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Why Accountable Care Organizations Won't Deliver Better Health Care—and Market Innovation Will

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Abstract: *The Patient Protection and Affordable Care Act (PPACA) creates federal "accountable care organizations" (ACOs). In theory, ACOs provide financial incentives to health care organizations to reduce costs and improve quality. In reality, given the complexity of the existing system, ACOs will not only fail; they will most likely exacerbate the very problems they set out to fix. ACOs will concentrate more and more power in fewer and fewer organizations—allowing them to become "too large to fail." Such a system undermines competition and entrepreneurship, the bedrock of innovation and job growth in this country. There is no evidence that supports the use of untested, complex organizational structures to improve quality of care and reduce costs. Creating incentives that focus on achieving higher quality of care, not quantity of medical procedures; providing choices to patients; and allowing real competition among health insurance providers is what will truly transform the health care system.*

The Patient Protection and Affordable Care Act of 2010 (PPACA) creates a new, federally financed mechanism for health care delivery via Medicare: the accountable care organization (ACO).

ACOs are merely the latest in a long history of health policy "silver bullets." Since the 1970s, Congress and successive Administrations have promoted a number of mechanisms to control rising health care costs, including the introduction of Medicare hospital payment formulas based on fixed payments for hospital services (payments for diagnostic related groups of

Talking Points

- The Patient Protection and Affordable Care Act creates a federally financed mechanism for health care delivery: the accountable care organization (ACO).
- While the goal of ACOs is laudable—to reduce costs and improve quality through cooperation and coordination among providers—they are merely the latest in a long history of health policy "silver bullets."
- ACOs fail to empower consumers to be stakeholders in their own care, fail to encourage provider accountability, and create an unfair competitive advantage for large organizations.
- Given the complexity of the existing health care system, ACOs will not only fail, they will most likely exacerbate the very problems they were designed to fix. ACOs will concentrate more and more power in fewer and fewer organizations—allowing them to become too large to fail.
- Only through market competition, and introducing transparency in cost and outcomes, will the goals of health care reform be achieved.

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services, or DRGs), as well as health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Costs have continued to rise despite these efforts. At the same time, concerns about fragmentation of care and diminished quality have increased significantly.

ACOs are promoted as a new mechanism for addressing the shortcomings of previous reforms.[1] So Congress, apparently unmindful of legislating an untested model in a field as complex as health care, included provisions in the PPACA to establish "accountable care organizations."[2] Only loosely defined by the legislation, ACOs consist of groups of physicians and other providers that work together to manage and coordinate care for Medicare fee-for-service beneficiaries, and to meet certain quality-performance standards. Through "shared savings" programs, ACOs will receive a portion of the shared savings if they sufficiently reduce costs and simultaneously improve quality. Curiously, under the statute, the Secretary of the Department of Health and Human Services (HHS) is charged with developing a method to assign Medicare beneficiaries to ACOs.[3] Because the statute is unclear about the resolution of many vital issues, the crucial details will be supplied and refined by federal regulators—as is the case for so many other provisions of the new health law.

It is unlikely that an untested organizational structure will create accountability.

Laudable Goals. The stated goal of an ACO is laudable—to reduce costs and improve quality of care through cooperation and coordination among providers. While a number of potential models were proposed before the PPACA was passed, it incorporated a model that does not exist in practice. Each of the proposed models, including the one incorporated in the PPACA, has a unique set of drawbacks, limitations, and difficulties. Creating a new organizational structure to remedy problems inherent in the existing system creates complications and risks. These complications are likely to result in the same or similar types of unintended consequences as earlier efforts, namely, consolidation and increased costs without improvements in quality.

It is unlikely that an untested organizational structure will be the most effective way to create "accountability for care." In theory, the ACO program "promotes accountability for a patient population and coordinates items and services…and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery."[4] However, the likely result will be a concentration of power not in the most efficient and highest quality health care organizations, but in the largest—simply because they control large segments of the market share. To achieve better health care at lower costs, policies must change the currently misaligned financial incentives (which simply encourage providers to offer more services) to let providers focus on delivering quality outcomes at reduced costs.

ACOs: Their Original Purpose

"Accountability for care" is not a new concept. It entered the spotlight in the 1990s through such programs as pay-for-performance and various managed care initiatives that were intended to create "greater accountability on the part of providers for their performance."[5] In this context, the locus for accountability was limited to individual providers

1. Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Bynum, and Daniel J. Gottlieb, "Creating Accountable Care Organizations: The Extended Hospital Medical Staff," *Health Affairs*, Vol. 26, No. 1 (2007), pp. w44–w46, at *http://content.healthaffairs.org/cgi/reprint/26/1/w44* (March 30, 2011).
2. Patient Protection and Affordable Care Act, Sec. 3022, "Medicare Shared Savings Program."
3. Grace-Marie Turner *et al.*, *Why Obamacare Is Wrong for America* (New York: Harper Collins, 2011), p. 63. The Department of Health and Human Services recently issued proposed rules for ACOs: Press release, "Affordable Care Act to Improve Quality of Care for People with Medicare," Department of Health and Human Services, March 31, 2011, at *http://www.hhs.gov/news/press/2011pres/03/20110331a.html* (April 11, 2011).
4. Patient Protection and Affordable Care Act, Sec. 3022, "Medicare Shared Savings Program."
5. Fisher, Staiger, Bynum, and Gottlieb, "Creating Accountable Care Organizations."

and did not address the need for integrated delivery of quality care.[6] In order to address the need for provider accountability across an integrated care continuum, a new model, the accountable care organization, was proposed. The ACO model developed as a way of addressing accountability of both health care providers and the delivery systems in which they practice, collaborate, and interact.[7]

ACOs are to provide a solution to the "serious gaps in quality and widespread waste" within the health care system.[8] The underlying intent of the ACO model was to address the lack of financial incentives for reducing costs while improving quality, coordination, and consistency of care.[9]

Evolving Concept. The ACO concept has evolved since its inception several years ago. Most proponents of ACO agree that they should, at a minimum, offer services across the continuum of care and in various institutional settings; be able to budget and forecast resource needs; and be *large enough* to sustain reliable and universal performance measurements.[10] By working with local providers already centered around and connected to one or more hospitals, it is presumed that physicians and hospitals can create an "organized system," which payers could then hold accountable for improvements in quality of care and costs.[11] At the conceptual level, the incentive for ACOs would be to increase efficiency and avoid overuse and duplication of services, resources, and facilities. In this model, ACO members would share the savings resulting from the increased coordination of care.

Nowhere in these discussions was there an attempt to enable a simplified market-based solution that puts patients at the center, requires transparency of cost and outcomes, and ensures that primary care physicians would play the critical role of health care quarterback on behalf of their patients.

ACOs: Their Role in the PPACA

The PPACA mandates a shared savings program among health care providers, which generally follows the ACO model discussed above, but does not include provisions for a pilot to test real-world feasibility. In effect, the legislation is an experiment with unknown consequences. Through this program, ACOs are awarded their portion of the "shared savings" if they sufficiently reduce costs and simultaneously improve quality. The ACOs will be tasked with distributing savings among participating providers—who will continue to be reimbursed on a fee-for-service basis. Aside from retaining the current fee-for-service reimbursement system, the PPACA does not indicate how savings should be divided among participants.[12]

The PPACA describes ACOs as provider groups that accept responsibility for the cost and quality of care delivered to a specific population of patients cared for by the groups' participating clinicians. The legislative intent is that these groups will have an incentive to invest in infrastructure and redesigned care for high quality and efficient delivery of services. From an organizational standpoint, however, the PPACA defines ACOs only loosely, and eligibility requirements are vague.

An ACO may include different participating groups, such as physician groups and hospitals, which are to coordinate their services. Eligible organizations must have a formal legal structure, must include enough primary care providers for 5,000 Medicare fee-for-service beneficiaries, and must

6. *Ibid.*
7. Kelly Devers and Robert Berenson, "Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?" Urban Institute and Robert Wood Johnson Foundation, October 2009, pp. 1–3, at *http://www.rwjf.org/files/research/acobrieffinal.pdf* (March 31, 2011).
8. Fisher, Staiger, Bynum, and Gottlieb, "Creating Accountable Care Organizations."
9. Devers and Berenson, "Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?"
10. *Ibid.*
11. Mark Merlis *et al.*, "Accountable Care Organizations," Robert Wood Johnson Foundation *Health Policy Brief*, August 13, 2010, p. 2, at *http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=23* (March 31, 2010).
12. Patient Protection and Affordable Care Act, Sec. 3022, "Medicare Shared Savings Program."

contract or employ any additional providers that their patient population requires. They must be prepared not only to meet specified performance standards, but also to measure and report quality outcomes in a uniform manner as required by the Centers for Medicare and Medicaid Services, using highly integrated information systems.[13] While steps to improve quality performance by standardizing metrics and reporting requirements are mandated in the PPACA, the requirements in the legislation are largely ambiguous, as performance standards and metrics are still undefined. The specifics will be determined by the Department of Health and Human Services and will include areas such as clinical processes and care, patient experience, and the amounts and rates of services rendered.

Fee-for-service, activity-based provider payment creates no incentive for providers to increase efficiency, and is a disincentive for those who take more time to coordinate care.

As developed in the PPACA, ACOs would create what are, in effect, "virtual" organizations composed of local hospitals and affiliated providers covering groups of patients.[14] There are no enrollment requirements for patients, who will be assigned to ACOs based on which provider they visit most frequently and may not even be aware of the ACO's existence. The performance standards that ACOs will be expected to meet will use metrics data collected from uniform information systems, which the ACOs themselves are required to implement. ACO spending will be measured against a comparable target (historic data for the same or similar patient population). If an ACO meets its performance and quality standards (which remain largely undefined), the ACO will share in any savings.[15]

Government-Sponsored Payment and Delivery Systems

Given the enormous size of the Medicare program, Medicare policy changes have a profound influence on private-sector health insurance practices, including payment systems.[16] Congressional leaders have long attempted to improve quality and lower costs by developing complex payment and delivery systems intended to increase accountability.

In the 1980s, Congress created a prospective payment system (PPS) for Medicare in an effort to control rising health care costs in hospitals.[17] Under this new system, hospitals were reimbursed a predetermined amount for each diagnostic related group (DRG) (category of inpatient cases). This new strategy was intended to place pressure on organizations to increase efficiency and minimize unnecessary spending, as they would only be reimbursed a set amount for each diagnostic category. To give organizations a way of monitoring provider efficiency by DRG category, resource-based relative-value units (RBRVU) were introduced. Each RBRVU corresponds to a DRG. RBRVUs, however, continued to reimburse providers on a fee-for-service basis, and reflected a highly complex set of calculations.[18]

Since they are paid for each service they provide, not for the outcomes they help patients achieve, providers continued to have a profit-based motive not to ensure the quality and efficiency of patient care, but to increase productivity at the service code

13. *Ibid*.
14. Fisher, Staiger, Bynum, and Gottlieb, "Creating Accountable Care Organizations."
15. Patient Protection and Affordable Care Act, Sec. 3022, "Medicare Shared Savings Program."
16. This influence is not necessarily benign. "The size and power of Medicare are such as to easily distort the healthcare marketplace, the consequences of which will ultimately be harmful to everyone." Harry Cain, "The Medicare Menace," *Harvard Health Policy Review*, Vol. 2, Number 1 (Spring 2001), p. 20.
17. Tim Brady and Barbie Robinson, "Medicare Hospital Prospective Payment System: How DRG Rates Are Calculated and Updated," U.S. Department of Health and Human Services, Office of Inspector General, Office of Evaluation and Inspections, August 2001, pp. 1–4, at *http://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf* (March 31, 2010).
18. Louise J. Sargent and Renwyck Elder, "Overview of Medicare for Managed Care Professionals," *Journal of Managed Care Pharmacy*, Vol. 2, No. 2 (March/April 1996), pp. 165–167, at *http://www.amcp.org/data/jmcp/Update_165-172.pdf* (March 31, 2010).

level. As a result, these changes did not ultimately translate to lower spending. In fact, they resulted in more spending, reduced the quality of care, empowered specialists to deliver more non-integrated and perhaps unnecessary care, and diminished the core role of primary care providers as "quarterbacks" or "gatekeepers" responsible for managing, coordinating, and directing patient care in the most efficient way possible. Fee-for-service, activity-based provider payment creates no incentive for providers to increase efficiency and acts as a disincentive for those who take more time to coordinate care.

With the Health Maintenance Organization Act of 1973, Congress directly promoted the growth of managed care arrangements in the private sector. In the 1990s, private organizations and employers sponsored HMOs, PPOs, and PHOs (Physician Hospital Organization) as part of their "managed care" efforts to reduce costs by eliminating provider incentives for inappropriate care and excess productivity.[19] These "managed care organizations" would often enter into capitated arrangements with contracted providers, where these providers would receive a fixed amount per patient "member" of the organization that chose to seek care through that provider. Capitated payments were determined based on historic fee-for-service (FFS) data. These efforts were intended to emphasize primary care as central to improving health care and keeping hospital costs under the capitated amount. Yet capitation created a new profit motive which was equally, if not more, detrimental to patients than productivity incentives created by FFS plans. Because payment was not tied to outcomes, capitation encouraged providers to cut spending *without* sufficient concern for patient welfare.[20]

The Top-Down Approach to Complex Health Policy Problems

Past health care initiatives that have relied on organizational structure to address the complex challenge of delivering higher quality at lower costs have not succeeded in improving either efficiency or performance. In fact, they have largely exacerbated the problems they were intended to address. Neither DRGs nor HMOs created a shared goal for all parties. In both cases, provider profit motives lacked the pressure of consumer demand to preserve quality while minimizing cost. While DRGs and RBRVUs encouraged providers to focus on production without consequence of unnecessary interventions, HMOs and other managed care organizations encouraged providers to minimize intervention, regardless of whether doing so could hinder the quality or completeness of patient care. Outside the HMO model, providers had the perverse incentive to fix the quality problems they frequently created.

In most industries, consumer demand drives service providers and product manufacturers to improve quality while maximizing efficiency. In health care, patients are not direct "consumers" when patients do not pay for their care directly. So, providers do not face pressure from the *consumer* to provide high-quality and affordable care. Generally, patients seek care from providers and organizations that are covered under their insurance plan, which, quite often, is selected by their employers. Providers and health care organizations negotiate the most favorable rates with payers to protect their revenue stream, without an incentive to increase efficiency or improve quality.

Past attempts at manipulating organizational structure to reduce cost (and implicitly improve outcomes) ignore the underlying problem—the minimal role that consumer (patient) demand plays in driving market competition among providers and organizations. Instead, these efforts have decreased accountability for, and quality of, care by:

- Preserving fee-for-service provider reimbursement, which encourages volume-driven production, not outcomes;
- Favoring large players who consolidate or monopolize the market, thereby reducing competition;

19. Harry A. Sultz and Kristina M. Young, "Chapter 7: Financing Healthcare," in *Health Care USA: Understanding its Organization and Delivery*, Sixth Edition (Sudbury, Mass.: Jones & Bartlett Learning, 2009), pp. 240–242.
20. Katherine Swartz and Troyen A. Brennan, "Integrated Health Care, Capitated Payment, and Quality: The Role of Regulation," *Annals of Internal Medicine*, Vol. 124, No. 4 (1996), pp. 443–444.

- Reducing the role of primary care providers, who were intended to be "gatekeepers" of patient care;
- Failing to create accountability that extends across a continuum of care; and
- Failing to require transparency of cost and quality outcomes in order for consumers to make informed choices and create effective competition in the market.

ACOs: The Key Deficiencies

As noted, ACOs were introduced to remedy the inadequate accountability for excess spending and quality of patient care. Under the PPACA, however, ACOs will likely fail to ensure accountability. Specifically, the PPACA provisions:

1. **Do not empower consumers to be stakeholders in their own care.** The PPACA provisions are obviously not a market-based set of solutions—they do not allow consumers to make fully informed choices about their coverage and care. Consumer-driven markets do not need to create artificial incentives to improve quality and performance because competitors are constantly working to improve their products, attract consumers, and ultimately increase market share. Except for unique services—cosmetic dermatology and Lasik eye surgery, for instance—the health care market does not operate this way. Since employers contract with insurers who enter into arrangements with providers, competition is limited, and the *real* consumer—the patient—has no part in driving that competition. The result has been a lack of transparency, and a lack of incentive for health care providers to offer quality "products." Instead of remedying this problem and increasing competition among payers and providers by treating patients as informed consumers, the PPACA includes vague requirements for performance measurement and fails to address underlying issues driving cost. Ironically, many physicians are reluctant to assume accountability for patient outcomes since they recognize that much of the outcome is directly under the behavioral control (and thus accountability) of the patient-consumer. Taking the patient-consumer out of the equation undermines any attempt at creating true accountability for health care decisions.
2. **Do not encourage provider accountability**. Though it seems that provider buy-in would be integral to an ACO's success in the shared savings program, providers continue to be paid for each service they perform. Given the uncertainties and practical complications of distributing savings, the fundamental incentive to provide a service and receive a fee remains in place. Even with the possibility of a bonus from shared savings, maintaining the fee-for-service system encourages providers to continue delivering an excess of services so that they can maximize their return. By creating incentives for each provider to increase his own productivity, fee-for-service payment undermines the importance of provider collaboration across the continuum of care. Providers have an incentive to "intervene" and "do something" as opposed to engaging in thoughtful discourse and collaboration with patients.
3. **Create an unfair competitive advantage for large organizations.** The mandated program centers on a single, untested, and vague model that is largely hospital-centric. Eligibility requirements, while vague and ambiguous, collectively suggest that larger, more complex organizations have an unspoken advantage. Groups of independent practitioners as well as other types of small and mid-sized practices may lack the infrastructure, Internet technology, or other resources needed to qualify and succeed on their own. Also, smaller, entrepreneurial organizations that want to venture alone may find themselves competing against similar physicians' practices that have joined ACOs or been acquired by larger organizations and, as a result, will be under less financial and clinical pressure to improve efficiency and quality. Large delivery systems are, once again, able to claim or consolidate their hold on substantial portions of their markets, resulting in less competition. Large systems may become "too big to fail" and will have increased leverage with payers; or, without effective competition, they might have little incentive to reduce spending or improve quality of care. Ironically, the most significant costs relate to end-of-life care, hospital inefficiency and hospitals' inability to manage "never events" (events that should never happen, but do, such

as surgery on the wrong limb or transfusion of the wrong blood type). Why reward the very institutions that failed to lead the industry in transformation?

Harnessing Consumer Choice and Competition to Encourage Accountability

Initiatives that rely on complex organizational experiments to build accountability are not only likely to fail, they are also likely to increase costs. Instead, policymakers should establish market conditions where innovative accountable organizations can flourish in a competitive environment, driven by consumer choice. It is easy to imagine how, in such an environment, organizations that are responsive and accountable to patients could flourish. They can focus on prevention, cost efficiency, and improved outcomes and rely on market incentives to enhance accountability across the care continuum.

Imagining a New Market. While the PPACA provides health insurance for Americans who previously lacked coverage, it does so at enormous cost and will exacerbate the trend of provider consolidation, thereby reducing competition, and lead to greater inefficiency, less innovation, and ultimately less access to health care for consumers. Achieving better health outcomes at lower cost can be accomplished by eliminating the perverse financial incentives and unnecessary bureaucracy. Repealing the PPACA and replacing it with legislation that would provide robust free-market choice and real competition would transform the delivery of health care. Market pressures would stimulate organizations to deliver better health outcomes at lower cost.

In a free market for health plans and providers, competing organizations will have powerful incentives to pay for health care delivery that reflects predictive care paths and evidence-based medicine. Providers *and* health care delivery organizations would be required to demonstrate that their services deliver economic and clinical value. To create accountability, health care delivery organizations would address variation in treatment practices and inefficiencies in care delivery. Establishing predictive care paths and effectively using evidence-based medicine would help providers and organizations achieve better and cost-effective health outcomes.

Properly used, clinical effectiveness research would be integral to assessing the value of various procedures, care paths, and strategies. Providers and the organizations with which they are affiliated would need to provide evidence to support the value of the care they administer before they can expect to be reimbursed for their services.

Using predictive care paths and evidence-based medicine would lead to effective treatment approaches which are good for all stakeholders—patients, physicians, and organizations. These policies would help improve outcomes, establish efficiencies, reduce variations in treatment patterns, and create baselines for determining effectiveness. Instead of the standard top-down administrative payment arrangements, modeled on Medicare, primary care physicians would replace RBRVUs with a time-based and outcome-based approach that reflects real prices, market value, and transparency.

Securing better health care at lower cost will involve changing the wrong-headed financial incentives and bureaucracy characterizing the present third-party payment system that dominates both the public and private sectors.

A truly competitive space provides smaller businesses with the same opportunity to flourish and achieve market share as large organizations.

Within every organization in a competitive and transparent environment, financial incentives that reward quality outcomes will be critical to improving quality of care and gaining market share. Primary care physicians would be able to take a leadership role in ensuring accountability for care; primary care physicians would be able to spend the appropriate amount of time required to accurately diagnose patients and focus on achieving better outcomes. The incentive to subject patients to tests or other procedures that may not be helpful is removed. This approach also will remove the incentives that drive specialists to conduct unnecessary medical procedures by creating counter-incentives to work across the care continuum to achieve improved health care.

The rapid evolution of the current system toward these types of organizational arrangements will not take place until federal and state policymakers eliminate the existing barriers to private health insurance competition and create a truly competitive marketplace by giving patient-consumers direct control of both health care dollars and decisions. In a transparent, information-driven environment, doctors would need to compete for patients—and those who follow predictive care paths and use evidence-based medicine to provide quality care in a cost-effective and transparent manner should succeed.

A truly competitive space provides smaller businesses with the same opportunity to flourish and achieve market share as large organizations. Each must be able to demonstrate accountability for its role in delivering integrated and coordinated care. In order to achieve such a level playing field, policymakers must break down the barriers to private insurance competition by increasing transparency, accessibility to market information and data, and consumer education while preventing patient discrimination and inappropriate denial of coverage. Doing so empowers the *real* consumers—the patients—to make informed decisions about the health care for which they are ultimately paying. Informing patients and letting them shop around for the coverage that best meets their needs will ultimately lead to increased demand for better outcomes, an emphasis on prevention and health maintenance, and lower premiums.

Imagining a New Organizational Model. Consider an alternative market-based model that could encourage accountability in the health care delivery system, and stimulate change in health care organizations, as opposed to relying on an institution to funnel accountability down to the various types of providers. Such a new organizational model for enterprising providers could:

1. **Require accountability from primary care providers and patients for prevention, health maintenance, health education, and primary care.** Primary care providers and patients are the foundation for this model, driving accountability across all four tiers. Primary care providers will be responsible for educating the patient and facilitating prevention, health maintenance, health education, and primary care. They will also be responsible for reassuming their traditional role as gatekeepers of patient care by collaborating with providers in other tiers, ensuring mutual accountability, and emphasizing prevention and primary care.
2. **Require accountability from specialists focused on the care continuum, cost efficiency, and increased quality of *needed* services.** Specialists that demonstrate a commitment to the care continuum, an emphasis on primary care and prevention, cost efficiency, and increased quality of *needed* services will comprise the second tier of this model. Under this new system, specialists will not be rewarded for the number of services they deliver, but for their contribution to effective, efficient, and tightly integrated delivery of quality care. This requires interdisciplinary communication, collaboration, and a commitment to each patient's best interests.
3. **Require institutional accountability, focused on delivering better outcomes at lower cost, coordinated by primary care physicians.** Hospitals and specialty care organizations will serve as the third tier in this model and will focus on delivering better outcomes at lower costs. They will be responsible for monitoring and managing progress by setting goals, assessing individual performance, and creating internal initiatives to promote collaboration and good practices. Rather than trying to force accountability among providers, organizations will simply serve as vehicles for integrating providers that have already demonstrated accountability. Again, primary care providers will be integral to coordinating and facilitating these organizational changes.
4. **Promote coordination across community agencies, reinforcing prevention, health maintenance, and disease management.** Responsibility for health and health care should not be confined to hospitals and physician practices. In order to truly empower patients as stakeholders in their own health, concepts like prevention, health maintenance, and disease management should be reinforced at the community level. Private-sector success will spill over into the public sector, and policymakers will be encour-

aged to hold social service agencies, nursing homes, home health organizations, and other community agencies accountable for continued patient education, support, and advocacy. Public and private entrepreneurs can begin to ensure that prevention, awareness, and accountability become part of a lifestyle that patients embrace and the health care industry is required to sustain.

Conclusion

In theory, ACOs provide financial incentives to organizations that, by encouraging providers to work under a common organizational umbrella, can reduce costs and improve outcomes. In reality, given the complexity of the existing system, such a strategy will not only fail—it will most likely exacerbate the very problems it was designed to fix. ACOs will concentrate more and more power in fewer and fewer organizations—allowing them to become too large to fail. Such a system will undermine competition and entrepreneurship, the bedrock of innovation and job growth in this country. Thus, the PPACA creates the potential for increased bureaucracy, fragmentation, and costs without improving outcomes.

There is no evidence that supports the use of untested, complex organizational structures to improve quality of care and reduce costs. Indeed, the evidence suggests the opposite. Only by systematically changing the underlying payment model, enabling competition, and introducing transparency in cost and outcomes will the goals of health care reform be achieved. Repealing the PPACA and creating incentives that focus on achieving quality outcomes, providing choice, and allowing real competition are what will transform health care delivery to a system that provides higher quality health care at lower costs.

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