

Strengthening Specialist Participation in Comprehensive Care through Condition-Based Payment Reforms



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EXECUTIVE SUMMARY

Efforts to implement comprehensive care models linked to improving health at the population level and lowering total cost of care are gaining momentum, with the Center for Medicare and Medicaid Services (CMS) setting a goal of enabling all Medicare beneficiaries and the vast majority of Medicaid beneficiaries to participate in accountable care relationships by 2030. Greater specialist engagement is critical for achieving this goal, given the vital role of specialist care in preventing and treating potentially serious health conditions. To date, though, payment reforms to support better specialty care have focused on acute events and major procedures, representing a limited component of specialists' impact on the patient care journey.

Longitudinal payment reforms with accountability for improving outcomes and lowering costs currently support many primary care practices in building comprehensive care models that feature diverse care teams, expanded data infrastructure, and patient supports. Furthermore, chronic conditions where specialists play a critical management role— including cardiovascular, musculoskeletal, respiratory, cancer, neurodegenerative conditions, and behavioral health – account for most Medicare spending and could benefit from similar approaches. For example, a 10% reduction in procedures and hospitalizations for just cardiac and musculoskeletal care from better condition management would reduce total Medicare spending by more than 2%.

Specialty Condition-Based Payment Models (SCMs) are condition-level payments for specialized care that could be “nested” within population-based payment models such as accountable care organizations (ACOs). Payments would be designed to support longitudinal condition management, coordination, and services to prevent costly

complications, allowing for flexibility in amount and risk to facilitate a range of primary-specialty alignment approaches. The shift to SCMs would be mandatory for hospital-led ACOs, which already have well-developed relationships with specialists, and voluntary for physician-led ACOs and providers in advanced payment models.

Advancing a complementary set of four policy reforms would help support SCMs:

1. Fee-for-service (FFS) payment changes to align with the goal of better condition management and to support specialist transitions to comprehensive care;
2. Acute episode bundled payments aligned with SCMs, potentially including a transition to mandatory bundled episode payments for major procedures and acute hospital events;
3. More timely data sharing, including condition-based performance metrics for common specialty care conditions, and implementation of patient-reported outcome measures; and
4. Aligning SCM payment reforms in Traditional Medicare with steps across Medicare Advantage and other payment systems to provide complementary supports for specialist participation in comprehensive care.

Overall, these steps would enable significantly greater specialist engagement in comprehensive care models, account for differences in capabilities across primary and specialty care practices, and advance a more integrated, person-centered approach to improving health.

INTRODUCTION

The Centers for Medicare and Medicaid Services (CMS) has set an [ambitious goal](#) for all Medicare beneficiaries, and the vast majority of Medicaid beneficiaries, to have access to comprehensive, coordinated, equitable care by 2030. The backbone of these efforts will be alternative payment models (APMs) with accountability for quality, health, and total cost of care (TCOC) at the beneficiary level—for example, Accountable Care Organization (ACO) models such as the Medicare Shared Savings Program (MSSP) in Traditional Medicare and complementary reforms in Medicare Advantage (MA). Initial APM efforts have understandably focused on strengthening primary care, attributing beneficiaries to an accountable relationship based on their actual or attested use of a main primary care provider, and offering some additional payments and opportunities for shared savings.

However, specialists comprise most of the physician workforce and oversee the vast majority of health care spending. [Figure 1](#) highlights the important and expanding role played by specialists in many parts of the patient care journey. CMS [has noted](#) that specialty care spending increased more than four times as much as primary care over a 15-year span. Much of this increase reflects unprecedented progress in diagnosing and treating a growing range of disabling, debilitating, and sometimes life-threatening conditions that require specialized expertise involving advanced diagnostic tests, imaging, open or minimally invasive surgical procedures, combination therapies, and regenerative medicine. Specialized care is likely to continue to grow in importance as these technological capabilities continue to evolve.

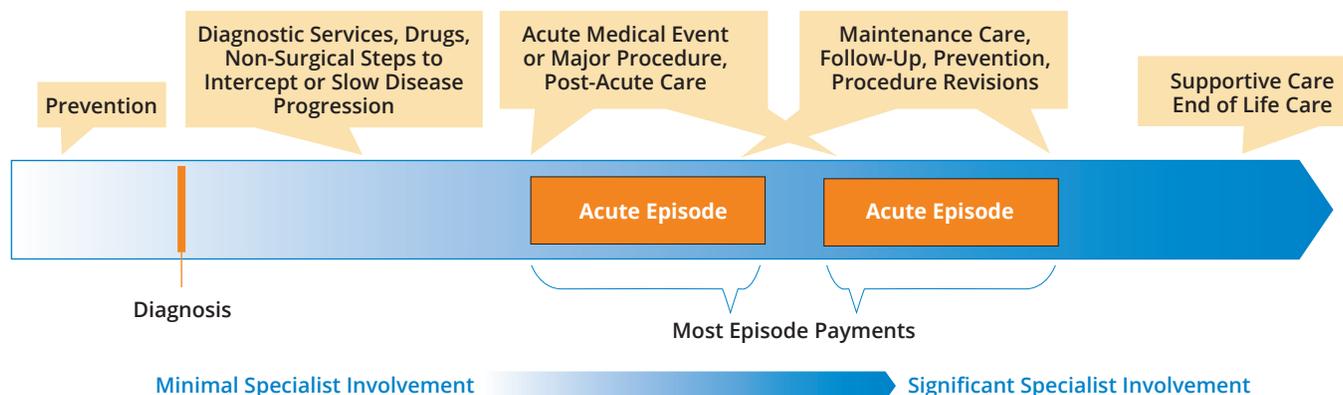
To date, Medicare payment reforms for specialists have largely focused on episode-based payments for major acute medical events (e.g., hospitalizations for heart

attacks or complications of chronic respiratory diseases) and major procedures (e.g., joint replacements or implantations of heart assist devices). While important, these acute events and procedures represent only a limited component of how specialty care can support better care journeys, outcomes, and affordability for patients.

The difference in payment reform approaches for primary and specialty providers impacts the type of care delivery models they can support. ACO reforms have enabled many primary care practices and some integrated systems to shift resources into care teams, data infrastructure, and innovative technology support - services not typically supported by fee-for-service. Such models can help support earlier and more efficient diagnosis of serious conditions and strategies to delay or avert acute events and unwarranted major procedures altogether.

[CMS has recognized](#) that truly comprehensive accountable care will benefit from payments that support aligned goals throughout the care journey for primary [and specialty providers alike](#). In this report, we describe how specialty care areas like musculoskeletal, cardiovascular, cancer, respiratory, neurodegenerative, behavioral health, and others are well suited for more comprehensive payment and delivery approaches because they account for a significant portion of Medicare spending and because specialists play a critical role in condition management beyond the acute episode. We then outline how to incorporate “nested” specialty condition-based payment models (SCMs) within population-based accountable care models, and describe how these reforms can be paired with other major payment and operational elements of Medicare’s comprehensive care strategy to help transform care pathways for patients.

FIGURE 1 Care Pathway/Care Journey within Primary and Specialty Care from Patient Perspective



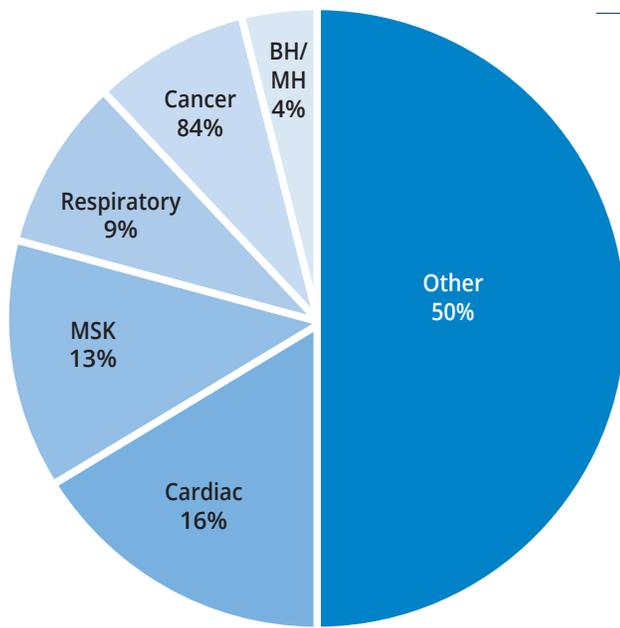
Promising Areas for Comprehensive Specialty Care

There are a range of common chronic conditions that drive both Medicare spending and offer significant opportunities for specialists to improve longitudinal care pathways not well supported by current payment models. Efforts to engage specialists should start here, rather than focus on all specialties at once. Because each specialty has its own unique care model and provider relationships that reflect disease conditions and available treatments, it will be challenging to construct a single payment model for all specialists to participate effectively in longitudinal care approaches.

Figure 2, based on spending estimates from a representative sample of Traditional Medicare beneficiaries, describes

spending share and key considerations for common, impactful conditions where most spending involves specialty care. The figure shows that payment reforms starting in a select group of specialty care areas could have a major impact. **Figure 3** follows this analysis by examining spending in three of these areas. This figure shows that a relatively small share of expenditures are devoted to base condition management compared to spending on major acute events (mainly hospitalizations for serious complications), major procedures, and minor procedures. Payment reforms for these three specialties have to date focused only on bundled payments for major acute events and procedures, with the goal of reducing costs and improving outcomes within these acute episodes. As we note in **Appendix A**, the focus on major events and procedures along with the voluntary nature of these payment reforms helps explain their limited impact on specialty care transformation.

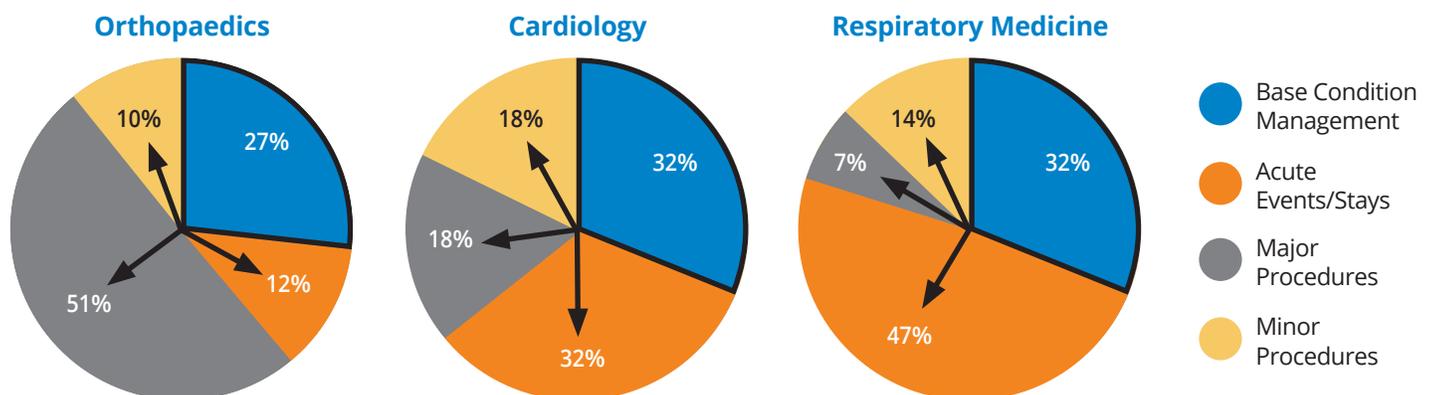
FIGURE 2 Percentage of Medicare Spending By Specialty Condition, With Specific Care Considerations (Authors' Analyses)



Opportunities for Specialized Care Improvement

Cardiology and Musculoskeletal (MSK)	Improved longitudinal patient management can slow or reverse disease progression and encourage appropriate use of procedures
Respiratory	Effective longitudinal management of asthma and emphysema can reduce acute exacerbations and hospital use
Cancer	Shared decision-making and coordinated care management can improve outcomes and reduce costs for early stage cancers; better oncologist coordination and support for primary care providers can reduce costs and improve surveillance for cancer survivors
Dementia	Coordinated, patient-centered dementia care models can increase independence and avoid costly complications
Behavioral Health	Integrated behavioral health specialists in primary care and longitudinal specialized care for patients with more severe behavioral health conditions can improve outcomes and reduce medical costs

FIGURE 3 Opportunities for Savings Through Improving Condition Management (Authors' Analyses)



In contrast, increased support for base condition management could help prevent the need for an acute episode or major procedure. Even modest impacts of payment reforms that address this opportunity could have large overall consequences: for example, a 10% reduction in procedures and hospitalizations for just cardiac and musculoskeletal care from better condition management would reduce overall spending for the Traditional Medicare program by more than 2%.

Comprehensive Care Reforms for Cardiovascular and Musculoskeletal Care

Figures 4 and 5 describe ways in which greater support for effective specialty care engagement and participation across the patient journey through comprehensive care models could lead to better outcomes and lower episode costs along with fewer acute complications and procedures in cardiovascular and musculoskeletal care. In [cardiovascular care](#), improved coordination with primary care providers for management of complex risk factors in the early stages of disease could slow or reverse progression. For patients who may benefit from elective procedures, more support

for shared decision making, tracking of patient functional status, and targeted interventions could lead to fewer major procedures while maintaining or improving health and well-being. For patients whose disease has progressed – for example, those with more advanced heart failure, valvular conditions, or serious rhythm disorders– specialized care teams led by a cardiologist may be best suited to provide an advanced “medical home” dedicated to optimizing a patient’s functional status and preventing further progression and complications alongside primary care providers managing the patient’s other conditions.

All of these steps can prevent the acute complications and major procedures that have been the focus of specialty payment reforms involving cardiovascular care to date. Following acute events, there is also [wide variation](#) in approaches to long-term rehabilitation with health maintenance and condition management services, and also variation of in-hospital mortality versus deaths in hospice for patients with advanced disease. Integrated care models may improve quality of life by increasing use of supportive care at home for patients with advanced conditions. Patients would also benefit from tighter longitudinal

FIGURE 4 Opportunities for Care Integration Supporting Comprehensive Cardiovascular Care

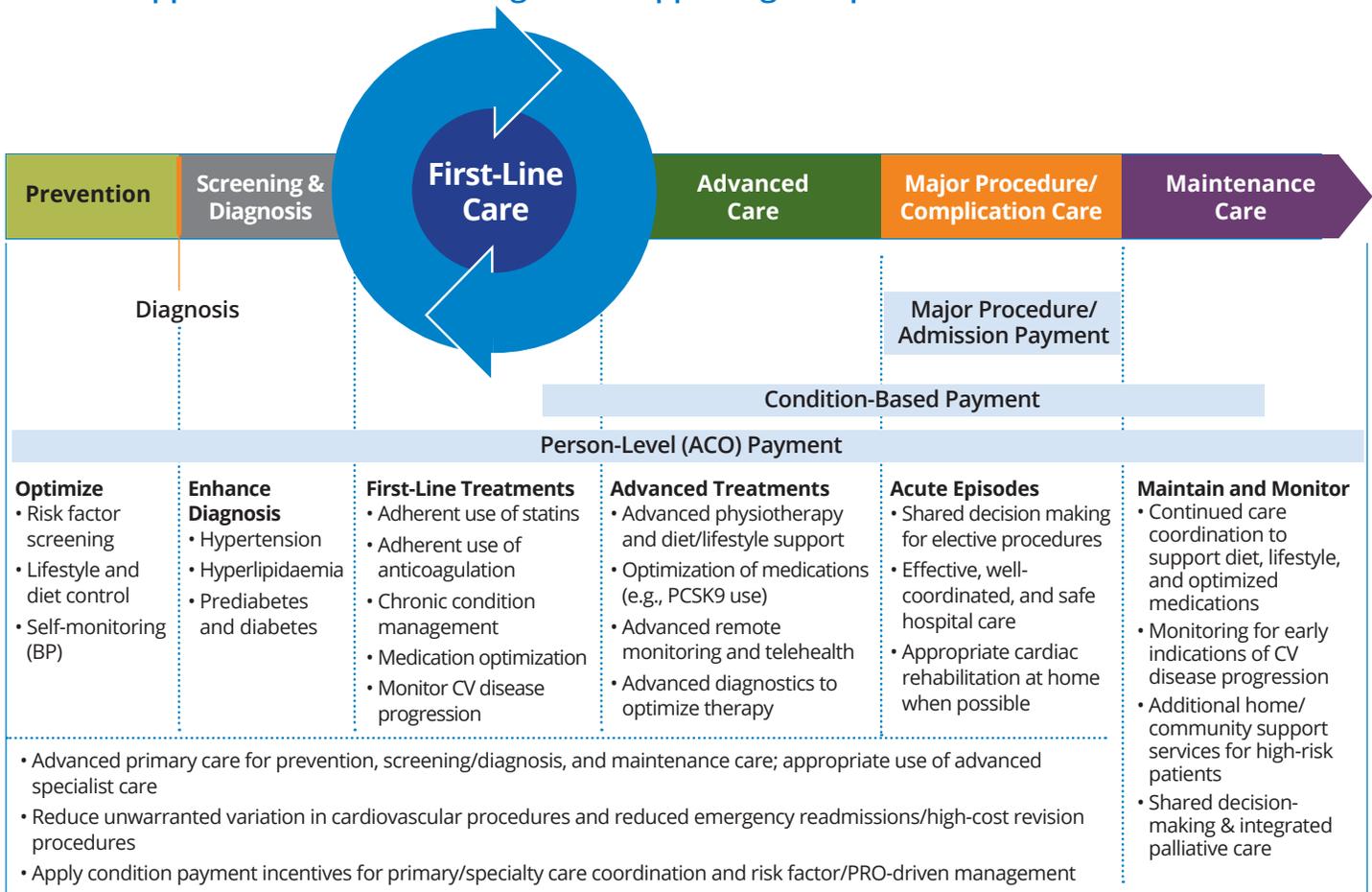
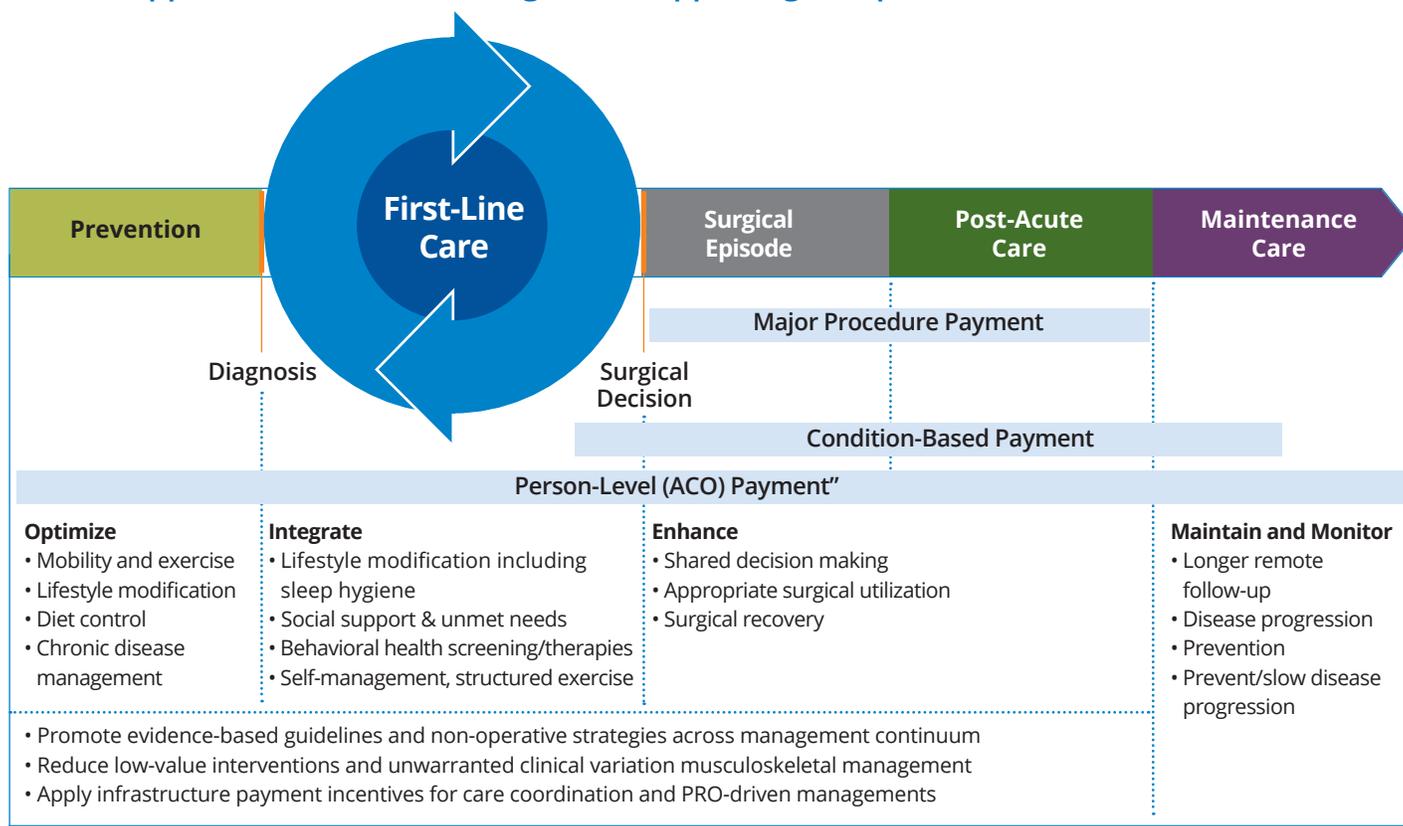


FIGURE 5 Opportunities for Care Integration Supporting Comprehensive Musculoskeletal Care



partnerships between primary care providers and specialty care teams, including both cardiologists focused on medical management and interventional cardiologists required during acute episodes.

In musculoskeletal care, [we](#) and others have documented significant underuse of evidence-based non-operative treatment strategies for populations experiencing joint pain and functional impairments. Relatively few patients referred for musculoskeletal care have their functional status tracked. Fewer still are systematically screened, informed about the evidence on treatment options, supported by a multidisciplinary integrated care team, and promptly guided toward a tailored treatment plan that matches their care goals and values. Notably, [a disproportionate number of musculoskeletal patients](#) experience psychosocial distress as a result of painful and debilitating musculoskeletal conditions, but rarely receive appropriate mental and social health services and support. Further, about [a third](#) of total knee replacements performed in the US result in high rates of dissatisfaction and are potentially inappropriate. Overall, primary (integrated) musculoskeletal care that promotes evidence based physical therapeutic practices, behavioral health support, management of unmet social needs, and shared decision making around treatment options is lacking.

More effective primary-specialty care integration could facilitate more appropriate utilization of non-surgical and surgical care pathways, and enhance surgical management and musculoskeletal health maintenance, leading to improved health outcomes, lower costs, and better patient experience. For example, the University of Texas Health Austin at Dell Medical School (UTHA-Dell) has implemented a [musculoskeletal care model](#) for its uninsured and underinsured population that [has shown improvements in patient-reported outcomes](#) and functional status while also lowering costs for patients. The model aims to reduce low-value services and unnecessary care, using the savings in part to build a diverse care team that also includes behavioral health providers, nutritionists, and physical therapists.

These care pathways as described are not financially viable under current payment arrangements and APMs. Rather, they create a financial burden for specialists who seek to advance them. Most patient engagement, care coordination, and treatments involved in these pathways are poorly reimbursed if at all under fee-for-service; moreover, if these care reforms are successful, a specialty practice or hospital would lose revenue from reductions in high-margin procedures and acute treatments.

Lack of Financial Alignment and Technical Challenges for Specialty Care Coordination and Integration

Substantial operational and financial challenges, which differ depending on whether specialists are part of an ACO or partner with one, affect specialists' incentives and support for engaging with primary care providers in longitudinal care. ACOs led by physician groups (with "low-revenue" used as a surrogate description) mainly consist of primary care providers with a relatively limited number of closely-affiliated specialists (e.g., in behavioral health). They have achieved some overall savings, such as through reducing emergency department visits, initial and subsequent hospitalizations, and managing post-acute care. Physician-led ACO supporters argue that enabling these groups to take risk and share savings would enable primary care groups to use the payment flexibility to implement coordinated care reforms and share savings with specialists. Yet [specialty-related care improvement efforts](#) in these ACOs appear to have largely come without active engagement and participation by specialty groups. For example, some physician-led ACOs have analyzed data on specialty utilization patterns to guide [referral patterns](#).

Most primary care practices have limited resources, infrastructure, and scale to engage specialist practices directly, and vice versa. Without well-established templates or coordinated models, and mutually-verifiable data on opportunities to improve outcomes and lower costs by collaborating, physician-led ACOs and specialty care providers may struggle to identify clear opportunities for improvement and attribution of savings. All but the largest primary care groups in a market may be too small for specialty providers to invest in trying to overcome these implementation costs.

Specialists are frequently employed or closely affiliated with hospital-led ACOs (with "high-revenue" used as a surrogate description). As with physician-led ACOs, shared savings in hospital-led ACOs may also come from reducing admissions, procedures, and tests. But except in "direct contracting" and similar models that rely primarily on person-level payment, the hospital's revenue remains strongly dependent on those same specialty activities, and any ACO shared savings only returns a fraction of that lost revenue. Further, especially for commercial insurance, the margins for these admissions, procedures, and tests are significantly higher than the margins for primary care or medical management services, and specialist compensation remains mostly linked to this revenue. Appendix B illustrates in additional detail

the potential significance of this lack of specialty financial alignment in current hospital-led ACO payment models. The distinct financial incentives for specialists are a plausible explanation for why hospital-led ACOs have been [substantially less likely to achieve net Medicare savings](#), with limited investments to support specialist engagement in more transformative care reforms.

Outside of Traditional Medicare, there is some movement towards longitudinal specialty care models. MA plans have accountability for overall total costs of care, with some implementing per-member per-month payments for specialty groups that partner with primary care practices taking on financial risk. (Such models are also easier to implement in MA plans with selective provider networks.) For example, UT Austin-Dell Medical School implemented its comprehensive joint care model for uninsured and underinsured patients in central Austin, where the local hospitals providing uncompensated safety-net care have strong financial incentives to avoid surgical procedures when possible. But without stronger steps toward specialty financial alignment with the bulk of ACOs in Traditional Medicare, it seems unlikely that such specialty models will reach a critical mass.

Underlying these limitations is a core challenge: fee-for-service (FFS) payment provides little financial support to work on care coordination and care improvement activities. Per-member, per-month (PMPM) "care coordination" payments for complex patients are now part of Medicare primary care compensation, and ACO models for smaller physician groups include additional up-front payments for primary care providers. CMS could implement analogous payments for specialists treating common conditions, but because specialists generally do not have TCOC accountability, it is at best unclear whether such payment reforms would achieve intended goals. For example, a PMPM for osteoarthritis care for a musculoskeletal care team not aligned with a patient's primary care provider could actually lead to potentially duplicative or excess services, complicating overall patient care coordination and increasing TCOC.

Existing payments do allow advanced primary care practices in ACOs to perform many of the specialized care reforms we have described – team-based care, shared decision-making, alternative care pathways with integrated behavioral health and physical therapy. But reforming specialty condition payments concurrently would provide much more financial support for primary and specialty care providers to develop and sustain these longitudinal care capabilities. Without greater financial alignment with specialists, progress toward such models will continue to be slow.

Implementing SCMs within Population-Based Accountable Care

Our SCM approach uses condition-based payments aligned with population-level payment reforms to support the goal of comprehensive care. **Figures 6 and 7** provide an overview of how SCMs fit within the patient care journey and align with similar comprehensive, longitudinal care models, with the goal of supporting slower disease progression, improved patient function, and lower TCOC. SCMs would be available for beneficiaries in an accountable model, including ACOs and other population-based models to ensure that SCMs are targeted to appropriate patients, and that the services provided are aligned with other primary care reforms supported by the ACO.

An SCM would be triggered by a specific diagnosis linked with an indicator or indicators related to severity. Two types of “reference benchmarks” could be imple-

mented for spending for the condition: a prospective reference benchmark based on risk-adjusted Medicare claims for the condition trended forward, and a retrospective benchmark based on actual spending for a reference population. While the SCM would be nested within a whole-person accountable care payment model, acute episode payments for admissions and procedures (e.g., a Bundled Payments for Care Improvement-Advanced [BPCI-A] successor model) would be nested within the SCM for purposes of condition accountability and could be paid separately (e.g., to a specialty provider accountable just for the acute episode). These acute episode bundles could be based on care and spending for a Diagnosis-Related Group (DRG) plus 30 post-hospital days, a reasonable period to encourage coordination among the patient’s longitudinal care providers and those involved in the acute episode.

FIGURE 6 Nested Structure of Payment Models

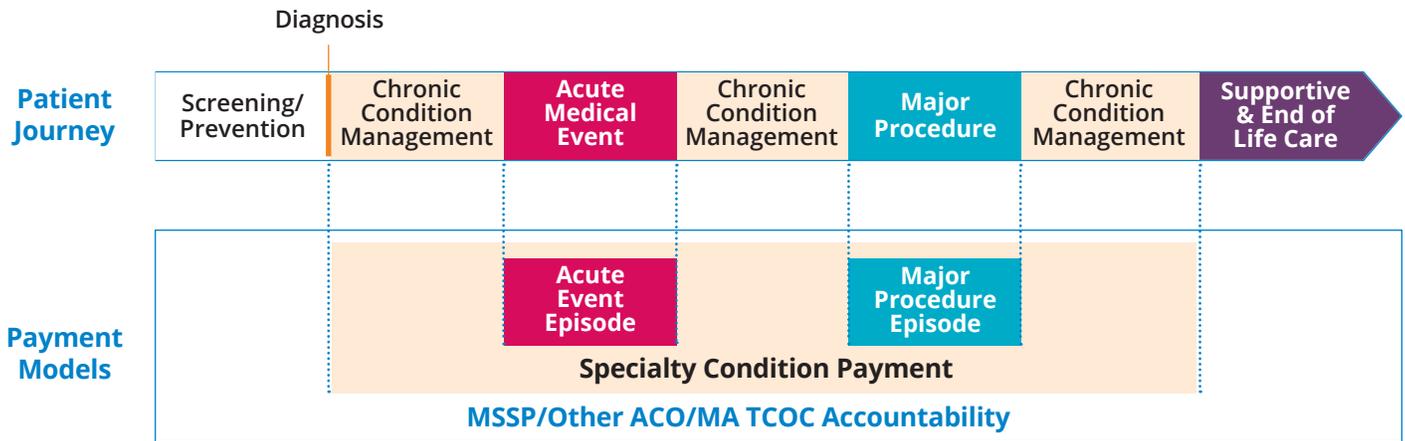
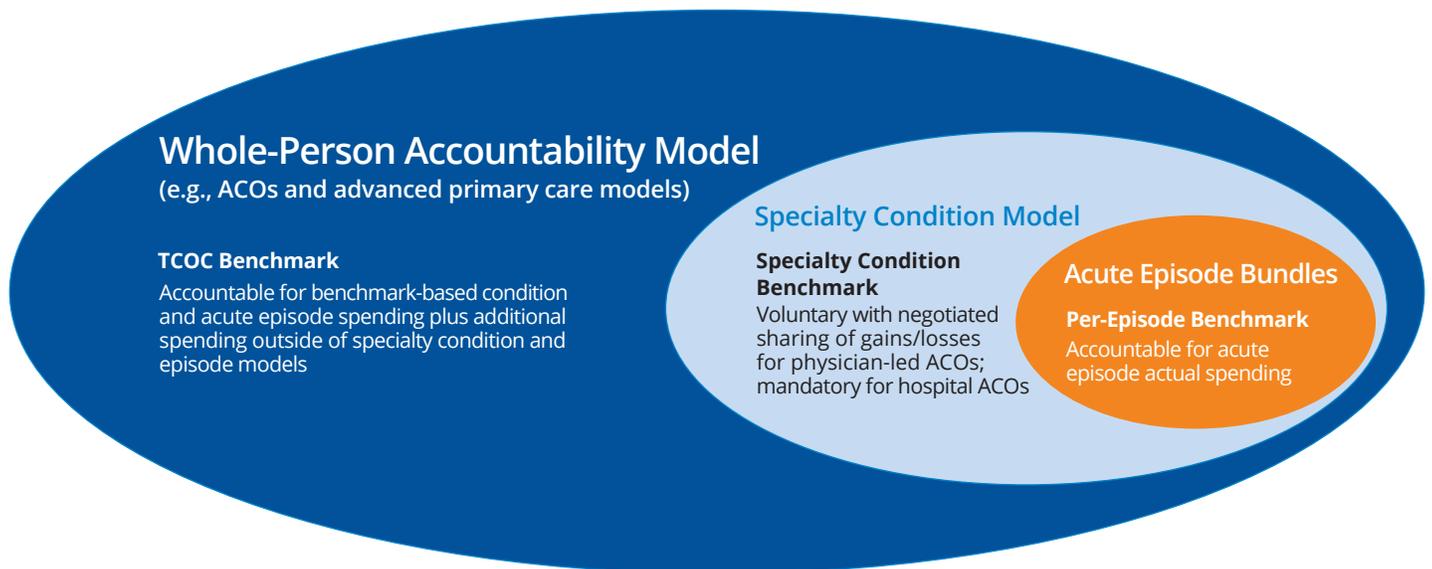


FIGURE 7 Bridging Accountability through TCOC, Specialty Condition, and Acute Episode Models



Key SCM Components

The development of an effective SCM requires addressing key model design components, as shown in **Figure 8**. These components are incorporated within current playbooks developed by UTHA-Dell, the Duke-Margolis Center, and other collaborators, which serve as tactical guides for navigating stakeholders from baseline evidence generation through to piloting and implementing SCMs.

An SCM begins with a trigger or starting point consisting of a diagnosis plus an indicator or measure of condition severity, along with rules for a start date or continuation (e.g., quarterly renewal under appropriate conditions) and for defining the specialty-related scope of services to be included. The accountable specialty condition entity would be determined by the ACO or other TCOC accountable entity, which would be responsible for notifying the beneficiary. As with other Medicare APMs, the beneficiary would not be restricted from receiving services from other specialty care providers. In effect, the accountable specialty group would be an extension of the ACO for specialty care. An ACO with appropriate condition management capabilities could also choose to implement the SCM itself; we expect that hospital-led ACOs would generally do so, but physician-led ACOs with appropriate capabilities might also do so rather than partnering with an independent

FIGURE 8
Core Model Design Components for SCMs

Model Design Components
A. Episode Definition (Trigger)
B. Episode Start Time (Anchor) and Duration
C. Patient Population and Risk Adjustment
D. Service Configuration
E. Accountable Entity
F. Payment Structure
G. Program Pricing and Incentives
H. Type and Level of Risk / Risk Adjustment
I. Performance/Quality Measures & Benchmarks
J. Data Sharing and Quality Reporting

specialty group. Analogous to ACO models, the specialty condition could include less or more “advanced” payment options, including shared savings with a modest condition-level payment component (PMPM or specialty care management fee), a larger shift to prospective payment with more downside risk, or an entirely PMPM-based payment with full financial risk within the condition. Payment benchmarks would be risk adjusted based on an existing Medicare model like the Hierarchical Condition Category (HCC) coding model. Condition payments and shared savings would provide new resources for chronic condition management and coordination, shared decisionmaking, specialty services to enable home-based care and remote monitoring, and other services and team members to support improvements in condition outcomes and avoid costly complications.

In addition to benchmarks for condition spending, SCMs would have quality benchmarks based on patient-reported outcome measures such as Hip Disability and Osteoarthritis Outcome Score [HOOS]/Knee Injury and Osteoarthritis Outcome Score [KOOS] for osteoarthritis and an appropriate functional status measure for a cardiovascular condition, validated measures of clinical risk reduction (e.g., improvements in key cardiovascular risk factors relevant to specialty care), and quality metrics related to utilization (e.g., major procedure rates, rates of hospitalization for preventable complications). SCMs would also include access measures (e.g., Consumer Assessment of Healthcare Providers and Systems [CAHPS]) and equity-related metrics based on these measures.

CMS or other payers would implement SCMs with a set of parameters (e.g., a “starter” SCM with limited PMPM payment amounts and financial risk, and an intermediate and “advanced” SCM with larger shifts from FFS payment and financial risk). But SCMs would be applied in two different ways depending on the type of whole-person accountable entity, reflecting the different financial alignment issues:

- Physician-led ACOs would implement SCMs voluntarily and would be free to negotiate alternative splits of payments and risk with the accountable specialty condition entity based on how they share responsibilities. For example, an ACO would likely be willing to make larger payments (and share more risk and savings) to a specialty group that is delivering all the services needed in the SCM. Alternatively, if the specialty condition providers rely more on the ACO to provide key elements of the model (e.g., data analytics and remote monitoring, associated behavioral and social services, support for key team

members), then more of the payments related to the model would go to the ACO.

- Hospital-led ACOs would be required to phase in SCMs. A hospital-led ACO that preferred to engage specialty condition providers outside of their employed or ACO-affiliated specialty providers would have flexibility to enter such an arrangement if it chose to do so.
- Advanced “direct contracting” ACOs (e.g. ACO REACH) could choose whether or how to implement SCMs.

Determining specific benchmark calculation methods and implementing appropriate condition-based quality measures presents some technical challenges. However, these models build on steps that CMS and other stakeholders are already undertaking, such as improvements in sup-

porting data and the development and adoption of quality measures and patient-reported outcomes. As we describe in the next section, CMS and stakeholders can take a series of steps starting now to work out key details of SCMs to enable large-scale implementation.

Determining specific benchmark calculation methods and implementing appropriate condition-based quality measures presents a range of technical challenges. However, these models build on steps that CMS and other stakeholders are already supporting, such as improvements in quality measures, patient-reported outcomes, and risk adjustment methods. As we describe in the next section, CMS and stakeholders can take a series of steps starting now to work out key details of SCMs ahead of potential large-scale implementation.

Implementing a Comprehensive Specialty Payment Reform Strategy Including SCMs

Creating SCMs that truly engage and support specialists in comprehensive care will be a substantial undertaking. But specialists are an essential part of realizing the vision of broad availability of such care – including for the chronic specialty conditions that matter deeply for the health and well-being of Medicare beneficiaries, and that make up most of Medicare spending. Here, we describe a CMS pathway for stakeholder and public engagement

to refine these concepts to help assure successful implementation, as well as how these reforms can fit into other key dimensions of Medicare’s overall payment reform strategy. **Table 1** provides an overview of these key elements. Medicaid and commercial purchasers could implement similar steps, especially if CMS provides a model approach.

TABLE 1 Key Elements of Specialty Payment Reform Strategy

Specialty Payment Reform Element	Key Steps
Implementation Pathway for Condition Payments	<ul style="list-style-type: none"> • Establish guidance and transition timelines that meet providers where they are, expanding opportunities for providers in FFS, MSSP ACOs, and advanced ACO Models
Complementary/Nested Acute Episode Payments	<ul style="list-style-type: none"> • Transition from DRGs and readmission penalties to DRG plus 30-day bundled episode payments for major procedures and acute medical admissions, nested within condition-based payments, with risk adjustment for social risk factors
Performance Measures and Supporting Data	<ul style="list-style-type: none"> • Release condition-level measures of quality and spending, shift to measures that better capture meaningful condition-level outcomes including PRO-PMs • Enhance longitudinal quality measures in MIPS • Reduce reporting requirements or increase data/feedback to increase engagement
Systemwide Alignment	<ul style="list-style-type: none"> • Share specialty data across payers and providers, support alignment when possible for efforts driven by states, purchasers, and MA

Implementation Pathway for SCMs

Table 2 below describes how SCMs can be implemented while meeting Medicare beneficiaries and their providers where they are. The pathway reflects the overall CMS goal of enabling all beneficiaries to participate in a comprehensive care arrangement either through an accountable entity like an advanced ACO or through an MA plan. While most beneficiaries are in at least early-stage accountable arrangements today either through MSSP or other ACO programs, or MA, many beneficiaries remain in FFS and many specialists are not well engaged in these care models.

Specialty Condition Payment Models can be implemented while meeting Medicare beneficiaries and their providers where they are.

For beneficiaries not in an ACO or MA plan today, the absence of an accountable coordinator for their care significantly complicates the implementation of SCMs. CMS should build on some of its existing policies to encourage more specialists to engage in comprehensive care models by building on the differential payment updates for providers in APMs and by updating its Merit-based Incentive Payment System (MIPS) payment adjustments to support providers who take steps toward improving specialty condition care. Such [Value Pathways](#) are already expanding in the 2023 performance year, and include quality measures, improvement activities, and cost measures focusing on areas of care such as stroke, heart disease, chronic disease management, and lower extremity joint repair, among others. CMS should also explore the implemen-

tation of a limited specialist care coordination payment for certain complex patients in FFS Medicare, like those that [have been implemented](#) for coordination by primary care and behavioral health providers. And as we describe below, CMS should begin sharing and then publishing an initial set of condition spending and quality measures for specialty providers and groups based on available data, and improve these measures for providers over time.

For beneficiaries in standard MSSP ACOs – a population that is expected to grow over time – CMS should propose and develop implementation plans for SCMs that reflect the different types of ACOs. As we have noted, hospital-led ACOs are particularly well-suited for the adoption of SCMs, as they are likely to employ or have well-developed contractual arrangements with specialty providers, and they are already encouraging referrals to those providers from their primary care practices. SCMs would better support these specialists to provide comprehensive care for the specialty conditions in collaboration with the ACO’s primary care providers. Consequently, as we have noted, CMS should aim to make the transition to SCMs mandatory for hospital-led ACOs.

Physician-led ACOs have strong incentives to improve longitudinal collaboration with specialists, and are already implementing initiatives to improve condition management and to selectively refer to specialists that manage patients efficiently. However, as we have noted, they have faced administrative burdens and problems of small scale in trying to engage specialists more effectively in these models, and specialists currently have little financial support or supporting data for redirecting their own activities

TABLE 2 Transition Guidance in Traditional Medicare Based on ACO Attribution

Beneficiaries Not in ACO Today	Beneficiaries Attributed to MSSP ACOs	Beneficiaries in Advanced APMs
<ul style="list-style-type: none"> • Fee-for-service modifications to support transition to alternative specialty care reforms (e.g. differential lower MIPS update, FFS adjustment in MIPS linked to performance on measures similar to those used in alternative payment models, longitudinal care coordination payment), building on MIPS Value Pathways when feasible 	<ul style="list-style-type: none"> • Mandatory transition to SCMs for hospital-led/integrated ACOs, required adoption of condition-level quality and equity measures • Voluntary transition to SCMs for physician-led ACOs, support from CMS in establishing sample contracts, parameters for participation, and sharing additional data on specialty practice performance • Required adoption of condition-level quality and equity measures 	<ul style="list-style-type: none"> • Flexibility to adopt own reimbursement arrangements within global payment as along as performance standards met • Required adoption of condition-level quality and equity measures • Implement complementary condition-based performance measures in Medicare Advantage STARS

to more comprehensive, coordinated models. CMS could help overcome these barriers by providing a core set of SCM models ranging from “starter” to “advanced,” along with more reliable, transparent data on how specialty groups are performing today at the condition level. The contracting framework and data on performance against “shadow benchmarks” would provide a much stronger foundation for ACOs to engage specialty care providers to work together on comprehensive care, and would give interested specialty care groups a clearer pathway to implement better care models at scale. This approach would also make it easier for some physician-led ACOs to adopt SCMs themselves, providing much more resources for coordinated care than is possible through primary care payment reforms alone.

Physician-led ACOs have strong incentives to improve collaboration with specialists.

Some MA plans are already implementing condition-based payments for specialists, and CMS should encourage faster progress. CMS should propose a timeline for implementing key condition-based quality and equity measures in its Medicare STARS ratings that are aligned with the key ACO condition-based measures. CMS should also seek public comments on implementing additional payments for specialty providers who participate in condition-based alternative payment models in MA. (CMS has the statutory authority to implement a payment bonus based on adoption of advanced APMs in MA, but has not yet clearly defined what kinds of alternative payment models would qualify.)

Complementary Strategy for APMs for Major Acute Events and Procedures

SCMs can also complement acute episode programs, such as successor programs for BPCI-A, to address some of the limitations of such models that we summarized earlier. One option is to transition to a mandatory acute episode program, which would be an extension of the (mandatory) DRG payment system. Like the existing BPCI-A model, this approach would use DRG triggers for episodes and extend the bundles to 30 days after discharge. A mandatory program would provide incentives to support short-term improvements in care coordination, efforts to avoid readmissions, and efficient use of post-acute care while avoiding the selection problems that have complicated achieving savings in BPCI-A. In turn,

nesting these acute episode models within longitudinal specialty payment reforms will better support specialty engagement in the rest of a patient’s care journey, provide more support for team-based care and analytics, enable specialists to improve outcomes and lower costs in acute episodes, and potentially avoid many of these episodes from occurring in the first place. Such condition-based models would also be a more effective place to embed payment adjustments for social risk factors that influence both the cost and the need for acute procedures and admissions.

Condition-Based Performance Measures and Supporting Data

To support the transition to SCMs, CMS could release an initial set of condition-level measures of quality and spending that can be calculated from claims and other available data for all specialty providers, to provide insights to providers and public transparency. For example, for patients that meet a triggering condition (e.g., primary diagnosis along with specialist referral), CMS could report on risk-adjusted rates of major acute events and procedures (along with spending relative to the condition episode benchmark, as described above). An orthopedist or orthopedic group would receive a report showing the rate of joint replacements he or she performs out of all attributed patients, versus referrals and participation in physical therapy or other potentially appropriate pain management programs. Cardiologists would receive a similar risk adjusted report for attributed patients with heart failure and other potentially serious conditions, which could include both major procedure rates and rates of hospitalization and emergency department use for potentially preventable conditions.

The condition-level measures could complement existing measures related to acute episodes in BPCI-A, such as spending measures and measures of acute complication rates, and could build on the Value Pathways in MIPS. By sharing these measures first with providers and then more publicly, CMS can encourage feedback to improve the quality of the measures and to help them be used more effectively for quality improvement and referral and contracting decisions. CMS should combine these efforts with developing a pathway for better data access for providers interested in improving care for common conditions and potentially participating in SCMs. Such data sharing could follow methods already being implemented for data sharing in ACOs and other existing APMs, including consistent methods for beneficiary opt-out and privacy protections.

More widespread adoption of condition-level quality measures is also badly needed. CMS has already noted and recently reaffirmed its interest in expanding adoption of patient-reported outcome measures (PROMs). By committing to a pathway for implementing APMs for specialty conditions, CMS would provide a much clearer pathway for specialists to make the needed investments to implement and use these measures; short-term episodes are not sufficient for doing so. With a clearer pathway toward meaningful use of PROMs in payment models to support specialists in optimizing outcomes that matter to patients, interested specialty groups and specialty societies could do much more to help specialists and collaborating primary care providers to implement these measures successfully. Most providers will need accompanying technical assistance in developing mechanisms for measurement and using the findings to improve care pathways for the condition.

Aligning with Condition-Based Payment Reforms Outside of Medicare

Broader efforts across the health care system can improve understanding and support implementation of SCMs in Medicare. CMS, states, private purchasers, and other health plans are all exploring ways to expand longitudinal specialty care – ranging from cardiovascular care and diabetes management, to maternity care, to back pain and joint conditions, to care for substance use disorders and complex behavioral health conditions. [Walmart](#) and [Morgan Health](#) are already leading complementary employer efforts to develop and share data on specialty condition care, for quality improvement and value-based benefit design. By describing a path forward for improving care for specialty conditions, and by releasing templates for such models, CMS can create opportunities for aligning reforms and best practices with other interested payers and purchasers to reduce the burden and increase the critical mass for specialty care reform.

CONCLUSION

Comprehensive Care for Patient Journeys

A pathway for SCMs like the one we have laid out above would support significantly more specialist engagement to achieve CMS' comprehensive care goals by 2030. Many major conditions, including cardiovascular and musculoskeletal disorders, have considerable evidence of fragmentation and care gaps, but also evidence of innovative care models that are very difficult to sustain under current payment incentives. Starting with some of these conditions for SCMs can help build momentum for further refinement and expansion across additional areas of specialized care.

While SCMs themselves may take a few years to develop and phase in, many steps can be taken now to support practices in building the infrastructure needed for improving longitudinal specialty care, including efforts to share a wider range of meaningful data and make it easier for primary and specialty providers to build collaborative relationships and establish better aligned financial relationships. A range of short-term efforts can also ensure that CMS meets providers where they are now, accounting for different levels of readiness and the different types of incentives faced by physician-led ACOs, hospital-led ACOs, and specialty organizations still primarily operating under FFS. Given both the importance of specialty care to improving population health and the financial impact on the health care system, effective specialist engagement should be a centerpiece of further efforts to achieve the goal of improving health outcomes and reducing costs through person-centered, integrated care.

APPENDIX A

Challenges with Uptake and Impact of Acute Episode Payment Models for Specialty Care

Current bundled payment models for major acute events and procedures have improved coordination and integration of care within acute specialty care episodes. For example, Medicare's Bundled Payment for Care Improvement – Advanced (BPCI-A) Model was estimated to reduce payments by \$743 per episode [over its first two years](#), largely due to lower spending on post-acute care (PAC) services. Joint replacement bundles have perhaps the most evidence of success: a [2020 evidence review](#) of bundled payments found that the majority of studies showing spending reduction focused on joint replacement. BPCI-A saw minimal changes in quality-of-care measures, with the exception of a lower readmission rate for pooled surgical clinical episodes, and limited “selection effects” of shifting to lower-risk patients. The limited impact on quality and non-PAC costs may have been the result of BPCI-A being implemented on top of strong pre-existing incentives to limit hospital costs and avoid significant short-term complications, including hospital prospective payments (diagnosis-related groups [DRGs]) and significant penalties for readmissions.

Overall, BPCI and early years of BPCI-A showed modest but important impacts on utilization without adverse outcome consequences, especially in PAC. However, the challenges of determining appropriate benchmarks for particular providers and episodes, combined with mostly voluntary participation, led to CMS estimating [an overall net Medicare loss](#) of \$65.7 million (0.4% of Medicare payments without BPCI-A). To address favorable selection and resulting losses, CMS implemented changes in BPCI-A at the beginning of the model's fourth year. These payment changes included a retrospective trend adjustment and a shift from individual Clinical Episodes (CEs) to Clinical Episode Service Line Groups (CESLGs) – which required providers to participate in all episodes in a broad area of care rather than picking particular episodes.

Together with a required 3% benchmark spending reduction before any savings are shared, these changes reduced Medicare's risk of losses but introduced significantly more uncertainty about achieving shared saving. An estimated [32% of participants left the program](#) after model year 4. This year, as results of the program became clear (i.e., savings for many groups, but less than the 3% threshold), [many more participating groups dropped out](#). Subsequently, CMS announced that it would lower the benchmark spending reduction threshold for shared savings from 3% to 2%, in its [extension](#) of BPCI-A through Model Year 6 (2023).

Despite these challenges, episode-based payment reforms remain important for supporting coordinated hospitalist and surgical care. One approach to increase participation while allowing more generous shared savings would be to make an updated version of the acute episode program mandatory, perhaps piloted in multiple regions and phased in over time, with the development of further evidence to refine implementation. Still, it seems clear that specialty procedure and acute episode payment reforms alone are unlikely to achieve the desired impact of facilitating major reforms in longitudinal care involving specialists.

Other models have supported specialists in longitudinal, whole person management. Payment reforms for advanced kidney disease, like [Kidney Care First and Comprehensive Kidney Care Contracting](#), support specialized nephrology teams that essentially function as a beneficiary's comprehensive medical home and care coordinator. Beneficiaries in ACOs and other comprehensive population-based models can effectively be attributed to specialists like cardiologists or endocrinologists if their main medical condition is managed by that specialist. Finally, Medicare's [Oncology Care Model \(OCM\)](#) and successor [Enhanced Oncology Model \(EOM\)](#), though not encompassing all or even most specialized care received by cancer patients, represent a significant longitudinal payment reform for the treatment episode for cancer patients undergoing new, substantial chemotherapy or radiation therapy for certain cancers.

These condition models have shown some progress, but also have required refinements. Recent kidney models seek to correct for substantial apparent overpayments resulting from early benchmark rules and risk adjustment, similar to issues seen early in the ACO program. The Oncology Care Model garnered significant participation and demonstrated a modest reduction in Medicare expenses; however, the initial \$160 per-beneficiary, per-month upfront payment [led to estimated net Medicare losses of \\$781 million](#). Consequently, the EOM has a lower upfront payment (still with opportunities for shared savings) and is limited to a set of cancers with acute treatments that generally require substantial chemotherapy and/or radiation therapy, and that have significant rates of short-term complications that often lead to hospitalizations. Further steps to extend and align these models with population-level accountability models, as we describe in our report, would provide better opportunities and incentives for ACOs and accountable specialty care providers to work out effective payment arrangements for these and other common conditions.

APPENDIX B

Illustration of Limited Alignment of Specialty Care Payment in Medicare Alternative Payment Models

Hospital-led and health system ACOs (“high-revenue” ACOs) might seem well suited to implement comprehensive, longitudinal care models that directly engage specialists. These ACOs have employed or affiliated primary care providers and specialists, so that collaboration can be supported within the organization. However, while a growing number of large health systems have successfully implemented longitudinal models with partial or full capitation, most hospital-led ACOs still have specialty-based organizational structures with most specialty revenue linked to procedures and acute admissions. Specialist compensation remains directly or indirectly tied to volume, with little or no linkage to lowering TCOC or improving longitudinal population outcomes.

This financial and organizational structure is a result of the fact that under current Medicare payment rules, a hospital-led ACO is likely to be able to achieve adequate overall ACO performance while increasing net revenue margins, through an approach that may both increase and decrease TCOC. First, the hospital implements incremental

primary care-based reforms to avoid costly medical admissions with relatively low margins. Second, it maintains or even enhances specialty referrals for higher-margin diagnostic and therapeutic procedures, many of which are paid through DRGs or short-term episode bundles (inpatient) or FFS (outpatient).

We illustrate this using a representative sample of 48,000 FFS beneficiaries (Table B1). In this analysis:

1. The representative sample of beneficiaries is attributed to a single hospital-led ACO;
2. The ACO's margins for medical and procedural DRGs are 5% and 6.5% respectively.
3. The yearly benchmark for each attributed beneficiary is \$13,868, with \$3,359 of the benchmark attributable to medical DRGs and \$2,769 attributable to procedural DRGs.
4. Shared savings are 60% of gross savings for year 1.

TABLE B1 Illustration of Hospital ACO Savings Through Reduced Medical DRGs and Increased Procedural DRGs

	Medical DRG	Procedural DRG	Total Costs	Shared Savings/Loss to ACO	Incremental Net Savings/Loss to ACO
Year 1	\$3,325	\$2,797	\$13,862	\$169,954	\$175,737
Year 2	\$3,292	\$2,825	\$13,857	\$322,251	\$335,489
Year 3	\$3,259	\$2,853	\$13,852	\$456,909	\$479,272
Year 4	\$3,227	\$2,882	\$13,848	\$573,942	\$607,103
Year 5	\$3,194	\$2,910	\$13,845	\$673,364	\$718,997

Due to investments in improving the medical management of the ACO's beneficiaries, the number of medical DRGs decreases by 1% per year. At the same time, the ACO increases the number of procedure DRGs by 1% per year. This shift in DRG composition is expressed in the yearly change in the per-beneficiary, per-year amount in the columns entitled Medical DRG and Procedural DRG. Overall, total per beneficiary cost goes down because the starting volume of Medical DRGs is much higher than procedural DRG. Because the overall per beneficiary costs are coming in below the benchmark, there are shared savings achieved by the ACO, which is shown in the "Shared Savings/Loss" column rising from \$170K to close to \$675K. For the ACO, however, there is actually an added bonus in net revenues (last column) because of the increase in procedural DRGs. For example, in year 1, the ACO generates an additional \$6K in margin despite shared savings being lower than would have been the case if the ACO didn't incrementally increase procedure DRGs, resulting in total incremental net revenues of close to \$176K. These incremental revenues increase over time, with the shift from medical to procedure admissions.

This is a relatively modest illustration; with more significant investments in shifting population management from medical to surgical procedures, a hospital ACO could achieve lower or no shared savings yet higher net revenues. Further, there are many other potentially higher-margin specialty opportunities besides elective inpatient procedures (e.g. increasing outpatient procedures). So long as specialty care payments are primarily tied to diagnostic and therapeutic procedures, and not longitudinal achievement of better outcomes and lower total costs, the optimal financial path for a hospital-led ACO may be to balance some ACO medical savings with increasing spending on high-margin specialty services.

The upshot is that a decrease in medical DRGs due to incremental improvements in the population health management of Medicare beneficiaries, driven primarily by the hospital-led ACO's primary care teams, can be at odds with financial incentives for specialists in the ACO to increase spending on procedures. This path to financial sustainability limits overall savings and undermines the goal of aligning all ACO providers to deliver comprehensive, efficient care. Conversely, more effective

longitudinal management of patient care to improve function and avoid complications should result in reductions in both medical DRGs and procedure DRGs (and outpatient procedures). But the resulting loss of specialty care net revenue limits the financial sustainability for a hospital-led ACO to invest in such care reforms. In the absence of condition-based payment reforms, independent specialists similarly have limited financial support for partnering on such models with physician-led ACOs. This financial misalignment underscores the need for a new pathway that can facilitate more substantive specialist condition management with aligned financial rewards.

APPENDIX C

Advancing Comprehensive Specialty Care Integration: The Missing Piece in Value-Based Health Care Reform

July 29, 2022 convening held by the Duke-Margolis Center and the University of Texas Health Austin at Dell Medical School

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Disclosures

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About Duke-Margolis

The mission of the Robert J. Margolis, MD, Center for Health Policy at Duke University is to improve health, health equity, and the value of health care through practical, innovative, and evidence-based policy solutions. For more information, visit healthpolicy.duke.edu and follow us on Twitter @DukeMargolis.

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