Three Data-Driven Approaches to Engage Specialists in ACOs

written by Theresa Hush | May 4, 2023

All ACOs, regardless of payment model, are built on a vision of primary care services to patients. Medicare attributes patients to your ACO based on the plurality of primary care services. CMS attributes a patient to a participating specialist only if the patient has not seen a primary care physician in the ACO or at other providers, and the specialist is providing “primary care” services to the patient.

But the vision of the primary care ACO rarely holds up to reality—for either care delivery or economics. The shortage of primary care physicians, complicated by time constraints, often dictates that patients who could be managed by primaries are referred to specialists. Conversely, complex conditions in patients are often appropriately treated by specialists, not primaries. Specialists manage uncontrolled diabetes and COPD or asthma when patients require intensive treatment. High risk, problematic conditions such as coronary artery disease, heart failure, and atrial fibrillation require specialty care.

Tackling Complex Care Requires Specialty Insight

Old school techniques to control costs often focus on limiting access to specialists. The days of HMOs requiring referral authorization to specialists still dominates some ACO thinking. But limiting patient access to specialists is not only unrealistic, it's also not the optimal strategy to both improve outcomes and cost performance. What is a better plan? Closer involvement of primaries and specialists through shared data analytics, clinical pathways, and communication.

The lack of data-sharing between ACOs and specialists blinds both specialists and ACOs to optimal management of patients and their costs. Without data, it is impossible to develop a guide to identify which patients meet the guidelines for specialty care, as well as to develop solutions that stratify patient risk. Let's take a closer look at the underlying issues and how data-sharing can be beneficial to all parties.

Should Specialists Be ACO Participating Providers?

An evaluation of ACO provider panels often reveals an uneasy relationship between the ACO and physicians. For organizations that are system- or hospital-driven, or anchored by large hospital-employed physician groups, ACO participating providers frequently include independent stakeholder specialty practices for political reasons. The strategy of keeping everyone on the ranch—and protecting the economics of revenue generators (hospitals and specialty practices)—is often perceived by organizational leadership as the only strategy to maintain good relationships.

Inclusion of core specialists such as cardiology and endocrinology makes sense if the physicians are integrated clinically in the same group. Inclusion of proceduralists and highly specialized practices, however, can be disadvantageous for the ACO and for specialists. Even large academic center groups should be examined to determine the effects of patient attribution. Such health systems can distinguish groups by tax identification number to avoid these effects, while maintaining a governing structure to ensure integration and coordination.

Nonetheless, broad participation of specialists helps neither specialists nor the ACO, eventually eroding the economics of both. ACO patients are attributed to specialists who draw referrals from a wide geographic area if the patients have either not visited primaries during the year or have high specialty-related expenses. For procedural specialties like orthopedics and neurosurgery, where osteoarthritis, osteoporosis, and spine conditions may be patients' major conditions, the inclusion strategy raises the cost of the ACO, which is now responsible for all costs for the patient with no primary care management.

For specialists, aligning with one ACO also creates competitive disadvantages. And, as ACOs

inevitably proceed to global risk arrangements, sub-capitation arrangements will deliver a direct strike to specialty group revenues.

CMS Directions for Specialty Value-Based Care

Late in 2022, CMS identified specialty care as a new area of focus in its Value-Based Care strategy, noting fragmentation of services, high use of specialists, and difficulty of access to key specialists as an equity issue. The agency also noted that consolidation in health care and employment of physicians is making care more expensive without improving quality.

The CMS specialty strategy outline provides a clear pathway from short-term to long-term initiatives, including incentives for ACOs to manage specialty care, development of episode-based payments for specialists that model the existing Bundled Payments for Care Improvement (BPCI) program, provision of data, and testing population-based/capitation payments to specialists.

Likewise, CMS called out specialty-focused payment models like Kidney Care Choices as examples of how care by specialists could be organized in patient-centered models with value-based payment models. These models are likely to be replicated across other higher cost conditions.

ACOs and specialists should take note of the CMS strategy, likely to be incorporated quickly in rules.

Three Approaches ACOs and Specialists Should Start Now

Meanwhile, it makes sense for both specialists and ACOs to start rethinking the divide over cost and outcomes, and start collaborating on how to improve them. Here's how to start:

1. Share data and analytics.

ACOs are already examining how they can aggregate data to perform required APP reporting in the future. Using data aggregation methods that optimize collection of clinically rich patient data, ACOs can build collaborative projects with specialists to examine specialty service use by patient risk, outcomes, and cost variation.

Many specialists are using independent, specialty-focused EHRs; assistance of technical vendors will be essential to collect and curate the data for review. Technology for Value-

Based Care must be able to match patients across all practice domains, to compile the patient's comprehensive history.

Shared costs of data collection is key to making the process work. As the data should benefit both specialists and the ACO, sharing the cost is one way of ensuring each party's active participation in design of analytics and agreements on data elements to be shared.

2. Create patient episodes of care for highest cost chronic conditions and procedures.

An essential component of data sharing is the construction of discrete condition and procedure episodes for comparisons. Unlike BPCI, which includes many disparate types of procedures under a single "episode," it is important to construct episodes for improvement programs in a way that they can be compared clinically. That is, they must be defined by a single diagnosis or intervention (procedure) to have clinical integrity when evaluated by physicians.

Without clinical integrity, cost variation could be caused by differing volumes of unrelated procedures or conditions, and physicians will be exhausted by sorting out important findings. Episodes can be rebundled at any point to replicate bundled payments or cost measures, but first must be examined for clinical interventions related to conditions or procedures.

3. Create referral networks using ACO-Specialist specialty care models.

Lack of an organized CMS payment model does not preclude ACOs and specialists from organizing specialty care models across major cost areas to improve outcomes and costs. Progressive specialty groups can initiate the development of episode-driven care pathways to drive analytics, improvement activities, and communication. Patient selection criteria for referrals and interventions are important elements in the agreement between specialists and the ACO.

ACOs should be prepared to use data as a mechanism to entice specialists into collaborative initiatives, as opposed to a hammer for redirection of patients. It would be impossible for ACOs to fairly examine costs unilaterally, and without time for specialists to respond and act.

Specialists already participating in BPCI initiatives should examine how to make the

episodes more clinically robust in data, since BPCI data is calculated only from claims by CMS, leaving specialists without detailed insight.

Specialists should maximize their participation in existing models, constructing analytics to guide evidence-based care within clinical conditions and procedures. Participation in Kidney Care Choices and Oncology Care models, if appropriate, will provide specialists and ACOs with both practice and data that will benefit future models in other specialties.

In the future, we are likely to see a much stronger distinction between payment models organized around primaries and specialty care. Physicians in some specialties will be integrated into primary care practices and will participate in ACOs. Other specialists who perform distinct services will be separated into specialty care models or even specialty ACOs.

Both ACOs and specialists will benefit by implementing a shared vision of patient care that relies on ensuring access to the best, but most affordable, specialty care, with contributions from both primaries and specialists. Such a collaboration will produce essential results for ACO patients and consumers: clear information to guide them to best choices about their self-care and health care services.

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