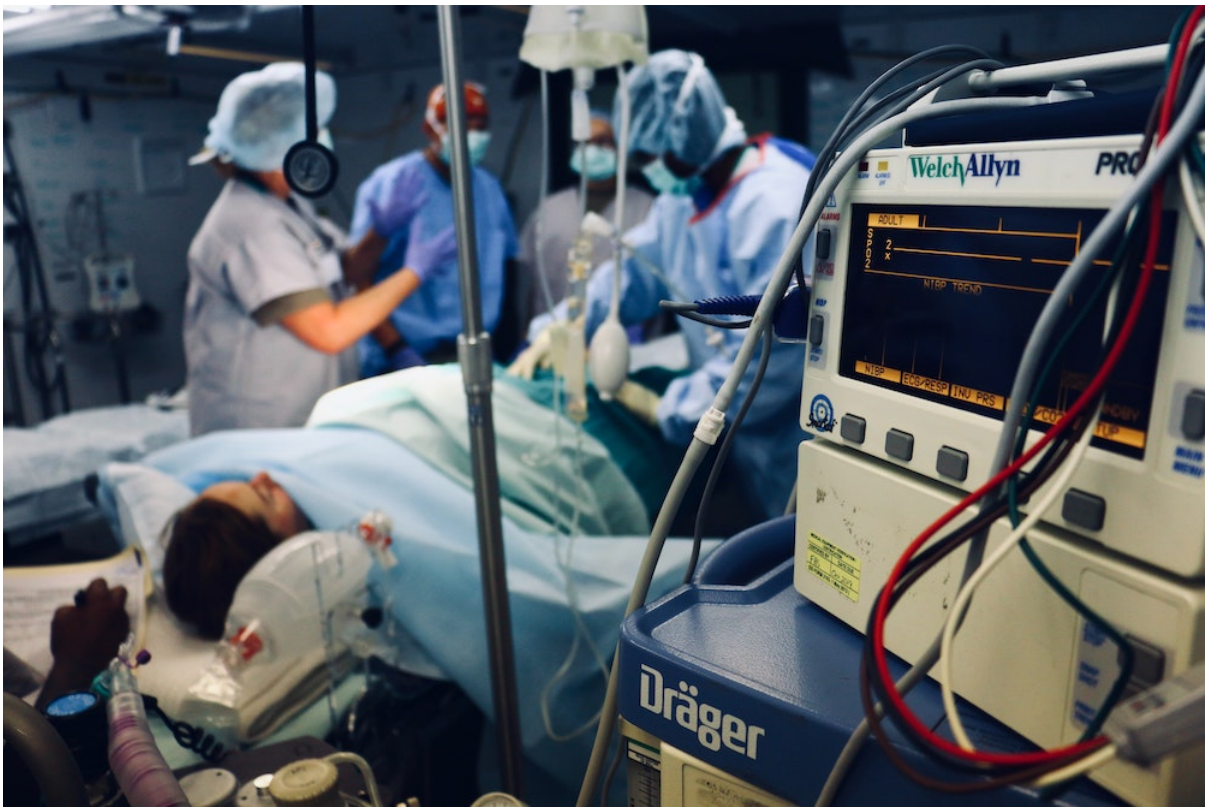
How ACOs Can Control Costs with Physician Help, in 3 Steps. Really.

written by Theresa Hush | August 13, 2020



Health care has been drained emotionally and financially by the COVID-19 pandemic. Yet, in a surprising twist, that trauma has accelerated providers' willingness to adopt financial Risk.

You may be one of many providers who have suddenly realized the value of predictable revenues like capitation. Receiving continual payments for attributed patients is appealing, especially when deferral of routine care has led many practices to the brink of failure.

That's why many providers are specifically considering capitation. For Groups with previous experience in managing risk pools, it's an easier decision. But if you represent an ACO that resisted CMS Rules to inject downside Risk into the model, or a Group still tiptoeing toward Risk, your path may be longer. Ask these questions: Can you prepare quickly for real Risk like global capitation? And if so, how will you protect yourself from costs you don't directly control?

There's a subtext here. Candid ACOs will express the reservation, "If only I could engage physicians." That's why it's essential to address these questions together: How can you achieve

cost control through physician engagement?"

Here's a synopsis of the steps needed to do just that, using solutions that Roji Health Intelligence has successfully piloted with our clients.

Step 1: Correct the Lack of Data Essential for Clinicians' Engagement in Risk

Many ACOs and Groups use claims data to establish their cost savings strategies, as well as analytics, population health, and provider comparisons. CMS has promised Direct Contracting entities will receive such claims data to help them with global capitation.

While claims data is adequate for aggregating total billed services by patient into annual Per Beneficiary Per Year (PBPY) Costs and identifying out-of-network services, it only gives you information that highlights and categorizes your costs. *It doesn't tell you why your costs or higher or point to what you can do.* That's because it misses a key attribute for ACO success: clinical patient status information.

Patient status includes discrete bits of patient clinical information stored in EHR problem lists, lab and other values, blood pressure readings, medication lists, and other clinical or demographic information. Unless you are able to harness relevant clinical information and connect that data with costs, you aren't in a position to help your clinicians engage in clinical solutions—or, for that matter, to even engage in the problem.

This is why Roji Health Intelligence first collects provider data to support their services. Correct the problem by collecting data from provider EHRs that can supplement transactional encounters as well as claims.

Step 2: Create Patient Episodes with Clinical Integrity and Interest

Patient clinical data lets you review what is actually happening to the patient before the ER visit, before and after procedures, and admissions. You can plot patient risks against outcomes, and track how patient symptoms were validated (or not) through diagnostic tests. As you connect all of these patient experiences through episodes of care, the enriched data will help your clinicians become involved in identifying issues that drive costs.

But to accomplish episodes, data must to be organized into comparable units that make sense

to physicians. The best method to normalize patient experience is with patient episodes by various categories, such as procedures, conditions/condition combinations, and patient risks or populations. Adequate data integrity and volume can generate the data needed for comparing episodes along key vectors: cost, outcomes, and diagnostics or treatment plans.

Payer episodes of care that support payment models have little “clinical” integrity; they are a mix of included and excluded procedure and diagnosis codes, and those inclusions or exclusions respond to either payer or provider financial or administrative issues. *By contrast, provider-developed episodes should be more inclusive so that they can illuminate more about the patient cases and engage providers in conversation.*

Step 3: Engage Physicians in Clinically-Based Cost Inquiries

After resolving data insufficiency and organization, you can create a process for your physician engagement. That process must not resemble scoring and similar cost comparisons if you want physicians to approach it positively.

Scoring turns physicians away from an active inquiry process and raises defenses. It’s also unfair. The data does not tell the full story, and, is often inaccurate. There can be missing pieces of information, such as the patient’s long-term history or services beyond the scope of data. Or, a full picture cannot be determined without data about patient risks, social determinants, or the extent of other conditions—none of which is always present in a single provider’s EHR, especially when patients see multiple physicians.

A more effective approach is, first, to coach physicians on what data is saying about their cases and costs. The objective is awareness, not scolding. The cases could well be in the lower cost range, and the inquiry focused on what happened that could help ensure similar cases with good outcomes. Or use cases across the spectrum of the physician’s patients, asking for feedback about what contributed to the variation in cases.

There are so many substantive threads to follow that where to begin is not really important. One could be the path from symptoms to diagnosis, evaluating the diagnostic services for consistency, duplication, and best practices– or the lack of a diagnosis related to presented symptoms that could signify a patient left stranded. Another could be cost variation spurred by different patient risks or by treatment approaches. Or, costs illuminated by patient age and risk category.

Can You Engage Your Specialty Referral Network?

With specialists driving a significantly large share of ACO costs, also consider how to use episode-based inquiries in your ACO strategy. The higher the financial risk for ACOs, the more critical it is to incorporate specialty episodes and other features effectively.

Contribution of data and episode review could be part of referral discussions and agreements. Episode analysis is positive for specialty groups and helps them on the path to competition as well as financial recovery, but initial reactions could also be defensive. Both your ACO and the specialty practices will need to approach data sharing and solutions in a way that will be mutually profitable.

Another bonus: In review of episodes, specialists can play a vital role in identifying and attaching key risk factors and diagnoses to the patient for primary care management.

In short, yes, it is possible to engage physicians in costs and discussions, so long as the language and subjects of those discussions are neither preempted by blame nor predetermined by scoring. Your ACO Administration must give credit to physicians for their clinical expertise—after all, that is why they are valuable—and use that talent instead of algorithms to pave a path to value.

For Medicare-focused ACOs, using clinical approaches to focus on long-term trends has an additional advantage. Only episodes and review of patient cases can reveal choices and decisions about treatment, patient selection, and alternative therapies—decisions made by both patients and physicians.

Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.

Image: Richard Catabay