ACOs and Specialty Physicians: How Episodes of Care Create a Win-Win Cost and Quality Strategy

written by Theresa Hush | May 10, 2018



Specialty care is a thorny cost and political issue for ACOs and physicians alike. No ACO can provide good or comprehensive patient care without specialists. But if ACOs are to produce savings, they will almost certainly need to address how, when and at what cost those specialists will be used.

The degree of concern about specialist-generated costs for most ACOs currently depends on the ACO's structure. ACOs that are hospital-led or formed by multi-specialty health systems or networks may be less apt to look to specialty care for savings, except when the specialists are outside the ACO. Physician-led groups with heavy primary care participation, on the other hand, are more eager to address specialty services. That may be one reason why physician-led ACO performance tends to outstrip hospital-led ACOs.

Regardless of how they are structured, however, all ACOs will

move to adopt methods of controlling both costs and patient use of specialty services. Why? Because payers are moving both Medicare and private sector ACOs toward accepting financial risk. ACOs and specialty groups must prepare for the new environment quickly.

The ACO-Specialty Conflict Arises from Perceived Business Risk

To reach targeted expenditures, ACOs must avoid overuse of specialty services, including the additional tests and technologies ordered by specialists. Medicare ACOs struggle with both maintaining continuity of patient care and controlling cost when assuming costs of specialty care. Because patients are free to go outside the ACO for services, the patient can easily be "lost" outside the ACO's purview once he or she is receiving specialty care. Additionally, the cost of direct services and any additional technology ordered by the specialist will impact the ACO's savings.

ACOs operating under a health plan contract may have less concern with continuity of care if the benefit plan restricts specialty care to the ACO's participating physicians and referral network. But health plan benefits are not always enough to deter patients from going out of network. Even if the benefit incentive structure works, since the ACO is "charged" the cost of specialty services, ACOs still must ensure that such costs are appropriate.

Thus, for ACOs there is a perceived risk of financial losses coming from specialty services. As a result, some ACOs are inclined to keep specialists outside the ACO participating physician panel, using them for referrals only.

For specialty physicians, ACOs are a potential threat to the continued flow of patients and their practice's survival. Single specialty groups with a regional base of patients must avoid being tied to a single ACO, yet are worried about how to maintain referrals from such an ACO.

The dilemma of how to participate in ACOs affects most groups, even those that are already participating in their own employed-physician-group- or health-system-sponsored ACO. Because the geographic referral area for specialists is much broader, such groups require a business strategy that will minimize the loss of volume, while rewarding them financially.

How to Reconcile the Needs of Specialists and the ACO

While the needs of ACOs and specialty physicians appear to be irreconcilable, certain strategies can benefit both. The key is to create win-win relationships that produce ACO savings while ensuring that specialists have adequate patient flow and a stake in the ACO's success.

Successful strategies must be bilateral, not unilateral. The ACOs and specialty groups have unique organizational structures, patient compositions and services. There is no one-size-fits-all strategy that will work for both ACOs and their specialty groups. However, there are common elements that must be present to meet the needs of an ACO or specialty group, respectively. In addition to sharing historical information of ACO costs of care and specialty episodic costs of care, the design of the future relationship should be founded on the following:

- Predictable costs/predictable patient referrals and revenues
- Cost measurement and performance
- Quality and outcome measurement and performance
- Continuity of care process
- Patient feedback of results
- Patient participation in medical decision-making

What's different about this list from past referral arrangements between health organizations? It is solidly built on the measurement of value in Value-Based Health Care (VBHC). While the relationship should be open and collegial, the newly added components speak to the triad of Cost, Quality and Patient Experience in VBHC. As such, it is a business venture that should respect the needs of both parties to control costs, yet maintain the professionalism and livelihoods of specialists, in order to engage in a transparent process of cost and quality measurement, as well as to include patients.

Implementing all these elements at once may sound challenging, but there is one mechanism that can tie everything together: episodes of care. It's worth examining how this might jumpstart the process for both specialists and ACOs.

Make Episodes of Care a Foundation for ACO-Specialty Ventures

Some physicians are wary of episodic payments based on experience with fixed capitation payments from the HMO years. While it's clear that Medicare as well as health plans are moving toward episodic payments, we need to be careful regarding how this works for ACOs. For starters, accounting for patient volume and how to recoup outlier complex cases will be vastly different in a smaller ACO setting versus health plans

and Medicare.

Second, there is a big difference between using episodes of care for cost and quality measurement, and producing episodic payments. The former can be used without the latter, at least initially. While there is a building movement that favors episodic payments as part of VBHC (The National Quality Forum released a paper that promotes them fulfilling patients' right to value in health care [PDF download]), it is fair to say that the magic formula for calculating fair fees has yet to be invented.

Episodes of care are the underlying clinical compilation of services related to a patient's care for a single diagnosis or procedure, within a determined range of time. In its first proposed MACRA rules, Medicare defined a vast number of care episodes that were later withdrawn in favor of a much smaller set. The longer list included, along with the usual clinical procedures, diabetes and breast cancer, plus other chronic illnesses. The inclusion of the long list clarified that episodes of care could be used to measure costs and other aspects of care across a wider spectrum than had been imagined; it was withdrawn due to concerns that such measurement might not respond fairly to differences in individuals and would too quickly morph into episodic payments.

The fact remains that current Fee-for-Service pricing has little future, and that some unit-based methodology for comparing costs of care is a necessity for specialty care. Episodes of care provide that basic methodology for aggregating all of the care inputs from various services across professionals, facilities, technologies and medications for

general episodes that can be compared patient-to-patient. Only through aggregation of costs and services by type of care is there is even a possibility to compare care results.

Build a Win-Win VBHC Relationship Using Episodes of Care

ACOs can establish episodes of care as central to their strategy with specialists. In the beginning, unless the health plan or Medicare is already making episodic payments for the services, the episodes can be used simply to measure cost of care, using claims data, and to compare the results between patients and between specialty groups.

The patient care episode can be the basis for capture of cost data from claims for professional, facility, technology and other services, as well as quality and outcomes data using EMR or registry data. Sharing that data with specialists will help them understand their own relative costs and may identify areas for intervention or improvement.

The episodes can also be used in population health modules to add patient feedback through outreach, electronic surveys or visit-based projects to capture patient data. For ACOs undertaking patient medical decision-making programs, measuring differences in cost or functional outcomes—as well as validating quality for patients in control groups versus those participating in medical decisions—can reveal whether cost performance can be improved even more with patient-focused projects.

Specialists can, likewise, use episodes of care to compile and evaluate the variations in care among patients and between

providers. This experience empowers specialists to collaboratively identify inefficiencies or problematic quality, and to define optimal care that is tailored to the individual. The knowledge gained through this exercise will inform the group how to identify cases of higher risk that, once episodic payments become a reality, should be established as outliers.

Analyzing episodes of care results can help specialty groups identify patients who are higher risk or face poor prospects without change in behavior, treatment change and so on. These patients can then be included in more tailored projects at the practice level to improve their outcomes.

Specialists who become comfortable with evaluating costs and quality in episodes can take the lead in developing marketing packages for employers and health plans, securing a better position than competing groups.

With a strategy based on cost rather than price, specialists and ACOs can use episodes of care to create dialogue and collaboration, instead of division. While this approach requires detailed data sharing and review of patient outcomes, the most important ingredient is not data but discourse. Episodes of care, within a provider-led ACO, can resemble peer review discussions—and as such, highlight the strength of the model. If “all health care is local,” as industry people love to say, then an ACO-Specialist solution that involves review of real costs and quality in patient care episodes is a promising venture.

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