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Accountable Care Organizations and Health Care Disparities

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Under Section 3022 of the Affordable Care Act, the Centers for Medicare & Medicaid Services is tasked with developing and testing accountable care organizations (ACOs). The goal of ACOs is to group hospitals and physician practices together to facilitate and incentivize quality improvement and cost containment—critical steps for US health care. However, careful consideration and monitoring during the program's implementation is needed to ensure that ACOs do not have the unintended consequence of reinforcing health care disparities.

Racial/ethnic disparities in health care are well documented in the United States. These disparities arise, in part, because of differences in the site of care. Black and white patients tend to receive care from different clinicians who work at different hospitals and in different health care systems.¹⁻³ Primary care clinicians for white and black patients report varying levels of institutional resources¹ and in many settings, hospitals that treat a large proportion of black patients appear to provide lower-quality care than hospitals that treat a larger portion of white patients.² The de facto segregation of the health care system has important implications for the creation and implementation of ACOs.⁴

The process of creating ACOs may reinforce racial/ethnic differences in sites of care by further concentrating patients from certain racial/ethnic groups within particular health care organizations. Although many integrated delivery systems and multispecialty group practices may already qualify as ACOs, other hospitals and independent practices must enter into contractual relationships to become an ACO.⁵ Profitable practices are more desirable partners for these relationships and wealthier hospitals likely have a greater ability to compete for these practices. Although not explicitly selecting patients by race, ethnicity, or socioeconomic status, the current reality is that profitability in health care is strongly correlated with caring for fewer low-income patients and low-income patients are disproportionately not white. To the degree that the creation of an ACO enables wealthy

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practices to preferentially align with one another, this process has the potential to further concentrate wealth and racial/ethnic groups within certain ACOs.

Once established, the successful implementation of an ACO would depend on its ability to influence costs and quality in treating its targeted population of patients.⁶ Exerting this influence will require ACOs to develop strategies to keep their patients within their own system because patients who travel between ACOs create substantial financial risk. To the degree that these strategies are successful in limiting movement between systems, they are likely to accentuate racial/ethnic differences in where patients receive care.

This segregation is problematic on its own but becomes even more concerning if it is associated with inequity in the quality and resources of the different ACOs. Programs and infrastructure to improve value within an ACO require financial investment. Fewer financial resources within health care systems that disproportionately care for lower-income patients may impede the system's ability to meet quality benchmarks, implement programs to reduce costs, and qualify for potential shared savings. Similar concerns have been raised for other pay-for-performance programs in health care.⁷ Without careful implementation, these programs can make the rich richer and the poor poorer, further widening racial/ethnic disparities in health care and health outcomes.

Moreover, because ACOs are a demonstration project, many hospitals that disproportionately care for patients from certain racial/ethnic groups may opt not to participate, either because of limited resources or because care for these populations is too fragmented. These health care systems are rarely early adopters of innovation.⁸ Although it remains uncertain whether ACOs will produce substantial, if any, benefits for patients, it is clear that patients who receive care at hospitals that do not participate in ACOs will not have the opportunity to experience any potential gains.

In a worst-case scenario, the cherry picking of practices in ACO formation and the process of owning patient panels will concentrate white patients within certain hospital systems that will be able to make the greatest investment in improving value and will receive the greatest benefit from the ACO arrangement. Although not intentional, this scenario leaves lower-income patients who are less likely to be white more concentrated in hospital systems that have relatively fewer financial resources and less ability to compete in a new world of accountable care.

Of course, the factors influencing racial/ethnic disparities are complex and several are likely to mitigate the chance of this worst-case scenario. The distribution of racial/ethnic groups across hospitals may vary by geography and may not always lead to worse care for patients who are not white. Urban academic medical centers serve a large proportion of city-dwelling populations and could be an important counterweight to these trends if they participate and succeed in the models of accountable care. In addition, because these patients often have fragmented care, initiatives that improve coordination of care may provide them with a greater benefit. Given appropriate risk and severity adjustment, ACOs with more lower-income patients who are not white may experience a higher return on investment if they can successfully address the burden of care fragmentation.

However, given the uncertainty about the potential impact of ACOs on racial/ethnic disparities in health care, it is critical to evaluate and address the potential unintended consequences of ACOs during program implementation. The legislation explicitly recognizes the need to risk-adjust for patient characteristics when determining benchmarks and to monitor for the avoidance of at-risk patients. At-risk populations should include not only individuals with high health care needs and expenses but also individuals from medically underserved racial/ethnic groups and individuals with low-socioeconomic status. Several additional steps should be considered.

First, the Centers for Medicare & Medicaid Services should mandate the reporting of quality indicators by race/ethnicity within ACOs to determine the impact—both positive and negative—on disparities. Second, it will be important to examine whether the distribution of patients by race/ethnicity between ACOs is associated with the quality of care Medicare beneficiaries receive. Understanding these system-level differences is critical for determining program effectiveness and improving its design. Third, some hospitals and clinicians will choose not to enroll in the demonstration project so the program should monitor which clinician and patient populations are excluded. Incentives may be necessary to ensure adequate representation of diverse patient populations and health care systems. Fourth, it may be necessary to take active steps to avoid patient and practice cherry picking in ACO creation. Monitoring and enforcing such a policy is likely to be the most challenging step, especially because ACOs are designed to reflect existing referral patterns. Recent hospital and practice consolidations have raised concern from an antitrust perspective⁹ and should be monitored from a disparities perspective.

ACOs hold substantial promise to modify existing reimbursement structures to reward high-value health care. Their success will require influencing the pathways through which patients receive specialty and hospital care. This process of ACO formation is playing out against a backdrop of widespread racial/ethnic disparities in health care, driven, in part, by segregation in hospitals and practices. Although any opportunity to influence the sites in which patients receive care could lead to more diverse racial/ethnic access to medical services, ACOs are unlikely to reduce and may even exacerbate disparities in care without active intervention to monitor and incentivize equity within and across ACO populations. The goals of improved care coordination, increased quality, and lower costs are critical for all segments of society.

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