NAACOS Annual Conference

Specialist Engagement – Context and Opportunity
September 2023

pwc

Agenda

1	What is specialty care and why is it important?
2	How should we think about outcomes and performance?
3	Why is this so hard?
4	Where can we start to address this?

What is Speciality Care?

Specialty care refers to the area of medical practice that focuses on diagnosing and treating specific conditions or diseases that require expertise beyond what a primary care physician can provide.

Specialty care involves healthcare professionals who have undergone advanced training and education in a particular medical field or subspecialty.

Patients typically access specialty care through referrals from their primary care doctors when the condition or disease requires specialized attention.

Specialty care often involves more focused and tailored treatments, as well as ongoing monitoring and follow-up to ensure optimal outcomes for patients with specific healthcare needs.

ACOs can improve patient outcomes and cost efficiency by engaging with specialists

We will focus on the value ACOs gain from re-evaluating their strategy for engaging specialists.

- Specialty care accounts for a substantial and growing portion of healthcare spending.
- Outcomes (cost and quality) vary significantly due to differences in clinical practices.
- Solving the problem is complex, but focusing on the right areas can create significant value.

Professional costs generally make up 25-30% of the total cost of care, with specialists making up most of that cost

Illustrative Medicare FFS Cost Breakdown

Service Categories	PMPM	% of Total Medical Spend
Inpatient	$375	32%
SNF	$75	6%
Home Health	$50	4%
Hospice	$75	6%
Outpatient	$225	19%
Professional	$300	26%
Part B DME	$25	2%
Total	**$1,175**	**100%**

Sub-Professional Categories	PMPM	% of Total Medical Spend
Primary Care	$60	5%
Specialist	$240	20%
Total	**$300**	**26%**

- Taking a narrow view of professional claims (i.e., those on the carrier file – Form 1500 claims) might indicate that total professional spending only makes up about a quarter of spending, while specialist spending makes up about 20%
- This narrow view **significantly** understates specialist costs

Source: Medicare FFS Limited Data Set Files, PwC Analysis

Specialists **impact** between 50-67% (or more) of a beneficiary's total medical spend, given their involvement in complex and costly treatments

	Estimated % of Total Medical Spend	
Service Categories	Low	High
Inpatient Acute	12%	29%
Outpatient Surgery	10%	10%
Office Visits	9%	9%
Procedure	4%	4%
Imaging	3%	3%
Lab/Path	3%	4%
Inpatient Visits	2%	2%
Administered Drugs	2%	2%
Chemotherapy	1%	1%
Outpatient Therapy	1%	1%
Other*	1%	1%
Total	**50%**	**67%**

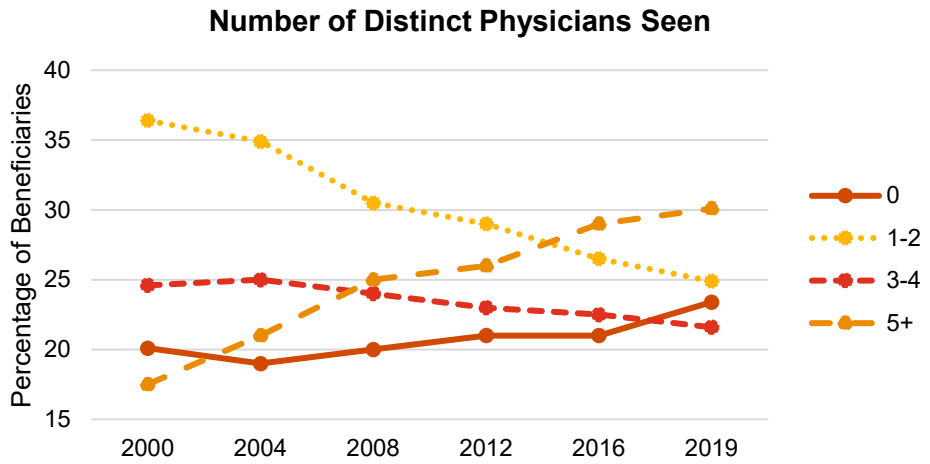
- Specialists typically impact (directly/indirectly) the majority of inpatient acute care since they often help manage episodes that include an inpatient admission.
- Outpatient surgeries and office visits make up the next largest portions of spending impacted by specialists

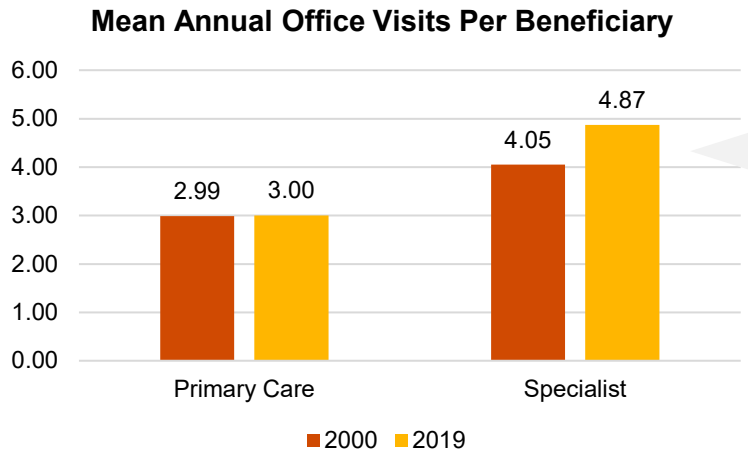
*Other includes services such as therapies (physical, occupational, speech), radiation therapy, ophthalmology, maternity, MHSA, anesthesia, and chiropractic services
Source: Medicare FFS Limited Data Set Files

The growing utilization of specialist care signifies the coordination challenges faced by PCPs

Between 2000 and 2019…

- Medicare beneficiaries have shifted towards more specialist care received from more physicians without increased primary care contact, with the number of unique specialists seen **increasing 34.2% from 1.63 to 2.18.**
- Along this time frame, total annual health care spending increased substantially, and **specialists accounted for 18% of this increase** while primary care only accounted for 4%.



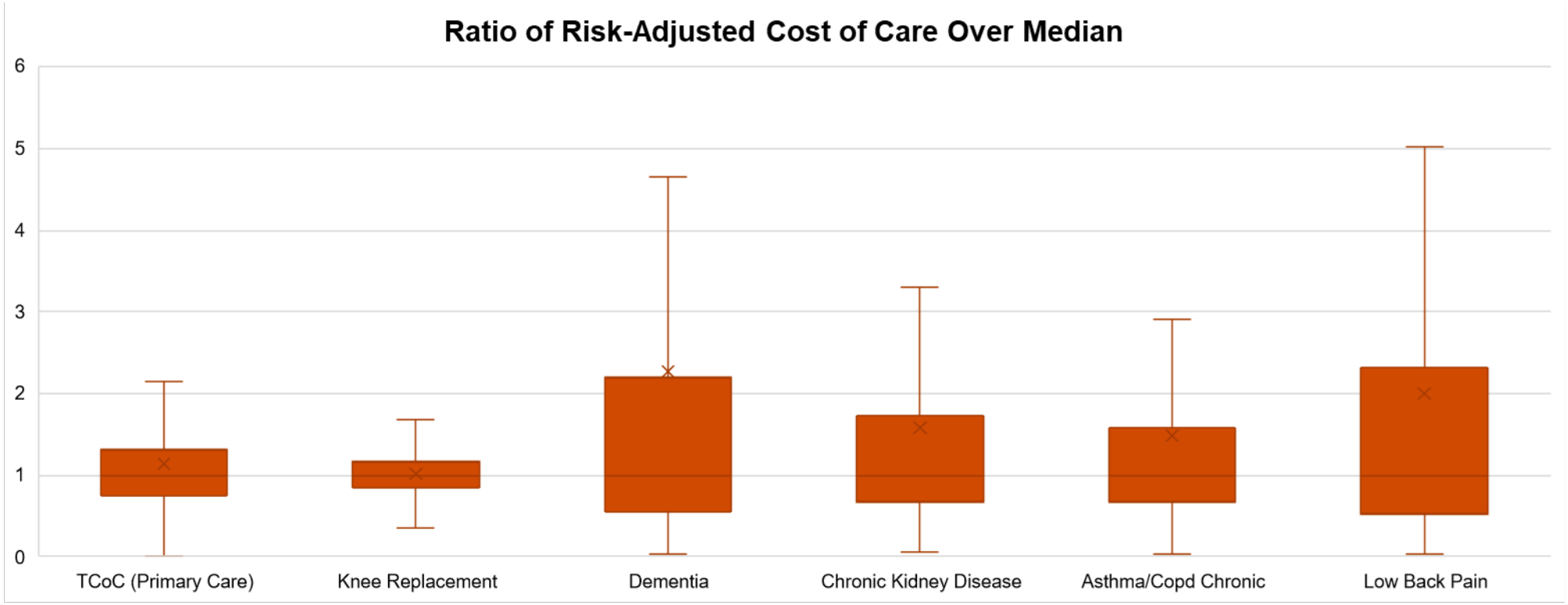


The mean annual number of **specialist visits increased by 20%**, and the average number of physicians with which a primary care provider **needs to coordinate with a specialist increased 83%.**

Sources: Trends in Outpatient Care for Medicare Beneficiaries and Implications for Primary Care, 2000–19

Episodic care, often managed by a specialist, tends to have a much wider spread relative to the Total Cost of Care overall

The plot below shows the volatility of Primary Care (based on the Total Cost of Care for the attributed population) compared to the volatility of episodic care across providers.

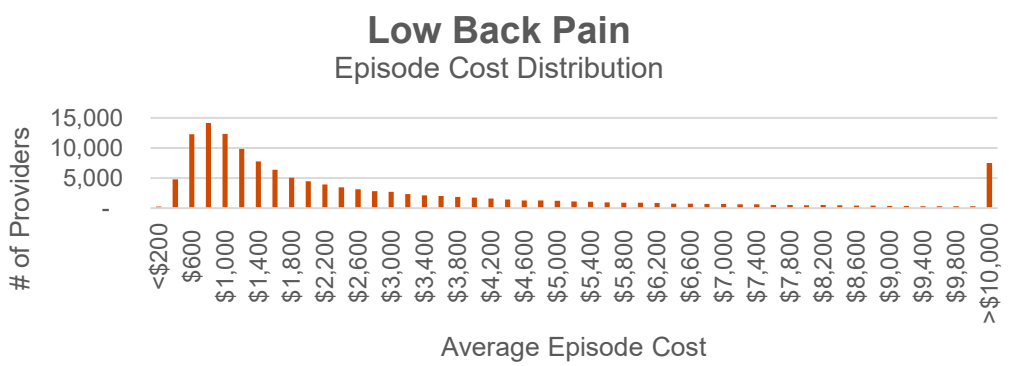


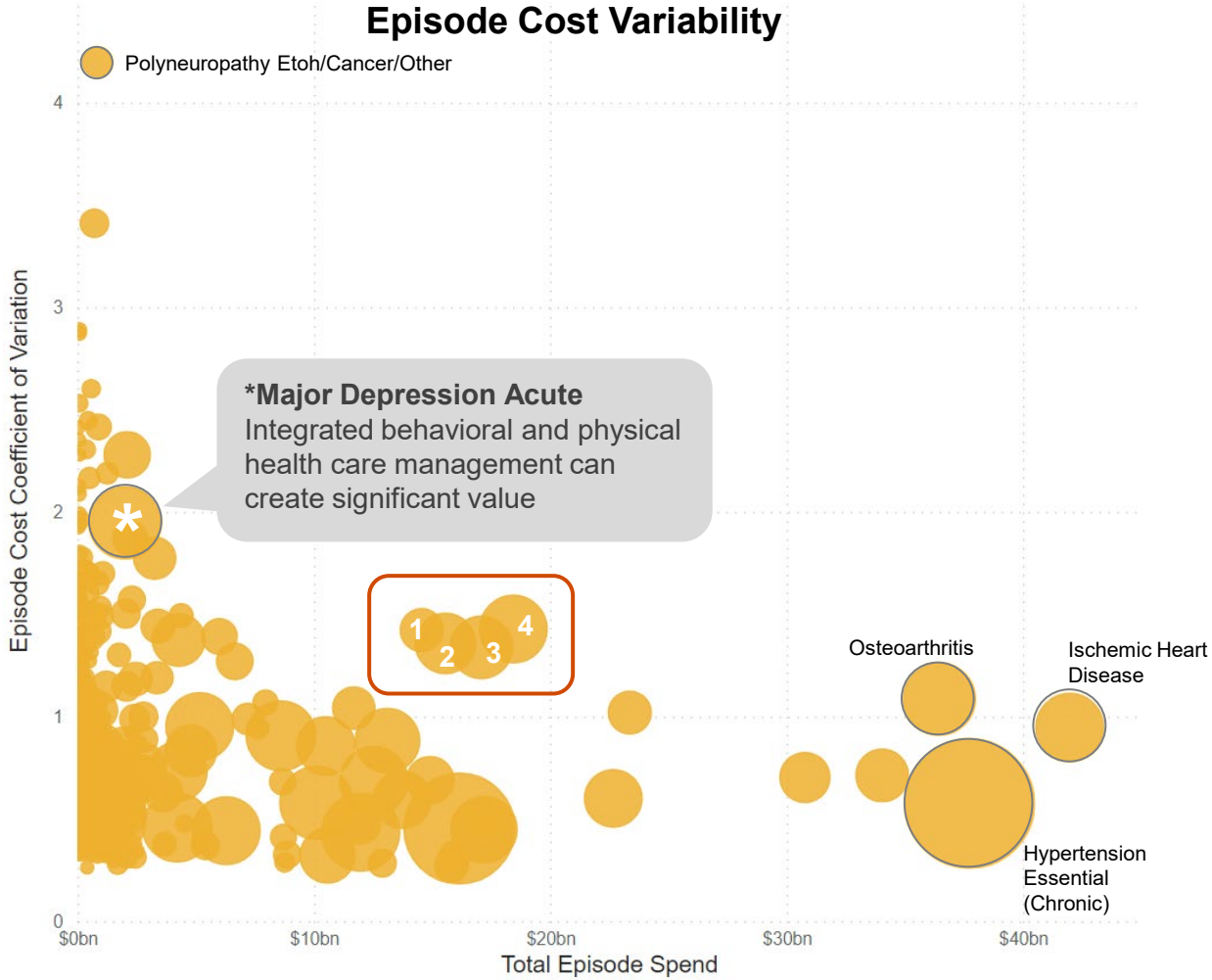
Note: Outliers not shown on plot
Source: Medicare FFS, PwC Analysis

The cost of treating a particular medical episode can exhibit substantial variation based on the specialist directing the care

Generally, as episode volume and total spending increases, cost outcome variability declines (consistency in care pathways or large fixed costs)

	Episode	# of Episodes	Average Cost per Episode	Coefficient of Variation
1	**Dementia**	1,703,072	$ 7,905	1.42
2	**Chronic Kidney Disease**	3,862,314	$ 3,353	1.36
3	**Asthma/COPD Chronic**	4,175,762	$ 4,382	1.34
4	**Low Back Pain**	5,006,130	$ 3,706	1.43





Source: Medicare FFS

Note: Visual filtered for episodes with >1,000 rendering providers and excludes Thyrotoxicosis W/O Goiter due to having a CV of 7.62

Treatment plans can vary between specialists due to their unique expertise and prioritized medical approaches

Consider three possible treatment approaches for knee osteoarthritis from a specialist's perspective:

	A. Physical Therapy and Conservative Management	B. Intra-Articular Glucocorticoid Injections	C. Surgical Intervention (Total Knee Arthroplasty)
Description	Patients work with a physical therapist to create a personalized exercise plan emphasizing knee muscle strengthening, flexibility improvement, and biomechanics optimization. Additionally, they may employ aids like knee braces or orthotics for pain relief and joint function enhancement. PT may offer substantial long-term savings by potentially delaying or avoiding surgical intervention.	A specialist injects corticosteroid medications directly into the affected knee joint to reduce inflammation and alleviate pain. These injections can provide temporary relief for some patients. While this approach can offer pain relief and delay the need for surgery, it may not provide the long-term benefits of physical therapy or surgical intervention.	During a total knee arthroplasty (TKA), the damaged knee joint is replaced with an artificial joint made of metal and plastic components. This procedure is typically performed by an orthopedic surgeon and may require hospitalization. Patients undergo post-operative rehabilitation to regain joint function.
Cost	**Mean** (1-year medical cost): $2,131 **Standard Deviation:** $1,015	**Mean** (1-year medical cost)**:** $2,113 **Standard Deviation:** $4,224	**Mean** (Inpatient): $17,151 **Mean** (Outpatient)**:** $14,863

Sources:
Cost-effectiveness of Physical Therapy vs Intra-articular Glucocorticoid Injection for Knee Osteoarthritis,
Total knee arthroplasty in the outpatient vs inpatient settings: impact of site of care on early postoperative economic and clinical outcomes

Place of service can vary between specialists due to their ability to analyze and understand each individual's needs

Care pathways can also vary by place of service, which can have a significant impact on outcomes and must be considered on a patient-by-patient basis.

For total knee arthroplasty (TKA), there are benefits to both outpatient and inpatient surgery. Orthopedic surgeries are being increasingly performed in outpatient settings, which can have outcome and monetary benefits.

One study performed by the Journal of Orthopaedic Surgery and Research on Medicare, Medicaid, and Commercial beneficiaries found that patients treated in the outpatient setting had similar knee-related costs in the next 90 days as patients treated in the inpatient setting, after matching on the outpatient cohorts comorbidities and demographics. The study showed that today's outpatient cases include patients with similar severe comorbidities to the inpatient cohorts. Outpatient surgeries were 13% less expensive than inpatient procedures.

Specialists can advise patients on the facility type and location that may be best for them to get optimal care, cost, and recovery.

Metric	Outpatient	Inpatient
Length of Stay: mean days	**0.00**	**2.08**
Discharge status		
• **Discharged to HHO**	**18.1%**	**37.6%**
• Home	79.2%	47.3%
• **SNF/Other**	**2.7%**	**15.1%**
Operating Room Time: mean minutes	132.10	133.83
Mean Costs: USD		
• Index admission	$14,863	$17,151
• **Index with 90 days post-index**	**$15,707**	**$18,388**
• Index with 90 days post-index, knee related	$15,182	$17,725
Reoperation at 90 Days: Y/N	**0.6%**	**0.7%**
All-Cause Readmissions at 90 Days: Y/N	28.1%	31.8%

Source: Total knee arthroplasty in the outpatient vs inpatient settings: impact of site of care on early postoperative economic and clinical outcomes

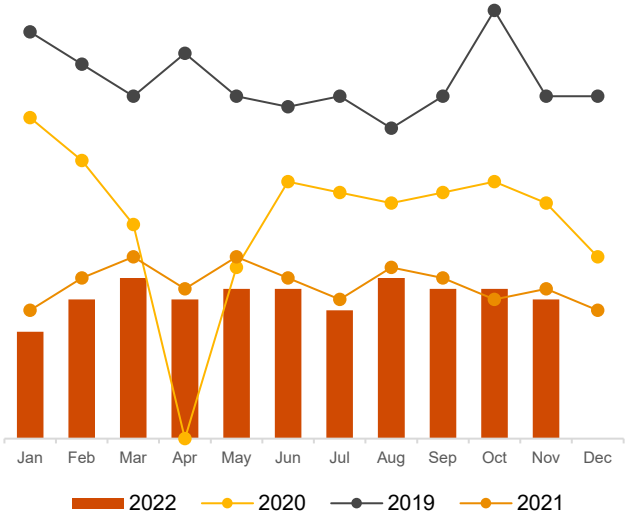
While many services have moved quickly to OP settings over the last few years, there is still room for improvement

The trend of transitioning from inpatient to outpatient place of service for knee replacement surgery has continued to progress since 2019.

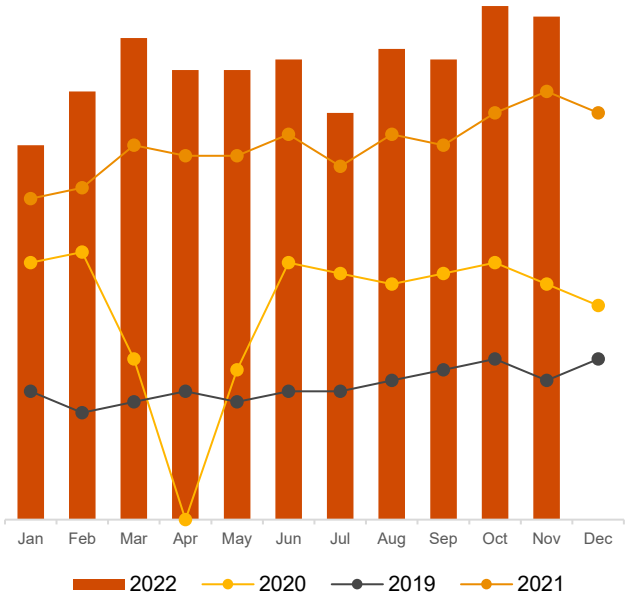
As of December 2022, the national volume of outpatient knee replacement surgeries increased by nearly 11% from December 2021 while inpatient knee replacement surgeries decreased 17%.

The shift has plateaued somewhat since 2021.

IP Primary Knee Replacement



OP Primary Knee Replacement

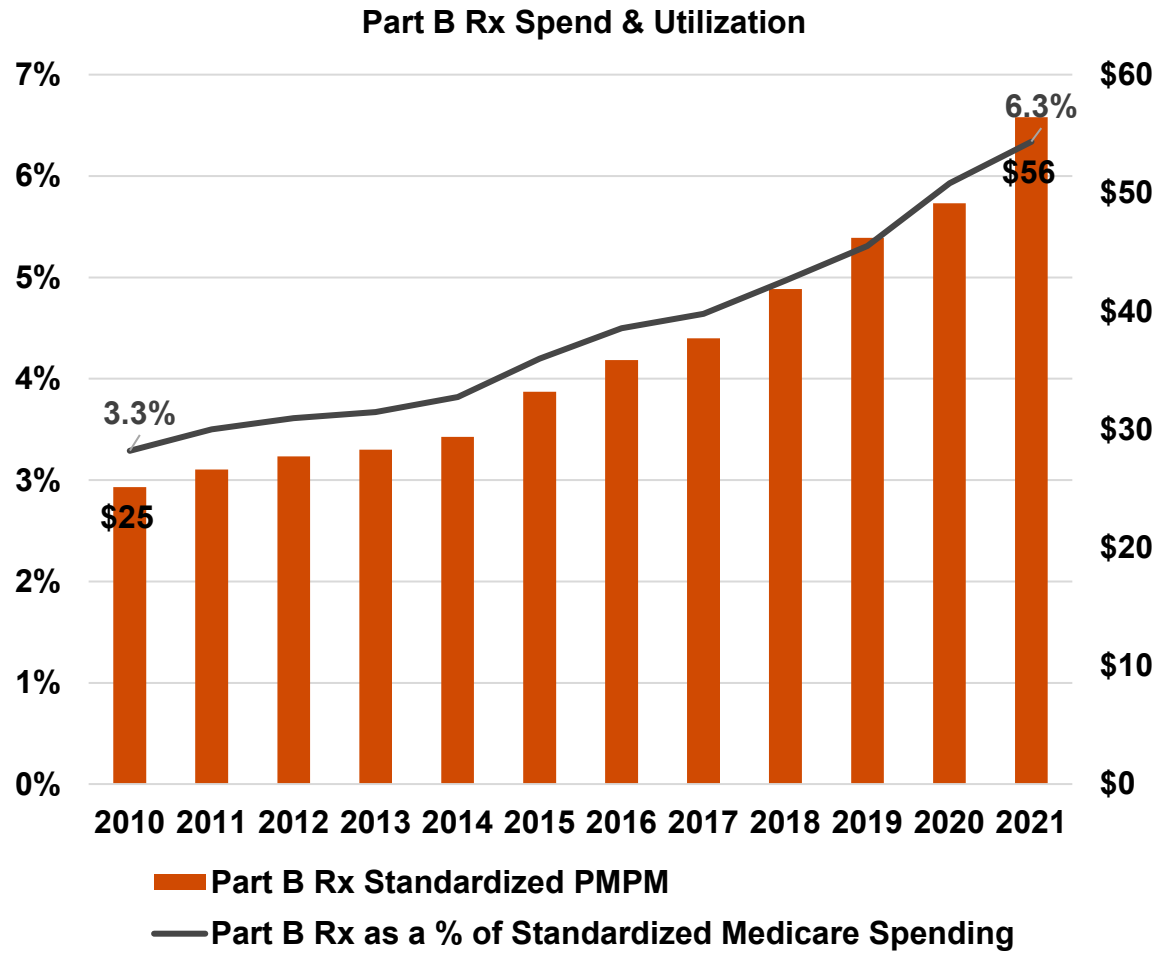


Source: Strata National Patient and Procedure Volume Tracker

Part B Drug costs and utilization have grown significantly in the last decade

Specialists are the main source of Part B Rx Utilization, which has continued to increase in not only total cost, but also grown as a percentage of total spend

- Medicare Part B Rx covers a limited selection of prescription drugs that are usually administered in a healthcare provider's office or outpatient setting. These drugs are often treatments for serious medical conditions, such as cancer, autoimmune disorders, and other complex health issues. They may include injectable or infused drugs, as well as some oral medications.
- Using Medicare FFS as a benchmark, since 2010
  - The % of members that utilize Part B Rx has risen from ~54% to >70%
  - The % of total healthcare spending has almost doubled growing from ~3.3% to 6.3%
  - The average PMPM spend has grown by ~125%, starting around $25 PMPM and rising to nearly $56 PMPM

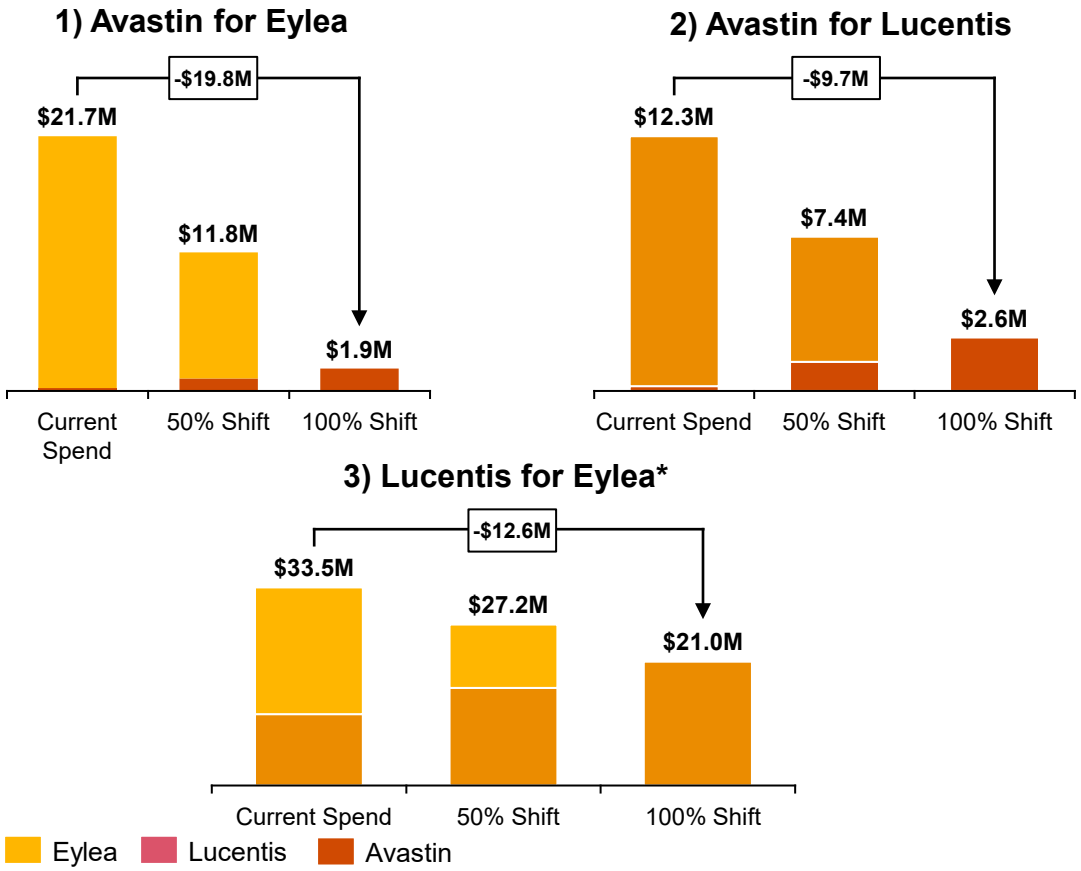


Source: Medicare Geographic Variation - by National, State & County, Data.cms.gov

There is significant cost variation between Part B drugs for the same condition

Ophthalmic injections are a key driver of drug spend, largely driven by increased use of two drugs – Eylea and Lucentis.

Drug Substitution Illustration for Wet AMD



Discussion

- Avastin typically costs <$100 per injection; Lucentis and Eylea typically costs >$1500 per injection[2]
- Substituting lower-cost drugs for wet age-related macular degeneration (AMD)
- Eylea and Lucentis are FDA-approved for wet AMD; Avastin has off-label approval
- Current US utilization is higher for Avastin, whereas client utilization is highest for Eylea

	Avastin	Eylea	Lucentis
Utilization Dist.	46%	32%	20%

Source: 1) PwC analysis 2) American Academy of Ophthalmology.

Low-value healthcare drives up ACO costs through unnecessary procedures, which can trigger downstream risks and associated costs

An estimated 75% of low-value care is neither provided by nor referred by the beneficiary's attributed primary care provider.

Low-Value Care

Services or supplies that provide little clinical benefit and may even pose risks to patients without significantly improving their health outcomes. May involve serial testing and imaging in low-risk patients without evidence of disease.

High-Value Care

Entails medical interventions that are effective, evidence-based, and improve patient outcomes relative to their costs. Aims to provide the best possible care while minimizing unnecessary tests, procedures, or treatments, ultimately leading to better patient outcomes and cost-efficiency in healthcare delivery

Studies of cardiovascular care value have shown:

- Up to **20% of echocardiograms** and up to **50% of all stress tests** performed are classified as rarely appropriate, many of which lead to subsequent invasive testing and its commensurate risk
- Nearly **70% of patients** referred for invasive coronary angiography are found to have **nonobstructive disease**.
- **10% to 15% of PCIs** performed in the United States are classified as rarely appropriate.
- **20% to 25% of implantable cardioverter defibrillators** were **not evidence-based**, and most patients receiving this receive a dual-chamber device despite not having clinical indications for pacing.
- Patients with cardiovascular disease are frequently prescribed **brand-name medications** that are more expensive than the generic equivalents that are similar in effectiveness.

Sources:
Pathways for Specialty Care Coordination and Integration in Population-based Models,
Strategies to Reduce Low-Value Cardiovascular Care: A Scientific Statement From the American Heart Association

There are many challenges when trying to engage specialists

Specialist Economics	Specialist incentives in value-based care models are often less transformative than those for primary care, making it difficult to gain buy-in from specialist practices
Rural Access	Shortages of specialists in rural areas leads to extended patient wait times and limits the degree the ACOs can actively engage these providers to improve outcomes
Care Coordination	Coordinating care between primary care and multiple specialists and facilities can be challenging
FFS Limitations	Fee-for-service models impede coordinated, person-centered care, and create challenging incentives
APM Complexity	Specialist Alternative Payment Models are often complex and difficult for specialists to manage

Source: Pathways for Specialty Care Coordination and Integration in Population-based Models

There are a number of ways ACOs can better engage specialists and improve cost and quality outcomes

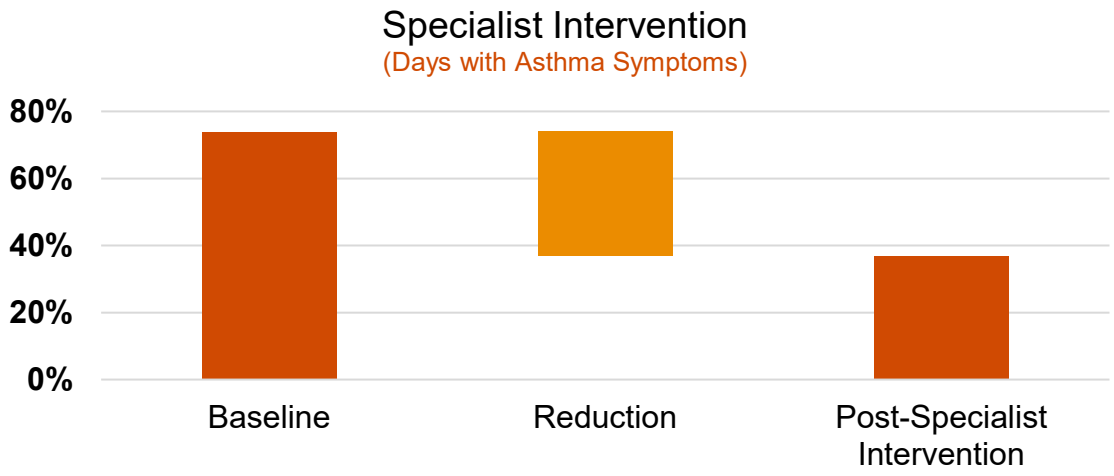
- Understand your existing specialist referral patterns
- Scan the market for other high-performers
- Benchmark to evaluate performance
- Adjust referral workflows
- Build integrated clinical programs
- Formalize partnerships with key groups
- Develop alternative payment models
- Continue to monitor costs/quality and adjust referrals

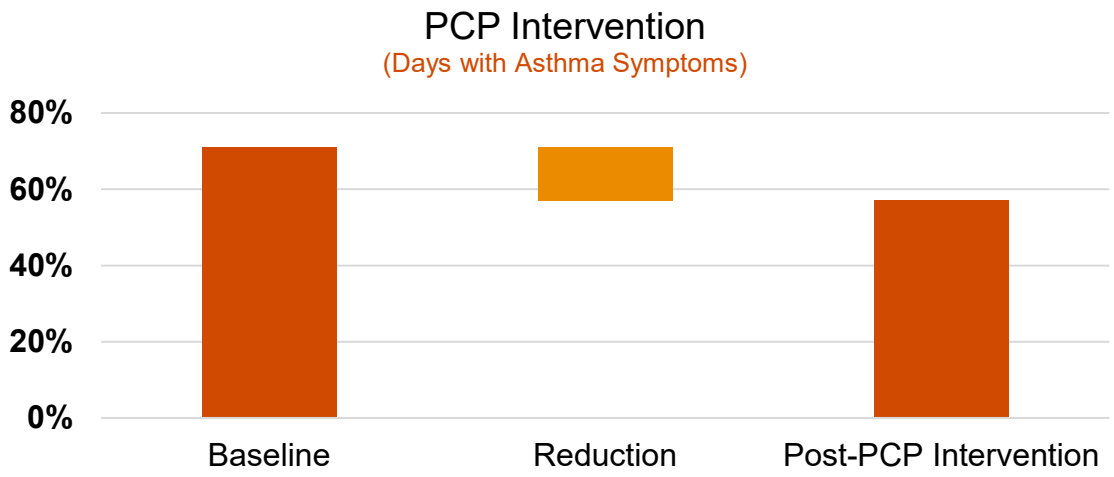
Appendix

Utilizing specialists can create better outcomes

A study of asthma patients showed that targeted specialist intervention vs. primary care intervention can reduce symptoms, leading to better long term impacts

- Asthma Study
  - A 3-year randomized longitudinal study of 472 patients with asthma and allergic rhinitis was created.
  - In this study patients were cared for by either a respiratory specialist or primary care physician.
  - Multiple outcomes were studied, including days experiencing asthma symptoms
  - The results show that treatment by a specialist can reduce symptoms, supporting long term quality care
    - These results imply:
      - Less long term severity and complications
      - Reduced disease based Emergency Room Visits and Hospitalization
      - More controlled treatment patterns
      - Limited variability in outcomes



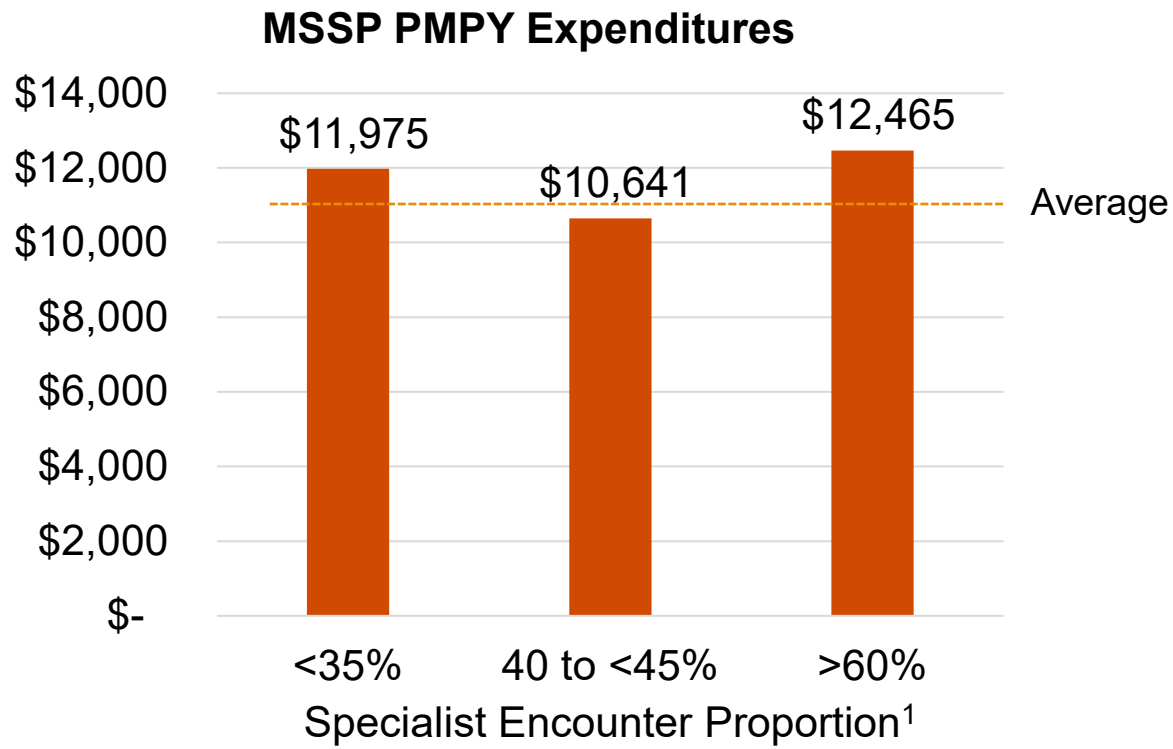


Source: Quality of care in patients with asthma and rhinitis treated by respiratory specialists and primary care physicians: a 3-year randomized and prospective follow-up study

ACOs must find the right balance of specialist involvement to optimize patient outcomes while reducing cost of care

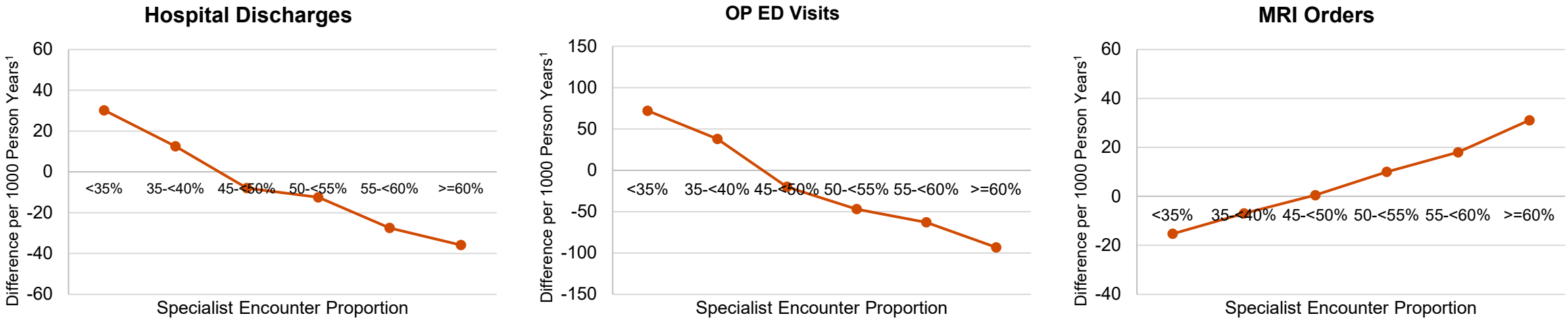
The right mix

- A cross-sectional study of 620 ACOs found that those with 40% to 45% of patient visits were provided by specialists had statistically significantly lower per-beneficiary person-year spending compared with those in which less than 35% or at least 60% of the visits were conducted by specialists.
- Limited specialist involvement may be explained by more patients receiving outpatient care (predominantly delivered by PCPs) associated with higher ED, hospital, and SNF encounter rates. Alternatively, excessive specialist involvement can result in higher costs due to unnecessary testing and procedures.
- PCPs are vital for coordinating care, but active specialist participation, such as acute diagnosis consultations and complex condition co-management, may enhance patient outcomes.



[1]Percentage of office visits provided by a specialist
Source: Association Between Specialist Office Visits and Health Expenditures in Accountable Care Organizations

Greater specialist engagement is associated with better outcomes but increased utilization of testing like MRIs



- ACOs with a higher proportion of specialist encounters tended to have lower rates of emergency department visits, hospital discharges, and skilled nursing facility discharges, but higher MRI volume
- The results indicate that ACOs balancing a mix between PCP and specialist office visits may have a better chance of achieving cost-effective utilization rates compared to those with skewed distribution

[1]Data points represent differences in utilization measures between each specialist encounter proportion group and the reference group (40% to <45%)
Source: Association Between Specialist Office Visits and Health Expenditures in Accountable Care Organizations

Thank you

pwc.com