Five Strategies to Help ACOs and Independent Specialists Create Common Ground on Data Sharing

written by Theresa Hush | November 20, 2020

To successfully manage the 40 to 60 percent of costs of care driven by specialty physicians, your ACO must overcome one major obstacle when you begin to address specialty costs: the lack of information to guide your actions.

Although ACOs have claims data to calculate total costs per ACO patient and totals for specialty services, you can't compare those costs. Why? Claims are not organized into cases or "episodes of care" that include all providers and services so that it is easier to compare case costs between patients or providers. More importantly, the small number of Medicare patients seeing any given specialist is not representative enough to evaluate that provider's average cost per episode, because the Medicare patients could be more or less sick.

The small number problem is why CMS moved MIPS quality measurement to an all-patient basis, in order to more accurately indicate how a particular provider performs against quality standards. That accuracy benefits providers—and ACOs under the proposed new rules—by providing actionable comparative data.

Specialty Practices' EMR Data Is Essential to Cost Performance Improvement

That's why it is so essential for ACOs to build the data and analytical tools to guide strategies for constraining costs. If you can't standardize a method of looking at cost, as quality measures do, you have no means for comparing case costs and identifying the reasons for differences. And, if your data lacks integrity because it's too sparse, it has little value.

Specialty patient data in practice EMRs hold the key to unlocking the potential for both specialists and ACOs. But unless the specialists are part of a group employed by the ACO or its health system, ACOs lack the data to determine whether specialty costs are reasonable and how to improve performance.

The lack of data is specific to ACOs where specialists are not employed or contributing data to the enterprise, a structure more common among physician-led independent ACOs. Health-system-owned ACOs with large multi-specialty employed practices have the data, although expertise is once again required to integrate that information with claims data and to organize care into episodes.

In this blog post, we'll address the specific issues of ACOs with outside specialists, and how to navigate strategies for collaboration. A future post will focus on the particular problems of ACO organizations owned by health systems and hospitals with multi-specialty groups.

Will Specialists Provide Practice Data to ACOs?

How and what data specialists will provide to ACOs is an important question for ACOs and practices to navigate. Here's why specialists may oppose data contribution:

> Specialty competition within the ACO: In areas with a lot of specialty competition, that data causes potential risk of harm to the contributing practice—an issue that ACOs must be willing to accept and negotiate. If two groups of the same specialty are in your ACO referral network, the contribution of data could possibly put one at a disadvantage for referrals based on perceived costs.
> Broad Specialty Patient Service Area: Specialists typically get referrals from a large

network of primary care physicians across a broad service area. The breadth of that geographic area will likely be an important factor in data sharing. Specialists could be more resistant if providing data to you prompts other ACOs to request data as well, with less favorable terms.

Flawed or Untrustworthy Data: Cost variation and excess costs can be caused by a variety of factors that cannot be controlled by a specialist—including facility costs, schedules and protocols, patient risks, and other physicians involved in the case. Data can also just be wrong. There is a fairness issue at the heart of comparative analytics, and your ACO will be well served by carefully implementing data sharing in an environment of education and innovation. If your plan is to use data in a way that appears hostile to specialists, they are less likely to cooperate.

Unfair or Unilateral Action from Data: Some organizations move too quickly to score specialty efficiency or value, without really understanding what the data says. There must be time for specialists to work through their results and vet episode details. This is a new concept for health care. The level of clinical and financial detail, as well as conclusions to be drawn from the data, must be part of a dialogue and negotiation between your ACO and specialty practices.

Who Controls the Data: Specialists may be willing to share results but not the data itself. Does your ACO really need to see the actual volume of patients that the specialty practice is seeing, or the identity of those patients? Using an intermediary vendor to aggregate the data, much like an auditor does for financial data, could be a useful way to submit quality and cost measure data to the ACO but maintain overall integrity of the specialists' data—most importantly, privacy and financial details.

Five Strategies to Help ACOs and Specialists Develop Common Ground on Data Sharing

1. Consider how to meet specialty concerns by how data will be collected and used.

The options include:

a. Require specialists to have a data-driven process to create and evaluate episodes, while maintaining that data entirely under Specialty Practice Control. Under this option, specialists would send episode analytics and cost variation or cost measure data to ACOs, while maintaining full control over the data and patient details itself. The data aggregation could be partially or fully ACO-financed, since there would be mutual benefits.

b. Use an intermediary to hold the data on behalf of the ACO, ensuring that you have access to the analytics results but not the underlying episode data. Simultaneously require network specialists to participate in ACO review processes on costs for mutual education and development of interventions.

c. Require specialists to contribute data to the ACO. Depending on competition in the area and the relationship between the parties, this can be realistic for some groups that are closely aligned.

2. Collaboratively design episodes of care to include both treatment and condition episodes.

Your higher cost specialty areas are priorities and will help get the program started. These typically comprise orthopedics, including joint replacements and spine surgery; cardiology/cardiac surgery; cancer; and kidney disease.

3. Create analytics that include both cost and outcome components, so that physicians can engage in clinical processes.

Roji Health Intelligence has targeted seven analytics as fundamental to episode analytics that provide a guide to what both ACOs and physicians need to see.

4. Implement data awareness and episode improvement processes for individual specialists and practices.

You will want to include a process for specialists to review a small sample of episodes each month and measure whether that occurred through your data vendor. In addition, there should be an overarching process in practices to review systemic reasons for higher costs that come out of the analytics. Both these activities should identify candidates for developing new clinical processes, streamlining care, examining patient selection, or looking at costs in different time-phases of the episodes.

5. Select episodes with treatment variations for developing physician-patient decision processes with patient-oriented data and cost transparency.

Extending the value of episodes from cost analytics into improvements in medical decision-making will help physicians and patients realize the potential of episodes.

Even in ACOs with independent specialist physicians, there are good reasons why episode analytics can be mutually beneficial. Improvement of costs—impossible for specialists without episodes that package services into a case and illuminate what drives cost differences—will help specialists become more competitive, have access to health plan contracts that reach more patients, and, possibly, open the field for employer-based agreements. For ACOs, engaging specialists in cost control strategies can determine whether you are successful in Risk. New options for conservatively collecting data can help both ACOs and specialists improve health care affordability and their futures.

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: Claudio Schwartz and @purzlbaum