ACOs Under Risk: Select Specialists Based on Collaborative Audit Process

written by Theresa Hush | September 20, 2018

ACOs have tiptoed into developing a physician network based on value. Building a full lineup of primary and specialty physicians to serve their patient population presents a daunting challenge. Even more relevant, until downside financial risk arrangements become mandatory, ACOs have been able to keep their physician networks inclusive; managing cost of care has been a lower priority than maintaining volume of patients or physician relationships.

All that is poised to change as ACOs come under downside financial risk. The threat of budgeted expense levels that mandate repayment to Medicare or forfeiture of revenues to health plans will change traditional ACO provider affiliations. ACOs will be forced to examine all their costs, targeting not only facilities and post-acute care, but also the specialists who generate those costs.

ACO Network Composition Reflects Historical Affiliations Rather Than Value

Historically, most ACOs have formed their networks from traditional relationships, rather than from a value-driven analysis. As a result, the network follows the structure of the ACO. In hospital-based ACOs with employed physicians or a clinically integrated network, for example, the network includes everyone, both primary and specialists. There may be additional selected independent specialists if needed, based on relationships with the hospital or physicians, sometimes as participating physicians and sometimes as "other entities."

In physician-driven ACOs, by contrast, primary-care-centric ACOs may keep the membership restricted to primary care physicians, so that specialists can be individually selected. Multi-specialty groups, however, usually include all group physicians regardless of specialty, making their selection process more akin to hospital-based ACOs.

The point is that existing networks are usually built on prior referral relationships and little—if any—data. There are some bold exceptions. But the norm is that communication between primary and specialists about patients—otherwise known as coordination of care—has formed the foundation of ACO relationships.

That may be one reason why hospital-based ACOs, as a group, fail to achieve the savings achieved by physician-led models. The latter place less burden on physicians to be inclusive and are thus able to create a stronger central organization to achieve ACO goals. They also have more clout with physicians to keep the focus on ACO cost performance.

Savings from "Coordination of Care" Are Tactical, but Are They Significant?

There is frequent discussion, even in regulatory reports, that ACO savings are derived from a higher level of care coordination. While savings will be realized if a care team improves patient hand-offs between settings and shares data between entities and systems, however, this is not the main explanation. Why? For one thing, avoidance of duplicative and other non-performed services cannot be and are not measured. But the message that coordinated care is effective sounds good to patients and to providers. Making the ACO appear less threatening to both groups downplays the specter of controlling costs by more aggressive tactics.

More aggressive tactics, however, will be required of ACOs to control costs. Rather than coordinate care, the task is to organize care. Coordination is achieved on a patient-by-patient basis by providers *who are already organized into a common set of goals.* Those goals focus on

providing a standard of patient care and costs. An ACO's network strategy should reflect this by how it selects its participants.

The major savings, as providers well know, come from steering patients into more efficient and effective health care. ACOs that have concentrated on post-acute services, for example, have found that significant savings can be achieved by developing contractual relationships with post-acute providers based on quality and cost. While patients referred into such care can be considered "coordinated," it is the measurement of value and pre-determined post-acute arrangements that engineers lower costs.

Savings are also realized by steering patients away from some services or by making those services more difficult to obtain. Therein lies the harm of having no sound network strategy that evaluates providers based on ACO goals. We need to ensure that when ACOs are at risk for losing significant amounts of money under financial risk arrangements, their organized networks will deliver affordable care at a high standard—and not limit patient choice or services.

Strategies for ACOs to Create Value-Based Network

ACOs can create a thoughtful, data-guided process for assessing fit between their organizations and their specialty network. The evaluation process should incorporate all four components of specialty physician value: cost, quality, patient services and coordination with primary care physicians.

Few ACOs will have the expertise to be able to accomplish this without help, but there are health care IT companies, such as QCDRs, that can provide the infrastructure and consultation to undertake the audit process.

Key to the evaluation are two important processes that will ensure greater validity as well as acceptance of results by both specialists and the ACO:

> The cost data must be specialty-specific and standardized by a valid unit cost standard, such as procedural episodes of care and medical episodes that are defined by patient parameters of diagnosis and risk. Packaging services in episodes of professional services and all services permit better comparisons across practices, as long as patient risk is also presented.
> Specialists must have the opportunity to participate in the evaluation process and validate the specific results or to explain them. Data never tell the story alone, but provide the basis for conversation and mutual goal-setting.

The ACO should design network needs based on meeting a majority of specialty services/diagnoses/historical procedures required by its patients. This will clarify the particular specialties for recruitment, and whom to include in organized referral arrangements.

ACOs that adopt these strategies will ensure the highest level of consideration about network formation to further their organizations' success:

1. Measure and compare specialty costs.

Sources of data from claims, provider source systems, and Medicare or health plan data files will support the cost audits and are critical to the process. All of these are available to ACOs either through the specialty practice or through their own operations, but the data must be aggregated and patient-centric, where feasible, to provide the highest value. The evaluation should result in metrics on the cost of care by procedure or diagnosis. In addition to cost performance, ACOs should be able to measure complications, redos, and readmissions incidence with claims data, and examine benchmark data from Medicare to compare costs by diagnosis with reports available from practice downloads.

2. Evaluate quality and outcomes for core specialty areas.

A QCDR or registry can use the source system data collected for cost audits to evaluate the practice performance in quality. Understanding how the practice performs for all patients, not just a Medicare sample, is necessary to avoid surprises when the sample doesn't match historical patients. The evaluation of quality should also match specialty volumes and patient risk profiles for those served in the past to ensure that the coverage is available for ACO patient services.

3. Obtain patient-reported functionality and outcomes.

No data speaks louder than patients; evaluating specialists requires at least a sampling of responses from patients regarding their experiences with those physicians.

4. Conduct primary care physician evaluations of specialists.

Responsibility for patient care is vested in primary care physicians, and they must feel confident that their input is considered when determining referral sources. Surveys constructed

to examine a variety of issues regarding referrals will spot potential issues. These surveys can also reveal issues that should be addressed in the primary care network.

This process of ACOs selecting specialists may sound contentious, because it affects individual physicians as well as their futures. Specialists have a legitimate reason to feel threatened. Therefore, the ACO, acting in territory once occupied only by payers, must ensure that it offers services and support for specialists as they try to transform their relationships.

Specialists who enter into referral arrangements with ACOs should be able to depend on mutual data sharing, participation in benchmark setting, and valid contributions to the creation of episodes and risk stratification. They should be respected for their contributions and invited to help the ACO and primary care physicians understand the factors that contribute to patient risk and better outcomes, so that these can be addressed in ACO projects and process changes.

Selecting specialists in a data-driven way upsets the existing hierarchy of relationships among physicians in health care, and alters the financial arrangements for all parties in ACOs. But the success of physicians of all specialties depends on working collaboratively to achieve common ground.

Founded as ICLOPS 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. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Denny Luan