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Ethical Practice Under Accountable Care

Abraham D. Graber¹, Asha Bhandary², and Matthew Rizzo³

¹Philosophy & Religious Studies, Western Illinois University, 456 Morgan, Macomb, IL 61455, USA

²University of Iowa, 258 English-Philosophy Building, Iowa, IA 52240, USA

³Department of Neurological Sciences, University of Nebraska Medical Center, 988440, Omaha, NE 68198 8440, USA

Abstract

Accountable Care Organizations (ACOs) are a key mechanism of the Patient Protection and Affordable Care Act (PPACA). ACOs will influence incentives for providers, who must understand these changes to make well-considered treatment decisions. Our paper defines an ethical framework for physician decisions and action within ACOs. Emerging ethical pressures providers will face as members of an ACO were classified under major headings representing three of the four principles of bioethics: autonomy, beneficence, and justice (no novel conflicts with non-maleficence were identified). Conflicts include a bias against transient populations, a motive to undertreat conditions lacking performance measures, and the mandate to improve population health incentivizing life intrusions. After introducing and explaining each conflict, recommendations are offered for how providers ought to precede in the face of novel ethical choices. Our description of novel ethical choices will help providers know what to expect and our recommendations can guide providers in choosing well.

Keywords

ACO; Ethics; PPACA; Principlism

Introduction

The Patient Protection and Affordable Care Act (PPACA) aims to make the healthcare system more just while mitigating soaring costs that have not improved healthcare quality (Berwick 2012; Berwick et al. 2008; Fuchs and Schaeffer 2012). The Accountable Care Organization (ACO) is an initiative within the PPACA that aims to incentivize physicians to use medical resources more efficiently. Physicians must understand these incentive schemes to avoid new ethical pitfalls (Decamp 2013). We critically examine ACOs and offer pragmatic guidance for providers who may soon face unfamiliar ethical choices.

Correspondence to: Abraham D. Graber.

Asha Bhandary and Matthew Rizzo have contributed equally to this work.

Background

ACOs, an important component of the PPACA, “are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients” (Centers for Medicare and Medicaid Services 2014). This definition of ACOs is open-ended, inasmuch as “there is no concrete vision of who would form an ACO, and it is open to any combination of hospital, physician practice, and ancillary care services” (Hong and Dimick 2012). Likely ACO configurations include multispecialty group practices, interdependent practice organizations, collaborative organizations composed of health plans and providers, and “jointly owned organizations that include a hospital and a subset of the hospital’s medical staff members” (Shortell and Casalino 2008).

The PPACA offers healthcare organizations financial incentives, in the form of shared savings, for enrolling in one of two programs: Pioneer ACOs and Medicare Shared Savings Program ACOs. ACO expenditures are compared to “ACO spending targets... [that are] determined on the basis of baseline Medicare spending for assigned populations, projected forward by average increases in national Medicare spending” (McWilliams and Song 2012). Pioneer ACOs and Medicare Shared Savings Program ACOs differ in that Pioneer ACOs accept “a greater degree of financial risk and reward” (Nichols 2012).

ACOs are charged with the “triple aim” of (1) decreasing healthcare costs, (2) improving healthcare quality,¹ and (3) improving population health (Berwick et al. 2008). Patients are assigned to an ACO based on the organization from which they have received a predominance of their primary care (Gourevitch et al. 2012). Financial incentives for achieving the triple aim only apply to the population of patients assigned to an ACO.

The demand that ACOs decrease costs suggests that ACOs may reprise problematic aspects of health maintenance organizations (HMOs); however, several aspects of the design of ACOs aim to distinguish them from HMOs (Weil 2012; Emanuel 2012).

Medicare will reimburse ACOs for patient care on either a capitated or fee-for-serve model (Iglehart 2011). ACOs that meet spending benchmarks will receive a portion of the money they have saved Medicare. However, ACOs are only eligible to receive cost reduction bonuses if they have maintained or improved the quality of care (Iglehart 2011). Thus, ACOs work on a mixed reimbursement model that always includes pay-for-performance. In an ACO, unlike in an HMO, incentives to decrease costs will be mediated by the need to maintain the quality of care (Hong and Dimick 2012).

¹It should be noted that “healthcare quality” can be understood in at least two importantly different ways. “Healthcare quality” or “quality of care” might refer to providing a patient with an accurate diagnosis and treating the diagnosed ailment in a way that balances the concerns of the patient and the physician. Alternatively, “healthcare quality” or “quality of care” may refer to the extent to which care corresponds with pre-determined quality measures. These quality measures may or may not line up with what patients and physicians consider quality care. In the remainder of this paper we will use the terms “quality of care” and “healthcare quality” to refer to pre-determined measures. We will, however, also assume that these pre-determined measures correspond with providing a treatment that balances the concerns of the patient and the physician. The possibility that quality measures might not correspond with treatment options that would satisfy both the patient and the physician constitutes a significant ethical concern. As this is a general problem with pay-for-performance, and not unique to ACOs, it falls outside of the scope of this paper.

ACO responsibility for population health constitutes a further noteworthy change in American healthcare. “Population health” is defined in terms of the health of patients assigned to an ACO, not the health of the population of a geographic area (Noble and Casalino 2013). The ACOs in the Medicare Shared Saving Program are currently not required to accept financial risk tied to population health—although one can already find commentary in the medical literature suggesting that such incentives be added (Calman et al. 2012). In contrast, by their third year Pioneer ACOs are required to accept financial risks linked to population health (Nichols 2012). The mandate to improve population health makes ACOs responsible for chronic health problems, e.g., alcoholism or obesity, for which patients have not sought care.

ACOs will need to change physician behavior to achieve the three aims of (1) decreasing the costs of care, (2) improving the quality of care, and (3) improving population health. Currently, ACOs have considerable latitude to determine whether to use rewards or punishment to motivate changes in practice. In the remainder of the paper, we will assume that physicians employed by an ACO will have a variety of incentives designed to change physician behavior to match the goals of the ACO. Much of ethical importance will depend on the specifics of these incentive structures. For now, we will have to wait and see how these incentives are implemented. Concomitantly, our discussion will focus on concerns we can expect to arise under any incentive structure aimed to bring physician behavior in line with the aims of an ACO.

Although the PPACA only establishes ACOs for Medicare patients, ACOs are also likely to influence private care (Trubek et al. 2012), and Pioneer ACOs are formally required to have “50 % of their private payer contracts ... [link reimbursement] to the efficient delivery of high quality care ...” by their third year (Nichols 2012). The ethical shifts generated by the ACO model will be felt throughout the profession.

Despite the potential importance of ACOs in American healthcare, surprisingly little has been written about the ethical challenges providers will face under the ACO model. While a PubMed keyword search of “accountable care organizations” retrieves 990 citations, a PubMed keyword search of “accountable care organizations and ethics” retrieves a mere 26 citations.² Of these 26 articles, only three have an explicitly ethical focus. Two focus on the ethical obligations of the ACO, with little mention of the individual physician (Decamp 2013; Slosar et al. 2013). The third article briefly considers the ethical implications physicians situated within an ACO can expect to face, but fails to contextualize this discussion within the principlist framework (Decamp et al. 2014). None of these three articles was published in a medical ethics journal.

There is a pressing need for ethical analyses of ACOs that (1) aim to offer ethical guidance to physicians employed by ACOs and (2) do so from within an ethical framework physicians are familiar with, i.e., principlism. Our aim is to start this discussion. In what follows, we will highlight a number of novel ethical concerns that may arise within ACOs. In places, our discussion moves quickly. Our goal is not to offer the definitive word on ethical practice

²Query performed on 5/06/2014.

under accountable care. Rather, we hope to spark discussion amongst the medical ethics community on a subject matter of pressing importance that has not received its due. So long as there is an ongoing absence of discussion of the ethical issues physicians can expect to face under accountable care, we as the medical ethics community have failed to fulfill one of our most important functions: offering physicians ethical guidance in the changing world of medicine.

Discussion and Recommendations

ACOs aim to provide incentives for physicians to improve population health under an overarching ethical commitment to promote the well being of the population. On the other hand, the four principles of bioethics—especially autonomy and beneficence—often come into conflict. Thus, as ACOs endeavor to recalibrate the balance between justice, beneficence, and autonomy, novel ethical conflicts will emerge. We hold that the best way to mediate these potential ethical problems is for physicians to be aware of the ways incentives in ACOs can influence physicians' behavior so that providers can avoid unwittingly compromising professional integrity and patient care.³ Accordingly, this article is devoted to an exclusive discussion of ways in which ACO incentives may conflict with three of the four principles of bioethics: beneficence, justice, and autonomy.⁴

Providers who work for ACOs are not merely employees to be pushed and pulled by incentive structures. They are independent professionals who can govern themselves in accord with ethical principles and benefit from practical examples, some of which are outlined below. Ethical awareness will improve when practitioners understand what needs monitoring, as in the campaign to mitigate medical errors (Kohn et al. 2000).

Before proceeding with our discussion, it is important that we stress how this paper should *not* be read. Given the highly politicized environment surrounding the PPACA, the reader may be tempted to understand what follows as a criticism of ACOs. Resist this temptation. In order to prepare physicians for ethical worries arising as a consequence of changing incentive structures, we highlight a range of ethically problematic aspects of ACOs. We do not, however, make any all-things-considered judgments about ACOs. ACO design may be fraught with ethical problems while still being the best incentive structure available. On the broader question of the advisability of ACOs, we remain agnostic.

Beneficence

The provider's duty to act in the patient's best interest is the obligation of beneficence. Achieving the triple aim can conflict with this obligation.

The Motive to Focus on Conditions with Performance Measures—One way to decrease the amount spent on healthcare is to offer less care. ACOs only receive financial

³The potential for bedside rationing is one of the most worrisome ethical issues raised by ACOs. Our aim is discuss ethical issues novel to the ACO. As there is already a wealth of literature on bedside rationing with regard to HMOs, we do not offer an in-depth discussion of the problem.

⁴The obligation to non-maleficence is generally understood to be the obligation to avoid inflicting harm (see Beauchamp and Childress, 2012). Because ACOs encourage physicians to do no harm—as do current arrangements—there is no section on non-maleficence.

incentives in the form of shared savings if they meet quality benchmarks. Thus, ACO reimbursement is partially pay-for-performance (Berwick 2011). Where performance measures are lacking, only the incentive to cut costs remains in place. Pay-for-performance may be effective at increasing the quality of care for illnesses with performance measures, but it can *decrease* the quality of care for illnesses that lack performance measures—given limited time, providers will focus their attention on treatments associated with financial rewards (Doran et al. 2011).⁵ Consequently, pressure to cut costs may lead providers to violate their obligation to beneficence in patients with conditions for which there are no performance measures.

The problem may be particularly acute regarding referral practices. Specialist referrals are expensive, and developing performance metrics for specialists is uniquely problematic (Greenberg et al. 2010). Where performance measures for specialist treatment are lacking, all incentives push towards cutting costs and, therefore, specialties that by-and-large lack performance measures can expect to see fewer referrals.

These problems lead us to recommend expanding the scope of performance measures. Organizations that represent specialists have an ethical mandate to develop performance measures; members of such organizations have an ethical obligation to participate in the development of these measures. If an organization has not begun the process of developing performance measures, members should use annual meetings to ensure that the production of performance measures is a central feature of the organization's plan for the upcoming year.

In addition, specialists for whom performance measures are lacking should advocate for the interventions they can provide. Strong advocacy may mitigate the effects of incentives that hinder specialty referrals. It is, however, important that specialists advocate cautiously. There is a significant threat of conflict of interest as successful advocacy can benefit the specialist financially. Striking this balance will not be an easy task.

Modern practice is characterized by a growing demand for evidence-based medicine. This trend reflects a plausible moral tenet: the physician is morally obligated to offer the treatments that are most effective, where judgments of efficacy are based on the best available scientific evidence. This moral tenet draws its plausibility from the principles of beneficence and non-maleficence; reliable judgments about the costs and benefits associated with a treatment option must be based on scientific evidence. There is a gap between possessing evidence that a treatment is effective and having a performance measure ready to help determine ACO reimbursement. Specialists should limit their advocacy to available evidence (potentially including anecdotal reports and personal experience when the science is lacking). Insofar as a specialist limits her advocacy to making others aware of evidence regarding the effectiveness of treatment options, there is little threat of conflict of interest. Patients can only benefit from providers having more awareness of the pros and cons of treatment options.

⁵The effectiveness of pay-for-performance remains contested. (See, for example, Jha et al. 2012).

Ultimately, the general practitioner will be responsible for making decisions about specialty referrals. Little can be done to change a reimbursement structure that disincentivizes quality care for conditions that lack performance measures. The best way for the general practitioner to mitigate the influence of such incentives is to nurture provider–patient relationships. The more carefully a provider listens to her patients, the less likely she is to overlook or under treat a condition (Hannon et al. 2012).

ACOs and Patient Trust—For pay-for-performance to be effective, financial incentives must improve the quality of care. But there is a danger that applying market norms more broadly to care will cause physicians to view their patients as merely instrumental to the pursuit of personal wealth. Using terms from German philosopher Immanuel Kant, treating patients as instrumental to personal wealth would be to view patients as “means”—valuable only in terms of their usefulness to others—rather than as “ends in themselves”—or beings worthy of respect and value in their own right. When providers are reimbursed via pay-for-performance they may be motivated to provide quality care by financial considerations, as opposed to being motivated to provide quality of care out of concern for patient welfare.

Studies have shown that patients who are aware of pay-for-performance incentives begin to doubt the motives of the provider (Hannon et al. 2012). Consequently, the pay-for-performance incentive structure may be damaging to trust within the provider–patient relationship. Not informing patients of incentive structures could allay the potential for damage to the provider–patient relationship; however, it is ethically obligatory to inform the patient about financial incentives. Furthermore, ACOs are legally required to inform their patients about their reimbursement structure (Meyer 2011).

There is little—ethically or legally—the provider can do to prevent patients from becoming aware of pay-for-performance. Some have argued that ACOs offer providers the opportunity to spend more time with each patient; ACOs hope to decrease costs by developing comprehensive treatment plans for all of a patient’s ailments—a process requiring significant face-time with a general practitioner (Luft 2012). The resultant development of close personal relationships with patients may make patients more confident of the provider’s motives for providing care.

It is not clear if ACOs will increase or decrease personal contact time between patients and providers. If performance measures usher in an era of decreased trust in physicians, bedside manner will become an increasingly important skill. If ACOs do not provide more face-time with patients, providers will need to do more trust building with the same per patient time allotment. In such an environment, improving communication skills and bedside manner will be critical. Towards this end, we recommend that providers who work within an ACO allocate a portion of their continuing medical education units (CMEs) towards improving these clinical skills. Where necessary, providers should explicitly request that CME sessions be offered on these topics. Physicians with better communication skills and bedside manner will be able to build more trust in the same limited time span.

Patient Satisfaction Ratings and Unnecessary Care—Patient satisfaction ratings are part of pay-for-performance (Luft 2012). When reimbursement is linked to patient

satisfaction, the provider has an incentive to fulfill patient demands, even when these demands are not medically indicated. This is one way in which the ACO further promotes the autonomy of its patients; however, interventions that are not medically indicated burden patients with an unjustified monetary cost and may be associated with health risks.

The conflict between patient satisfaction ratings and a provider's obligation to beneficence is mitigated by cost reduction incentives. Interventions that are not medically indicated unnecessarily increase the cost of healthcare. Providers may, nonetheless, feel pressure to provide unnecessary care. Providers should keep the principle of beneficence in mind. Providing interventions that are not indicated is a violation of the provider's obligation to her patients.

Problems associated with reliably measuring patient satisfaction are well documented (Fenton et al. 2012). There remains no consensus on how providers can act to mitigate potentially perverse incentives. For now, the best we can do is draw provider attention to the concern, raising provider awareness of potential avoidable conflicts.

The Provider's Incentive to Retain Patients—In some payment models, the number of patients assigned to an ACO (partially) determines reimbursement (Devore and Champion 2011). Providers have an incentive to discourage patients from receiving care outside of the ACO, potentially influencing referral decisions. Providers will have a financial bias towards in-house referrals, even if the in-house specialists are not the best available practitioners (Berenson 2010).⁶ To prevent financial considerations from affecting the welfare of patients, providers should (1) discuss the treatment plan in detail with the patient and educate them about the availability of a second opinion if the patient has any concerns, and (2) in those cases where the best care available is offered by a competing ACO, cultivate a preference for external referrals.

Justice

Justice is perhaps the most controversial of the four principles. What sort of justice are providers responsible for upholding? To whom they owe this obligation? Does the obligation to justice fall on the shoulders of the provider or the healthcare institution? The PPACA, overall, aims to promote the justice of the healthcare system by providing affordable healthcare for people who were previously priced out of purchasing healthcare. Nonetheless, there are some potential pitfalls for ACOs concerning justice that we highlight below.

“Population Health” and a Disproportionate Focus on Medicare Patients—

“Population” is never explicitly defined in the PPACA; however, “population health” is taken to refer to “the health of the Medicare beneficiaries attributed to a health care organization,” and financial incentives are only attached to the health of Medicare beneficiaries (Noble and Casalino 2013). Consequently, ACOs have no incentive to implement population health programs for non-Medicare patients. Furthermore, because the implementation of programs designed to improve population health come at some cost to an ACO, ACOs may provide worse care to non-Medicare patient populations.

⁶Anti-trust laws have been relaxed for ACOs, potentially legalizing previously illegal in-house referrals (Leibenluft 2011).

Physicians can resolve this problem by demanding that these programs be implemented across populations. If an ACO requires that providers talk to Medicare beneficiaries about not smoking, providers should insist that this expectation be expanded to every patient population. When an ACO does not ensure that all of its patients receive the highest quality of care, this obligation falls on the physician as a norm of professional integrity.

Disincentive to Care for Patients who are not Assigned to One's ACO—Patients assigned to an ACO can receive care anywhere; however, an ACO is only rewarded for health improvements in patients assigned to that ACO. Just as pay-for-performance incentives decreased the quality of care for patients suffering from illnesses that lack performance measures (Doran et al. 2011), it is likely that patients receiving care from an ACO to which they are not assigned will receive lower quality care. Given limited time, we can expect physicians to proportion their time in accordance with the potential for reimbursement. Likely, providers will spend more time caring for, and consequently offer higher quality care to, patients assigned to their ACO.

In order to ensure equal care for all patients, a patient's ACO attribution status should remain unknown to providers. If providers are ignorant of ACO assignment status there will be no incentive for physicians to provide lower quality of care to patients not assigned to their ACO. In reality, ACO assignment status will not remain unknown to providers. Reliance on electronic health records is an important ingredient of the ACO (Bitton et al. 2012). Brief examination of health records will reveal where a patient has received a predominance of care and thus offer evidence of a patient's assignment status.

In order to prevent these inequalities, we advise providers to meet regularly to review patients' treatment histories. The treatment of patients assigned to an ACO should be compared to similar cases of patients not assigned to the ACO.⁷ Meetings may be informal, consisting of a small group of providers within an ACO. Alternatively, meetings could be comparatively formal and integrated into standing review processes, e.g., treatment histories could be presented at grand rounds, reviewed by the hospital ethics board, or considered at a meeting of an ACOs board. If there are significant discrepancies in the quality of care, review should be frequent. If little discrepancy is found, review can be intermittent or may not be needed at all. Research is needed to determine if reviews are necessary and, if so, how they would be best implemented.

The task of establishing review is sizeable and largely out of the hands of any individual practitioner. How should the practitioner respond? ACOs promise to bring a variety of changes to clinical practice. Many of these changes will come in the form of new demands providers are expected to meet, e.g., managing population health and conformity to performance measures. In this environment of changing clinical expectations practitioners would be well advised, for purely pragmatic reasons, to have a list of unfamiliar demands available during appointments. This list—perhaps available via hardcopy or alternatively part of an electronic records system—will serve as a reminder, helping to ensure that the practitioner does not inadvertently fail to fulfill an unfamiliar duty associated with the

⁷This kind of self-study is characteristic of high-value healthcare organization (Bohmer 2011).

change to ACOs. Importantly, this approach to remembering changing clinical expectations can serve a double duty. In addition to helping the practitioner keep track of changing demands, these reminders can help mitigate the concern that non-ACO patients will receive a lower quality of care. A quick scan of such a document at the end of an appointment will quickly highlight potential oversights in care, allowing a practitioner to easily identify cases in which she may have unintentionally provided lower quality care to non-ACO patients.

Bias Against Transient Populations—The worries of the previous section are intensified by the method of ACO assignment. Patients are assigned to an ACO based on where, during a specified time period, they have received a predominance of their primary care. This method of patient assignment may lead to difficulties in accommodating geographic mobility among patients. Problematic cases include patients who have “no visits to a... [primary care provider] in any one year” and instances when “so many... [primary care providers] are seen that no one accounts for a majority of the visits” (Luft 2012). Patients who frequently relocate, e.g., patients reliant on seasonal work, are less likely to be assigned to an ACO and are less likely to receive care from their assigned ACO. As pay-for-performance only incentivizes improved quality of care for patients assigned to the provider’s ACO, the burden of sub-optimal care will fall disproportionately on underprivileged patients.

Even in cases where ACO assignment is relatively unproblematic, we can still expect transient populations to receive lower quality care. Providers may be unwilling to “invest in longer-term improvements in care for patients with chronic conditions ... if they perceive that the benefits to patients will take years to accrue and that many of their patients are unlikely to remain assigned to them [by the time benefits are realized]” (Pham et al. 2007). It is unlikely that physicians will benefit financially from helping transient patients improve chronic conditions. By the time the patient sees improvement regarding her chronic condition, she will likely no longer be assigned to the same ACO.

The recommendations offered at the end of the previous section apply here as well. ACOs should regularly review patient treatment histories to ensure that temporary consumers (e.g., migrant workers) are receiving the same level of care as their more permanently located counterparts. As such review has not yet been implemented, we advise that practitioners end each appointment by briefly looking over a reminder of new clinical expectations set in place by their ACOs, allowing practitioners to easily identify potential oversights in care. As noted above, we expect that, for purely pragmatic reasons, physicians will already be engaging in this process for patients assigned to their ACO.

Autonomy

In Western bioethics, respect for autonomy is often considered the central principle.⁸ As a working definition, autonomy is “self-rule... free from both controlling interference by others and limitations that prevent meaningful choice, such as inadequate understanding” (Beauchamp and Childress 2012).^{9, 10} Stated more generally, the bioethical commitment to

⁸This de facto prioritization of autonomy is at odds with Beauchamp and Childress’ presentation.

autonomy includes negative and positive forms of liberty. Patients should have freedom from unwanted interference and should also have conditions for positive freedom—which includes information as well as a threshold capacity for agency, the ability for patients to make care choices for themselves based on adequate informed consent. By promoting physician interference beyond the subset of medical problems for which a patient sought treatment, the ACOs goal of population health is in tension with patients' negative liberty (freedom from interference). The focus on population health, though, can promote the physical well being of patients, which is a precondition for pursuing an autonomous life at all.

Population Health Management and Life Intrusions—A given ACO is accountable for the health of the population of individuals assigned to it (Gourevitch et al. 2012). Prior to the establishment of ACOs, patients received treatment only when they sought help for a condition. On the previous model of care, primary care physicians were charged with managing health risks such as high blood pressure but it was a patient's prerogative to choose his or her lifestyle, safe or unsafe. In this way, current practices better respect autonomy as a form of freedom from interference, or negative liberty, but physicians still balance the value of respect for patient autonomy with beneficence (the ethical responsibility to do what is “best” for a patient) in cases where a patient does not want to maintain a healthy lifestyle. For instance, cardiologists regularly counsel patients with chest pain who have high likelihoods of coronary artery disease to stop smoking, lose weight and begin regular exercise when able. These recommendations are components of advice to pursue a healthy lifestyle which the patient is free to accept or reject.¹¹

ACOs shift the balance between respect for autonomy and beneficence by providing physicians with financial incentives for population health management, which includes improving the health of patients regarding conditions for which they may not have sought treatment. For instance, “risky” alcohol use is a likely target for population health management (Calman et al. 2012).¹² ACOs can receive lower reimbursements for their services if their population engages in the unhealthy use of alcohol. This may prompt physicians to provide more information to their patients about the negative effects of excessive alcohol consumption. Indeed, we can expect ACOs to offer providers an incentive to push patients to drink less *even in the face of significant opposition on the part of the patient*.¹³ In this way, ACOs will amplify interventions in life choices that patients have not previously considered part of the purview of their physician's authority. Although physicians have previously provided unsolicited recommendations for the well-being of the patient,

⁹There is significant debate regarding the appropriate analysis of “autonomy.” Our use of this definition should not be taken to be indicative of the commitments of any author.

¹⁰This definition should not be taken to imply that autonomy grants the patient a right to whatever she desires. Patient autonomy is best thought of on the model of a negative, not a positive, right.

¹¹We thank an anonymous referee for this journal for this point.

¹²The authors are aware that addiction significantly complicates considerations related to autonomy. “Risky alcohol use” need not entail addiction. Binge drinking or alcohol dependence (but not addiction) both fall in this category.

¹³It should be noted that instead of putting the burden of convincing patients to change their behavior on the physician, patients themselves could be incentivized—through, e.g., discounts on their co-pay. Such changes would come at the institutional level rather than at the level of the physician. Given that no societal consensus has been reached about if and how to change the balance between beneficence and autonomy, it is preferable to put the burden of improving public health at the institutional level. Doing so leaves intact the established equilibrium between these two principles.

ACOs create external pressures and incentives for physicians to extend these recommendations.

To maintain due respect for patient autonomy, we offer two recommendations. Providers must engage in careful dialogue with their patients prior to making decisions. The provider should offer advice only after giving consideration to the patient's goals, while understanding that sometimes patients need education to refine or develop their goals (Ozar 1984). The existence of a personal relationship between the provider and patient will help ensure that the provider offers advice with each patient's aims in mind.

Patients are assigned to an ACO based on their "history of health service utilization" (Gourevitch et al. 2012). Thus, where a patient receives her care will determine her ACO assignment status, giving providers an incentive to offload patients who refuse to manage health risks onto competing ACOs. Consequently, patients may feel coerced to manage health risk factors as failure to do so could lead to the termination of the provider-patient relationship. Decisions made under coercion are not autonomous. While a patient's continued failure to follow a treatment plan can constitute grounds for the termination of the provider-patient relationship, it is not permissible for the provider to terminate the relationship without finding an alternative source of care. An alternative source of care should be found within the ACO where the provider operates. This will ensure that the patient remains assigned to the same ACO and, consequently, the patient's management—or lack thereof—of health risk factors will continue to be relevant to the ACOs reimbursement and the provider's payment. Finding alternative care within a provider's ACO minimizes concerns regarding the existence of a conflict of interest in terminating the provider-patient relationship.

Patient Knowledge of ACO Assignment—Patients have a right to make informed decisions regarding their healthcare. In order to make an informed healthcare decision, patients need knowledge of the facts relevant to potential treatment options *and* facts about a provider's financial incentives. Physicians have substantial expertise that cannot be condensed for a patient; when offering treatment recommendations, providers cannot present all treatment options. Instead, the provider should offer the treatment options she judges to be best, given the medical facts and the patient's goals (Ozar 1984).

Due to these communication constraints, ACOs should offer a formal statement of the financial incentives providers are offered, perhaps best presented in the form of a pre-appointment consent form, allowing patients to make maximally informed decisions about potential treatment options.¹⁴ Access to this information will enable patients to filter the recommendations of the physician through possible sources of bias. This is particularly important because patients can be assigned to an ACO with no knowledge that the assignment has taken place (Sinaiko and Rosenthal 2010). Thus, patients may lack information about financial incentives that may, in the ways discussed above, influence their provider's treatment suggestions.

¹⁴Providers should not be tasked with informing patients about their ACO assignment status because providers' access to this information is ethically problematic. See the section on the disincentive to care for patients who are not assigned to one's ACO for further elaboration.

Shortcomings

The preceding discussion has two primary shortcomings. There is little pre-existing literature on the ethical issues raised by ACOs. Conflicts between the aims of ACOs and three of the four principles were largely identified based on the philosophical and medical expertise of the research group. Given the emerging nature of ACOs, the practical instantiation of policies may raise unexpected problems and deliver underappreciated benefits. It would be surprising if our discussion offered an inclusive list of the important ethical issues associated with ACOs.

Applied ethical analysis of ACOs must be an ongoing project that continues as more ACOs are established and findings are vindicated or refuted. Our recommendations are not based on empirical research. Further research is needed to find maximally effective recommendations for the conflicts identified.

Conclusion

The PPACA will fundamentally change healthcare in America. The mandate to form ACOs constitutes one important mechanism for these changes. ACOs offer to improve both the quality and cost of healthcare but present novel ethical challenges. We have identified some of these challenges and offered recommendations for providers.

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