

# Is It Time for ACOs to Start Tackling the High Costs of Surgery?

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In the nation's transformation from volume-based health care to value-based health care, we have seen 2 relatively recent, disparate trends. Chronic care management has shifted to nontraditional endeavors outside of the health care sector, such as Kaiser Permanente and UnitedHealth building affordable housing for the indigent as a main way to reduce health care costs for these complex populations.<sup>1</sup> In contrast, to control acute and postacute care, organizations have realized that they must turn inwardly to the health care franchise to address, above all, the costs and quality of surgery head on. For example, Walmart created a network of high-quality spine centers for its employees that includes Virginia Mason Hospital in Seattle and the Mayo Clinic.<sup>2</sup> It found that one-third of referrals did not need spinal surgery. Other types of surgeries are directed to Geisinger's Destination Medicine program. Similarly, Amazon has also recently taken such a Center of Excellence approach for its employees. This comes at a time when even standard surgeries like coronary artery bypass have been shown to be no better than drug therapy at preventing heart attacks and death.<sup>3</sup>

For the Medicare fee-for-service (FFS) program, it is less clear if these types of innovations can be implemented. Medicare has had a Center of Excellence approach to bariatric surgery for some time now; nevertheless, there is a concern that to make any more headway into value-based care, its largest incentive program—the Medicare Shared Savings Program (MSSP) accountable care organization (ACO) program—will also have to make a similar pivot away from traditional chronic care management and toward a more focused management of surgeries. ACO net cost savings amounted to about \$52 per beneficiary from 2013 to 2015.<sup>4</sup> It is not clear if any more savings can be squeezed out of chronic care. Indeed, a few niche ACOs in Medicaid are pivoting their

chronic care management to nontraditional neighborhood outreach under the mantra, “It’s the zip code that matters.” However, for the traditional FFS MSSP, it is believed that any future cost savings must now come from addressing the elephant in the room: surgical care. In fact, 51% of Medicare FFS spending is on surgical care.<sup>5</sup>

ACOs, as originally envisioned by Fisher et al, were expected to be virtual networks of physicians that included surgeons.<sup>6</sup> They estimated from FFS claims that for each 100 beds in a hospital, 88 physicians are usually involved in the episodes of care. Of these 88, 20 are surgeons and 30 are primary care physicians. Unfortunately, the early ACOs formed as groups of primary care physicians instead of multispecialty groups. In fact, in a survey of the early ACOs, 88% of managers did not know how much they spent on surgery, and 86% ranked the goal of reducing unnecessary surgery as a “medium,” “low,” or “very low” priority.<sup>7</sup> As expected, there were no cost savings on inpatient surgery in the early ACOs.<sup>8</sup>

However, now may be the time to rethink surgeries in ACOs. Navathe and Liao recently estimated that across 24 common surgeries in Medicare, the proportion performed under MSSP ACOs increased from 12% in 2013 to a projected 42% in 2020.<sup>9</sup> In this issue of *The American Journal of Accountable Care*<sup>®</sup>, Modi and colleagues revisit the impact of MSSP ACOs on surgery expenditures.<sup>10</sup> They analyzed Medicare surgery claims and found that ACOs were associated with a reduction of \$181 in spending per beneficiary-year. This was accomplished in 2 ways. First, among inpatient surgical episodes, average payments were \$956 lower for ACOs, mainly due to more efficient postacute care. Second, more surgeries were shifted to outpatient under ACOs.

These results are promising, considering that a long-standing worry has been that ACOs have no mechanism

to control surgical referrals, especially at a time when more than half of primary care physician practices are owned by hospitals. With more than 20% of surgeons now participating in ACOs, it could be that ACOs are becoming more like virtual multispecialty groups, as was initially intended.<sup>11</sup> Multispecialty groups may have a better ability to coordinate care. There is indication of this in recent work by Baker et al.<sup>12</sup> Examining Medicare claims, they find that patients moving from single specialty primary care practices to multispecialty practices have a 28% drop in annual spending, mainly due to reduced hospitalizations.

To engage even more surgeons, it is likely that MSSP ACOs will have to work with surgeons in the various Medicare bundled payment programs for surgery. A recent paper by Liao and colleagues examined lower-extremity joint replacement surgeries conducted jointly under both the MSSP and the Bundled Payments for Care Improvement (BPCI) initiative.<sup>13</sup> They found that both programs individually lowered costs, but jointly they did not achieve any extra savings. It is promising that we see now both the MSSP as well as the BPCI initiative starting to affect surgical costs. Clearly, the next stage is to examine how these different programs can work together to produce even more savings in surgical care.

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## REFERENCES

1. Bion XS. Health care system accepting new math: housing = health. California Health Care Foundation. November 18, 2019. Accessed July 20, 2020. <https://www.chcf.org/blog/health-care-system-accepting-new-math-housing-health>
2. Frakt A, Skinner J. The puzzling popularity of back surgery in certain regions. *New York Times*. February 13, 2017. Accessed July 20, 2020. <https://www.nytimes.com/2017/02/13/upshot/medical-mystery-why-is-back-surgery-so-popular-in-casper-wyo.html>
3. Maron DJ, Hochman JS, Reynolds HR, et al; ISCHEMIA Research Group. Initial invasive or conservative strategy for stable coronary disease. *N Engl J Med*. 2020;382(15):1395-1407. doi:10.1056/NEJMoa1915922
4. Mechanic R, Gaus C. Medicare Shared Savings Program produces substantial savings: new policies should promote ACO growth. *Health Affairs*. September 11, 2018. Accessed July 20, 2020. <https://www.healthaffairs.org/doi/10.1377/hblog20180906.711463/full/>
5. Kaye DR, Luckenbaugh AN, Oerline M, et al. Understanding the costs associated with surgical care delivery in the Medicare population. *Ann Surg*. 2020;271(1):23-28. doi:10.1097/SLA.0000000000003165
6. Fisher ES, Staiger DO, Bynum JPW, Gottlieb DJ. Creating accountable care organizations: the extended hospital medical staff. *Health Aff (Millwood)*. 2007;26(1):w44-w57. doi:10.1377/hlthaff.26.1.w44
7. Dupree JM, Patel K, Singer SJ, et al. Attention to surgeons and surgical care is largely missing from early Medicare accountable care organizations. *Health Aff (Millwood)*. 2014;33(6):972-979. doi:10.1377/hlthaff.2013.1300
8. Nathan H, Thumma JR, Ryan AM, Dimick JB. Early impact of Medicare accountable care organizations on inpatient surgical spending. *Ann Surg*. 2019;269(2):191-196. doi:10.1097/SLA.0000000000002819
9. Navathe A, Liao J. Surgical care in accountable care organizations: a growing opportunity. Leonard Davis Institute of Health Economics. May 12, 2020. Accessed July 20, 2020. <https://ldi.upenn.edu/healthpolicysense/surgical-care-accountable-care-organizations>
10. Modi PK, Moloci N, Herrel LA, Hollenbeck BK, Hollingsworth JM. Medicare accountable care organizations reduce spending on surgery. *Am J Accountable Care*. 2020;8(3):12-19.
11. Resnick MJ, Graves AJ, Buntin MB, et al. Surgeon participation in early accountable care organizations. *Ann Surg*. 2017;267(3):401-407. doi:10.1097/SLA.0000000000002233
12. Baker LC, Bundorf MK, Royalty AB. The effects of multispecialty group practice on health care spending and use. National Bureau of Economic Research working paper 25915. June 2019. Accessed July 20, 2020. <https://www.nber.org/papers/w25915>
13. Liao JM, Emanuel EJ, Venkataramani AS, et al. Association of bundled payments for joint replacement surgery and patient outcomes with simultaneous hospital participation in accountable care organizations. *JAMA Netw Open*. 2019;2(9):e1912270. doi:10.1001/jamanetworkopen.2019.12270