The Accountable Care Organization for Surgical Care

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KEYWORDS

• Accountable Care Organization • Surgical care • Population Health

KEY POINTS

- Rising health care costs superimposed on uncertainty surrounding the relationship between health care spending and quality have resulted in an urgent need to develop strategies to better align health care payment with value.
- Such approaches, at least in theory, work to achieve the dual aims of reducing growth in health care spending and improving population health.
- To date, surgery has not been prioritized in accountable care organizations (ACOs).
- Nonetheless, it is critically important to begin to consider strategic and impactful mechanisms through which surgery can be seamlessly woven into innovative population health models.

BACKGROUND

Rising health care costs superimposed on uncertainty surrounding the relationship between health care spending and quality have resulted in an urgent need to develop strategies to better align health care payment with value. Such approaches, at least in theory, work to achieve the dual aims of reducing growth in health care spending and improving population health. The US government is the largest payer in the current health care system, providing health care for 57 million and 71 million individuals in the Medicare and Medicaid programs, respectively.[1] Rising health care costs have resulted in the need to fund approximately 50% of government health care entitlement programs with sources other than payroll taxes and premiums, diverting tax revenue from other sources.[2] The same issues face employers, spending an increasing share

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of revenue on health care for employees, thereby limiting wage growth and economic development. Finally, individual beneficiaries face rising out-of-pocket premiums, copays, and deductibles, all of which significantly limit wealth creation and impede macroeconomic growth.

Over the last 50 years, fee-for-service (FFS) has served as the primary method of payment in the US health care system under which providers are compensated for services rendered. The US FFS system financially rewards providers for the volume and complexity of services that they deliver. Despite potential benefit of FFS with respect to aligning incentives toward production, there are myriad potential challenges, specifically related to financial incentives underlying health care delivery. The FFS environment drives direct financial incentives for providers and health care institutions to "do more" irrespective of the value of the service or services delivered. Indeed, there is ample evidence that physicians respond to financial incentives,[3,4] raising appropriate concerns surrounding the ability of the current payment landscape to drive value.

Superimposed on financial incentives driving disproportionate use of tests and procedures is the current US system of health insurance, which effectively untangles the relationship between service delivery and cost, thus limiting the role of cost in treatment decision making. Although individuals are responsible for a proportion of the cost of health care services delivered, to date, this share has been relatively small, and the administrative complexities of the US health care system have effectively prevented individuals from using meaningful estimated cost data in decision making, as one might for the purchase of any other consumer good. What has resulted is a "perfect storm" of incentives for health care providers and organizations to deliver more health care services and for patients to accept more health care services. Indeed, financial incentives perpetuated by FFS have been implicated in widely observed geographic variation in health care spending and health care quality. Furthermore, the financial incentives perpetuated by FFS have been linked to the $300 billion spent on unnecessary health care services.[5]

With this backdrop, there is renewed interest in transitioning to value-based payment, and ultimately, health care accountability through the transfer of financial risk from the payer to the health care provider or provider organization. To this end, The Centers for Medicare and Medicaid Services (CMS) have prioritized the transition from FFS to value-based payment. Specifically, CMS intends to link 50% of all payments to alternative payment models by 2018.[6] The Medicare Authorization and CHIP Reauthorization Act of 2015 codified these goals with the development of the Quality Payment Program, including both the Merit-Based Incentive Payment System and the Advanced Alternative Payment Model tracks. Alternative payment models, including accountable care organizations (ACOs), patient-centered medical home models, and episode-based payments engineer payment to promote the delivery of high-value services and minimize waste, largely through assumption of financial risk for the cost and quality of care delivered. Provider organizations are incentivized to optimize care coordination and care delivery through the promise of shared savings if care meets quality benchmarks and is achieved at a cost less than an established benchmark. The remainder of this article reviews the intersection between surgical care and the ACO model.

THE LANDSCAPE OF UNITED STATES CANCER CARE

It is estimated that in 2017, 1.69 million Americans will be diagnosed with cancer,[7] and the Medicare program will bear financial responsibility for nearly half of all US cancer care. In 2004, Medicare payments comprised 45% of all cancer spending accounting for nearly 10% of total Medicare spending.[8] Furthermore, spending on cancer care is