

Accountable Care Organizations: How to Dress for Success

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Health system reforms in several countries have changed accountability relationships in healthcare. Traditional payers of healthcare, like governments and health insurers, have now started sharing the accountability for healthcare costs and quality with care providers. The introduction of accountable care organizations (ACOs), as laid out in the Affordable Care Act and in regulations issued by the Centers for Medicare & Medicaid Services, will change accountability relationships in a similar fashion. ACOs are held financially and clinically accountable for the costs and quality of the entire spectrum of care provided to a defined patient population, and share in the savings or losses relative to a spending benchmark. Thus, ACOs bear a financial risk similar to that of traditional payers of healthcare. In order to manage this financial risk, ACOs will have to reconsider their provider configuration.

ACO provider configurations are commonly described in terms of the medical specialties involved, but attention must also be paid to how ACOs plan to organize their contractual relationships with these providers. Broadly speaking, ACOs can opt for either firm organization or market organization. When an ACO opts for firm organization, it extends its organizational boundaries to include a newly employed physician or medical discipline. A typical market contract is one in which physicians remain autonomous and are paid a fee-for-service (FFS).

When should ACOs prefer firm organization over market organization and vice versa? The question we refer to as the “boundary problem” has now become more pertinent as care providers—organized into ACOs—are held financially and clinically accountable for all care provided to their patient population.

The Unbalanced Treatment of Market and Firm Organization in the ACO Debate

A solution to the boundary problem requires a balanced treatment of market and firm organization and the recognition that each has properties that can turn into relative strengths. It is unfortunate that the ACO debate is therefore largely devoted to the anticompetitive properties of firm organization alone, as is evident from discussions on the

employment of primary care physicians by hospital-led ACOs and physician self-referral.² Now that it is recognized that providers’ lack of knowledge regarding organizational structures impedes the effective

Accountable Care Organizations (ACOs) need to reconsider their provider configuration and make it capable of managing clinical and financial risk. To that aim, their management must decide which medical procedures are done by the ACO itself, and which are contracted out to market providers. Making this decision requires a balanced treatment of market and firm organization, recognizing that each has properties that can turn into relative strengths. Such a balanced treatment is lacking in the ACO debate. Using the transaction cost theory, we provide such a balanced treatment of market and firm organization, and discuss implications for the design of ACOs and accountable care initiatives in general.

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Take-Away Points

Market and firm organization need a balanced treatment in the accountable care debate. The urgency of such a balanced treatment is 3-fold:

- Care providers' lack of knowledge on the workings of market and firm organization impedes the effective implementation of accountable care.
- Accountable care initiatives will not reach their full potential when there is a mismatch between the strategy of participating care providers and their contract management. Such a mismatch may occur when market and firm organization do not get a balanced treatment in decision making.
- Balanced treatment would allow for a more refined view of coexisting volume and value incentives that characterize many accountable care initiatives.

implementation of accountable care,¹ a balanced treatment of market and firm organization is even more urgent.

Transaction Cost Theory^{3,4}: A Balanced Treatment of Market and Firm Organization

ACOs and individual providers maintain contractual relationships in a volatile market characterized by technological change⁵ and shifts in population health.⁶ Turnover in assigned patient populations, as will be experienced by ACOs participating in the Medicare Shared Savings program,⁷ will additionally increase this volatility.

Market volatility implies that contracts must continuously be adapted to the current landscape. To that aim, ACOs' management will need to (1) remain informed regarding the care providers' value as contract partners, (2) resolve contractual gaps, and (3) determine a form of reimbursement such that care providers are incentivized to act in the spirit of the contract. These 3 processes have to be organized in such a way that the resulting costs—"transaction costs"—are minimized. The transaction cost theory concerns itself with the efficient organization of contractual relationships. An efficient organization of contractual relationships is one that minimizes transaction costs. The theory distinguishes 2 different methods of organizing a contractual relationship: the price system and hierarchy. When an ACO opts for the price system, its care providers remain autonomous. The ACO will go by market prices when determining a care provider's value and reimbursements are based on output valued at market prices. Under hierarchy, care providers transfer their right to make productive decisions to the ACO's management in exchange for receiving an income independent of volume (eg, a fixed salary).

Markets and firms are economic institutions that use a different mix of organizing methods. Markets predominantly rely on the price system and firms on hierarchy.⁷ The differences between the price system and hierarchy have implications for transaction costs. To understand why, one must know the 2 human traits believed to lie at the bottom of these costs. The first trait is contract parties' limited ability to collect and analyze

all information necessary to make optimal decisions. The second trait is a tendency to opportunistically exploit these situations of imperfect knowledge. This can manifest in multiple ways. ACOs may need to confront supplier-induced demand and stinting on care by some of their contracted providers. Furthermore, the FFS reimbursement system which remains in place does not by itself incentivize individual providers to

practice in congruence with an ACO's policy of cooperation, task substitution, and evidence-based care.

To minimize transaction costs, one must curb these opportunistic behaviors. As the price system rewards for volume, it addresses stinting on care. However, this volume incentive of the price system sometimes gets in the way of effective care. This happens when a lack of transparency prevents ACOs from monitoring whether demand for care has been induced and fulfilled properly. Market prices then fail to reflect the value of the underlying medical service, which may incentivize providers to induce demand. A hierarchical organization of contractual relationships lowers this incentive because it complicates the relationship between the volume of services and income. A range of options is available—bundled payments, global payments, and traditional capitation all complicate the relationship between volume of services and income by acting as price ceilings. However, under these payment options, volume of services and income are still linked through the marginal costs of providing care which are borne by the providers themselves. Only under a fixed salary contract are providers' incomes independent of volumes. The fixed salary these care providers receive also make them more willing to follow directions regarding cooperation and task substitution, as these activities will no longer have an impact on their income through a lower volume of services.⁸

Although hierarchical organization addresses several perverse incentives that failing markets for medical services introduce, they may reintroduce stinting on care and on-the-job consumption. Depending on the medical service that is contracted, however, ACOs may be better able to monitor these behaviors rather than demand inducement.

Apart from the incentives resulting from different forms of reimbursement, transaction cost theory also discusses the differential effects of organizing methods on the information collection process and bargaining under different competitive environments. The theory's contribution to the ACO debate would be that ACOs' provider configurations be viewed in terms of the organizing methods they employ and that each organizing method has a different impact on care providers'

behavior and eventually, transaction costs. This has several implications.

Implications and Conclusions

ACOs' provider configurations are made up of contractual relationships with care providers. When deciding on ways to organize these contractual relationships, ACOs must consider the incentives that each organizing method brings along. These incentives must be compatible with ACOs' strategies for fulfilling their financial accountability. A strategy of preventive medicine requires a different way of incentivizing care providers than a strategy of task substitution. Evidence from The Netherlands, where organizations similar to ACOs called "care groups" have been held accountable for the cost and quality of chronic care as of 2007,⁹ suggests that this match between contractual organization and strategy is overlooked in practice.¹⁰ For example, care groups experienced difficulties realizing task substitution in fundus examinations for diabetic patients. Care groups wanted to shift this procedure from ophthalmologists (specialist care level) to optometrists (primary care level). However, because ophthalmologists were paid on the FFS-base by the care group, they were not incentivized to cooperate, as the shift would lower the number of patients that returned to them for an extensive eye examination. This example illustrates how ACOs could potentially miss out on savings when contractual organization is not compatible with their cost-containment strategy.

The idea that the price system and hierarchy each have a different way of incentivizing parties to a contract further refines the discussion regarding coexisting volume- and value-based reimbursement systems that characterize so many accountable care initiatives. Berenson¹¹ approaches this issue from the perspective of risk management and concludes that direct FFS payments compare favorably with uncertain future shared savings. A transaction cost approach refines this statement in 2 ways. First, ACOs will only collect FFS payments from their employed care providers. The ACO then maintains a hierarchical relationship with its care providers which may make it problematic to order these care providers—for whom volume and income may only be weakly related—to maximize volumes and profits. Second, patients of ACOs that do not extend their organizational boundaries will sometimes need to go outside the ACO's network. For these ACOs the value incentives of shared savings—determined over the total spectrum of care—may overrule the volume incentives, which have partially leaked onto independent providers. Contractual organization at the physician level thus plays an important role when hypothesizing about whether the value incentives of shared savings will counter any parallel volume incentives of FFS payment system.

For each contractual relationship, ACOs must determine whether or not to extend their organizational boundaries. Apart from the lack of transparency previously discussed, the instances of market failure for which firm organization could provide relief are well documented.¹² Viewing firm organization solely as a means to secure patient referrals (or to secure a shift to outpatient care under population-based payment)² does not do justice to the economics of firm organization, the hierarchical organizing method on which it relies, and the instances of market failure it will address. An unbalanced treatment of market and firm organization in either policy, practice, or the public debate could therefore limit ACOs' potential in successfully taking on clinical and financial accountability for patient outcomes.

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