Seven Key Analytics to Direct Your ACO's Specialty Strategies for Risk

written by Theresa Hush | October 9, 2020



As ACOs become subject to Risk arrangements, especially global capitation, specialty costs should be one of the first areas to examine for long-term savings potential. Optimal use of specialists and engagement with specialty providers will prove essential for cost management.

This is new territory for providers who have decentralized most decisions about specialty referrals and subsequent specialty medical decisions. Leverage for collaboration and examination depends on the ACO's strength position vis a vis specialty business and competition among specialists for ACO referrals. A primary ACO strategy for cost performance, therefore, must start with its market strategy.

Your ACO Competition, Medicare Advantage Plans, Are Already Going After Specialty Costs

As I've explained in previous articles, ACOs are most directly

in competition with commercial Medicare Advantage (MA) plans. With the advent of lower-cost/narrow-network MA plans for 2021 enrollment, commercial plans are signaling their willingness to choose specialists based on price. For ACOs, self-selected enrollment of healthy seniors in MA will pose further risk to your own cost structure. No amount of risk adjustment will fix that cost problem.

Fortunately, many specialty practices, often very focused on market competition, are hungry to examine avenues for achieving better cost and outcome performance. If your ACO is in a population-dense region, you need specialists who are willing to collaborate.

How Your ACO Should Evaluate Specialty Referrals and Costs

In the 1980's and 1990's, Health Maintenance Organizations (HMOs) forced an unpopular, strict review of specialty services by requiring pre-authorization, often including consults. Some primary care practices austerely managed their patients with heart and other problems internally, rather than refering them. Since data during this period was rare, it is now hard to assess the impact of these practices on patient outcomes.

Your ACO now has the capability to develop a much more focused and collaborative approach with specialists, for mutual benefit. What is your leverage to interest your referral network in this approach? Comparison of outcomes and costs. While this is more difficult with groups versus payers because of volume, you can overcome this obstacle for higher volume procedures and conditions if you have the technology needed to correctly examine costs.

Episodes of care, extensively discussed in previous articles, is the appropriate unit of measurement for cost of care for specialty services. Starting with procedures, claims data together with provider EMR data can provide the unit of cost measurement for the pre-, during- and post-trigger services for patient care associated with a procedure.

So let's say you have episodes constructed, and can map them along a cost curve and compare by physicians. Let's review key analytics that will help you identify what is driving costs, and how to create strategies that will change procedural costs long-term.

Seven Key Analytics for Procedural Episodes of Care

Where you start with episodes is important. Your first three analytics should focus on the areas most likely to bear fruit for cost performance, as well as provide traction for future efforts.

1. Episode volume and type. Begin with specialty services that are both high volume and considered elective (most of the time). Joint replacements and repair as well as other orthopedic or neurosurgery procedures are usually at the top of this list, along with frequent cardiac procedures, cholecystectomy, screening colonoscopy, cataracts. Conversely, you will also want to note providers for whom volume of procedures is very low, as this can correspond to poorer outcomes and should be part of specialist selection.

2. Variation in episode costs from an average. Variation will be a function of the range between each episode cost,

indicating variety of different approaches to surgery, clinical reasons for the procedure, or physician practice patterns. Cumulative costs over the average is also useful; in cost curves with high variation of episode costs but many episodes on the lower cost end of the curve, these cases bring down the average.

3. Volume spread of closely related procedures. Category assessment about how many procedures are performed in an open versus laparoscopic approach, among other variables to clinical approach, will reveal differences in cost that could be due to either patient risk or physician expertise.

After prioritizing episodes, your work will involve illuminating three overarching situations:

- Episodes (like trauma and cancer surgery) where there may be multiple procedures or organs involved, critical care services, and where options for improving costs are questionable.
- Procedures where there are multiple choices of therapies, such as shoulder repair and replacements or spinal surgeries, where costs and outcomes vary widely.
- Procedures where there are associated events that affect costs, such as complications or readmissions.

This analytic set includes:

4. Cost curve analysis to separate episodes into cost tiers and clinically-relevant clusters. All tiers will be reviewed to explore common elements and differentiators from other cost tiers.

5. Key notable observations that affect costs. Events that fall post-trigger may be costs that could have been predicted and avoided because of patient factors, or problems related to the procedure itself. Post procedure diagnoses, complications, sepsis, and subsequent procedures; readmissions; place of service; and major contributory costs, such as anesthesia type and imaging, are frequent candidates. There may also be unexpected associations of events that may look unrelated, like DVT, poor healing, and smoking status, that could drive costs higher.

6. Multi-trigger episode analysis. Episodes that overlap could represent normally sequenced procedures, such as certain cardiovascular episodes. They could also represent bundles of separate procedures for the benefit of the surgeon or patient preference. Because multi-trigger episodes almost always will push costs up, review of cases to examine outcomes and post-procedure events are essential.

7. Pre-procedure risk factors. Episode analysis will always reveal a small number of high cost episodes where a patient’s risk factors or condition might have eliminated the patient as a candidate. These episodes, however, are only evident in hindsight and should be clinically evaluated by the proceduralist.

It should be clear that cost strategies to manage specialty services require a collaborative and positive process between physicians and your ACO. There are many reasons beyond specialist performance that drive costs higher, and the magic solution is to identify what you can predict, what you can control in advance, and to establish appropriate clinical

criteria to tell the difference.

Working within a Risk arrangement, the best method of paying and rewarding specialists is important; you can’t fight volume-based incentives while you are trying to reduce costs. Finally, improved physician-patient decision-making for specialty episodes—with primary care input, review of alternative therapies, and cost transparency—should help ACOs create a more holistic strategy that involves the patient, specialists, and primary care physician in an effort to optimize services.

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: Aditya Wardhana