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Evidence of savings in accountable care organizations and cancer care

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Approximately 10 percent of Medicare spending is for cancer care, and Medicare spending is nearly four times higher for beneficiaries with cancer than in those without the disease. Little is known about how to curb spending growth while maintaining or improving quality of care for these high-risk, high-cost patients.

Researchers from The Dartmouth Institute for Health Policy & Clinical Practice report that savings may be found in accountable care organizations (ACO) through reductions in hospitalizations. The analysis published in the December issue of the journal *Healthcare* provides the first empirical evidence on how the shared savings ACO model may affect the cost and experience of care for cancer patients.

The researchers looked at the Physician Group Practice Demonstration, which ran from 2005 to 2010 in 10 physician groups, for the best current evidence on the likely effectiveness of accountable care organizations for Medicare beneficiaries. Under an ACO contract, a group of physicians is eligible to share in savings they create if they meet quality standards.

The researchers report that a significant reduction could be found in Medicare spending of $721 annually per patient, a 3.9 percent decrease, with no adverse consequence for survival. The savings were associated with fewer admissions for inpatient care among beneficiaries with prevalent cancer due to better management of acute care, especially in beneficiaries eligible for both Medicare and Medicaid. However, there

were no reductions in cancer-specific treatments, such as chemotherapy or surgical procedures.

There was no significant change of proportions of deaths occurring in the hospital, reductions in hospice use, hospital discharges or ICU days. But there was an improvement in mortality.

"This could be viewed optimistically," said Carrie Colla, principal investigator in the study. "This payment reform was not associated with stinting on cancer-specific treatment."

Disappointing though, Colla said, was that the Demonstration group did not make changes in services more likely to be discretionary (such as imaging), which are both expensive and common in cancer treatment. The researchers noted that as more expensive chemotherapy agents and new procedures are introduced into the market, payments for inpatient care may be dwarfed by spending on cancer treatments.

Spending on cancer care is expected to increase as the population ages and new and expensive treatments are deployed. Payers are legally obligated to provide coverage for cancer treatment regardless of cost.

"ACOs have the potential to align incentives that could support a variety of value-based approaches to cancer care," Colla said. "These approaches might include encouraging physicians to consider patient preferences and value when weighing treatments, implementing evidence-based treatments, and discouraging overuse of imaging or expensive chemotherapy agents with suitable substitutes."

More information: www.sciencedirect.com/science/ … ii/S2213076413000183

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