Capsule Commentary on Anderson et al., Quality of Care and Racial Disparities in Medicare among Potential ACOs

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In this issue of *JGIM*, Anderson and colleagues report on an evaluation of the impact of physician group size (as a reflection of eligibility for Centers for Medicare and Medicaid Services (CMS)-defined Accountable Care Organizations [ACOs]) on racial disparities for Medicare beneficiaries.[1] The investigators model the contribution of practice size, racial composition and health care quality on black-white differences in the delivery of select HEDIS measures and preventable hospitalizations for patients with diabetes and cardiovascular disease.

The authors find that large, ACO-eligible practices serve a high proportion of white and high socioeconomic status (SES) beneficiaries. Large practices were associated with smaller disparity gaps in evidence-based care. There was no advantage associated with large practice groups in preventable hospitalizations. There was no consistent correlation between process quality and disparities; and the authors found larger disparities *within* ACO eligible groups than *between* them.

At best, the findings represent a cautionary tale for those who believe that ACOs could address healthcare inequities and disparities.[2] At worst, the findings reinforce the fears of those who predict unintended consequences and worsening disparities with the diffusion of ACOs.[3] But, overall, the results of the study are not surprising. High SES and non-minority patients have historically received care in health systems with adequate resources and high quality care delivery.[4] Under the current CMS definition, developing ACOs may merely represent consolidation of smaller provider groups that retain old, highly variable and potentially discriminatory practice patterns. This may explain why within-group disparities were generally more pronounced than between-group disparities.

In 2006, Samuel RG Finlayson suggested that in order to truly address disparities, we must end the racial discrimination and economic injustice of the society in which the US healthcare system functions.[5] Until that time, policymakers must remain vigilant and consider the rational design of incentivized programs that reward ACO's for promoting health equity and reducing disparities in care. Based on the work by Anderson, and colleagues, it is quite clear that increasing practice size without enforcing change in practice patterns is simply not enough.

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Conflict of Interest: *The author has no conflict of interest with the material in this capsule commentary.*

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