



AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Cost Efficient/Clinically Effective Specialist Selection

Quick Reference Guide

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SPECIALIST SELECTION IN VALUE-BASED CARE

This QRG provides a practical selection model for PCPs, care coordinators, medical groups, ACOs, and Medicare Advantage teams. Its purpose is to **align specialty referrals with better outcomes, lower total cost, reliable communication**, and an acceptable **patient experience**. Selection begins **only after** the clinical need for referral has been established.



AAVBC PERSPECTIVE

Move from habit- or relationship-based referral patterns to **transparent, data-informed specialist selection**. **Clinical effectiveness** is the entry requirement; cost efficiency, access, coordination, network status, and patient preference then **determine the best available match**.

Core Clinical Standards When Choosing a Specialist

STANDARD	OPERATIONAL MEANING ¹⁻³	VALUE PROTECTED ⁴⁻⁶
Match acuity	Pair clinical risk, diagnostic uncertainty, procedure complexity, and comorbidity burden with the appropriate level of specialty expertise	Timely expertise without unnecessary escalation
Review performance	Use: risk-adjusted outcomes, complications, readmissions, evidence-based care, access, communication, and episode cost	Objective selection beyond reputation alone
Promote value	Prioritize specialists who use appropriate tests, treatments, sites, products, medications and follow-up intensity	Lower utilization and patient financial burden
Track results	Monitor: referral completion, note return, outcomes, downstream utilization, and total cost over time	Accountability and continuous improvement

Value Based Operational Goals

- **Reduce avoidable leakage while maintaining:** patient choice, network adequacy, and clinically necessary exceptions^{7,8}
- Send complete, clinically relevant records **before** the first specialist interaction^{9,10}
- **Prevent duplicate testing** by transferring usable prior laboratory, imaging, and treatment information⁸

- Select the **best available match** for the patient **rather than defaulting** to the same specialist for every case^{2,11}



CLINICAL PEARL: JUDGE COST BY THE EPISODE, NOT THE PRICE TAG

The lowest-priced visit or procedure is **not necessarily the lowest-cost episode**.^{12,13} Complications, repeat testing, readmissions, post-acute care, and follow-up intensity often **determine the larger financial and clinical result**.^{14,15}

QUADRUPLE AIM AND SELECTION STANDARDS

PCP teams should judge whether each preferred relationship **improves outcomes and experience, lowers avoidable total cost, and reduces administrative friction** for clinicians.^{16,17}

AIM	SELECTION ACTIONS ^{7,18,19}	EVIDENCE TO MONITOR ^{7,20,21}
Enhanced patient experience	Offer clinically appropriate choices with: understandable cost, wait-time, travel, language, and accessibility information; transfer records before the visit	Access burden; completion; patient experience; complaints; affordability barriers
Improved health outcomes	Prefer specialists with strong risk-adjusted outcomes, guideline adherence, low complications, timely access, and coordinated return of information	Clinical outcomes; readmissions; adverse events; PROMs; pathway adherence
Lower total cost	Use high-value in-network partners, e-consults, existing diagnostic data, appropriate sites, and cost-effective products	Episode cost; avoidable testing; outpatient shift; ED use; network adherence
Clinician well-being	Embed scorecards and referral choices in the workflow; define referral standards; automate status and note return	Staff touch time; referral rework; inbox burden; unresolved loops

ABBREVIATIONS: PROMs = patient-reported outcome measures; ED = emergency department

From Volume to Value

Value-based referral management replaces blind or loyalty-based routing with **measurable selection**.^{2,22} The goal is appropriate referral to specialists who **reliably deliver effective care,**

use resources **efficiently**, communicate **promptly**, and help the patient **complete the recommended plan**.^{8,23}



MAKING CONNECTIONS

Consult the [AAVBC When to Refer to a Specialist QRG](#) for emergency red flags, specialty-specific referral thresholds, e-consult suitability, urgency, and pre-referral clinical preparation. The current guide addresses **which specialist** to select **after referral is appropriate**.



QUALITY OUTCOME: TIMELY ACCESS IS A CORE COMPONENT OF VALUE

Prioritize **clinically effective, cost-efficient specialists** who provide access proportionate to clinical urgency, coordinate care promptly, and deliver better outcomes. **Timely access** to emergency, urgent, and medically necessary specialty care is a **hallmark of a high-value specialist network**.²⁴

STAKEHOLDER ALIGNMENT AND ACCOUNTABILITY

STAKEHOLDER	PRIMARY OBJECTIVE ^{2,18,25}	REQUIRED CONTRIBUTION ^{9,18,26}	CONNECTION TO THE NEXT TEAM ^{19,27,28}
PCP and primary care team	Select a clinically effective, cost efficient high-value specialist	Specific question ; acuity; relevant workup; medication list; barriers; patient preferences	Follow-up and integrate clinical recommendation(s) from specialist into longitudinal care
Specialist or specialty group	Deliver timely, targeted, clinically effective , cost efficient care	Use supplied data ; minimize unnecessary repetition ; apply evidence-based and efficient treatment	Return findings, changes, pending tests, follow-up, and care ownership
Care coordinator or navigator	Move the patient through the referral pipeline	Verify network ; schedule; transfer records; resolve barriers; monitor attendance and note return	Match patient needs with payer-approved high-value options and close open loops
Payer, ACO, or MSO	Optimize quality, utilization, and total cost across the network	Provide transparent profiling , tiering, benefits, authorization, and claims data	Support EHR decision tools , streamlined authorization, and fair performance review

ABBREVIATIONS: PCP = primary care physician; ACO = accountable care organization; MSO = management services organization; EHR = electronic health record

Minimum Shared Commitments

- The PCP **retains responsibility** for **matching patient need to the referral route** and specialist capabilities^{7,29}
- The analyst or payer **explains the data period, attribution method, comparator, risk adjustment, and reliability limits**^{30,31}
- The coordinator **verifies** that the preferred option is **actually accessible** under the patient's plan and circumstances^{8,32}
- The specialist **returns clinically usable information** and **avoids unnecessary duplication**^{9,26}
- The patient **participates in the final selection** when more than one clinically suitable option exists³³



MAKING CONNECTIONS

Use the **AAVBC Value-Based Care Specialist Management QRG** to define consultation, co-management, or principal-care tracks; establish care compacts; reconcile recommendations; monitor network performance; and return routine care to the PCP.

QUALITY-FIRST SPECIALIST SELECTION WORKFLOW

Under the status quo, referrals are typically routed by **habit, proximity, personal familiarity**, or the **first available appointment**, with **quality and total episode cost rarely examined** before the order is signed.^{2,7} A value-based referral **inverts that default**: it treats specialist selection as a deliberate, evidence-informed decision that **screens for clinical quality first**, then compares total value, access, and patient fit, and finally **confirms the loop closed with the expected result**.^{34,35} The sequence below operationalizes that shift.

STEP	DECISION ^{2,36,37}	REQUIRED EVIDENCE ^{10,38-40}	OUTPUT ^{3,19,41}
1 Confirm need and route	Is referral, e-consult, direct procedure, urgent escalation , or continued PCP management appropriate	Clinical pathway ; acuity; prior treatment; red flags; patient goals	Appropriate route and response window
2 Establish the quality gate	Which specialists meet minimum clinical effectiveness and safety standards	Risk-adjusted outcomes ; complications; readmissions; guideline measures; credentialing	Clinically effective candidate set

STEP	DECISION ^{2,36,37}	REQUIRED EVIDENCE ^{10,38-40}	OUTPUT ^{3,19,41}
3 Compare total value	Which acceptable candidates manage similar episodes with the most cost efficiency	Total episode cost ; utilization; site; testing; pharmacy; downstream care	Cost-efficient candidate set
4 Check access and network fit	Which candidate can see the patient inside the required timeline, within the healthcare plan network and is geo-accessible	Network tier; authorization; wait; location; language; digital access	Shortlist of specialists who can actually be booked , each with its patient burden noted (expected wait time, travel distance, out-of-pocket cost, and any access barriers)
5 Use shared selection	Which option best fits the patient	Preference ; cost sharing; transportation; caregiver needs; continuity	Documented specialist selection
6 Track performance	Did the referral complete and produce the expected clinical and operational result	Attendance; note return; outcomes; cost; duplication; patient experience	Closed loop and updated patient outcomes

ABBREVIATIONS: PCP = primary care physician

What the Sequence Prevents

- A low-cost specialist being preferred **despite inadequate quality**^{2,37}
- A high-quality designation being accepted **without considering geoaccess or episode cost**^{3,42}
- A payer tier being treated as the **only** selection input^{37,42}
- A patient being routed to an inaccessible option and then **lost to follow-up**^{3,43}
- A referral being counted as successful **when no usable recommendation returns**^{3,44}



CLINICAL PEARL: COMPARE COST ONLY AFTER PASSING THE EFFECTIVENESS GATE

Do not compare cost **until candidates pass a clinical effectiveness gate**.^{2,45} Efficiency means producing appropriate outcomes with prudent resource use, **not simply spending less**.^{46,47}

DATA SOURCES AND ANALYTIC READINESS

These data sources and analytics serve two linked goals: evaluating how a completed referral performed, and mapping the available specialist network so that future referrals can be directed to the highest-value option.⁴⁸ **Organizations with analytic capacity should combine:** claims, clinical, access, network, and patient-reported information to **build a working picture** of who is in the network, how each specialist or group performs, and where access or leakage gaps exist.³⁴ Smaller practices may use **payer directories** and **tier designations** as a practical starting point for characterizing the network, **but should add** local experience with communication/outreach, availability, and referral completion.³⁷

DATA SOURCE	WHAT IT CAN SHOW ⁴⁹⁻⁵¹	KEY LIMITATION ^{37,52-54}
Multi-payer or ACO claims	Episode cost; utilization; readmissions; complications; site of service; pharmacy; network leakage	Data lag; attribution error; limited clinical detail; misses care outside the data set
EHR and health information exchange	Clinical status; pathway adherence; test duplication; note return; medication changes	Variable interoperability and documentation
Payer provider directory or tiering	Network status; tier; plan-specific cost/quality designation; location	Method may be proprietary, plan-specific, or based on an older period
Registry and specialty quality data	Procedure outcomes; disease control; complications; PROMs; guideline-concordant processes	Differences in participation and reporting, and in the denominator (which cases each program counts), limit comparability
Referral management platform	Acceptance rules; scheduling; attendance; wait times; loop closure; communication history	Operational performance alone does not establish clinical quality
Patient and caregiver feedback	Access burden; communication; financial strain; functional status (ability to perform daily activities); experience	Response bias and small samples

ABBREVIATIONS: ACO = accountable care organization; EHR = electronic health record; PROMs = patient-reported outcome measures

Minimum Analytic Readiness Check

- Identify the **measurement period, geographic market, specialty, episode definition,** and **comparator group**^{38,55}

- Confirm **minimum case volume** and **statistical reliability before** assigning a performance label^{55,56}
- Use **group-level results** when the contracting and care-delivery unit **is the group**, while monitoring membership changes^{57,58}
- Combine multiple payer sources **when feasible** to avoid an incomplete view of performance^{31,55}



QUALITY OUTCOME: PAYER PROFILING AS FALLBACK INPUT

When internal analytics are unavailable, **use plan profiling** from leading health insurance organizations as one input, then **verify current network participation, geo-access, and local care-coordination performance**.

CLINICAL EFFECTIVENESS AND PERFORMANCE GATE

Physicians or groups that do not meet clinical performance standards **do not advance to the cost-efficiency comparison**. The gate should use **specialty-relevant measures**, adequate case volume (at least 10 relevant cases), and **sufficient statistical reliability** to support a credible assessment.



CLINICAL PEARL: USE CMS PERFORMANCE DATA AS ONE SELECTION INPUT

When available, consult **Medicare Care Compare** and the **CMS Provider Data Catalog** for **publicly reported performance information** on individual clinicians and groups.⁵⁹ These datasets are collected through the Quality Payment Program, primarily through the **Merit-based Incentive Payment System (MIPS)**, and may include quality measures, performance-category scores, improvement activities, and other clinical performance information.^{60,61} Use CMS data **alongside** local claims, registry outcomes, readmissions, complications, and care-coordination measures because **public reporting availability and completeness vary** among clinicians and groups.^{60,62}

Clinical Performance Domains for Specialist Evaluation

PERFORMANCE DOMAIN	MEASURES ^{48,63,64}	INTERPRETIVE QUESTION ^{7,65,66}
Outcomes	Patient outcome improvement; functional recovery; disease control; procedure success	Do similar patients achieve the intended result ?

PERFORMANCE DOMAIN	MEASURES ^{48,63,64}	INTERPRETIVE QUESTION ^{7,65,66}
Safety	In-hospital complications ; adverse events; infection; return to operating room	Is preventable harm acceptably low ?
Downstream utilization	Thirty-day readmission rate ; ED use; unplanned follow-up; post-acute care	Does the care plan prevent avoidable deterioration ?
Evidence-based treatment	Specialty-specific therapies, processes, or pathway adherence shown to improve outcomes	Is care consistent with recognized clinical standards ?
Professional readiness	Board certification ; relevant external recognition; performance-improvement participation	Does the physician or group meet defined structural expectations ?
Technology and communication	Electronic records ; e-prescribing; direct communication; note return	Can the specialist participate in reliable coordinated care ?

ABBREVIATIONS: ED = emergency department

Claims-Based Gate

- Use **at least 10 cases** in a measure **before** evaluating that claim-based result^{67,68}
- Apply **specialty-specific standards** because one common outcome set **will not** fairly represent every specialty
- Recognize that a case may mean one patient for some measures and one event for others^{67,69}
- Use standards derived from **respected national medical and quality organizations**
- **Re-assess the gate** as group membership, technology, treatment, and measurement methods change



QUALITY OUTCOME:

A designation should identify **acceptable clinical performance**, **not imply that one specialist is best for every patient**. Match the individual case to the **specialist's capabilities** after the gate is passed.

TOTAL COST OF CARE AND COST EFFICIENCY

Specialist **total cost of care** includes **direct specialty services** and the **downstream spending generated by the episode**. A clinically effective specialist may appropriately use an **advanced or expensive intervention while remaining cost-efficient** if that intervention prevents complications, repeated services, or a more costly site of care.^{70,71}

COST PERSPECTIVE	WHAT IS INCLUDED ^{39,72,73}	WHY IT MATTERS ^{39,74,75}
Transactional price	One visit, test, procedure, infusion, implant, or drug	Useful for benefit and site comparisons but incomplete
Episode cost	All related services during the defined condition or procedure episode	Captures utilization choices and downstream consequences
Population cost	Condition-related or total medical spending for an attributed population and period	Supports chronic specialty management and network planning
Patient financial burden	Deductible, copay, coinsurance, travel, time, and uncovered services	Determines whether the selected plan is executable

ABBREVIATIONS: ED = emergency department

Cost Efficiency Assessment

- **Compare** observed episode costs with peer costs for similar episodes in the same specialty and geographic area^{39,76}
- **Adjust for severity of illness** and case mix **before** ranking or assigning a tier^{39,77}
- Order comparable costs **from lowest to highest** and convert results into percentiles when comparing different episode types^{39,78}
- Review the number and type of services, **not cost alone**, to understand why performance differs^{39,79}



CLINICAL PEARL: BEYOND THE VISIT: EPISODES INCLUDE "ALL RELATED SERVICES"

When comparing specialists on cost, remember that an episode captures **far more than the specialist's own professional fee**. "All related services" bundles the **professional charges, facility or institutional costs, imaging, laboratory testing, pathology, anesthesia, pharmacy and infusions, durable medical equipment**, and any **downstream visits or readmissions** that flow from the specialist's management decisions. A specialist whose office visit appears inexpensive **may still generate a high-cost episode** by ordering excessive imaging, routing procedures to a hospital outpatient setting, or driving avoidable follow-up utilization. For routing decisions, **evaluate the total episode signal** rather than transactional price alone, because the downstream services, not the index encounter, usually determine whether care was truly cost-efficient. When episode-level data are unavailable, use **site-of-service patterns, imaging and testing intensity**, and **readmission or complication rates** as practical proxies for the fuller cost picture.



CLINICAL PEARL: MATCH THE COST WINDOW TO THE TYPE OF SPECIALTY CARE

Time-limited procedural care, such as **total knee replacement**, may be evaluated using a defined episode that includes the **three months before and after surgery**.^{80,81} Chronic medical management, such as cardiology care for heart failure, is **better assessed over an annual episode**.⁸² Use **consistent, condition-appropriate timeframes** so surgical and medical specialists are **compared fairly**.



MAKING CONNECTIONS

Use the **AAVBC Value-Based Care Specialist Management QRG** for ongoing network scorecards, action triggers, peer feedback, corrective action, and decisions about tier demotion or network removal after validated persistent variance.



CLINICAL PEARL: EFFICIENCY IS VALUE PER EPISODE, NOT CHEAPEST INPUTS

An efficient specialist may use costly technology, imaging, medication, or procedures **when clinically indicated**.^{13,83} The key question is whether the total episode delivers high-quality outcomes at a **lower overall cost** — through **appropriate sites of care**, use of **generics** or **biosimilars** when available, and **fewer avoidable services and complications**.^{13,84}

TOTAL COST OF CARE DRIVERS

Utilization and Site of Service

Downstream Utilization and Complications

DRIVER	HIGH-VALUE PATTERN ⁸⁵⁻⁸⁷	PERFORMANCE SIGNAL ^{87,88}
Emergency care	Clear red flags, rapid contact, and outpatient rescue prevent avoidable post-treatment ED use	Condition-related ED rate
Readmission	Reliable transition planning, medication reconciliation, and timely follow-up reduce avoidable returns	Thirty-day readmission and cause review
Complications	Evidence-based technique, infection prevention, and early recognition lower corrective care	Complication, adverse event, infection, and return-to-OR rates
Post-acute care	Use home health , outpatient rehabilitation, or caregiver-supported recovery when safe	SNF use ; home health use; functional recovery; total post-acute cost

ABBREVIATIONS: ED = emergency department; OR = operating room; SNF = skilled nursing facility

Site of Service Optimization

OPTION	VALUE-BASED USE ^{89,90}	SELECTION CONSIDERATION ⁹¹⁻⁹⁴
Ambulatory surgery center	Shift appropriate procedures from inpatient or hospital outpatient settings	Clinical eligibility ; anesthesia needs; comorbidity; emergency backup; network
Office-based service	Perform suitable diagnostics and minor interventions in a clinic	Safety, equipment, accreditation, and patient tolerance
Telehealth	Use virtual follow-up when examination, testing, or procedure is not required	Technology, hearing, cognition, language, privacy, and caregiver support
Hospital outpatient or inpatient	Retain when complexity, instability, monitoring, or rescue capability requires it	Do not force a lower-cost site when clinical risk makes it inappropriate



CLINICAL PEARL: GEOACCESS IS PART OF SITE-OF-SERVICE VALUE

For Medicare Advantage patients, **evaluate geoaccess alongside clinical safety and cost.**^{95,96} **CMS enforces network-adequacy requirements**, including maximum travel-time and travel-distance standards plus minimum provider-to-enrollee ratios, that **vary by specialty**

(29 clinician and 14 facility specialty types) and by **county type**.^{95,97} County types are assigned primarily by **population density**, from densest to least dense: **Large Metro** (highest-density urban cores), **Metro** (other metropolitan counties), **Micro** (smaller urban clusters), **Rural**, and **Counties with Extreme Access Considerations (CEAC)** (the most sparsely populated, hardest-to-reach areas).⁹⁶

Because allowable travel scales inversely with population density, the same specialty is held to a **tight standard in a Large Metro county** and a much **looser one in a CEAC county**. As a rough reference for a high volume specialty, standards widen roughly as follows across the five county types:⁹⁶

- **Large Metro** (~15 miles max, ~15 min max)
- **Metro** (~20 miles max, ~30 min max)
- **Micro** (~30 miles max, ~45 min max)
- **Rural** (~60 miles max, ~75 min max)
- **CEAC** (~100 miles max, ~110 min max)

A lower-cost site is **not higher value** if excessive travel time or distance **delays care, increases caregiver burden, or prevents the patient from completing treatment.**^{98,99}

This effect is most pronounced in rural and CEAC counties, where **networks are narrowest** and **long travel** is independently associated with reduced follow-up and lower receipt of guideline-recommended care.^{99,100}

Older Adult Selection Overlay

For Medicare enrollees, assess **frailty, cardiopulmonary reserve, cognition, mobility, transportation, caregiver support, post-procedure recovery needs, and supplemental coverage.**^{101,102} A **lower-cost site** may become **lower value** if it cannot safely support the patient or creates an unmanageable access burden.^{90,103}

Variation, Testing, and Pharmacy

Clinical Variation and Standardization

- Use **evidence-based pathways** to reduce unexplained variation in tests, procedures, and follow-up.^{104,105}
- Use an appropriate trial of **evidence-based conservative care before invasive procedures** or surgery when **clinical urgency does not require immediate intervention**.^{106,107}
- Standardize high-cost device and implant choices **when clinically equivalent options exist**

- Optimize and control modifiable conditions or risk factors such as diabetes, smoking , blood pressure, nutrition, medication risk/polypharmacy before **procedures**¹⁰⁸
- Document the clinical reason when an individual case **requires a higher-intensity pathway**¹⁰⁴

Diagnostics, Imaging, and Laboratory Testing

- Apply **appropriate-use criteria** to advanced imaging and specialized testing¹⁰⁹
- Use clinically current laboratory, imaging, and diagnostic results provided by the PCP **when they answer the referral question** and are accessible¹¹⁰
- **Before duplicating a PCP-delivered study**, document why the prior result is outdated, unavailable, insufficient, or no longer reflects the patient's clinical status
- Use **in-network reference laboratories**, such as Quest Diagnostics or Labcorp, instead of hospital outpatient laboratories when clinically appropriate and accessible¹¹¹
- Use accredited, **in-network freestanding imaging centers** instead of hospital outpatient imaging departments when the required study and patient's clinical needs **can be safely accommodated**¹¹¹
- Avoid repeating standard pre-admission testing solely because it originated outside the specialty practice¹¹⁰
- Track **duplicate scans and laboratory panels** as a **network-level analytic tool**¹¹⁰

Pharmacy and Medication Management

OPPORTUNITY	HIGH-VALUE EXPECTATION ^{7,112}
Generics and biosimilars	Use lower-cost clinically equivalent products when appropriate and covered
Infusion site	Use home or independent infusion when clinically safe, operationally reliable, covered, and preferred
Polypharmacy	Coordinate with primary care to deprescribe, stop unnecessary or duplicate medications after treatment
Specialty medication monitoring	Assign prescribing, laboratory, adverse-effect, affordability, and duration responsibility

Care Coordination and Referral Management

Tight PCP alignment **prevents repeated work**, while cross-specialty integration **reduces conflicting clearances, tests, medications, and recovery plans**.⁷ Selection should therefore include **communication performance**, not only clinical and financial results.⁴⁸



MAKING CONNECTIONS

The **AAVBC Value-Based Care Specialist Management QRG** provides the companion workflow for care compacts, note-return standards, medication reconciliation, test ownership, and transition back to primary care.

RISK ADJUSTMENT AND FAIR PEER COMPARISON

A fair specialist comparison requires a **consistent baseline** for disease burden, complexity, benefit design, and geography.¹¹³ **Relevant factors include** age, gender, chronic disease risk such as MRA or HCC context, and insurance product type such as SNP or dual eligibility.¹¹⁴

ADJUSTMENT DOMAIN	EXAMPLES ^{115,116}	WHY IT MATTERS ^{115,117}
Clinical severity	Disease stage ; acute severity; comorbidities; complications present before treatment	Higher-risk cases may need more intensive services and have worse expected outcomes
Demographics and function	Age; sex or gender variables used by the model; frailty; disability; functional status	Older or functionally limited populations may require different sites and recovery support
Chronic disease burden	Supported HCC or other morbidity measures; number and interaction of chronic conditions	Prevents penalizing clinicians who treat medically complex patients
Insurance and social context	SNP ; dual eligibility; benefit design; transportation; language; caregiver availability	Coverage and access barriers can alter completion and downstream utilization
Episode and market context	Specialty; diagnosis; procedure; geographic market; measurement period	Creates an appropriate peer group and price environment

ABBREVIATIONS: HCC = hierarchical condition category; SNP = special needs plan

Reliability and Attribution Controls

- Use a **defined minimum episode or case count** (typically >10 cases) and **report uncertainty** when samples are small⁶⁸
- Confirm which clinician or group has **enough influence over the episode** to be held accountable^{39,78}
- Exclude or separately review **unrelated catastrophic events** and clearly defined statistical outliers¹¹⁸

- **Validate:** diagnosis coding, episode assignment, clean periods, absence windows, and pharmacy linkage¹¹⁹

EXAMPLE PATHWAY FOR SPECIALIST EVALUATION AND ATTRIBUTION

Begin by identifying physicians and specialty groups **within the relevant geographic area** for the 12 most frequently referred specialties. Candidates should have a **sufficient volume of comparable episodes** and **meet established clinical performance criteria** before cost efficiency is evaluated.^{37,39}

STAGE	OPERATIONAL ACTION ^{39,120}	DECISION RULE ^{39,120}
Define scope	Identify the locally highest-volume referral specialties , relevant geographic markets, and contracted networks	Use the top 12 or a locally justified scope
Define accountable unit	Determine whether the physician, group, facility, or combined episode is being evaluated	Match the unit to contracting and actual care delivery
Confirm volume	Count eligible cases or episodes for each measure and episode type	Suppress or qualify unreliable small samples
Apply clinical gate	Evaluate: specialty-specific outcomes, safety, evidence-based care, and structural standards	Only clinically acceptable candidates proceed
Assess efficiency	Compare risk-adjusted total episode cost and utilization with geographic specialty peers	Identify statistically credible efficient performance
Add operational fit	Review access, network status, communication, referral completion, and patient needs	Assign preferred, standard, or review status

Physician Versus Group Evaluation

When a physician practices within a group, **evaluate performance at the group level** when shared protocols, facilities, staffing, and downstream referral patterns **materially influence care delivery**.¹²¹ Because group results reflect the performance of multiple clinicians, **they may not represent every physician equally**. **Reassess profiles** as group composition, technology, medications, procedures, and practice patterns change.

Reassessment Cadence

- Refresh network status **after each defined measurement period** rather than treating a designation as permanent⁹⁵

- Keep physician specialists up to date by **deleting retired physicians** and **adding new physicians** joining a group
- **Review material changes** in group membership, ownership, location, hospital affiliation, or service availability⁹⁵
- **Recheck access** and **network participation** at the point of referral³
- Monitor **local referral outcomes** between formal profiling cycles^{3,7}

CLINICAL QUALITY EVALUATION STANDARDS

Clinical quality designations may incorporate outcomes, technology capabilities, external recognition, board certification, performance-improvement activities, and claims-based measures.⁶⁰ Confirm that all recognition programs, criteria, and thresholds **remain current and applicable** to the evaluated physician or group.¹²²

CATEGORY	EXAMPLES ^{66,121}	CURRENT IMPLEMENTATION APPROACH ^{60,123,124}
Use of technology	Group thresholds for recognized office systems, electronic records, e-prescribing, or endorsed health-technology measures	Verify interoperable: records, electronic prescribing, data exchange, and reliable communication using current criteria
External recognition	NCQA or Bridges to Excellence recognition in diabetes, cardiac, stroke, spine, asthma, hypertension, or practice systems	Accept only active, relevant recognition with a transparent standard and measurement period
Board certification	At least 75% of specialists in a group board certified	Apply the contracting program's credentialing standard and confirm current certification status
Performance improvement	At least 50% completed a PIM or MOC Part 4 activity within two years	Use recent, relevant improvement participation as supporting evidence, not a substitute for outcomes
Claim-based measures	At least 10 cases; readmission, complications, adverse events, and specialty-specific effective treatment	Use reliable specialty measures with defined denominator, attribution, exclusions, and comparator

ABBREVIATIONS: NCQA = National Committee for Quality Assurance; PIM = performance improvement module; MOC = maintenance of certification

How to Use Structural Measures

- Use them when **direct outcomes are unavailable** or as **context** for outcome interpretation⁵⁷
- **Do not** assume technology adoption alone produces high clinical quality
- Confirm that an **external designation remains active** and applies to the measured group¹²⁵
- **Avoid double counting** related recognition and technology measures in a composite score
- **Update criteria** as accrediting programs and maintenance requirements change

HEALTH PLAN PROFILING AND TIERED NETWORKS

Tiered high-performing physician networks categorize physicians or groups according to **clinical effectiveness** and **cost efficiency**.⁵⁶ Insurers may encourage selection of **higher-performing options** through **lower patient cost sharing**.⁵⁶ Plan-specific tiering programs are available through major health plan insurers.

TIERING COMPONENT	TYPICAL INPUT ³⁷	PCP USE ^{37,42,126}
Clinical quality	Claims-based process or outcome measures; external certification; technology measures	Confirm the candidate met a defined quality gate
Cost efficiency	Episode-level cost and utilization compared with specialty peers	Use as one signal of total episode value
Network status	Contract participation and plan-specific preferred designation	Reduce out-of-network financial exposure
Patient incentive	Lower co-pay , coinsurance, deductible exposure, or benefit tier	Explain the financial difference without coercive steering
Local operating performance	Availability, note return, completion, communication, and patient experience	Add information the plan directory may not capture

ABBREVIATIONS: PCP = primary care physician

Safe Use of a Tiered Directory

- Verify the patient's exact plan, product, network, and current participation **before scheduling**

- Review the plan's **explanation of the designation** and **measurement period** when available
- Offer **more than one clinically acceptable option** when feasible
- **Document exceptions for:** urgency, unique expertise, continuity, geography, language, accessibility, or patient preference
- **Do not** represent a payer tier as a guarantee of outcome for an individual patient



MAKING CONNECTIONS

The [AAVBC When to Refer to a Specialist QRG](#) helps establish whether referral is appropriate; the [AAVBC Value-Based Care Specialist Management QRG](#) governs the relationship after selection. Payer tiering sits between those decisions as one specialist-matching input.

ETG PROFILING: PURPOSE AND CORE LOGIC

Episode Treatment Group (ETG) profiling is a claims-based methodology used by insurers and analytic organizations to **bundle related care** into clinically **similar episodes**, **compare** physician or group **performance**, and support cost-efficiency and quality designations.³⁷ **ETG systems may include** approximately 600 condition groups, although the methodology, episode definitions, and number of groups **vary by product and version**.⁸²

Core Profiling Logic

INPUT	GROUPING ACTION ^{39,82}	PROFILE OUTPUT ^{39,77}
Patient diagnosis and claims history	Identify a condition or procedure episode	Defined episode type and time window
Inpatient and outpatient services	Link related facility and professional claims	Total medical utilization and cost
Specialist visits	Attribute relevant physician or group services	Accountable provider profile
Pharmacy, laboratory, and imaging	Associate related downstream services using clinical logic	More complete episode cost
Complications and comorbidities	Assign severity and risk context	Expected cost and outcome comparison

INPUT	GROUPING ACTION ^{39,82}	PROFILE OUTPUT ^{39,77}
Regional specialty peers	Benchmark like episodes in the same market	Cost-efficiency index, percentile, or tier

Intended Uses

- **Tier designation in payer directories**, including labels such as Tier 1 or plan-specific premium status³⁷
- **High-performance** or **narrow-network design**
- Identification of **potentially avoidable utilization** and unexplained practice variation⁷⁶
- Peer feedback and **value-based contracting**¹²⁷
- **PCP referral decision support** when paired with clinical and access information

ETG Grouper Mapping for Specialist Profiling

The table below outlines how the **core ETG structural categories align with medical and surgical specialties** for provider performance profiling and benchmarking:

MAJOR PRACTICE CATEGORY (MPC)	PRIMARY MEDICAL SPECIALIST PROFILE	PRIMARY SURGICAL SPECIALIST PROFILE	EXAMPLES OF ASSIGNED ETG EPISODES
Cardiology/Cardiovascular	Cardiologist	Cardiothoracic Surgeon	Ischemic heart disease, hypertension, valve replacement
Orthopedics/Musculoskeletal	Rheumatologist	Orthopedic Surgeon	Osteoarthritis, joint replacement, spine fusion, bone fractures
Gastroenterology	Gastroenterologist	General Surgeon/Colorectal	GERD, Crohn's disease, colon cancer, cholecystectomy
Endocrinology and Metabolism	Endocrinologist	General Surgeon (Thyroid)	Diabetes (uncomplicated/complicated), hypothyroidism
Neurology/Neurosurgery	Neurologist	Neurosurgeon	Migraines, epilepsy, stroke, spinal stenosis
Oncology	Medical Oncologist	Surgical Oncologist	Breast cancer, lung cancer, chemotherapy management

MAJOR PRACTICE CATEGORY (MPC)	PRIMARY MEDICAL SPECIALIST PROFILE	PRIMARY SURGICAL SPECIALIST PROFILE	EXAMPLES OF ASSIGNED ETG EPISODES
Pulmonology	Pulmonologist	Thoracic Surgeon	Asthma, COPD, pneumonia, sleep apnea
Urology/Nephrology	Nephrologist	Urologist	Chronic kidney disease, renal calculi, prostate cancer
Ophthalmology	Neuro-ophthalmologist	Ophthalmic Surgeon	Cataracts, glaucoma, macular degeneration
Otolaryngology (ENT)	Allergist	Otolaryngologist (ENT)	Chronic sinusitis, tonsillitis, otitis media
Dermatology	Dermatologist	Plastic/Mohs Surgeon	Psoriasis, melanoma excision, severe dermatitis
Obstetrics and Gynecology	Maternal-Fetal Specialist	OB/GYN	Pregnancy/delivery, endometriosis, hysterectomy

ABBREVIATIONS: MPC = major practice category; ETG = episode treatment group; GERD = gastroesophageal reflux disease; COPD = chronic obstructive pulmonary disease; ENT = ear, nose, and throat; OB/GYN = obstetrics and gynecology

How ETG Profiling Works

- Episode Building:** The software **automatically uses ICD diagnosis** and procedure codes to catch, open, and cleanly group **all chronologically related claims over a fixed timeframe**⁸²
- Specialist Attribution:** The episode is **formally attributed to the provider** who holds the plurality of evaluation and management (E&M) or high-cost surgical care^{21,39}
- Peer Group Benchmarking:** Attributed costs are **risk-adjusted based on patient comorbidities** and compared exclusively against a peer group of at least 10 (or up to 100) identical specialists **within the same geographic region**³⁹

ETG EPISODES: CONSTRUCTION AND SEVERITY

Anatomy of an Episode

COMPONENT	DESCRIPTION ^{39,82}	REVIEW QUESTION ¹²⁸
Anchor clean period	A look-back interval with no treatment for the condition signals the start of a new episode	Is the clean period appropriate for this condition?
Claim-line allocation	Professional, facility, pharmacy, laboratory, and imaging services are linked using clinical logic	Were unrelated or missing services assigned correctly?
Absence window	The episode closes after a defined time with no related claims; chronic conditions may use a calendar-year window	Does the closing rule capture the actual care cycle?
Base class	A methodology-specific code groups a condition and body location into a clinically homogeneous unit	Are compared cases genuinely similar?
Peer group	The physician is compared with regional clinicians in the same specialty treating the same episode type	Is the market and specialty comparator credible?

Severity Adjustment Engine

- Comorbidities account for **important pre-existing conditions** that can **increase expected resources**³⁹
- Complicating conditions identify problems that **alter the course of treatment**⁷⁶
- **Outlier filtering** may remove extreme low- or high-cost episodes that would **distort the baseline**⁵⁵

Common Validation Questions

- Did the model **distinguish** a **pre-existing comorbidity** from a **treatment complication**?
- Was the specialist attributed services **ordered by another clinician or facility**?
- Did a missing pharmacy, laboratory, or out-of-network claim **make the episode incomplete**?
- Were **chronic** and **acute episodes** assigned appropriate windows?
- Are there **enough homogeneous episodes** to support the comparison?



QUALITY OUTCOME:

Use the vendor's **current technical specification** for episode definitions, severity classes, clean periods, absence windows, and attribution.

COST EFFICIENCY INDEX: SCORING AND USE

Basic Cost Efficiency Index Formula

COST EFFICIENCY INDEX: Actual average cost per provider episode divided by the expected peer average cost for the same ETG and severity level.

ILLUSTRATIVE CEI RESULT	INTERPRETATION ^{55,128}	RESPONSIBLE USE ³⁹
1	Observed episode cost equals the expected regional peer average	Review quality, access, and utilization pattern before assigning status
<1.00	Observed episode cost is lower than expected	Confirm clinical quality and determine whether lower cost reflects appropriate efficiency
>1.00	Observed episode cost is higher than expected	Identify case mix, site, testing, pharmacy, complications, or attribution drivers before action

From Index to Tier

- Combine the **CEI** or **percentile** with the **clinical effectiveness gate**³⁹
- **Require statistical reliability** rather than ranking small random differences⁵⁵
- Review the service mix to **distinguish appropriate advanced care from avoidable intensity**³⁹
- Use **regional specialty** and **episode peers** instead of a broad cross-specialty comparison³⁹
- **Recalculate** after meaningful changes in data, group composition, treatment technology, or contracts

Do Not Infer

INDEX FINDING	WHAT IT DOES NOT PROVE ⁵⁵
Low episode cost	That clinical quality is high, access is adequate, or the patient experience is acceptable
High episode cost	That care is wasteful, inappropriate, or poor quality
Preferred payer tier	That the specialist is the best match for every diagnosis, procedure, or older adult
Stable group result	That every individual clinician in the group performs identically



CLINICAL PEARL: A COST INDEX SHOULD TRIGGER REVIEW, NOT JUDGMENT

A cost index should prompt a question **about the episode, not replace the question.**⁵⁵
Patient-level review is essential before changing referral pathways or applying referral restrictions.¹²⁹

REFERRAL SELECTION METRICS

Track financial, clinical, access, and coordination performance **together**.

CATEGORY	METRIC	DEFINITION OR FORMULA ^{39,130}	COST AND CLINICAL VALUE ^{4,39}
Cost efficiency	Total cost per episode	All related claims from the first specialist service through the defined recovery or post-discharge window	Identifies whole-episode resource use
Cost efficiency	In-network adherence	Referrals to contracted specialists divided by all specialist referrals , multiplied by 100	Reduces avoidable out-of-network cost
Cost efficiency	Avoidable testing rate	Duplicate or low-value scans and laboratory tests divided by specialist visits , multiplied by 100	Measures data reuse and diagnostic waste

CATEGORY	METRIC	DEFINITION OR FORMULA ^{39,130}	COST AND CLINICAL VALUE ^{4,39}
Cost efficiency	Outpatient shift ratio	Eligible procedures performed in ASCs divided by eligible ASC and HOPD procedures, multiplied by 100	Measures appropriate lower-cost site use
Clinical effectiveness	Patient outcome improvement	Patients achieving the defined clinical or PROM target divided by eligible patients, multiplied by 100	Directly tests whether care works
Clinical effectiveness	Thirty-day readmission	Patients readmitted within 30 days divided by eligible treated patients, multiplied by 100	Signals transition and episode quality
Clinical effectiveness	Complication rate	Patients with defined adverse events divided by eligible treated patients, multiplied by 100	Measures harm and corrective utilization
Clinical effectiveness	Guideline adherence	Cases matching the defined pathway divided by reviewed cases, multiplied by 100	Supports evidence-based care
Operational and access	Referral completion	Completed specialist encounters divided by opened referral loops, multiplied by 100	Detects patient loss and access failure
Operational and access	Days to first appointment	Average calendar days from referral order to completed visit	Detects clinically important delay
Operational and access	Consult note return	Average time from specialist encounter to receipt of a usable note	Measures handoff reliability

ABBREVIATIONS: PROM = patient-reported outcome measure; ASC = ambulatory surgery center; HOPD = hospital outpatient department



QUALITY OUTCOME: METRIC DESIGN

Define numerator, denominator, exclusions, episode window, attribution, risk adjustment, and data lag **before publishing results**. Pair every utilization measure with an **outcome** or **access balancing measure**.

SPECIALIST PERFORMANCE SCORE CARD EXAMPLE

DOMAIN AND WEIGHT	METRIC	ILLUSTRATIVE TARGET	WEIGHT	SCORING LOGIC
Clinical effectiveness 40%	Patient outcome improvement	At least 85% meet goals	15%	15 points at target; 10 within 10%; 0 below 75%
Clinical effectiveness 40%	Thirty-day readmission	Below regional average	15%	15 below average; 5 at average; 0 above average
Clinical effectiveness 40%	Complication rate	Below 2%	10%	10 below 2%; 5 at 2% to 4%; 0 above 4%
Cost efficiency 35%	Total cost per episode	Lowest 25% of peers	15%	15 lowest quartile; 10 mid-tier; 0 highest quartile
Cost efficiency 35%	Avoidable testing rate	Below 5% duplicate orders	10%	10 strict reuse; 5 occasional duplicates; 0 high duplication
Cost efficiency 35%	Outpatient shift ratio	At least 70% in ASCs	10%	10 high ASC use; 5 mixed sites; 0 mostly HOPD
Operational and access 25%	Days to first appointment	14 days or fewer	10%	10 at 14 days or fewer; 5 at 15 to 30; 0 above 30
Operational and access 25%	Referral completion	At least 80% kept visits	10%	10 at 80% or more; 5 at 60% to 79%; 0 below 60%
Operational and access 25%	Consult note return	Within 48 hours	5%	5 within 48 hours; 2 at 3 to 5 days; 0 above 5 days

Scorecard Use Rules

- Treat all targets as **illustrative until localized for**: specialty, episode, case mix, payer contract, and data reliability
- **Do not reward ASC use** when the patient or procedure requires hospital capability¹³¹
- Use **specialty-relevant patient outcome definitions** rather than one universal 85% target

- Validate the profile with case-level review **before** changing routing status

PERFORMANCE TIERS AND ROUTING GUARDRAILS

TIER	SCORE	INTENDED ROUTING	REQUIRED GUARDRAILS
Preferred	85 to 100 points	Top option for automatic high-value routing	Current network status; capacity; clinical match; informed patient choice
Standard	70 to 84 points	Acceptable option based on: geography, continuity, access, or patient preference	Explain tradeoffs and continue performance monitoring
Review	Below 70 points	Clinical peer review before routine future referral	Verify data; preserve urgent access; allow exceptions; offer improvement pathway

Routing Decision Checklist

CRITERION	QUESTION
Clinical fit	Does the specialist have the expertise and setting required for this case?
Quality gate	Is performance acceptable for comparable patients and services ?
Network and benefit	Is the specialist contracted under the patient's specific product and tier ?
Access	Can the patient be evaluated within the required clinical window ?
Geoaccess	Is the specialist reasonably accessible based on travel distance, transportation, mobility, service area, and telehealth availability?
Patient fit	Are location, language, accessibility, cost sharing, continuity, and preference workable ?
Coordination	Can the practice receive records, return notes, and support a closed loop ?

Permitted Exception Categories

EXCEPTION	DOCUMENTATION
Urgency or emergency	Required timing and why the preferred option cannot meet it
Unique expertise or technology	Clinical capability needed and unavailable within the preferred tier
Continuity of care	Established therapeutic relationship and risk of disruption
Network adequacy or geoaccess	Distance, travel time, capacity, transportation, mobility, language, or accessibility barrier
Patient preference	Options discussed, financial implications explained, and informed selection



MAKING CONNECTIONS

Use the [When to Refer to a Specialist QRG](#) to determine urgency and route. Use the [Value-Based Care Specialist Management QRG](#) after booking to define ownership, close the loop, monitor performance, and transition appropriate care back to the PCP.

PCP IMPLEMENTATION PLAYBOOK

The following strategies give primary care practices concrete, **data-driven levers to route patients to high-value specialists** while reducing duplication and closing referral loops. Each pairs a specific PCP or group action with the **operational value it produces**, drawing on established **practice-improvement** and **care-coordination evidence**.

Five High-Yield Practice Strategies

STRATEGY	PCP OR GROUP ACTION ^{7,25,132}	VALUE PRODUCED ^{7,25,132}
1 Deploy scorecards and profiling	Use claims and clinical data to: compare TCOC, outcomes, readmissions, complications, testing, and site patterns	Transparent selection and targeted improvement
2 Build a high-value network	Create a preferred list; surface it in the EHR; cross-check the patient's plan and current access	Faster routing with fewer out-of-network surprises

STRATEGY	PCP OR GROUP ACTION ^{7,25,132}	VALUE PRODUCED ^{7,25,132}
3 Use e-consults and direct communication	Send focused questions, laboratory results, and images asynchronously ; use applicable interprofessional consultation workflows and billing	Resolves suitable low-acuity questions without unnecessary visits
4 Establish care compacts	Define: PCP workup, specialist data reuse, note return, follow-up, and discharge criteria	Less duplication and clearer ownership
5 Embed coordinators or navigators	Own: scheduling, authorization, record transfer, patient barriers, network guidance, attendance, and closure	Higher completion and fewer open loops
ABBREVIATIONS: TCOC = total cost of care; EHR = electronic health record; PCP = primary care physician		

Ninety Day Launch Roadmap

TIMING	RECOMMENDED PRIORITY ACTIONS
Days 1 to 30	Identify the highest-volume specialties ; map current referral patterns; select initial quality, cost, access, and coordination metrics; name an operational owner
Days 31 to 60	Validate data and payer tiers ; define the quality gate; create the first preferred and backup options; configure EHR visibility and exception fields
Days 61 to 90	Launch with selected specialties ; train PCP and coordinator teams; review access and completion weekly; begin specialist communication and compact development
Quarterly	Refresh performance ; review patient and clinician experience; validate exceptions; update preferred status and improvement priorities
ABBREVIATIONS: EHR = electronic health record; PCP = primary care physician	

TEN KEY TAKEAWAYS

1 Confirm appropriateness first

Select a specialist only after the referral route and urgency are clinically established.

2 Quality is the entry gate

Do not prefer lower cost over unacceptable clinical effectiveness or safety.

3 Measure the whole episode

Include downstream facility, diagnostic, laboratory, pharmacy, complication, and post-acute costs.

4 Compare like with like

Use severity, case mix, specialty, episode, geography, and credible sample-size controls.

5 Use multiple data sources

Combine claims, clinical results, access, coordination, patient experience, and payer network information.

6 Treat payer tiers as one input

Verify current methods, network participation, local performance, and patient fit.

7 Interpret ETG and CEI carefully

Claims-based episode models require attribution, construction, and patient-level validation.

8 Make preferred routing actionable

Embed choices, backups, cost and access information, and exception fields in the workflow.

9 Preserve informed choice

Explain tradeoffs and allow medically necessary, access-related, continuity, and preference exceptions.

10 Close the learning loop

Track completion, outcomes, communication, cost, and patient burden so future selections improve.

AAVBC SUMMARY AND CONCLUSION

AAVBC supports data-driven specialist selection that places clinical effectiveness before cost efficiency and evaluates the complete episode rather than an isolated service. **PCPs should limit referrals** with few exceptions **to specialists** and groups **that achieve strong outcomes, minimize preventable complications and duplicate testing, use appropriate sites of care** and products, provide **timely access**, return usable information in a timely manner, and support coordinated care.¹

Internal multi-payer analytics can provide the most complete local view.³⁷ Where those data are unavailable, **payer profiling** and **tiered directories** can support selection if their methods are understood and the **PCP verifies current network, access, and patient fit**. **ETG** and **CEI tools** should inform, **not replace**, clinical judgment.^{37,55} The **operational endpoint** is a clinically appropriate, accessible, affordable, and accountable specialty relationship that **improves the patient's outcome** and **total episode value**.

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