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Christensen, Flier and Vijayaraghavan: The Coming Failure of 'Accountable Care'

The Affordable Care Act's updated versions of HMOs are based on flawed assumptions about doctor and patient behavior.

By CLAYTON CHRISTENSEN, JEFFREY FLIER And VINEETA VIJAYARAGHAVAN

Spurred by the Affordable Care Act, hundreds of pilot programs called Accountable Care Organizations have been launched over the past year, affecting tens of millions on Medicare and many who have commercial health insurance.

The ACOs are in effect latter-day health-maintenance organizations—doctors, hospitals and other health-care providers grouped together to provide coordinated care. The ACOs assume financial responsibility for the cost and quality of the care they deliver, making them accountable to patients. With President Obama's re-election making it certain that the Affordable Care Act will begin taking full effect next year, the number of ACOs will continue to increase.

We believe that many of them will not succeed. The ACO concept is based on assumptions about personal and economic behavior—by doctors, patients and others—that aren't realistic. Health-care providers are spending hundreds of millions of dollars to build the technology and infrastructure necessary to establish ACOs. But the country isn't likely to get the improvements in cost, quality and access that it so desperately needs.

The first untenable assumption is that ACOs can be successful without major changes in doctors' behavior. Many proponents of ACOs believe that doctors automatically will begin to provide care different from what they have offered in the past. Doctors are expected to adopt new behavior that reduces the cost of care while retaining the ability to do what's medically appropriate. But the behavior of doctors today has been shaped by decades of complicated interdependencies with other medical practices, hospitals and insurance plans. Such a profound behavior shift would likely require re-education and training, and even then the result would be uncertain.

To give one example, if ACOs are to achieve their cost-saving goals and improve medical care, most doctors will need to change some of their approaches to treating patients. They'll need to employ evidence-based protocols more often to determine optimal treatment—for instance, in prescribing medication or deciding whether certain kinds of surgery are necessary. Doctors will also have to find ways to move some care to lower-cost sites of service, such as more surgery in ambulatory clinics instead of a hospital. ACOs aren't designed or equipped to transform physician behaviors on the scale that will be needed.

Associated Press

President Obama signs the Affordable Care Act at the White House, March 2010.

The second mistaken assumption is that ACOs can succeed without changing patient behavior. In reality, quality-of-care improvements are possible only with increased patient engagement. Managed care, as formulated in the 1990s by the HMO model, left consumers with a bad taste because the HMOs acted as visible gatekeepers to patient access to care. ACOs, seemingly wary of stirring a similar backlash, allow Medicare patients to obtain care anywhere they choose, but there is no preferential pricing, discounting or other way for ACOs to steer patients to the most effective providers.

The Everett Clinic in Washington state has taken steps to plug this hole by deciding not to become a full-fledged ACO. Last year, the clinic told patients that to remain with Everett, they must shift to Medicare Advantage—which encourages preventive care and supports disease-management programs. Those who want to remain on regular Medicare were required to obtain their care elsewhere.

Accountable Care Organizations are also on the hook for patients who don't comply with recommended treatment or lifestyle changes. Patients can even decide not to share their claims data or medical history with the ACO. If a woman from, say, Massachusetts, spends half the year in Florida and receives care there, the Massachusetts ACO is still responsible for managing the patient's medical costs, though it in no way was able to manage the Florida care. The seems to be unfair both to the responsible ACO provider and to the patient, who will likely not receive optimal care in these transitions.

In other words, ACOs hold caregivers accountable without requiring patient accountability. How can this work?

The third and final flawed assumption of the Affordable Care Act is that ACOs will save money. Even if the pilot Medicare Pioneer ACOs—as the 32 most advanced Medicare ACOs are called—achieve their full desired impact, the Congressional Budget Office estimates that the savings would total $1.1 billion over the next five years. This is insignificant in a total annual Medicare budget of $468 billion. As for the commercial and Medicare ACOs that are operating outside these pilot programs, even the most optimistic assumptions come up with relatively small reductions to annual health-care spending nationally.

The architects of the ACO initiative somehow assume that making the existing system more efficient will make health-care affordable. But slowing the rise of health-care costs can't address the challenge of adding 50 million uninsured to the system while keeping expenditures the same or even somewhat lower than the unsustainable percentage of national wealth that they already represent. No dent in costs is possible until the structure of health care is fundamentally changed.

How can that level of change be achieved? We beseech policy makers in Washington to study a range of reform approaches that aren't burdened by as many untenable assumptions as Accountable Care Organizations, and go well beyond them in their aspirations.

• Consider opportunities to shift more care to less-expensive venues, including, for example, "Minute Clinics" where nurse practitioners can deliver excellent care and do limited prescribing. New technology has made sophisticated care possible at various sites other than acute-care, high-overhead hospitals.

• Consider regulatory and payment changes that will enable doctors and all medical providers to do everything that their license allows them to do, rather than passing on patients to more highly trained and expensive specialists.

• Going beyond current licensing, consider changing many anticompetitive regulations and licensure statutes that practitioners have used to protect their guilds. An example can be found in states like California that have revised statutes to enable highly trained nurses to substitute for anesthesiologists to administer anesthesia for some types of procedures.

• Make fuller use of technology to enable more scalable and customized ways to manage patient populations. These include home care with patient self-monitoring of blood pressure and other indexes, and far more widespread use of "telehealth," where, for example, photos of a skin condition could be uploaded to a physician. Some leading U.S. hospitals have created such outreach tools that let them deliver care to Europe. Yet they can't offer this same benefit in adjacent states because of U.S. regulation.

These and other innovative approaches have potentially large payoffs in how health care is delivered and what it will cost. By contrast, Accountable Care Organizations over the long haul may ease the path to slightly lower reimbursements or redistribute physician compensation among specialties. But what ACOs most assuredly will not do is deliver the disruptive innovation that the U.S. health-care system urgently needs.

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