



Short communication

Gynecologic oncology care in the world of accountable care organizations

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ABSTRACT

Accountable Care Organizations (ACOs) are an example of alternative payment models that are becoming increasingly common in our healthcare system. ACOs focus on increasing value through cost reduction and improved outcomes, and historically focus on Medicare patients within primary care practices. As ACOs grow, attention will likely turn to costly subspecialty care as an area for improvement and standardization. This brief communication addresses the potential benefits and consequences of ACOs on Gynecologic Oncologists and for patients with gynecologic malignancies.

In 2010, the Affordable Care Act expanded insurance coverage and encouraged the adoption of alternative payment models (APMs). The goal of an APM is to engage providers and health systems in achieving improved outcomes while reducing the rate of rise of medical expenditure for a given patient population. Replacing the traditional fee for service models which reward volume of care provided, “value-based payment models” tie reimbursement to quality and cost targets. Of the many programs that were explored, two have importance in the field of Gynecologic Oncology: Bundled payment models and Accountable Care Organizations (ACOs) (Ko et al., 2018; Porter, 2010).

The Bundled Payments for Care Improvement (BPCI) initiative uses the concept of bundled payments to hold providers accountable for the quality and cost of a discrete episode of care; a single payment is administered for the disease or medical event, and providers are able to maximize their profit by keeping costs (and complications) low and quality high. Accountable care organizations (ACOs) are groups of providers who share accountability for outcomes versus total per capita spending across a population. Specialists have generally been focused on bundled payments for episodic care, but it is important to note that ACOs also have implications for specialty care such as Gynecologic Oncology. As such, the objective of this manuscript is to familiarize the reader with the concept of ACOs and the potential impacts on our field.

Within the Medicare Shared Savings Program, an ACO forms when a group of providers and/or a hospital system partners with Medicare to share in savings if their per capita medical expenses are lower than projected based on trend. Shared savings are then further modified by the ACO's quality scores. Medicare is not the only convener of ACO's; commercial insurers and several state Medicaid programs are taking a

similar approach. The potential for shared savings generally prompts an ACO to develop novel programs to help coordinate care and address avoidable spending, particularly in their most costly and high-risk populations. Though ACOs generally focus on Primary Care redesign, many specialists, including Gynecologic Oncologists, will find themselves participating in or having close affiliation with ACOs.

Currently in the United States there are over 1000 ACOs covering 33 million lives (Muhlestein et al., 2018). Interestingly, health care systems who form an ACO are not required to enroll all patients. It is not unusual for systems to have some patients cared for in a fee-for-service model, while others are in a risk contract or ACO. Often physicians are unaware where the patient falls, and while promotes equity in management it does contribute to a confusing and complex reimbursement landscape. For patients in risk contracts, most of their care is centered within Primary Care Providers (PCP) and in Patient Centered Medical Homes. Yet as ACOs become more common in the healthcare system, subspecialty care will likely also be subsumed into a value-based approach (Dupree et al., 2014; Khullar et al., 2016). The Center for Medicare and Medicaid Innovation has now developed the Oncology Care Model. This future was highlighted in the 12th Joint Meeting of the Board of Scientific Advisors and the National Cancer Advisory Board, who discussed the importance of value and cost containment within oncology and oncology drug development (Department of Health and Human Service, 2018).

1. Positive impacts of value based care

In recent years there have been increased attempts to prove the

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benefits of incentivizing value-based care (McWilliams et al., 2013, 2014). The amount of data exploring ACOs in Medicare populations is increasing but is still difficult to interpret. A large review of care delivery models in oncology was inconclusive (Aviki et al., 2018). Even less is known about the effect of ACOs on specialty care. This is particularly troublesome because subspecialties like oncology add tremendously to the overall cost of care and are critical to any assessment of value provided (Dupree et al., 2014).

While impact of cost versus quality may still be unknown, ACOs do portend other benefits. ACOs focus intensely on primary care and attaining metrics associated with improved screening and population health. Gynecologic cancers such as cervical cancer would clearly be impacted by improved access to screening. Patient comorbidities which can impact oncologic treatment, such as diabetes and cardiovascular disease, are more aggressively managed. More frequent visits to a PCP also increase the chance that a woman will be diagnosed at an earlier stage in any disease, particularly salient for women with ovarian cancer.

Accountability for total medical expenditure also encourages investment in novel resources to improve care coordination (ex: population health coordinators, psychologists, social workers in residence at primary care office). This has the potential to benefit the complex gynecologic oncology patient and help provide continuity between office visits and inpatient stays. While skeptics may raise concerns that ACO PCPs are incentivized to limit expensive subspecialty referrals, the data does not suggest this is true. A large study examining cancer patients within ACO hospitals versus non-ACO hospitals found no difference in 30-day mortality rate, readmission rate, complication rate, and prolonged hospitalization (Dupree et al., 2014; Herrel et al., 2016).

In addition, responsibility for the full spectrum of care requires ACOs to focus on improvement in post-acute care facilities. High quality post-acute care is vital to prevent unnecessary hospital readmissions and to reduce the risk of complications in vulnerable patients, such as those with malignancy. McWilliams et al., observed that participation in an ACO contract was associated with reduced post-acute care spending without decrease in quality of care (McWilliams, 2017). This increased ability for coordination across the spectrum of care is an additional potential benefit for gynecologic oncology patients (Kaye et al., 2018).

Finally, a pillar of value-based systems is a focus on patient outcomes. While we traditionally have tracked overall survival, progression free survival, and toxicity as outcomes, a value-based approach would include patient reported outcome measures (PROMs) such as sustainability of functional status, therapy induced illnesses, symptoms from therapy, and quality of life (Muhlestein et al., 2018). A focus on patient centric outcomes, and the research that it generates, can only serve to improve the lives of oncology patients. In addition, the emphasis on the intersection between value-based care and patient values has the potential to improve utilization of palliative care and hospice services, improving the end of life care of our patients.

2. Concerning impacts

While ACOs can provide novel benefits to care delivery, they also present unique challenges. One challenge that is of particular concern to our field is the notion of patient and physician autonomy. Gynecologic oncology patients are a heterogeneous group; patients with the same disease may choose different treatments ranging from experimental treatments to only palliative care. Clinical decision making focused on proving value while lowering cost increases restrictions on high cost or novel drugs, and pressure for more standardization and stringent pathways. This may not be appropriate for a field with our complexity or culture, as gynecologic oncologists are often directed by patient preferences after presenting evidence-based recommendation. Our ethical obligation to improve healthcare costs for society and our healthcare systems may challenge our ethical obligation to patient

autonomy (Markovitz et al., 2019).

A second concern is that to provide high quality care at a lower cost, physicians (including gynecologic oncologists) in an ACO may be incentivized to take only young, fit patients with adequate social support (DeCamp et al., 2014). The most complex, ill, and elderly patients would likely be referred to the closest tertiary/quaternary care institute. In addition, if health status adjustments are not applied to the projected cost of care for that population, those institutions that serve a safety net function would be further financially penalized (Markovitz et al., 2019). This behavior could unfairly reduce cost for some centers while increasing costs for others (DeCamp et al., 2014). Also of concern is that current ACO quality metrics may not be applicable to the gynecologic oncology patient, where hospital admissions can be frequent, necessary, and expected. Ultimately, there is a risk that women with gynecologic malignancies or other complex illnesses could have access to health care restricted, as assuming their care would impose elevated financial risk. This is particularly concerning given that ACOs do not appear to reduce health care disparities more than existing paradigms (Lewis et al., 2017; Adepoju et al., 2015).

Given the rising cost of healthcare, Accountable Care Organizations will become increasingly more common and more heterogeneous. While the focus has been primarily on Primary Care, costly subspecialty care will likely become the next focus of quality improvement efforts to increase value. As a surgical and oncologic subspecialty, we will have to partner closely with our primary care practices as they will be choosing value-based Oncologists who adhere to the mission of superior outcomes, improved experience, and lower cost.

Author contribution

All authors were involved in writing and editing this manuscript.

Declaration of Competing Interest

The authors declared that there is no conflict of interest.

Appendix A. Supplementary material

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.gore.2019.100507>.

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