

Preliminary Comments Development Team (PCDT) Presentation:

**Improving Care Delivery and Integrating Specialty Care in
Population-Based Models**

Jennifer Wiler, MD, MBA (Lead)
Lawrence Kosinski, MD, MBA
Terry (Lee) Mills Jr., MD, MMM
Soujanya (Chinni) Pulluru, MD
James Walton, DO, MBA

March 2, 2023

Objectives of This Theme-Based Meeting

- Increasing specialty care provider engagement in population-based total cost of care (PB-TCOC) models where:
 - Specialists share accountability with primary care providers for providing high-value care and bearing appropriate financial responsibility for patient outcomes
- Examining issues related to improving care delivery and specialty integration in population-based models, such as:
 - Structuring and improving coordination between primary and specialty care providers in advanced primary care models (APCMs) and Accountable Care Organizations (ACOs);
 - Identifying best practices for defining and nesting specialty episodes in population-based models, determining attribution, structuring financial incentives, and selecting appropriate performance measures; and
 - Increasing participation of safety net and rural providers

Background of This Theme-Based Meeting

- September 2022 public meeting covered payment issues related to PB-TCOC Models.
- PTAC has deliberated on the extent to which 28 proposed physician-focused payment models (PFPMs) met the Secretary's 10 regulatory criteria, including *Integration and Care Coordination*.*
- Many of these proposals raised issues and challenges regarding specialty integration.
- *The goal for this meeting is to better understand these challenges and how various experts and providers have sought to address them.*

* Nearly all of the 35 proposals that have been submitted to PTAC addressed the potential impact on costs and care coordination, to some degree – including at least 16 proposals that addressed issues related to improving specialty integration in APCMs and episode-based or condition-specific models. Please see the Appendix for additional information.

Preliminary Working Definition of the Characteristics of Specialty Integration* in the Context of Value-Based Care

PTAC is using the following working definition of the characteristics of specialty integration:

- Specialty integration is a desired characteristic of population-based models where:
 - Primary and specialty care provider roles and responsibilities are clearly delineated throughout the care journey for a given condition or episode of care;
 - Specialist care includes a continuum of responsibilities for a patient or condition, including, but not limited to, single consultation, co-management, and primary management;
 - Primary and specialty care providers coordinate to provide patient-centered care using bidirectional, synchronous and asynchronous communication;
 - Specialists provide consultations and/or ongoing care via multiple modes in a timely manner; and
 - Primary and specialty care providers have access to use shared real-time data to inform care decisions.

* This definition will continue to evolve as the Committee collects additional information from stakeholders.

Model Design Elements for Specialist Integration in Population-Based Models

MANAGEMENT

- Consult/referral
- Co-management¹ with shared management
- Co-management with principal care by specialist
- Specialist principal management

ATTRIBUTION

- Patient self-report
- Wellness visits
- Primary care visits
- Prescription data
- Evaluation and Management codes

Specialty Integration

DATA SHARING AND COMMUNICATION

- Reporting only → Partial access → Full access
- Unidirectional → Bidirectional
- Synchronous ↔ Asynchronous
- Performance metrics

FINANCIAL ACCOUNTABILITY

- Current fee-for-service (FFS) mechanism with no shared accountability
- Non-specialist model entity voluntarily or mandatorily shares risk with participating specialists
- Specialist model entity assumes risk in voluntary or mandatory model

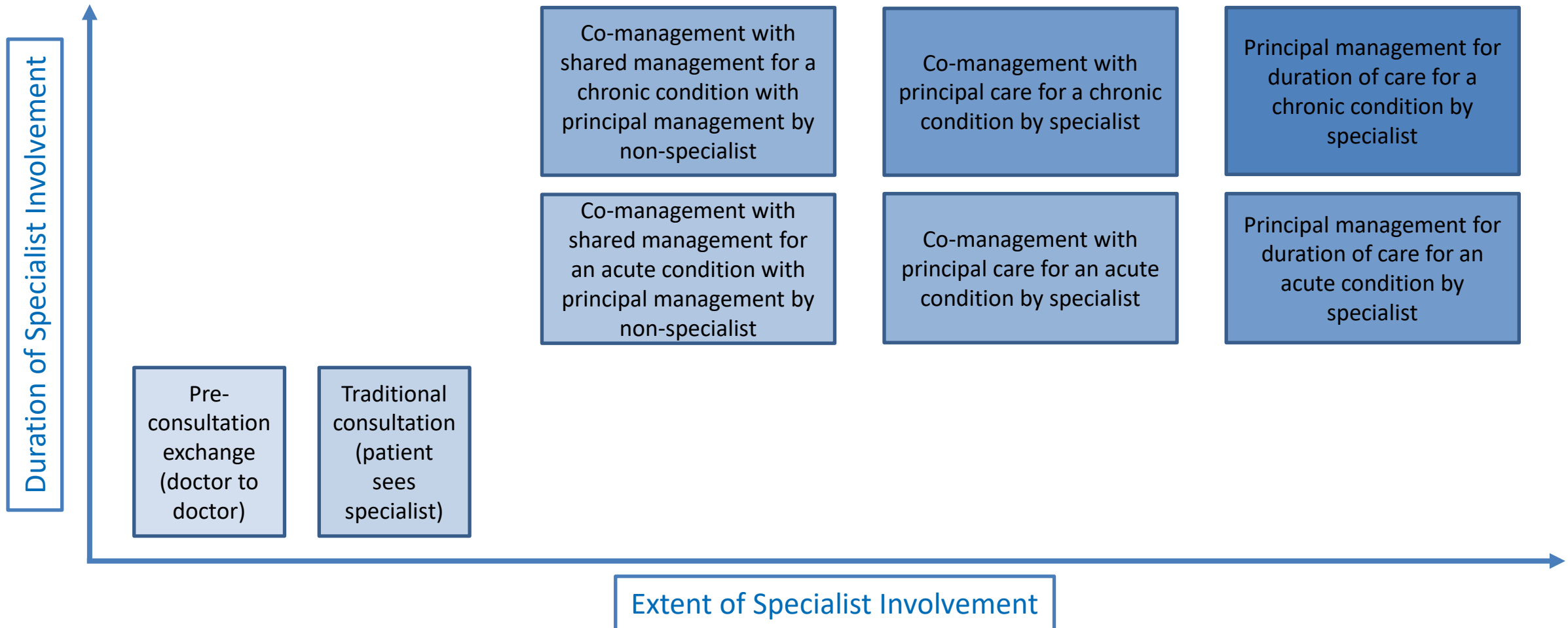
Characteristics that affect elements and their interrelationships include, but are not limited to:

- Patients with multiple chronic conditions²
- Condition/procedure type and severity
- Provider location (urban/rural)
- Cooperative agreements
- Organization type
- Financial viability
- Provider employment status
- Prevailing market conditions
- Data quality and infrastructure

¹Co-management may include a primary care provider and one or more specialty care providers on the patient's care team.

²As of 2018, 69% of Medicare beneficiaries had two or more chronic conditions.

Specialists' Roles in Delivering Care in Coordination With Primary Care Providers Varies Based on the Extent and Duration of Involvement Needed



Example of Specialists' Roles in Coordinating Care With Primary Care Providers for Nephrology

- Pre-consultation exchange (doctor to doctor)
 - Primary care provider (PCP) calls nephrologist for advice on diagnosis and care for patient with diabetes and high blood pressure, conditions that place them at high risk for chronic kidney disease (CKD) and end-stage renal disease (ESRD).
- Traditional consultation (patient sees specialist)
 - PCP requests traditional consultation from nephrologist for a patient whose estimated glomerular filtration rate (eGFR) reaches 59, indicating CKD Stage 3a.
- Specialist co-management with shared management by a PCP for a chronic condition
 - PCP provides periodic assessments of a patient with Stage 3a or higher CKD, and nephrologist follows up if eGFR continues to decline.
- Specialist co-management with principal care for a chronic condition
 - Nephrologist oversees dialysis treatment and management of patient with ESRD, and PCP coordinates screenings and preventive care and manages other conditions.

Potential Criteria for Categorizing Specialty Conditions By Appropriateness for Episode-Based Payments

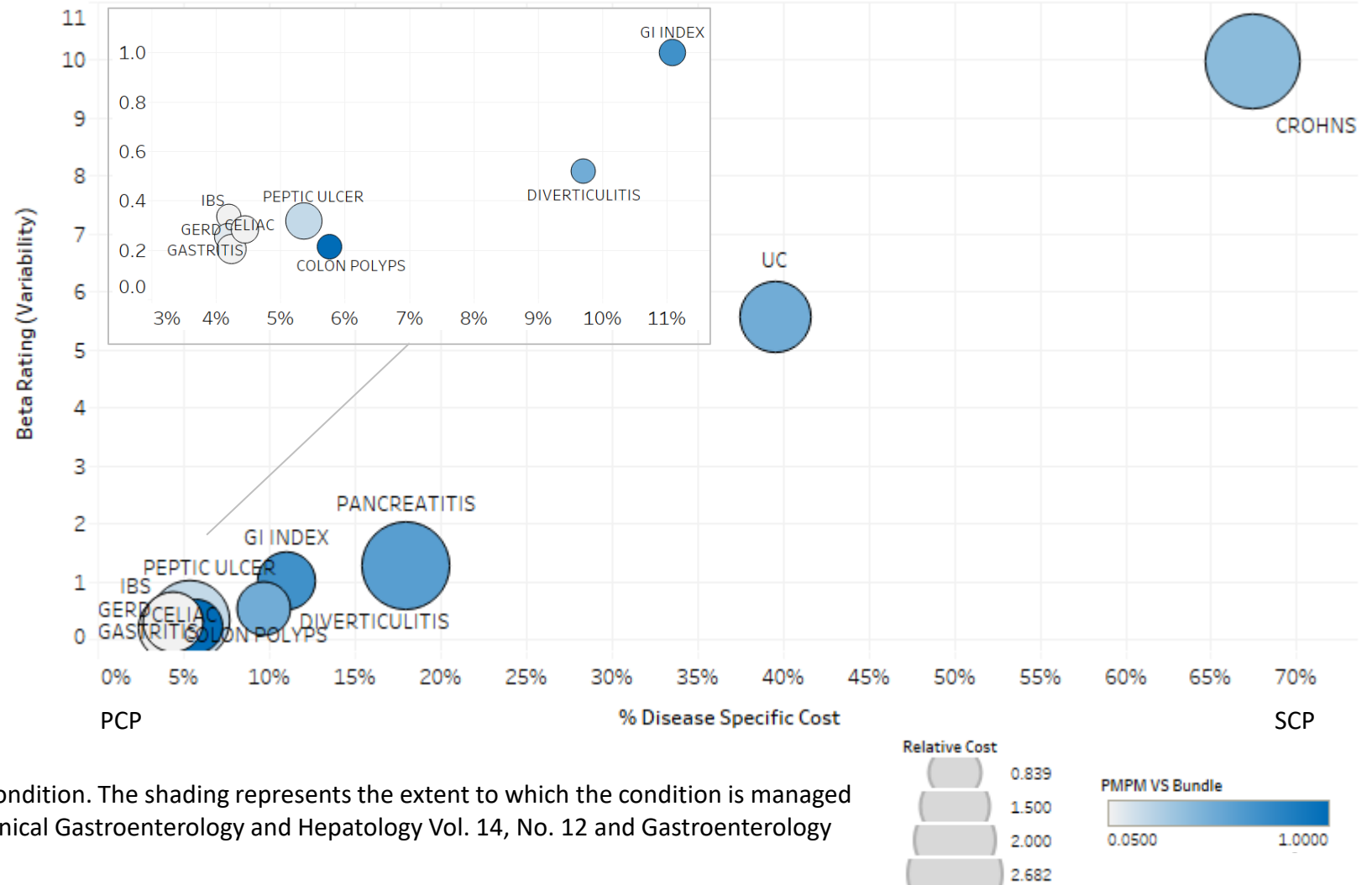
- Specialty disease conditions vary by the way that the condition is managed, the extent to which there is shared management with a PCP, and the amount of variation in spending.
- Criteria for identifying specialty conditions that may be more appropriate for bundled episode-based payments include:
 - Specialty-driven
 - Generally managed procedurally
 - Low variation in spending
- Criteria for identifying specialty conditions that may be more appropriate for per member per month (PMPM) chronic disease management payments:
 - Generally managed cognitively/non-procedurally
 - May involve shared management with a PCP

Example of Cost Attribution Approach to Identify Which Gastroenterology (GI) Disease Conditions May Be Appropriate for Episode-Based or PMPM Payments

Methodology

- Identify GI ICD-10 codes
- Calculate % of Annualized Disease Specific Cost
- Calculate Cost/Decile
- Calculate “Beta Rating” or Variability (standard deviation of Cost/Decile)
- Profile each condition by Cognitive/Procedure ratio = Per Member Per Month (PMPM)/Bundle ratio*

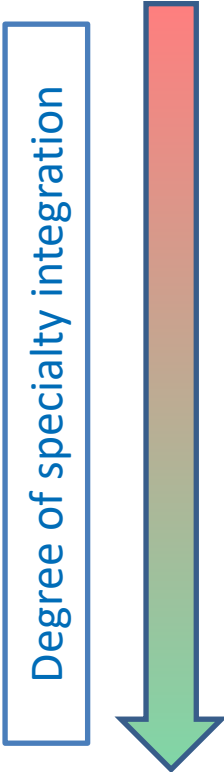
Beta Rating vs Annualized Disease Specific Cost – GI Example



*The size of each circle represents the relative cost for each condition. The shading represents the extent to which the condition is managed by bundles or PMPM payments. References: Adapted from Clinical Gastroenterology and Hepatology Vol. 14, No. 12 and Gastroenterology Vol. 158, Issue 3, Supplement S79: Feb 2020.

Payment Design Features That May Support Specialty Integration

Use of Nested Specialty Models in Selected Innovation Center Models*



Payment Design Feature	How Payment Design Feature Supports Specialty Integration	Selected Innovation Center Models
Bundled payments	May better support conditions with low variability	Oncology Care Model (OCM), Comprehensive Care for Joint Replacement (CJR), Bundled Payments for Care Improvement (BPCI) Advanced
Per beneficiary per month (PBPM) payments	May be more appropriate for chronic conditions; can cover care management and coordination activities without adding a separate FFS-based charge for non-procedural services	Million Hearts [®] : Cardiovascular Disease (CVD) Risk Reduction Model, Next Generation ACO Model, Pioneer ACO Model
Capitated payments	Research has tended to focus on chronic conditions and oncology care; results are mixed with respect to the efficacy of capitation	Global and Professional Direct Contracting (GPDC)/ACO Realizing Equity, Access, and Community Health (REACH) Model

*All of the above design features can be used for developing nested specialty episodes in PB-TCOC models

Care Delivery Challenges Related to Improving Specialty Integration in PB-TCOC Models*

Care Delivery Model

1. Defining roles of primary and specialty care providers at various stages in patients' disease progression, including potential overlap between specialists
2. Defining and measuring high-value specialty care
3. Clinical care pathways to support patient-centered care
 - Availability – existence of evidenced-based, condition-specific clinical care pathways
 - Timing – when primary care providers should engage specialty care (e.g., make referrals to specialists)
 - Care management continuum – extent and duration of co-management between PCPs and specialists
 - Resources – existing assets, or access to assets, that support provision of evidenced-based care
4. Limited access to certain specialty services (e.g., in rural communities or due to insurance status)
5. Data quality and sharing
 - Varying levels of data access and coordination between primary and specialty care providers and across care settings
 - High resource needs for developing infrastructure for high-value data exchange

*Representative list; this will continue to evolve as the Committee collects additional information from stakeholders.

Examples of Specialist Approaches to Care Delivery that Support High-Value Care

- **Specialist visit duration:** FFS environments may encourage specialty providers to increase patient volume, seeing more patients per day and spending less time with patients at each visit. In contrast, seeing fewer patients and spending more time with each patient could support measurable care improvements across several dimensions.
 - Longer visits may support improvements in diagnostic decision-making, provider-patient relationships and patient trust, and care management and patient education.
 - For example, increasing orthopedic visit duration may support utilization of non-operative management and prevent avoidable surgery.
- **Frontloading care:** May involve higher frequency or intensity of medical or surgical interventions earlier in the care episode or at earlier stages of disease. Initially, this strategy may be more costly, but it may generate cost savings and improve long-term outcomes.
 - Frontloading care may be especially relevant for specific populations.
 - For example, research demonstrates that cost, utilization, and quality outcomes over time are better for ESRD patients when dialysis is initiated with a fistula or a graft, which are costlier and of higher clinical intensity, as compared to a catheter.

Considerations for Structuring Data Sharing and Communication to Support Specialty Integration

- Encouraging data sharing during consultation/referral
- Policies facilitating data use agreements between providers/practices
- Variation in how providers use and share data
 - Providing patients with price information for different providers and procedures
 - Creating policies that allow for quick and easy information transfer between organizations
 - Creating patient identifiers and maps while working with other providers and stakeholders
 - Facilitating referrals to specialty care providers who provide high value care

Payment Model Challenges Related to Improving Specialty Integration in PB-TCOC Models*

Payment Model

1. Currently, insufficient financial incentives for encouraging specialists to move into value-based relationships
2. Identifying attribution methods that are most appropriate for primary care and specialty providers in PB-TCOC models, including those with nested condition-specific or episode-based models
3. Determining amount of flexibility accountable entities in PB-TCOC models should have in deciding which conditions and episodes should be nested, and how to structure financial incentives for participating providers
4. Identifying specialties and conditions that are most appropriate for nesting within PB-TCOC models, and whether certain specialties should not be included in PB-TCOC models
5. Arrangement for structuring entity-level and provider-level risk
6. Increasing participation of safety net and rural providers
7. Creating meaningful benchmarks for evaluation of high-value care

* Representative list; this will continue to evolve as the Committee collects additional information from stakeholders.

Challenge 1: Currently, There Are Insufficient Financial Incentives for Encouraging Specialists to Move Into Value-Based Relationships

Factors That Can Affect Specialists' Financial Incentives Related to Improving Specialty Integration

- Overlap between episode-based and condition-specific models and PB-TCOC models
- Variable access to, or participation in, developing care pathways, performance measures, and financial incentives for PB-TCOC models
- Lack of reimbursement for activities related to care coordination
- Less participation in value-based care and smaller proportion of overall patient panel in value-based care arrangements
- Greater reliance on volume-based FFS reimbursement within, and outside of, value-based care models
- Imbalance in incentives for procedural and cognitive specialists (PBPM vs. FFS)

Challenge 2: Identifying Attribution Methods That Are Most Appropriate for Primary Care and Specialty Providers in PB-TCOC Models

Considerations for Attributing Patients to Primary Care and Specialty Providers in PB-TCOC Models (including those with nested condition-specific or episode-based models)

- Plurality of services
 - Where patients receive the majority of their primary care or specialty care services
 - Voluntary attestation vs. claims-based attribution
- Timing of attribution
 - Based on utilization of the prior year or current year
- Duration of attribution
 - Monthly, quarterly, annually
 - On an episode-by-episode basis
 - Characteristics of process for reattribution
- Potential for shared accountability with primary care providers and/or other specialists for certain conditions and disease stages

Use of Beneficiary-Level Attribution in Existing Models

- Beneficiary-level attribution in Innovation Center Models included prospective and retrospective claims-based approaches, usually based on the majority of Evaluation & Management (E&M) visits for primary care or condition-specific care, and voluntary attestation.
 - Examples: ACO REACH Model, End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model, Pioneer ACO Model
- Models that did not have beneficiary-level attribution often attributed episodes based on diagnosis codes or Diagnosis Related Groups (DRGs) or screened beneficiaries for enrollment.
 - Examples: OCM, Accountable Health Communities (AHC) Model

Challenges 3 and 4: Determining Amount of Flexibility and Specialties or Conditions for Nesting in PB-TCOC Models

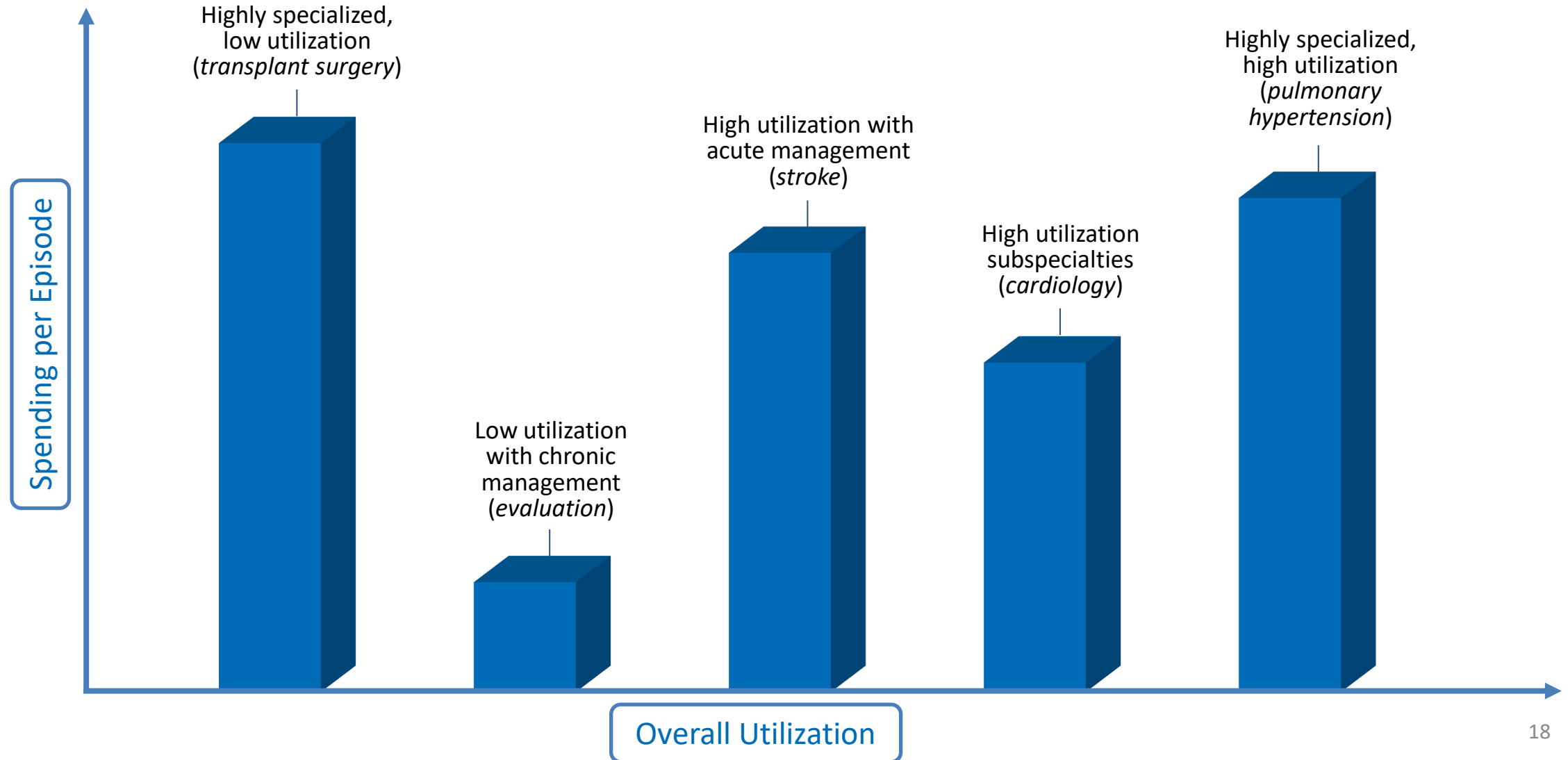
Challenge 3: Determining the amount of flexibility accountable entities in PB-TCOC models should have in deciding which conditions and episodes should be nested, and how to structure financial incentives for participating providers

- Certain financial incentives (e.g., episode-based, PBPM, or capitated payments) may be better suited to support value-based care for certain conditions or procedures.

Challenge 4: Identifying specialties and conditions that are most appropriate for nesting within PB-TCOC models, and whether certain specialties should not be included in PB-TCOC models

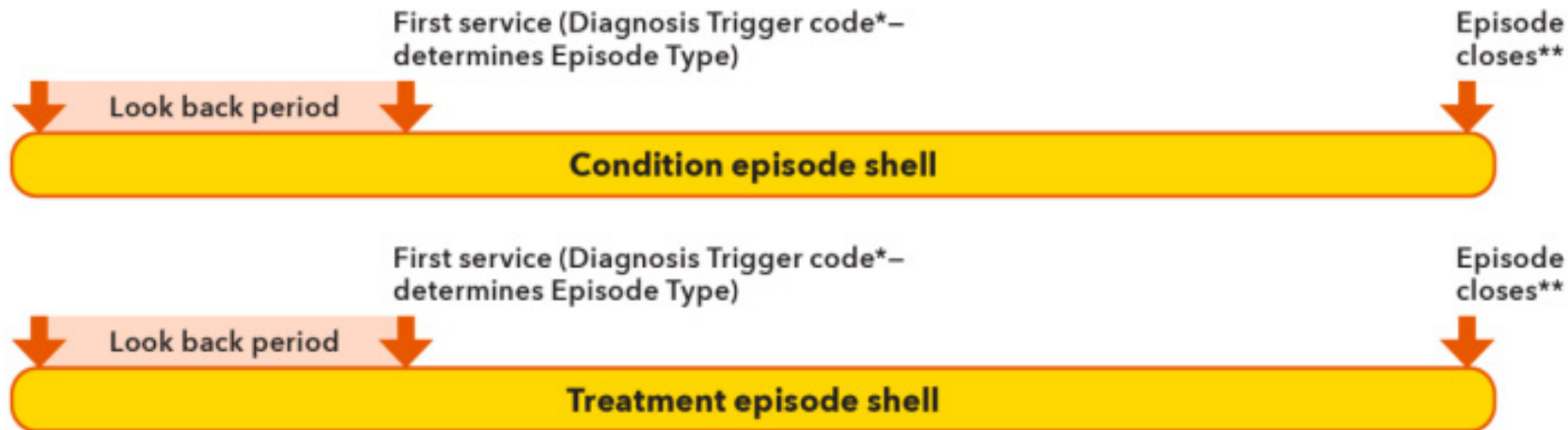
- Certain conditions or procedures may be more appropriate for nesting.
- Example: Conditions/procedures with predictable care trajectories and low variability in spending

Considerations for Developing Specialty-Focused Models For Nesting in PB-TCOC Models by Specialty Characteristics



Example of a Nesting Model for One Condition or Episode

TRIGGER RULES AND EPISODE SHELLS



*Each EGM episode has its own predetermined trigger codes (diagnoses for condition episodes, procedure codes for treatment episodes) that define them. All episodes are defined by selected trigger rules, which indicate criteria such as timing of services, setting of services, or any additional requirements.

**Closing rules are based on fixed-length episodes, which means that episodes close after a predetermined period of time from trigger event, or until the patient leaves Original Medicare

***This example illustrates a fixed length episode. EGM also supports variable length episodes.

- Additional Considerations
 - Combination condition episodes (*based on clinical similarity or conditions that are manifestations of underlying chronic conditions*)
 - Combination treatment episodes (*treatments of the same modality or otherwise not allowed to co-occur*)
 - Accounting period (*episodes ending in a one-year accounting period*)

Note: EGM = Episode Grouper for Medicare

Reference: "Proposal for a Physician-Focused Payment Model: ACS-Brandeis Advanced Alternative Payment Model," ACS-Brandeis

Challenge 5: Arrangement for Structuring Entity-Level and Provider-Level Risk

- Implementation of specialty integration strategies may vary with the level or risk assumed by entities or providers.
- Developing PB-TCOC models that include entity-level risk for quality and TCOC could help to improve specialty integration while providing flexibility for organizations to determine how to structure provider-level risk.
- Policies that facilitate closing the referral loop would help to support shared risk between primary and specialty care providers.

Challenge 6: Increasing Participation of Safety Net and Rural Providers

- Rural and safety net providers may be slower to participate in PB-TCOC models and other Alternative Payment Models (APMs), and less able to enhance integration with specialists, often due to insufficient monetary and technological resources.
- Care delivery model design features that specifically address rural and safety net providers:
 - Increased use of telehealth for specialty consultations and virtual specialty visits
- Payment model design features that specifically address rural and safety net providers:
 - Risk adjustment approaches that do not penalize these providers
 - Additional financial incentives
 - Lower-risk/one-sided risk options may encourage these providers to participate
 - Different participation or reporting requirements

Challenge 7: Creating Meaningful Benchmarks for Evaluation of High-Value Care

Considerations for Measuring the Value of, and Access to, Specialty Care Episodes

- Measuring access to specialists and patient satisfaction with specialty care
 - Availability (e.g., number of specialists within certain mile radius, ratio of participating specialists to aligned beneficiaries, wait time for initial specialty visit)
 - Specialty visits as a percent of all office visits
 - Patient-reported measures (e.g., Consumer Assessment of Healthcare Providers and Systems [CAHPS] survey)
 - Stratification of measures (e.g., by level of integration, patient characteristics)
- Approaches to benchmarking
 - Baseline established from historical and/or geographical performance, rate book
 - Achievement vs. improvement thresholds – stratifying by provider volume for “apples to apples” comparison

Use of Measures and Benchmarks in Existing Models

Measures in Innovation Center Models include specialty/episode-specific spending, utilization, and quality, as well as broader measures relevant to the model's patient population.

- **Oncology Care Model (OCM)** – hospital admissions, ED visits, disease-specific process measures
- **Comprehensive Care for Joint Replacement (CJR) Model** – complications following total hip arthroplasty and/or total knee arthroplasty (THA/TKA), hospital CAHPS summary score
- **ESRD Treatment Choices (ETC) Model** – home dialysis rate, transplant rate

Benchmarks in Innovation Center Models were often based on historical performance and sometimes developed specific to states/regions or for specific conditions.

- **OCM** – based on risk-adjusted historical expenditures
- **CJR Model** – performance year target prices based on hospital-specific and regional episode expenditures including a three percent discount
- **ETC Model** – based on historical home dialysis and transplant rates for non-participating ESRD facilities and Managing Clinicians who provide care in comparison geographic areas

Areas of Focus for This Meeting

- **Increasing specialty care provider engagement** in PB-TCOC models where specialists share **accountability** with primary care providers for providing high-value care and bearing **appropriate financial responsibility** for patient outcomes
- Issues related to specialty integration in advanced primary care models and Accountable Care Organizations (ACOs)
- Approaches for **structuring coordination** between primary care providers and specialists
- Options for **defining and embedding specialty episodes** within population-based models, structuring financial incentives, and reducing cost-shifting
- The role of health information technology (HIT) and data analytics in specialty integration
- Addressing challenges affecting safety net providers and rural providers
- Identifying **appropriate performance measures** for specialty integration

Appendix on High-Cost Chronic Conditions
and Existing Episode-Based and Condition-
Specific Specialty Models

Centers for Medicare & Medicaid Services (CMS) Hierarchical Condition Categories (HCCs) for Chronic Conditions with Higher Spending

Chronic Condition HCC	Mean Actual Expenditures Per Beneficiary
Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	\$57,916.21
Respirator Dependence/Tracheostomy Status	\$50,847.42
Dialysis Status	\$44,594.26
Pressure Ulcer of Skin with Full Thickness Skin Loss	\$42,079.44
Metastatic Cancer and Acute Leukemia	\$41,183.12
Atherosclerosis of the Extremities with Ulceration or Gangrene	\$39,652.13
Cystic Fibrosis	\$38,191.12
Severe Hematological Disorders	\$38,121.69
Pressure Ulcer of Skin with Partial Thickness Skin Loss	\$37,361.44
Quadriplegia	\$36,596.24

Source: <https://www.cms.gov/files/document/report-congress-risk-adjustment-medicare-advantage-december-2021.pdf>. The 10 chronic condition HCCs with the highest mean actual expenditures per beneficiary are shown. Mean actual expenditures are derived from Medicare 2014–2015 100% sample FFS claims and enrollment data. Mean actual expenditures per beneficiary reflect the average Medicare Part A and B expenditures for a FFS beneficiary with this condition, not the cost of treating the condition, and are annualized to account for partial year enrollment and changes in status throughout the year. Chronic conditions were identified using the Agency for Healthcare Research and Quality’s (AHRQ’s) Healthcare Cost and Utilization Project (HCUP) Chronic Condition Indicator (CCI) and empirical methods.

Features of Existing Models that Target Specialty Episodes and Condition Management by Specialist Type

Specialist Type / Associated Model	2021 Estimated Medicare FFS Spend*	Payment Features	Episode or Chronic Condition	Episode/Care Pathway Trigger	What Defines Episode/Pathway Duration?	What Services Are Included?	Who Is Responsible for Overall Patient Care Coordination?
Cardiology <i>Acute Myocardial Infarction Model</i>	~\$5.73 Billion	Retrospective episodes with quality-adjusted target prices that incorporate hospital-specific historical and regional spending; reconciliation payment based on spending and quality performance	Episode	Inpatient admission for acute myocardial infarction	90 days following inpatient stay	All Part A and B expenditures with exclusions for unrelated services not related to inpatient procedure	Primary care
Gastroenterology <i>Bundled Payments for Care Improvement Initiative</i>	~\$1.47 Billion	Payment arrangements that included financial and performance accountability for episodes of care	Episode	Inpatient admission or start of an outpatient procedure for select group of clinical episodes (e.g., bariatric surgery)	Inpatient stay or outpatient procedure through the 90 days following the procedure	Part A and B expenditures with exclusions, including certain inpatient admission/readmissions, contralateral procedures, technology add-on payments, and cardiac rehab services	Primary care
Oncology <i>Enhancing Oncology Model</i>	~\$12 Billion	Participating practices will take on financial and performance accountability for chemotherapy episodes for patients with common cancer types	Episode	Receipt of initial cancer therapy	Six-month period following triggering event	Medicare expenditures for all items and services provided during the episode	Specialist

*Source: CMS Medicare utilization data available [here](#).

Features of Existing Models that Target Specialty Episodes and Condition Management by Specialist Type, Continued

Specialist Type / Associated Model	2021 Estimated Medicare FFS Spend*	Payment Features	Episode or Chronic Condition	Episode/Care Pathway Trigger	What Defines Episode/Pathway Duration?	What Services Are Included?	Who Is Responsible for Overall Patient Care Coordination?
Nephrology <i>Kidney Care Choices</i>	~\$1.67 Billion	Capitated payments to ESRD-focused ACOs	Condition	Chronic kidney disease (CKD) stage 4 or 5	From diagnosis of CKD to end of life, post-successful transplant, or patient's health improves through dialysis	Medicare expenditures for all items and services provided during the episode	Specialist
Orthopedics <i>Comprehensive Care for Joint Replacement</i>	~\$3.12 Billion	Retrospective bundled payments for episodes with procedure-specific target prices	Episode	Diagnosis of hip or knee joint replacement needed	Surgery through the 90 days post-discharge from inpatient hospitalization or the date of the outpatient procedure	All Medicare Part A and B expenditures during the episode with exceptions for acute clinical conditions not arising from joint replacement complications	Primary care
Behavioral Health <i>Psychiatric Collaborative Care Model</i>	~\$1.42 Billion	Bundled payments corresponding to billing codes for behavioral health integration and collaborative care	Condition	Patient's behavioral health assessment taken during routine visit with PCP indicates risk	Possibly when patient indicates improved mental health for prolonged period of time; however, many patients require perennial care	Medication assignment, patient assessment, referral to other BH specialists, and monitoring patients' treatment adherence	Specialist (Care Manager with billing provider oversight)

*Source: CMS Medicare utilization data available [here](#).

Appendix on Innovative Care Delivery and
Specialty Integration Approaches and
Components in Proposals Submitted to PTAC

Selected PTAC Proposals that Included Specialty Integration Components

Nearly all of the proposals that have been submitted to PTAC addressed the potential impact on costs and care coordination, to some degree – including at least 16 proposals that addressed issues related to improving specialty integration in advanced primary care models and episode-based or condition-specific models.*

Proposals with an Advanced Primary Care Focus:

- American Academy of Family Physicians (AAFP)
- Avera Health (Avera)
- University of Chicago Medicine (UChicago)

Proposals with a Specialty Integration Focus:

- American College of Physicians – National Committee for Quality Assurance (ACP-NCQA)
- The American College of Surgeons (ACS)

Proposals with a Specialty Focus – Acute Management:

- American College of Emergency Physicians (ACEP)
- Icahn School of Medicine at Mount Sinai (Mount Sinai)
- Personalized Recovery Care (PRC)
- University of New Mexico Health Sciences Center (UNMHSC)

Proposals with a Specialty Focus – Chronic Management:

- American Academy of Hospice and Palliative Medicine (AAHPM)
- American Society of Clinical Oncology (ASCO)
- Coalition to Transform Advanced Care (C-TAC)
- Hackensack Meridian Health and Cota, Inc. (HMH/Cota)
- Innovative Oncology Business Solutions (IOBS)
- New York City Department of Health and Mental Hygiene (NYC DOHMH)
- Renal Physicians Association (RPA)

*These proposals received a PTAC rating of “Meets” or “Meets and Deserves Priority Consideration” for Criterion 7, Integration and Care Coordination.

Key Characteristics of Selected PTAC Proposals with Specialty Integration Components

Submitter Name	Clinical Focus	Patient Population	Specialty Integration Components	Payment Design Features
1. AAFP	Primary care	PCPs' patient panels	PCPs thought to be best positioned to coordinate care across settings; promoting behavioral health diagnosis and treatment; collaboration with condition-specific models	Capitated per beneficiary per month (PBPM) payment with shared risk options for accountability
2. Avera	Primary care (skilled nursing facilities [SNFs])	SNF residents	Addresses multidisciplinary care in SNFs following an acute event, establishing accountability or negotiating responsibility	Add-on PBPM with shared risk options for accountability
3. UChicago	Frequently hospitalized patients	Frail/complex patients with hospitalizations	Multispecialty care around an acute event, during episode	Add-on PBPM with shared risk
4.ACP-NCQA	Coordination between specialists and PCPs	Patients with multiple chronic conditions	Incorporate criteria from the Medical Neighborhood Model (MNM) and Merit-based Incentive Payment System (MIPS)-eligible Patient-Centered Specialty Practices (PCSPs)	Add-on PBPM with shared risk
5.ACS	Cross-clinical focus	Broad (includes 100+ conditions or procedures)	Multispecialty care provided by general and specialty surgeons during an episode of care defined by a selected set of procedural/condition episodes	Episode-based model with continued FFS and shared risk
6. ACEP	ED services	Patients with qualifying ED visits	Ensure follow-up care when barriers exist to primary or specialty care access	Episode-based model with continued FFS, with shared risk options for accountability
7. Mount Sinai	Inpatient services in home setting	Eligible patients with acute conditions	Multidisciplinary care around an acute care event providing pre-acute, acute, and transition services	Prospective, episode-based payment replacing FFS and with flexibility to support non-covered services; shared risk through retrospective reconciliation
8. PRC	Inpatient services in home setting	Eligible patients with acute conditions	Multidisciplinary care around an acute care event	Bundled episode-based payment replacing FFS, with shared risk

Key Characteristics of Selected PTAC Proposals with Specialty Integration Components, Continued

Submitter Name	Clinical Focus	Patient Population	Specialty Integration Components	Payment Design Features
9. UNMHSC	Cerebral emergent care	Patients with neurological emergencies	Within condition specialty care around an acute care event, including emergency medicine, hospitalists, family medicine, primary care, and internal medicine physicians in the rural setting, and telemedicine physician specialists in disciplines such as neurosurgery, neurology, and critical care	Additional one-time payment without shared risk
10. AAHPM	Serious illness and palliative care	Patients with serious illness	Multispecialty care during episode of advanced illness; interdisciplinary team with 24/7 access	Capitated PBPM with shared risk options for accountability
11. ASCO	Cancer care	Patients with cancer	Community case conferences allow a panel of multi-specialty providers to discuss and determine the most appropriate care	Episode-based payment with two tracks; add-on payments worth 2-3 percent of total cost of care, including FFS payments; add-on performance payments
12. C-TAC	Serious illness and palliative care	Patients with serious illness	Multidisciplinary care during episode of advanced illness; across major clinical dimensions	Capitated PBPM with shared risk
13. HMM/Cota	Oncology	Patients with cancer	Within condition; multidisciplinary; recommendations for standardization across specialties	Prospective, bundled episode-based payments with retrospective reconciliation, replacing FFS; shared risk
14. IOBS	Cancer care	Patients with cancer	Virtual patient accounts using Medicare claims to estimate spending and value for internal and external providers	Episode-based model with continued FFS payments; shared risk for cancer-related expenditures
15. NYC DOHMH	Hepatitis C Virus	Patients with chronic condition (HCV)	Within condition; multidisciplinary; telementoring with specialists; integrating medical and behavioral health care	Bundled episode-based payment replacing FFS, with shared risk
16. RPA	End-stage renal disease	Patients with chronic condition (incident ESRD)	Within condition, single specialty within episode; coordination among medical specialists and with dialysis providers	Episode-based model with continued FFS payments and an additional payment for transplant; one- and two-sided risk options