and thereby risk suggesting that costs supersede patients’ interests. Alternatively, it might establish a referral

process for patients with abnormal screening exams plus appeals procedures for special requests; that way, physicians can advocate fully on behalf of their patients. Arguably, this latter design better aligns the ACO’s structural initiatives with physicians’ obligations of beneficence. ACO leaders should design financial and non-financial incentives that ensure professionals’ ethical obligations remain intact.²¹

Leaders should also assist professionals by modeling ethical behavior and creating an environment conducive to the identification and management of ethical issues. For example, leaders should not engage in practices counterproductive to the ACO mission. Examples include cherry-picking a patient population (by encouraging complex or “non-adherent” patients to seek care elsewhere),^{22,23} shifting costs to the private sector or parts of Medicare not included in the expenditure benchmark,²⁴ or using an ACO’s market power to raise prices.^{25,26} Payers might monitor these behaviors, but leaders should avoid them, recognizing their role in fostering an ethical culture.²⁷

3. Developing Fair Decision Processes

Leaders will face decisions involving disagreement (e.g., regarding resource allocation). Making these requires using decision-making processes based on

Table 1. Critical Ethical Challenges and Example Management Strategies for Accountable Care Organizations

Stakeholder	General Ethical Issue	Example Challenge: How should ACOs	Example Management Strategy
Leaders	Resource Allocation (fairness)	...fairly distribute shared savings among clinicians? ...fairly distribute shared savings among patients (if legally permitted)? ...determine quality metrics on which to direct resources?	Involve clinicians in the design of shared savings plans Ensure use is consistent with the ACOs' purpose and incentive is not coercive Inform decision-making with fair decision processes (see below)
	Protecting Professionals' Ethical Obligations	...design incentives aimed at reducing costs?	Ensure the incentives protect clinicians' professional role as advocates within an agreed upon rules framework
	Fair Decision Processes	...choose and involve beneficiary representatives on ACO leadership boards?	Ensure the beneficiary truly represents the community and is treated with respect
Clinicians	Professional Autonomy	...design quality improvement initiatives that do not result in actual or perceived diminished clinician autonomy?	Use clinician engagement strategies to develop mutually shared goals with clinicians
	Dual Responsibility	...manage clinicians' perceived pressure to withhold care or "upcode" to assist the ACO's financial goals?	Monitor clinicians' experience of dual responsibility and educate clinicians about professionalism and high-value care
	Managing Competition	...manage perceived competition between primary care and specialists in an ACO, which might lead to uncooperative behaviors and distrust?	Develop teamwork, collaboration, and communication strategies; designs shared savings plans fairly (see above)
Patients	Autonomy	...inform patients about the ACO?	Pilot communication strategies with focus groups and conduct ongoing evaluation of communication strategies
	Privacy and Confidentiality	...balance protection of confidentiality with the importance of data sharing?	Provide adequate privacy and confidentiality safeguards and inform patients of these during ACO notification
	Engagement	...engage patients and communities meaningfully and ethically?	Utilize proven patient engagement strategies for ACO design, governance, and policymaking

ethical principles of transparency, relevance, revisability, and enforcement.²⁸ Leadership of Medicare's MSSP ACOs reflects such processes: 75 % of the governing board must be composed of ACO participants, and a Medicare beneficiary must be included. Fair decision processes will require effectively engaging clinicians.²⁹ Attention will also need to be given to choosing community/beneficiary members of the board who truly represent the community and who are awarded appropriate respect in decision-making.

Clinicians

Clinicians within ACOs—primary care providers, specialists, nurse practitioners, clinical nurse specialists, physician assistants, and others—occupy the interface between the patient and the ACO. Ethical issues for clinicians include:

1. Professional Autonomy

From the conceptualization of ACOs² to public comments on the draft CMS rule in 2011, clinicians have expressed concern about ACOs infringing their professional autonomy. For example, could requiring clinicians to focus on quality metrics over other patient needs, or to reduce interventions that might be accepted standard of care outside the ACO, reduce clinicians'

ability to customize care for individual patient needs or place them at liability risk? Some argue this fear is misplaced because ACOs and clinicians ideally share the goal of the patient's best interest.³⁰ On the other hand, prior concern has existed outside the ACO context that guidelines and evidence used to generate quality metrics might not be appropriate for all patients.³¹ Much will depend on how ACOs operate and which goals they prioritize. To increase a sense of shared purpose, ACOs should work with clinicians (including those at the front-line of caregiving) to develop mutually shared goals.³²

2. Dual Responsibility

Echoing criticisms about overuse of services under fee-for-service models and gatekeeping or withholding care in managed care,³³ clinicians might perceive problematic dual responsibility (or conflict of interest) to the ACO and to their patients.^{34,35} Evidence outside the ACO context suggests patients might distrust physicians whom they perceive as focusing too much on costs.³⁶ A cost-only focus might lead to other ethical transgressions, such as physician upcoding of their patients' illness severities to increase allowable expenditures. Payers will likely monitor for this behavior. However, managing dual responsibility is more fundamental, ethically, for maintaining trust in the physician-patient relationship. ACOs should be vigilant for the

occurrence of dual responsibility issues and educate clinicians and patients so that they understand that parsimonious, high value care need not threaten trust or professionalism.^{37,38}

3. Managing Competition

Part of professional ethics involves appropriate relationships with other professionals. “Shared accountability” or the potential for differentially shared savings might create unwelcome competition between primary care providers and specialists,³⁹ among specialists,⁴⁰ or between physicians and hospital leadership.⁴¹ For example, tension might arise if primary care clinicians have an incentive to decrease referrals while shared savings are insufficient to compensate lost income to specialists. Similarly, strong incentives to manage conditions outside the hospital could create tension between outpatient clinicians and hospital leadership. These relational dynamics can present ethical concerns. First, if patients sense competition or mixed motives, they might come to distrust ACO clinicians. Second, if competition leads clinicians to change their behavior—for example, by reducing appropriate referrals or hospitalizations—patients’ best interests might become secondary to the competitive drive or financial interest of ACO clinicians. ACOs should therefore develop strategies to minimize competition by fostering teamwork and collaboration.⁴²

Patients

Patients should be the central focus of ACOs. Critical ethical issues for patients include:

1. Autonomy and Choice

Patient autonomy, choice (e.g., among providers) and informed consent will be important ethical challenges for ACOs. The CMS MSSP expresses the importance of this by explicitly maintaining a patient’s choice in clinician.⁴³ If ACO-like models attain cost savings through control over referral patterns, as evidence suggests,⁴⁴ it will be important to examine whether or under what circumstances this imposes unreasonable constraints on patient autonomy. Because finding an appropriate balance between autonomy and ACOs’ broader goals of higher quality care at reduced cost will likely raise controversial questions, it will be particularly important to organize fair decision processes that help adjudicate disagreement and reach compromise.

Respecting autonomy arguably requires informing patients about ACOs. Being in an ACO “happens to” patients passively and retrospectively based on claims data; patients do not actively “enroll in” an ACO. This

detail, along with the linguistic similarity of ACOs to managed care organizations, might complicate patients’ understanding of ACOs. CMS requires ACOs to notify patients in-person or in writing that their clinician is an ACO participant.⁵ Respecting patient autonomy requires understanding different notification methods and investigating how patients interpret “accountable care.” ACOs should ensure that ACO informational materials truthfully describe “shared savings” and cost control, and they should consider piloting materials prior to widespread use.

2. Privacy and Confidentiality

The success of an ACO depends in part on sharing claims and health data between clinicians, the ACO, and payers. Recognizing the ethical value of privacy and confidentiality, CMS ACOs include an opt-out provision that allows patients to prevent CMS from sharing certain identifiable claims and prescription data with ACOs.⁶ ACOs should ensure that privacy and confidentiality are protected, and take steps to understand how patients interpret the opt-out provision. Regulatory revision of this provision might also be carefully considered, if use of the data opt-out provision hinders ACO success.

3. Patient Engagement

Engaging patients (or making them “accountable”) throughout ACO development was an important theme that emerged in our review.^{19,45} Recent work has argued that the ethical obligation to engage patients is based upon respect for persons and the improved health outcomes that result from effective engagement. This obligation is shared among patients, clinicians, organizations, and payers.⁴⁶ At present, ACOs may be ill-prepared to engage patients comprehensively—from the level of individual patient care to involvement in governance boards to broader patient and community engagement.⁴⁷ Nevertheless, patient and community engagement might be necessary for ACOs to achieve improved health outcomes.⁴⁸ ACOs should therefore develop strategies that meaningfully engage patients within quality improvement, cost containment, and other ACO planning teams.⁴⁹

DISCUSSION

From our content analysis, we conclude that the ACO literature rarely addresses ethics in explicit terms. This may be because ACOs developed only recently, and ACO stakeholders have yet to experience or express the ethical challenges they have faced. When carefully examined, however, the literature reveals nine critical ethical chal-

Challenges that leaders, clinicians, and patients might face in the design and implementation of ACOs. Most were consistent with our initially hypothesized themes; in these cases, our content analysis revealed important and novel aspects, such as the multiple types of “competition” that might arise under an ACO model.⁵⁰ Other challenges, particularly the importance of patient engagement, emerged from our in-depth review. With little explicit reference to ethics, however, ACO stakeholders may be unaware of their ethical dimensions.

Not all of the challenges are new. All forms of health organizations and payment have the potential to face challenges, such as dual responsibility, confidentiality, competition between providers—challenges recognized in the earliest medical oaths. Traditional fee-for-service, for example, creates the incentive for more, sometimes unnecessary services that can harm patients or reduce trust in clinicians. In ACOs, however, some ethical issues may become more salient or manifest in relatively unique ways. At a fundamental level, for example, clinicians might object to the idea that “incentives”—a term commonly used in this subject area and frequently encountered in our review—are necessary for improving the quality and affordability of care. Whether or not this is true, the net effect of the shift to accountable care from the standpoint of ethics is unknown. Our work begins to explore these possibilities as a necessary first step to assist ACOs in managing potential ethical challenges.

Failing to identify ethical challenges as such is more than semantic. Identifying them allows for discussion and management of these issues, which is critical to the patient–clinician relationship, patient outcomes, and the practice of medicine generally. In addition, the backlash over managed care offers a reminder that attention to ethical issues may be necessary for the acceptance of reforms. Ethics and professionalism properly construed can help address these challenges (as they are, e.g., in *Choosing Wisely*³⁸).

Our findings have limitations. First, ACOs’ diversity and ongoing implementation mean that ethical issues might change over time or be context-dependent. Private payer ACOs, for example, might have different rules than CMS ACOs. However, our results should inform most ACO models. Flexibility afforded to ACOs’ implementation could be a comparative advantage for developing ethically informed practices; ACOs’ organizational structure could help facilitate these practices and processes. Second, our literature search was last performed in July 2012; subsequent publications could have affected our findings. We reviewed search results in an ongoing manner; none suggested significant developments in the ethics literature regarding ACOs. Third, by focusing on ACOs, our search did not necessarily capture the well-established literature on health care organizational ethics. That this did not occur, however, has an important practical implication: It suggests the potential and need for these spheres to intersect. Finally,

we did not include policymakers explicitly as stakeholders. This was intentional, to demonstrate the range of actions available to ACO stakeholders within existing regulations.

In the future, it will be important to investigate whether and how these challenges arise and to refine effective management strategies. One question worth exploring is whether specific quality metrics—such as those included in CMS’s Patient/Caregiver Experience domain, which includes patients’ ratings of providers—capture particular ethical issues. One could imagine, for instance, that physician communication or shared decision-making metrics might associate with the ethical challenges regarding patients’ autonomy. If so, an intervention that better informs patients about the ACO might be a way to improve that communication metric, to ensure ACOs’ success, and most importantly, to protect patients’ autonomy.

More general questions remain about the role of ACOs in public health, health disparities, and social justice. Is it enough if ACOs happen to benefit vulnerable patients,⁵¹ or should this be their explicit mission?⁵² Should ACOs embrace a broader role in public health,⁵³ or do they lack the relevant incentives or capabilities?⁵⁴ Answering these questions and managing the ethical challenges described here will be critical to the long-term success and ethical operation of ACOs.

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