

# Physician-Focused Payment Model Technical Advisory Committee

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September 22, 2023

Xavier Becerra, Secretary

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Washington, DC 20201

Dear Secretary Becerra:

On behalf of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), we are pleased to submit PTAC's report on improving care delivery and integrating specialty care in population-based models, in the context of Alternative Payment Models (APMs) more broadly and physician-focused payment models (PFPMs). Section 1868(c) of the Social Security Act directs PTAC to: 1) review physician-focused payment models (PFPMs) submitted to PTAC by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary.

Within this context, from time to time, it may be beneficial for PTAC to reflect on proposed PFPMs that have been submitted to the Committee to provide further advisement on pertinent issues regarding effective payment model innovation in APMs and PFPMs. In some cases, the importance of an emerging topic may lead PTAC to consider how proposals the Committee has reviewed in the past may inform that emerging topic. For example, PTAC may wish to assess information in previously submitted proposals and other sources that could serve to further inform the Secretary, as well as PTAC itself on these topics. This is the case regarding the topic on improving care delivery and integrating specialty care in population-based models.

From 2016 to 2020, PTAC received 35 proposals for PFPMs and voted on the extent to which 28 of these proposals meet the Secretary's 10 regulatory criteria. Nearly all of the 35 proposals that were submitted to PTAC addressed the proposed model's impact on quality and costs to some degree. PTAC conducted a series of theme-based discussions in 2022 to explore care delivery and payment issues related to developing and implementing population-based total cost of care (PB-TCOC) models. A key theme that emerged from these meetings was the importance of specialty care integration.

Additionally, at least 16 of the proposals that have been submitted to PTAC discussed improving care delivery and specialty integration in advanced primary care models and episode-based or condition-specific models, including care coordination between primary care providers (PCPs) and specialists. For this reason, PTAC now sees value in further exploring elements in previously submitted proposals related to this topic, along with current information on improving care delivery and integrating specialty care in the context of population-based models and value-based care transformation. To ensure that the Committee was fully informed, the Committee conducted a theme-based discussion on this topic during PTAC's two-day March 2023 public meeting. The theme-based discussion included an overview presentation by PTAC members; listening session presentations by previous submitters, and various subject matter experts (SMEs); as well as panel discussions with other SMEs on various issues related to integrating specialty care into population-based TCOC models. PTAC also requested public input during the meeting and through a Request for Input (RFI).

This report provides PTAC's findings and valuable information on best practices related to improving care delivery and integrating specialty care in population-based models. The information that PTAC has gleaned from a review of previous PFFM proposals and other literature that addresses this important topic, as well as input received during the theme-based discussion, will help to inform PTAC in its review of future proposals. This material has informed the Committee's comments, which are summarized in the following broad topic areas in this report:

- Topic 1: General Principles for Improving Primary and Specialty Care Integration;
- Topic 2: Care Delivery Model Features to Support Primary and Specialty Care Integration;
- Topic 3: Enablers to Support Desired Care Delivery Features;
- Topic 4: Payment Model Features to Support Improving Primary and Specialty Care Integration; and
- Topic 5: Enablers to Support Payment Features.

Key highlights include:

- It is important to promote prospective, longitudinal care management that seeks to anticipate, identify, and address patient needs early; and includes:
  - The involvement of primary care and specialty providers supported by an interdisciplinary care team; and
  - The use of a risk screening process to identify medical, behavioral, and health-related social needs (HRSN) data to inform proactive patient care.
- Care delivery and payment model design should focus on condition-specific or disease-based models, rather than using a specialty-specific approach because 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.

- Emphasize the development of nested models to reward the prevention of disease progression, rather than carve-outs – with the potential to move some nested, condition-specific models from voluntary to mandatory participation.
  - There is a need to consider long-term improvements and infrastructure development in addition to short-term returns in investments (ROIs). This could potentially involve including capitated payments to support upfront costs.
- Patient-centered care can be promoted across primary care and specialty providers through:
    - Bidirectional, synchronous, and/or asynchronous communication and active collaboration among providers; and
    - Implementation of technology-enabled care using telemedicine, e-consultations, and remote monitoring of chronic conditions, funded through payments to accountable entities.
    - Improvements in specialist-led or supported, condition-specific care coordination and reductions in administrative burden can be used to encourage specialist engagement with population-based models.
- Provision of timely data on quality, cost, and utilization is essential for facilitating patient care management and identifying high-value providers. It is important to facilitate data analytics and data sharing with data that are ubiquitous, actionable, and shareable.
  - It is important to attribute patients to providers that have the greatest ability to influence a patient's outcomes; and clearly define provider roles and workflows throughout a patient's disease progression, including any overlap between specialists.
  - Providers should be categorized by their main function within their specialty, such as screening, acute care, and chronic longitudinal care.
  - Additional best practices include:
    - Applying financial risk at the entity level rather than individual provider level in integrated primary and specialty care models;
    - Prospectively attributing patients to accountable entities;
    - Aligning financial and non-financial incentives for specialists to participate in population-based models;

- Measuring and assigning value to effective communication and collaboration between primary and specialty care providers;
- Assessing practices' readiness to participate in integrated primary and specialty care models;
- Including payment strategies that focus on the local and accountable care organization (ACO) level rather than solely focusing on the national level;
- Monitoring and addressing overutilization and underutilization of services;
- Linking performance metrics to spending, including patient-reported outcome measures (PROMs);
- Rewarding specialists for providing high-value care to improve a patient's overall health while taking into account the patient's preferences for care; and
- Engaging multiple payers to increase the percentage of providers' panels that are in value-based care, and further incentivize investments in value-based transformation.

In addition to summarizing the Committee's findings and comments related to these topics, the report also identifies areas where additional research is needed, issues for policy makers, and some potential next steps.

The members of PTAC appreciate your support of our shared goal of improving the Medicare program for both beneficiaries and the providers who care for them. PTAC members would be happy to discuss any of these observations with you. However, the Committee appreciates that there is no statutory requirement for the Secretary to respond to these comments.

Sincerely,

//Lauran Hardin//

Lauran Hardin, MSN, FAAN  
Co-Chair

//Angelo Sinopoli//

Angelo Sinopoli, MD  
Co-Chair

Attachment

# REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

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

September 22, 2023

## About This Report

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to: 1) review physician-focused payment models (PFPMs) submitted by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary. PTAC reviews submitted proposals using criteria established by the Secretary in regulations at 42 CFR §414.1465.

Within this context, from time to time, it may be beneficial for PTAC to reflect on proposed PFPMs that have been submitted to the Committee to provide further advisement on pertinent issues regarding effective payment model innovation in Alternative Payment Models (APMs) and PFPMs. Given that, in the past, several proposals that were submitted to PTAC incorporated elements relevant to improving care delivery and integrating specialty care in population-based models, PTAC now sees value in reviewing these elements within these proposals, along with current information on specialty care in population-based models and value-based care transformation. To ensure that the Committee was fully informed, PTAC's March 2023 public meeting included a series of theme-based discussions on improving care delivery and integrating specialty care in population-based models.

This report summarizes PTAC's findings and comments regarding improving care delivery and integrating specialty care in population-based models. This report also includes: 1) areas where additional research is needed and some potential next steps; 2) a summary of the characteristics relevant for integrating specialty care in population-based models from proposals that have previously been submitted to PTAC; 3) an overview of key issues relating to specialty care integration and value-based care transformation; and 4) a list of additional resources related to these theme-based discussions that are available on the Office of the Assistant Secretary for Planning and Evaluation (ASPE) PTAC website.

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## SUMMARY STATEMENT

From 2016 to 2020, PTAC received 35 proposals for PFPs and voted on the extent to which 28 of these proposals meet the Secretary's 10 regulatory criteria. Nearly all of the 35 proposals that were submitted to PTAC addressed the proposed model's impact on quality and costs to some degree. PTAC conducted a series of theme-based discussions in 2022 to explore care delivery and payment issues related to developing and implementing population-based total cost of care (PB-TCOC) models. A key theme that emerged from these meetings was the importance of specialty care integration.

Additionally, at least 16 of the proposals that have been submitted to PTAC discussed improving care delivery and specialty integration in advanced primary care models and episode-based or condition-specific models, including care coordination between primary care providers (PCPs) and specialists (see Appendix 2 for a summary of the 16 proposals). For this reason, PTAC now sees value in further exploring elements in previously submitted proposals related to this topic, along with current information on improving care delivery and integrating specialty care in the context of population-based models and value-based care transformation. To ensure that the Committee was fully informed, the Committee conducted a theme-based discussion on this topic during PTAC's two-day March 2023 public meeting. The theme-based discussion included an overview presentation by PTAC members; listening session presentations by previous submitters and various subject matter experts (SMEs); as well as panel discussions with other SMEs on various issues related to integrating specialty care into population-based TCOC models. PTAC also requested public input during the meeting and through a Request for Input (RFI).

This report provides PTAC's findings and valuable information on best practices related to improving care delivery and integrating specialty care in population-based models. The information that PTAC has gleaned from a review of previous PFP proposals and other literature that addresses this important topic, as well as input received during the theme-based discussion, will help to inform PTAC in its review of future proposals. This material has informed the Committee's comments, which are summarized in the following broad topic areas in this report:

- Topic 1: General Principles for Improving Primary and Specialty Care Integration;
- Topic 2: Care Delivery Model Features to Support Primary and Specialty Care Integration;
- Topic 3: Enablers to Support Desired Care Delivery Features;
- Topic 4: Payment Model Features to Support Improving Primary and Specialty Care Integration; and
- Topic 5: Enablers to Support Payment Features.



Key highlights include:

- It is important to promote prospective, longitudinal care management that seeks to anticipate, identify, and address patient needs early; and includes:
  - The involvement of primary care and specialty providers supported by an interdisciplinary care team; and
  - The use of a risk screening process to identify medical, behavioral, and health-related social needs (HRSN) data to inform proactive patient care.
- Care delivery and payment model design should focus on condition-specific or disease-based models, rather than using a specialty-specific approach because 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.
  - Emphasize the development of nested models to reward the prevention of disease progression, rather than carve-outs – with the potential to move some nested, condition-specific models from voluntary to mandatory participation.
  - There is a need to consider long-term improvements and infrastructure development in addition to short-term returns in investments (ROIs). This could potentially involve including capitated payments to support upfront costs.
- Patient-centered care can be promoted across primary care and specialty providers through:
  - Bidirectional, synchronous, and/or asynchronous communication and active collaboration among providers;
  - Implementation of technology-enabled care using telemedicine, e-consultations, and remote monitoring of chronic conditions, funded through payments to accountable entities; and
  - Improvements in specialist-led or supported, condition-specific care coordination and reductions in administrative burden can be used to encourage specialist engagement with population-based models.
- Provision of timely data on quality, cost, and utilization is essential for facilitating patient care management and identifying high-value providers. It is important to facilitate data analytics and data sharing with data that are ubiquitous, actionable, and shareable.
- It is important to attribute patients to providers that have the greatest ability to influence a patient's outcomes; and clearly define provider roles and workflows throughout a patient's disease progression, including any overlap between specialists.
- Providers should be categorized by their main function within their specialty, such as screening, acute care, and chronic longitudinal care.

- Additional best practices include:
  - Applying financial risk at the entity level rather than individual provider level in integrated primary and specialty care models;
  - Prospectively attributing patients to accountable entities;
  - Aligning financial and non-financial incentives for specialists to participate in population-based models;
  - Measuring and assigning value to effective communication and collaboration between primary and specialty care providers;
  - Assessing practices' readiness to participate in integrated primary and specialty care models;
  - Including payment strategies that focus on the local and accountable care organization (ACO) level rather than solely focusing on the national level;
  - Monitoring and addressing overutilization and underutilization of services;
  - Linking performance metrics to spending, including patient-reported outcome measures (PROMs);
  - Rewarding specialists for providing high-value care to improve a patient's overall health while taking into account the patient's preferences for care; and
  - Engaging multiple payers to increase the percentage of providers' panels that are in value-based care, and further incentivize investments in value-based transformation.

In addition to summarizing the Committee's findings and comments related to these topics, the report also identifies areas where additional research is needed, issues for policy makers, and some potential next steps.

## **I. PTAC REVIEW OF SPECIALTY CARE INTEGRATION IN POPULATION-BASED MODELS**

In developing the comments in this report, PTAC considered information from the theme-based discussion during the March 2023 public meeting and an environmental scan developed to provide information on improving care delivery and integrating specialty care in population-based models.

PTAC formed a Preliminary Comments Development Team (PCDT) for the March 2023 theme-based discussion, which was comprised of Jennifer Wiler (Lead), Larry Kosinski, Lee Mills, Chinni Pulluru, and Jim Walton (see Appendix 1 for a list of the Committee members). The PCDT reviewed the environmental scan and delivered a summary presentation to the full Committee

during the theme-based discussion. The theme-based discussion included panel discussions with stakeholders from organizations that had previously submitted PFPM proposals that addressed specialty integration in advanced primary care models and episode-based or condition-specific models. The theme-based discussion also featured perspectives from a diverse group of SMEs and an opportunity for public comments. At the end of the theme-based discussion, Committee members identified comments to be included in this Report to the Secretary (RTS).

The Committee synthesized information from PTAC proposals, the environmental scan, the RFI, and panel discussions with SMEs and previous submitters at the March 2023 public meeting on improving care delivery and integrating specialty care in population-based models. This RTS summarizes PTAC's comments from its findings, which are organized in five categories:

- Topic 1: General Principles for Improving Primary and Specialty Care Integration;
- Topic 2: Care Delivery Model Features to Support Primary and Specialty Care Integration;
- Topic 3: Enablers to Support Desired Care Delivery Features;
- Topic 4: Payment Model Features to Support Improving Primary and Specialty Care Integration; and
- Topic 5: Enablers to Support Payment Features.

For each topic, relevant issues are highlighted, followed by a summary of PTAC's comments. Appendix 3 provides a list of additional resources related to PTAC's specialty care integration theme-based discussion that are available on the Assistant Secretary for Planning and Evaluation (ASPE) PTAC website. Appendix 4 includes a complete list of the Committee's comments.

## **II. BACKGROUND: DEFINITIONS AND CONTEXT RELATED TO IMPROVING CARE DELIVERY AND INTEGRATING SPECIALTY CARE IN POPULATION-BASED MODELS**

As described in the [\*Report to the Secretary of Health and Human Service: Optimizing Population-Based Total Cost of Care \(PB-TCOC\) Models in the Context of Alternative Payment Models \(APMs\) and Physician-Focused Payment Models \(PFPMs\)\*](#), the Center for Medicare and Medicaid Innovation (Innovation Center) is striving to move more providers into value-based payment arrangements. In its 2021 Strategic Refresh, the Innovation Center articulated the goal of having every Medicare fee-for-service (FFS) beneficiary with Parts A and B in an accountable care relationship with providers who are responsible for quality and TCOC by 2030.<sup>i</sup> In November 2022, the Innovation Center issued its Strategy to Support Person-centered, Value-

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<sup>i</sup> See <https://innovation.cms.gov/strategic-direction-whitepaper>

based Specialty Care.<sup>ii</sup> The strategy includes four elements: enhancing specialty care performance data transparency, maintaining momentum on acute episode payment models and condition-based models, creating financial incentives within primary care for specialist engagement, and creating financial incentives for specialists to affiliate with population-based models.

In the [\*Environmental Scan on Improving Care Delivery and Integrating Specialty Care in Population-Based Models\*](#), PTAC provided several definitions of concepts relevant for improving care delivery and specialty integration in population-based models. Most importantly, the Committee set 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 and active collaboration among providers;
- 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.

Additional information can be found in PTAC's *Environmental Scan on Improving Care Delivery and Integrating Specialty Care in Population-Based Models* (see Appendix 3).

### **III. CHARACTERISTICS OF PTAC PROPOSALS RELEVANT TO IMPROVING CARE DELIVERY AND INTEGRATING SPECIALTY CARE IN POPULATION-BASED MODELS**

From 2016 to 2020, PTAC received 35 proposals for PFPs and voted on the extent to which 28 of these proposals meet the Secretary's 10 regulatory criteria, including Integration and Care

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<sup>ii</sup> See <https://www.cms.gov/blog/cms-innovation-centers-strategy-support-person-centered-value-based-specialty-care>

Coordination.<sup>iii</sup> The goal of this criterion is to “encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.”

At least 16 of the 28 proposals discussed improving care delivery and specialty integration in advanced primary care models and episode-based or condition-specific models, including care coordination between primary care providers (PCPs) and specialists. Eight of these proposals mentioned improving multispecialty integration during or following an acute event or during an episode of advanced illness, and four proposals mentioned improving specialty integration within condition. Additionally, several of these proposals used targeted approaches to improve specialty integration, and included different clinicians involved in the care team and responsible for patients’ care, as well as different tasks designated to varying care team members. Thirteen of the proposals that included components related to specialty integration mentioned providing specialist consultations.

Some proposals included telehealth components such as synchronous communication via telephone or video with patients and providers, as well as between providers. A smaller subset of proposals suggested the use of telemonitoring and other mobile health tools to facilitate the sharing of patient data with providers outside of a clinical setting.

All 16 of the proposals that included components related to specialty integration included approaches for improving care coordination. A majority included clinical care coordinators who were responsible for transitioning patients from one clinical setting to another. Most of the objectives of these coordinated transitions were related to reducing rehospitalizations and emergency department (ED) visits.

PFPMs that focus on improving care delivery and specialty integration, such as those proposed to PTAC, can help enhance larger population-based models in several important ways. For example, PFPMs can help to identify best practices in integrating specialty care into APMs, and best practices related to the use of episode-specific payment structures imbedded in APMs; identify opportunities for incentivizing reductions in TCOC for services that are provided by specialists within Accountable Care Organizations (ACOs); highlight approaches for increasing participation of safety-net providers and rural providers in value-based care; and demonstrate ways to improve specialty provider readiness to gradually assume higher levels of risk.

PTAC members noted several issues for consideration related to specialty integration and improving care delivery in the proposals they reviewed. Notably, PTAC members agreed that clear, standardized approaches to inter-provider communication are needed to support integration of specialty care for a wide range of specialties. PTAC members further noted that without adequate financial incentives, providers may have limited resources to invest in

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<sup>iii</sup> The remaining seven proposals were withdrawn prior to the Committee’s deliberation.

specialty integration. Last, PTAC members noted that structuring payment around episodes that of care that are “nested” within new or existing APMs may provide opportunities for specialty integration.

#### **IV. COMMENTS FOR CONSIDERATION BY THE SECRETARY**

Based on findings from the Committee’s analysis of PTAC proposals; information in the literature; listening session presentations from PTAC members, previous submitters, and SMEs at the March 2023 public meeting; panel discussions with additional SMEs at the March 2023 public meeting; and stakeholder responses to a Request for Input (RFI), this section summarizes PTAC’s comments regarding optimizing PB-TCOC models in the context of APMs and PFPMs. PTAC’s comments are organized in five topics:

- Topic 1: General Principles for Improving Primary and Specialty Care Integration;
- Topic 2: Care Delivery Model Features to Support Primary and Specialty Care Integration;
- Topic 3: Enablers to Support Desired Care Delivery Feature;
- Topic 4: Payment Model Features to Support Improving Primary and Specialty Care Integration; and
- Topic 5: Enablers to Support Payment Features.

For each topic, relevant issues are highlighted, followed by a summary of PTAC’s comments. Additionally, the Committee has identified areas where additional research is needed, as well as some potential next steps related to each topic. Appendix 4 includes a complete list of the Committee’s comments.

##### **IV.A. General Principles for Improving Primary and Specialty Care Integration**

Several principles are essential for guiding the development of integrated primary and specialty care models. These principles include:

- Engaging in prospective, longitudinal care management;
- Classifying providers by their function in the care continuum rather than specialty;
- Focusing on disease- or condition-specific approaches;
- Using care coordination to encourage specialist engagement with population-based models;
- Providing timely data on quality, cost, and utilization to facilitate patient care management; and
- Balancing long-term improvements and infrastructure development with short-term returns on investment (ROIs).

PTAC’s comments on these principles are listed in Exhibit IV.1.

**Prospective, longitudinal care management.** The Committee emphasized the need to focus on prospective, longitudinal, whole-person care when thinking of better care models. In order to address these goals, both primary care and specialty providers need a team around them to support longitudinal care management. These teams should be interdisciplinary, including clinical staff, as well as social workers and community health workers. Care team members should be able to practice to their license, creatively look at design efficiency, and learn to come together to serve patients holistically. One Committee member noted how longitudinal relationships can foster trust between providers and patients.

The Committee also discussed the importance of anticipating, identifying, and addressing patient needs early. Care team members should focus on reaching out to patients rather than waiting for patients to experience a crisis before care is delivered. In a similar vein, anticipating that a patient will be a candidate for disease management can help providers proactively address clinical and health-related social needs.

**Classifying providers by their function in the care continuum.** Committee members observed that providers may be better categorized not by their specialty, but by their main function in their specialty, such as screening, acute care, and chronic longitudinal care. Complex patient attribution models can then be applied based upon patient needs and provider function, with payment models based upon this function. Options include paying for specific “bundles” of acute care or chronic and longitudinal care, and designating a single provider accountable for patient care in the context of those bundles regardless of the provider’s specialty.

**Focusing on disease- or condition-specific approaches.** Similar to classifying providers by function, the Committee members agreed that integrated primary and specialty care models should focus on patients and their diseases rather than providers in their chosen field of practice. The Committee noted that not all primary care services are the same nor are all specialists the same, and that models that tailor care to patient needs based on their disease or condition are appropriate. Developers of integrated primary and specialty care models can look at both cost and utilization factors by disease or condition to build models that target specific potentially avoidable costs that vary from patient to patient. In this way, models can encourage providers to focus on high-value services tuned to the nuanced needs of specific patients.

**Using care coordination to encourage specialist engagement with population-based models.** Based on SME discussions, one Committee member remarked that many specialists appreciate the importance of care coordination and can benefit from resources that support care coordination, which may be built into integrated primary and specialty care models.

**Providing timely data on quality, cost, and utilization to facilitate patient care management.** The Committee widely agreed on the importance of giving providers timely and comprehensive data and facilitating data sharing across providers in models that encompass both primary and specialty care. Providers need actionable, transferable information in order to provide high-quality care and manage financial risk. Price and data transparency would help providers find opportunities to lower spending and create value.

## **Balancing long-term improvements and infrastructure development with short-term ROIs.**

Committee members recognized that practice transformation takes time, is expensive, and requires flexibility. Care transformation in integrated primary and specialty care models can generate improvements and save money in the long term; thus, the focus in value-based payment models should be on long-term improvements rather than immediate ROI.

### **Exhibit IV.1: PTAC Comments**

#### ***Topic 1: General Principles for Improving Primary and Specialty Care Integration***

**Comment 1A.** The objectives for improving primary and specialty care integration include facilitating prospective, longitudinal, whole-person care, including anticipatory symptom management and disease management.

**Comment 1B.** There are many nuances related to categorizing primary and specialty care providers and the different aspects of their care delivery. Providers may be better categorized by their main function in their specialty (e.g., screening, acute care, chronic longitudinal care) rather than only by the specialty itself.

**Comment 1C.** Efforts to improve primary and specialty care integration should focus on disease- or condition-specific approaches.

**Comment 1D.** The potential for improvements in care coordination can encourage specialist engagement with population-based models.

**Comment 1E.** Providers need to receive timely data on quality, cost, and utilization to facilitate patient care management and manage financial risk.

**Comment 1F.** Because practice transformation takes time, in addition to considering short-term return on investment (ROI), efforts to improve specialty integration in APMs should also focus on long-term improvements and infrastructure development.

## **IV.B. Care Delivery Model Features to Support Primary and Specialty Care Integration**

Committee members identified best practices and key recommendations related to desired care delivery model features to support and improve primary and specialty care integration. Care delivery model features included:

- Patient-centered care;
- Risk screening;
- Technology-enabled care;
- Systems for monitoring service utilization;
- Preference-sensitive care;



- Proactive patient attribution into appropriate care models;
- Clearly defined roles and workflows; and
- Measurement and valuation of provider collaboration.

PTAC's comments regarding desired care delivery features are listed in Exhibit IV.2.

**Patient-centered care.** Primary and specialty care providers should collaborate and coordinate to provide patient-centered care. Patient-centered care can be provided through bidirectional, synchronous, and/or asynchronous communication and active collaboration among providers. Starting with the referral process, a patient-centered approach would include clear communication on why the patient is being referred, the goals for the referral, the role of the specialty care provider, and a process for transitioning care management back to the primary care provider once the patient is stable. Moreover, with a patient-centered approach, the focus of care should be on the patients and their diseases or conditions rather than on the providers and their specialties.

**Risk screening.** Committee members emphasized that making data, including patient reported outcomes data, transparent and ubiquitous is important to help providers understand quality and cost of care. Using risk screening to collect medical, behavioral, and health-related social needs (HRSN) data can help providers anticipate how to focus care on symptom and disease management and develop proactive patient care plans. With appropriate access to data, providers can identify high-risk populations for whom to prioritize interventions and target opportunities to reduce disparities.

Although the development of infrastructure to support high-value data exchanges requires a large amount of resources, shared real-time data should be used to inform care decisions and deliver high-quality care. Additional work is needed to understand what high-value data exchanges look like.

**Technology-enabled care.** Technology-enabled care should be leveraged to facilitate improved patient access to a limited health care workforce. Telemedicine, e-consultations, and remote monitoring of chronic conditions can facilitate care coordination between primary and specialty care providers. This approach to care coordination can be particularly useful in geographical areas where access to specialists is limited. Upfront funding should be provided for technology-enabled care that can address patient-level barriers, such as limited access to providers and challenges with transportation.

**Monitoring utilization of service.** Overutilization and underutilization of services should be monitored and addressed. Although cost efficiency has an implicit assumption that less utilization is better, it is just as important to monitor for instances where utilization may be too low, or where health patients are not receiving any care. Patients with no record of health care utilization may lack access to care or lack trust in providers and/or the health care system.

One way to monitor underutilization could be through the collection of patient-reported data. Providers should use data disaggregated by patient age, race and ethnicity, income level, and other patient-level characteristics to identify individuals who are not seeking care, and conduct proactive outreach to those individuals.

**Preference-sensitive care.** Specialists should be rewarded for providing high-value care to improve a patient's overall health while taking into account the patient's preferences for care. The current FFS system cannot account for avoided utilization. As a result, current models that do not account for preference-sensitive care do not reward providers for preventing more expensive future care.

Preference-sensitive care is especially important at the end-of-life. One stakeholder noted that most older adults have never had a conversation with their PCP about their end-of-life wishes, often leading to care that is more expensive and not in line with what the patient would have wanted. When discussing end-of-life care in speciality care, one Committee member suggested that more work is needed to identify incentives that would encourage specialities to have end-of-life care discussions with patients.

**Proactive patient attribution.** It is important for providers to understand which patients any given primary care and specialty team is accountable for managing. Attributing patients to specific care teams can be complex because patients commonly receive care at different touchpoints across multiple providers and networks, especially as care-related needs change over time for patients with chronic health conditions. Models should identify those providers that can most influence a patient's outcomes as the accountable entities for the purpose of patient attribution. The assessment of which provider can most influence a patient's outcomes should be based on the provider's function and the patient's needs at the time of attribution.

Several different methods may be used for patient attribution, such as self-reported attribution by the patient, or attribution based on wellness visits, primary care visits, prescription data, or evaluation and management codes. For many patients, determining the most accountable provider can be complex. In some cases, accountability for care does not hinge on a single provider-patient relationship. Therefore, models that rely on weighted attribution or co-attribution may be appropriate as they take into account the nuances of real-world care delivery where multiple providers are involved in a patient's care. Weighted attribution and co-attribution models allow patients to be attributed to all of the providers involved in their care based on pre-determined weights. Considering patients' preferences, utilization patterns, and needs, as well as providers' roles, can facilitate proactive patient attribution. Moreover, providers should affirm the accountability relationship with the patient during this process.

**Clearly defined roles and workflows.** Although care coordination is imperative to care delivery, a clear definition of quality care coordination has yet to be established. Defining provider roles and care pathways throughout a patient's disease progression, including any overlap between specialists, will facilitate primary and specialty care integration. Because engagement with specialists can run the gamut from a single consultation with a specialist, to the specialist

engaging in co-management of a patient over a period of time with another provider, to being the main manager of a patient's care, there should be an understanding of when specialty referrals should be made and which provider(s) are responsible for managing the patient's care at various points throughout their care journey.

Specialists' roles in delivering care in coordination with primary care providers should be based on the extent and duration of involvement needed. The specialists' roles lie on a continuum. Early communication through a pre-consultation exchange between primary care and specialty care management teams should occur to determine whether specialty consultation is needed. When it is needed, incorporating specialty care earlier in the patient's care journey could increase the likelihood of better patient outcomes. Depending on the patient's condition, principal management may be provided by the primary care provider, the specialist, or there will be shared responsibility by both the primary care provider and the specialist.

**Measurement and valuation of provider collaboration.** Additional work is needed to understand how models can measure and develop a methodology to assign value to effective communication and collaboration between primary and specialty care providers. Effective collaboration will not only promote high-value care but also help to determine when care coordination should occur and identify which providers should be accountable for the patient's care. These efforts should typically be funded at the practice level.

## **Exhibit IV.2: PTAC Comments**

### *Topic 2: Care Delivery Model Features to Support Primary and Specialty Care Integration*

**Comment 2A.** Desired care delivery model features for improving primary and specialty care integration include:

- The use of a patient-centered approach (focusing on patients and their diseases or conditions, rather than on providers and their specialties).
- The use of risk screening to capture medical, behavioral, and social determinants of health (SDOH) data, and develop proactive patient care plans.
- Incorporating and expanding the use of technology-enabled care (i.e., through telehealth, e-consultations, and remote monitoring) to facilitate patient care and extend the reach of a limited health care workforce.
- Monitoring and addressing issues related to overutilization and underutilization of services.
- Accounting for “preference-sensitive” care that will improve a patient’s overall health, given that patients have multiple conditions and different priorities and, improve care at the end of life in particular.

**Comment 2B.** It is important for providers to collectively understand which patients the primary care and specialty team is accountable for managing. Proactive attribution of patients to accountable providers can be facilitated by using information on a patient’s preferences, utilization patterns, and needs, as well as the specific role that each provider should play at a given point in the patient’s care journey independent of provider specialty.

**Comment 2C.** There is a need to develop care pathways and clearly-defined workflows indicating when it is appropriate to make a specialty referral, what information the referring provider needs from the specialist, and who will be responsible for managing the patient’s care at various points during the care journey.

- Conversations between the primary care and specialty care management teams should begin early through a pre-consultation exchange to determine if a specialty consultation is appropriate, and what tests should be ordered before the patient sees the specialist.

**Comment 2D.** More information is needed on how models can measure and value the communication and collaboration between primary and specialty care providers necessary for providing high-value care, determine when that coordination should occur, and identify which providers should be accountable.

#### IV.C. Enablers to Support Desired Care Delivery Feature

Stakeholders identified several enablers to promote primary and specialty care integration and the care delivery functions described in the previous section. These include:

- Practice assessments to identify readiness to participate in models;
- Robust data analytics and data sharing; and
- Support for the physician workforce.

**Practice assessments.** Before joining integrated primary and specialty care models, practices should undergo a self-assessment of their readiness to participate in such models. For providers with minimal value-based care experience, more infrastructure support and lower-risk payment model options may be needed to transition from FFS. Practice assessments, supported by funding care coordination activities, can help practices identify expectations and goals for provider and payments, and encourage groups to move to the next level in value-based care. This approach requires coordination between government agencies that support providers and pay for health care, and may be challenging from a policy or regulatory perspective, but it is necessary to promote value-based care.

**Data analytics and data sharing.** As discussed under general principles, data analytics and data sharing are essential to improve health outcomes for patients. To put practices in a position to take on financial risk linked to outcomes, data should be ubiquitous, actionable, and shareable.

One SME described providing shadow bundle data to ACO participants, with claims data constructed into episodes of care and provided alongside target prices for attributed beneficiaries. Committee members agreed that shadow bundles would enable an ACO to analyze spending and care patterns for specialists, as well as offer a new way to engage with specialists.

Although SMEs and Committee members recognized the potential for artificial intelligence (AI) to optimize data analytics, they cautioned that AI can reflect and perpetuate bias. One Committee member noted that AI algorithms are sensitive to skewing data to those less represented groups that are marginalized and find themselves on the wrong end of health care quality and oftentimes avoidable morbidity and mortality.

**Supporting the physician workforce.** The Committee provided several recommendations for supporting the physician workforce in integrated primary and specialty care models, with the goal of maintaining career fulfillment and avoiding burnout. First, Committee members suggested having a team to work with primary care providers to alleviate the administrative burden of participating in complex models. They also noted the importance of relationship building among providers in integrated models and the need to measure and reward collaboration. Finally, the Committee members cited the need for education and training to help providers navigate care transformation activities.

### Exhibit IV.3: PTAC Comments

#### *Topic 3: Enablers to Support Desired Care Delivery Feature*

**Comment 3A.** The use of practice assessments can help to identify readiness and encourage participation in value-based care models.

**Comment 3B.** Robust data analytics and data sharing are necessary to facilitate coordination among providers. This includes:

- Improving access to timely data that can be used to identify opportunities to derive more value from referrals to specialists and services provided by specialists.
- Creating shadow bundles and providing that data to ACOs.

It is also important to consider potential biases of artificial intelligence programs in data sharing that might disadvantage patients traditionally underserved by health care resources.

**Comment 3C.** It is important to support the future physician workforce by reducing administrative burden, promoting relationship building, and providing education and training for providers participating in integrated primary and specialty care models.

#### **IV.D. Payment Model Features to Support Improving Primary and Specialty Care Integration**

Committee members discussed payment model features to support primary and specialty care integration. Committee members emphasized four main features to consider:

- Disease- or condition-specific models rather than specialty-specific models;
- Population-based models with specialty services nested within, rather than carved out;
- Models that reward providers for slowing disease progression;
- Capitated payments to support upfront investment in infrastructure and increase model participation; and
- Prospectively attributing patients to the providers accountable for outcomes.

PTAC's comments regarding payment model features to support primary and specialty care integration are listed in Exhibit IV.4.

**Disease- or condition-specific models.** The Committee suggested that disease-based models are preferable to specialty-specific models. Specialists often treat a range of conditions; therefore, it is not appropriate to adopt a payment model that can be applied universally across a given specialty. For example, a high proportion of costs associated with the gastrointestinal specialty are driven by the two inflammatory bowel diseases: Crohn's disease and ulcerative colitis. Patients with these conditions often see a gastroenterologist more than they see any other physician; treatment occurs over a long period of time; and the cost of care can vary substantially from patient to patient. Gastroenterologists' role in treating other conditions such as colon polyps is typically a limited episode around provision of a procedure with less variation

in cost from patient to patient. Therefore, in the case of gastroenterology, a condition- or disease-specific payment model focused on Crohn’s disease and ulcerative colitis may make sense, while a bundled payment model may be more appropriate for care related to treating a colon polyp procedurally. Conversely, conditions such as colon polyps, which tend to be procedural, are better suited for bundled payments.

In some cases, disease-specific models are more appropriate for designing value-based payment models. For instance, disease-specific models provide a framework to support clear attribution of accountability for a patient with a provider, developing and implementing appropriate risk adjustment procedures, and encouraging the use of specific approaches to care planning, which are usually disease- or condition-based rather than specialty-based. A disease-specific approach would allow models to leverage knowledge of different providers in treating a condition rather than create a focus around care from a specific type of specialist when their role in patient care will vary widely depending on the patient’s condition. The Committee highlighted the importance of evaluating cost and utilization factors associated with different diseases as a way to identify avoidable costs in the system.

**Nested models rather than carve-outs.<sup>iv</sup> There was widespread agreement among Committee members and SMEs that it is better to “carve-in” specialty care than to “carve-out” specialty care from population-based models.** Condition-specific models nested with population-based models may include sub-capitated payments to providers that are sufficient to cover costs associated with chronic care management. They also noted that nested, condition-specific models could benefit from a sub-capitation payment feature—i.e., an arrangement in which a provider being paid via capitation contracts with other providers on a capitated basis.

**Rewarding the prevention of disease progression.** Committee members discussed the need to reward providers that focus on preventing disease progression and, in turn, help save costs. As public meeting presenters noted, preventing disease progression and controlling spending requires more care to be delivered upstream, earlier in the course of a disease. The Committee members and SMEs suggested that incentives that support care that prevents disease progression could be achieved, in part, through the use of condition-specific payment approaches nested within broader APMs.

The Committee identified additional options for structuring disease-specific models that included using disease-specific patient characteristics to create “buckets” of patients that are at high risk of needing care subsequent to disease progression; creating separate bundled payments based on the provider’s function for acute, chronic, and longitudinal care; expanding payment for management of a chronic condition separate from payments for specific interventions related to disease progression; establishing longitudinal episodes for payment; and implementing a per member per month (PMPM) approach for a cognitive, risk-adjusted component and market-based procedure payments.

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<sup>iv</sup> Additional Committee comments related to nested models and carve-outs are addressed in further detail in the Total Cost of Care Report to the Secretary section IV.G, Topic 7: Model Design Considerations.

**Capitated payments to support upfront costs.** Committee members agreed that use of prospective, capitated approaches to payment could effectively fund the development of infrastructure essential to integrated primary and specialty care models. Prospective, capitated payments, which could be used to support investment in health technology infrastructure, have the potential to lower future costs while also supporting high-quality care. Additionally, prospective, capitated payments for infrastructure may enable more organizations and providers to participate in models by reducing front-end financial burden. Stakeholders noted that prospective payments have been used by some organizations to support care coordination activities and e-consultations, but not infrastructure. In addition to providing funding for infrastructure prospectively, future models may also benefit from implementing formal measures to assess whether upfront infrastructure investments are sufficient to support practices' participation.

**Alignment of incentives for specialists to participate in population-based models.** Both financial and non-financial incentives can help shift incentives for providers to move away from FFS and toward APMs. Committee members emphasized the importance of keeping specialists in mind when designing both kinds of incentives. If APMs offer the right incentives for specialists, there may be healthy competition among providers vying to manage care for the same group of patients.

Committee members noted that many care coordination activities are not generally reimbursed within current relative value unit (RVU)-based systems such as the Medicare Physician Fee Schedule (MPFS) used in FFS Medicare. It is difficult for specialists to have time to engage in care coordination activities that are generally not reimbursed within the MPFS.

**Identifying the accountable entity for financial risk and incentives.** Committee members discussed which types of organizations should bear financial risk and be subject to incentives. Financial risk should be at the entity level in integrated primary and specialty care models, whether the entity is an ACO, hospital, or group practice. These large entities are better able to spread risk across a larger patient and provider population than independent physician practices or individual providers. However, Committee members agreed that these entities should then extend incentives down to providers where they have the potential to influence care delivery more directly.

**Level of payment intervention.** Committee members discussed the challenges of creating a robust payment approach at the national level that can influence care and improve outcomes. Instead, Committee members suggested that payment strategies should focus on the local level and ACO level. Payment incentives focused on ACOs, for example, then would allow the ACO to develop a process to extend incentives to providers using the appropriate balances and protective measures. Pilot models can potentially be used to test the effectiveness of different approaches that could be employed by different ACOs or risk-bearing entities.



**Prospective attribution of patients to providers.** The Committee indicated that prospective attribution of patients to accountable entities and providers is a best practice that encourages accountability and leads to high-value care. Committee members noted that, under some models, prospective attribution allows for clear understanding and affirmation of accountability relationships among both patients and providers. The Committee also discussed a weighted attribution model, which would allow a single patient to be attributed to more than one provider (multi-attribution), for scenarios where multiple providers should be accountable for a patient’s care at different levels. A multi-attribution arrangement may more accurately reflect the typical care arrangement. Further testing and verification is needed, however, with respect to the design, implementation, and execution of weighted, multi-attribution models.

#### **Exhibit IV.4: PTAC Comments**

##### *Topic 4: Payment Model Features to Support Improving Primary and Specialty Care Integration*

**Comment 4A.** The use of disease- or condition-based care models may be more effective than models focused on all care provided by a given specialty to incentivize primary and specialty integration. Disease- or condition-specific utilization and cost data can help identify appropriate financial incentives and areas of potentially avoidable cost to inform the development of these models, with the caveat that the historical data may reflect inequity in the health care system.

**Comment 4B.** To support effective integration between primary and specialty care, payment for care delivered by specialists should be “carved in,” or nested within population-based APMs, instead of being “carved out.”

**Comment 4C.** It is important to reward providers for preventing disease progression that will lead to higher costs. One option could involve developing nested, condition-specific models with sub-capitation payments to specialists to support longitudinal care management for chronic conditions, as well as acute and surgical episodes.

Other potential payment model features for disease-based models include:

- Disease-specific buckets of risk based on the desired services;
- Payments based upon functions, including bundles for acute care and bundles for chronic and longitudinal care;
- Expanded payment for managing an underlying (base) chronic condition to enable specialists to have time to engage in care coordination activities that are generally not reimbursed within the current relative value unit (RVU)-based systems used in FFS;
- Longitudinal episodes for payment; and
- Per member per month (PMPM) payments for the cognitive, risk-adjusted component and market-based procedure payment, with protections to avoid stinting on necessary procedures.

**Comment 4D.** The increased use of capitated payments could help to support the upfront costs needed to develop the infrastructure needed to support integrated primary and specialty care models, and enable more organizations and providers to participate in these models.

**Comment 4E.** It is important to ensure alignment of financial and non-financial incentives to encourage specialists to participate in integrated primary and specialty care models rather than remain in FFS. With the right incentives and participants, providers will want to participate, and there could potentially be “healthy competition” among providers for managing care for given patient populations.

- It is difficult for specialists to have time to engage in care coordination activities that are generally not reimbursed within the current relative value unit (RVU)-based systems.

**Comment 4F.** Financial risk should be at the entity level in integrated primary and specialty care models, whether the entity is an ACO, hospital, or group practice, with financial incentives at the provider level.

**Comment 4G.** Payment interventions should focus on the local level and ACO level. It is challenging to dictate care at a national level. The risk-bearing entity can develop a process with the appropriate balances and protective measures. Pilot models can potentially be used to test the effectiveness of various payment models.

**Comment 4H.** The use of prospective attribution can enable proactive care coordination in integrated primary and specialty care models. To ensure that patient preferences are considered in alignment, patients can be given an opportunity to affirm the provider relationship. Weighted attribution models can also be considered so that attribution is not solely based on a single relationship, which does not typically reflect actual care delivery.

#### **IV.E. Enablers to Support Payment Features**

Committee members discussed enablers to support desired payment features within the context of specialty care integration in TCOC models, with four main themes emerging:

- Technology-enabled care;
- Evolution from voluntary to mandatory participation models;
- Linking performance metrics to spending; and
- Multi-payer strategies.

**Technology-enabled care.** Technology-enabled care encompasses a broad range of activities, including telehealth visits, digital health services, and e-consults. Experts noted several ways in which technology-enabled care could improve specialty integration, focusing on care management and e-consults. One expert noted that telemedicine services can support patients post-discharge as they transition to home health care, improving continuity of care. Another innovation mentioned was remote monitoring of hypertension using Bluetooth-enabled blood pressure cuffs, which can help enable more timely physician intervention in primary care settings and, potentially, reduce avoidable utilization (for example, ED visits or hospital admissions).

E-consults can improve communication between primary care providers (PCPs) and specialists, and support care coordination between providers. Experts noted the importance of e-consults with respect to improving behavioral health care integration and patient safety (e.g., through medication management). Specialty care e-consults can also improve access and help reduce disparities in access, especially for populations in underserved or rural locations where fewer specialists may practice.

Without sufficient funding and reimbursement for technology-enabled care, providers may face challenges in implementing these activities in their existing workflows. Current mechanisms to reimburse providers for technology-enabled care are limited in scope. For example, the Medicare Physician Fee Schedule includes reimbursement for telehealth, but e-consults are reimbursed at a lower rate, as compared to in-person visits. To address this issue, specific ACOs may provide participating providers with additional funding for technology-enabled care. One expert noted that, to improve specialty care integration, their ACO planned to provide salary support to specialists, bringing them into their delivery system for a set time each week to provide e-consults and telephonic consultations with PCPs. Although individual organizations have reported some success with these approaches, piecemeal solutions are insufficient to drive value-based care transformation. In particular, funding e-consults through payment model design may encourage specialist engagement in APMs.

**Evolution of nested, condition-specific models from voluntary to mandatory participation.**

Experts noted that existing, specialty-focused models that engage a portion of specialty care providers are not adequate to drive value-based transformation or person-centered, longitudinally-focused care. However, in order for a model to move from voluntary to mandatory participation, there needs to be sufficient evidence of its effectiveness. One approach they identified was to have “beta testing” of current mandatory models, eventually pivoting to a sustainable system with value-based models ultimately becoming the standard of payment. As participation in nested, condition-specific models evolves from voluntary to mandatory, ACOs may require support related to attribution and provider networks. Experts noted that, with nesting, different services rendered as part of the care episode or bundle can be attributable to different providers. Although the plurality of care may be provided by a specialist, patients are usually attributed to PCPs and, effectively, specialists may not bear accountability for TCOC relative to their involvement in patient care.

Model entities may have some flexibility to share savings or losses with their participating providers. Sharing risk and accountability with specialists may be challenging when patients seek care from specialists that are not in the entity's practice or network, or when care delivery is provided through vertically integrated systems. Horizontally integrated practices and multidisciplinary care teams may be better poised to engage in innovative approaches to attribution and risk sharing.

With voluntary participation in nested, condition-specific models, ACOs have the flexibility to choose whether to participate; they can make rational decisions based on their patient populations, resources, existing provider networks, and quality and availability of specialty care in their markets. Experts noted that ACOs will be unlikely to participate in voluntary nested, condition-specific models if they perceive that they are unable to succeed in them or if the incentives are insufficient to motivate participation.

Moving to mandatory participation in nested, condition-specific models will require additional strategies to support ACO participation. For instance, ACOs may not have sufficient provider networks to offer all the types of specialty care that their patient populations use. One expert explained that, to improve readiness for nested models, ACOs could partner with other ACOs that have complementary specialty providers in their networks. Given a sufficient market supply of specialists, this approach could potentially improve specialty care availability for each ACO's patient population.

ACO readiness for participation in mandatory nested, condition-specific models may vary by their organizational structure and by the type of care management that the condition requires. Experts noted that hospital-based ACOs, in particular, may have a more straightforward pathway to engage specialists in acute care episodes. These ACOs can focus on bundled payments for care episodes with acute conditions or major procedures as anchor events. Under this approach, ACOs would share risk and accountability with specialists for the acute portion of patient care, but not for any related chronic care components of the patient's treatment journey.

**Linking performance metrics to spending.** Committee members noted that APMs have the opportunity to improve specialty care integration in value-based care models through performance measurement. By using meaningful, condition-specific measures of utilization, spending, and quality to evaluate specialty care, providers will have a more comprehensive understanding of specific areas for improvement. Payment model design can also connect specialist performance to payment, incentivizing care delivery improvements through, for example, benchmarking and one- or two-sided risk. Committee members emphasized the importance of four performance measure categories in driving value-based care transformation: patient-reported outcome measures (PROMs), process measures, population health measures, and equity-related measures.

Experts identified PROMs as being fundamental in the shift to measures that better capture meaningful, condition-specific outcomes. Outcomes that provide the patient's perspective (e.g.,

health status, pain, functional status, satisfaction or experience with care, and quality of life) may not often be a focus of payment model design. PROMs may be more burdensome to measure, due in part to data collection. However, PROMs can provide additional context for changes in utilization and spending measures; one expert noted that measuring self-reported health status can guard against underutilization and associated reductions in spending.

Although process measures can provide a more comprehensive picture of the care delivery landscape, they may be underutilized in the transition to value-based care. For example, one expert described the importance of process measures in evaluating quality of care for patients with end-stage renal disease (ESRD), who may be able to receive equivalent dialysis care in inpatient or less costly, outpatient settings; measuring PCP engagement with nephrologists could provide insight into how to better manage care and reduce avoidable hospital admissions for patients with ESRD. Experts also recommended building process measures that emphasize proactive engagement and communication between providers (PCP-to-specialist and specialist-to-specialist) into payment model design.

Population health measures, especially those related to provider panel management, can incentivize team-based care. However, one expert mentioned that specialty care practices are not typically optimized to focus on population health. Experts noted that care delivery systems can address this barrier by organizing workflows under a population health “umbrella.” Under this framework, joint responsibility would be assigned among PCPs and any specialists participating in the patient’s care plan, encouraging team-based care. To truly leverage population health measures, experts stated that providers need access to tools beyond electronic health records (EHRs) to aggregate patient data, including improved natural language processing (NLP) and electronic clinical quality measures (eCQMs).

Equity-related measures have substantial potential to drive value-based care transformation for historically underserved populations. Key themes of equity-related measurement may include data availability and infrastructure, stratification by subpopulations, measures designed for specific subpopulations, and evaluation of initiatives to reduce disparities.

- Newer technologies and approaches to analysis provide an opportunity to bridge disparities in care for underserved populations. For example, machine learning algorithms can be trained to be sensitive to bias and skew data to less represented groups. However, experts also noted the importance of training and retraining algorithms to ensure that machine learning does not perpetuate historical biases.
- Experts suggested stratifying quality outcomes by specific patient characteristics. One expert noted that their organization focused its efforts on dually eligible populations, where they observed the greatest number of preventable hospitalizations.
- Equity-related measures may be designed for or pertinent for use in specific subpopulations. Although no experts mentioned measures designed for specific subpopulations, one expert noted that their organization targeted care delivery improvements for conditions with higher incidence and prevalence rates in certain racial and ethnic minority groups.

- Initiatives to reduce disparities may include building measure stratification and review of social determinants of health (SDOH) into workflows, and communication and reporting of disparities. One expert noted that their organization presented stratified measure results in a scorecard, enabling providers to develop specific care delivery innovations to address disparities for these populations.

**Multi-payer strategies.** Experts emphasized the importance of considering multi-payer participation in payment model design as a means of accelerating value-based care transformation. Multi-payer participation for all specialty conditions is vital to ensuring adequate provider panel size, which may promote participation in value-based care models. The Committee noted that having a disproportionate number or a majority of patients in a panel who are engaged in value-based programs can provide an incentive for participation. Multi-payer participation has been addressed in specialty-focused models, as well as models that integrate specialty care. Experts noted oncology care models as an example, as multi-payer participation can encourage patient-centered approaches to care. Multi-payer participation can also support medical home models, with participants using volume to build economies of scale and improve quality.

#### **Exhibit IV.5: PTAC Comments**

##### *Topic 5: Enablers to Support Payment Features*

**Comment 5A.** The provision of technology-enabled care can be incentivized by providing funds to the accountable entity, and making the accountable entity responsible for digitizing records, supporting telehealth, and other processes and resources.

**Comment 5B.** Participation in nested, condition-specific models could evolve from being voluntary to being mandatory for certain types of providers, such as hospital-affiliated ACOs, to increase participation in value-based care and encourage sustainable improvement.

**Comment 5C.** It is important to identify appropriate performance metrics that can be linked to payments, while acknowledging that some providers may not have experience in value-based models, particularly specialists. Examples of potential performance measures include:

- Patient-reported outcome measures (PROMs) such as pain, functional status, and patient satisfaction;
- Process measures such as engagement rates across different kinds of patients;
- Population health measures related to panel management to incentivize team-based care; and
- Equity-related measures, improvement plans, and reports to ensure health equity.

**Comment 5D.** The use of a multi-payer strategy is important to ensure that enough patients in a provider's panel are in value-based programs to encourage participation and engagement.

## **APPENDIX 1. COMMITTEE MEMBERS AND TERMS**

**Lauran Hardin**, MSN, FAAN, *Co-Chair*

**Angelo Sinopoli**, MD, *Co-Chair*

### Term Expires October 2023

**Jay S. Feldstein**, DO

*Philadelphia College of Osteopathic Medicine*

Philadelphia, PA

**Lauran Hardin**, MSN, FAAN

*HC2 Strategies*

Laguna Hills, CA

**Joshua M. Liao**, MD, MSc

*University of Washington School of Medicine*

Seattle, WA

### Term Expires October 2024

**Lawrence R. Kosinski**, MD, MBA

*SonarMD, Inc.*

Chicago, IL

**Soujanya R. Pulluru**, MD

*Independent Consultant*

Bentonville, AR

### Term Expires October 2025

**Lindsay K. Botsford**, MD, MBA

*One Medical*

Houston, TX

**Walter Lin**, MD, MBA

*Generation Clinical Partners*

St. Louis, MO

**Terry L. Mills Jr.**, MD, MMM

*CommunityCare*

Tulsa, OK

**Angelo Sinopoli**, MD

*UpStream*

Greensboro, NC

**Jennifer L. Wiler**, MD, MBA

*UCHealth and University of*

*Colorado School of Medicine*

Aurora, CO

**James Walton**, DO, MBA

*JWalton, LLC*

Dallas, TX

**APPENDIX 2. CHARACTERISTICS OF SELECTED PTAC PROPOSALS IDENTIFIED AS BEING RELEVANT TO IMPROVING CARE DELIVERY AND INTEGRATING SPECIALTY CARE IN POPULATION-BASED MODELS, DECEMBER 2016 – DECEMBER 2020**

Submitter and Proposal	Clinical Focus, Setting, and Payment Mechanism	Specialty Integration Components	Payment Design Features
<b>Advanced Primary Care Focus</b>			
<p><b>American Academy of Family Physicians (AAFP)</b></p> <p><i>Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM)</i></p>	<p><b>Clinical Focus:</b> Primary care</p> <p><b>Setting:</b> Primary care practices</p> <p><b>Payment Mechanism:</b> Capitated per beneficiary per month (PBPM)</p>	<p>PCPs thought to be best positioned to coordinate care across settings; promoting behavioral health diagnosis and treatment; collaboration with condition-specific models</p>	<p>Capitated per beneficiary per month (PBPM) payment with shared risk options for accountability</p>
<p><b>Avera Health (Avera)</b></p> <p><i>Intensive Care Management in Skilled Nursing Facility Alternative Payment Model (ICM SNF APM)</i></p>	<p><b>Clinical Focus:</b> Primary care in skilled nursing facilities (SNFs)</p> <p><b>Setting:</b> SNFs, nursing facilities (NFs)</p> <p><b>Payment Mechanism:</b> Add-on PBPM</p>	<p>Addresses multidisciplinary care in SNFs following an acute event, establishing accountability or negotiating responsibility</p>	<p>Add-on PBPM with shared risk options for accountability</p>
<p><b>University of Chicago Medicine (UChicago)</b></p> <p><i>The Comprehensive Care Physician Payment Model (CCP-PM)</i></p>	<p><b>Clinical Focus:</b> Frequently hospitalized patients</p> <p><b>Setting:</b> Home care and rehabilitation</p> <p><b>Payment Mechanism:</b> Add-on PBPM</p>	<p>Multispecialty care around an acute event, during episode</p>	<p>Add-on PBPM with shared risk</p>
<b>Specialty Integration Focus</b>			
<p><b>American College of Physicians-National Committee for Quality Assurance (ACP-NCQA)</b></p> <p><i>The “Medical Neighborhood” Advanced Alternative Payment Model (AAPM)</i></p>	<p><b>Clinical Focus:</b> PCPs and specialists</p> <p><b>Setting:</b> Primary care practices</p> <p><b>Payment Mechanism:</b> Add-on PBPM</p>	<p>Incorporate criteria from the Medical Neighborhood Model (MNM) and Merit-based Incentive Payment System (MIPS)-eligible Patient-Centered Specialty Practices (PCSPs)</p>	<p>Add-on PBPM with shared risk</p>



Submitter and Proposal	Clinical Focus, Setting, and Payment Mechanism	Specialty Integration Components	Payment Design Features
<b>American College of Surgeons (ACS)</b>  <i>ACS–Brandeis Advanced Alternative Payment Model</i>	<b>Clinical Focus:</b> Cross-clinical  <b>Setting:</b> Inpatient, outpatient, ambulatory  <b>Payment Mechanism:</b> Episode-based model with continued FFS	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
<b>Specialty Focus – Acute Management</b>			
<b>American College of Emergency Physicians (ACEP)</b>  <i>Acute Unscheduled Care Model (AUCM)</i>	<b>Clinical Focus:</b> Emergency department (ED) services  <b>Setting:</b> ED <b>Payment Mechanism:</b> Episode-based model with continued fee-for-service (FFS)	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
<b>Icahn School of Medicine at Mount Sinai (Mount Sinai)</b>  <i>HaH Plus (Hospital at Home Plus) Provider-Focused Payment Model</i>	<b>Clinical Focus:</b> Inpatient services in home setting  <b>Setting:</b> Patient home  <b>Payment Mechanism:</b> Bundled episode-based payment replacing FFS	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
<b>Personalized Recovery Care (PRC)</b>  <i>Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home</i>	<b>Clinical Focus:</b> Inpatient services in home setting  <b>Setting:</b> Patient home  <b>Payment Mechanism:</b> Bundled episode-based payment replacing FFS	Multidisciplinary care around an acute care event	Bundled episode-based payment replacing FFS, with shared risk
<b>University of New Mexico Health Sciences Center (UNMHSC)</b>  <i>ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Cerebral Emergencies</i>	<b>Clinical Focus:</b> Cerebral emergent care; telemedicine  <b>Setting:</b> Inpatient; outpatient; or ED  <b>Payment Mechanism:</b> Additional one-time payment	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
<b>Specialty Focus – Chronic Management</b>			

Submitter and Proposal	Clinical Focus, Setting, and Payment Mechanism	Specialty Integration Components	Payment Design Features
<p><b>American Academy of Hospice and Palliative Medicine (AAHPM)</b></p> <p><i>Patient and Caregiver Support for Serious Illness (PACSSI)</i></p>	<p><b>Clinical Focus:</b> Serious illness and palliative care</p> <p><b>Setting:</b> Inpatient, outpatient, other</p> <p><b>Payment Mechanism:</b> Capitated PBPM</p>	<p>Multispecialty care during episode of advanced illness; interdisciplinary team with 24/7 access</p>	<p>Capitated PBPM with shared risk options for accountability</p>
<p><b>American Society of Clinical Oncology (ASCO)</b></p> <p><i>Patient-Centered Oncology Payment Model (PCOP)</i></p>	<p><b>Clinical Focus:</b> Cancer care</p> <p><b>Setting:</b> Inpatient, outpatient</p> <p><b>Payment Mechanism:</b> Episode-based payment with two tracks</p>	<p>Community case conferences allow a panel of multi-specialty providers to discuss and determine the most appropriate care</p>	<p>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</p>
<p><b>Coalition to Transform Advanced Care (C-TAC)</b></p> <p><i>Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model</i></p>	<p><b>Clinical Focus:</b> Serious illness and palliative care</p> <p><b>Setting:</b> Patient home</p> <p><b>Payment Mechanism:</b> Capitated PBPM</p>	<p>Multidisciplinary care during episode of advanced illness; across major clinical dimensions</p>	<p>Capitated PBPM with shared risk</p>
<p><b>Hackensack Meridian Health and Cota, Inc. (HMH/Cota)</b></p> <p><i>Oncology Bundled Payment Program Using CAN-Guided Care</i></p>	<p><b>Clinical Focus:</b> Oncology</p> <p><b>Setting:</b> Inpatient and outpatient care</p> <p><b>Payment Mechanism:</b> Bundled episode-based payment replacing FFS</p>	<p>Within condition; multidisciplinary; recommendations for standardization across specialties</p>	<p>Prospective, bundled episode-based payments with retrospective reconciliation, replacing FFS; shared risk</p>
<p><b>Innovative Oncology Business Solutions, Inc. (IOBS)</b></p> <p><i>Making Accountable Sustainable Oncology Networks (MASON)</i></p>	<p><b>Clinical Focus:</b> Cancer care</p> <p><b>Setting:</b> Outpatient</p> <p><b>Payment Mechanism:</b> Episode-based</p>	<p>Virtual patient accounts using Medicare claims to estimate spending and value for internal and external providers</p>	<p>Episode-based model with continued FFS payments; shared risk for cancer-related expenditures</p>

Submitter and Proposal	Clinical Focus, Setting, and Payment Mechanism	Specialty Integration Components	Payment Design Features
<p><b>New York City Department of Health and Mental Hygiene (NYC DOHMH)</b></p> <p><i>Multi-provider, bundled episode of care payment model for treatment of chronic hepatitis C virus (HCV)</i></p>	<p><b>Clinical Focus:</b> HCV</p> <p><b>Setting:</b> Primary care and specialty care</p> <p><b>Payment Mechanism:</b> Bundled episode-based payment replacing FFS</p>	<p>Within condition; multidisciplinary; telementoring with specialists; integrating medical and behavioral health care</p>	<p>Bundled episode-based payment replacing FFS, with shared risk</p>
<p><b>Renal Physicians Association (RPA)</b></p> <p><i>Incident ESRD Clinical Episode Payment Model</i></p>	<p><b>Clinical Focus:</b> End-stage renal disease (ESRD)</p> <p><b>Setting:</b> Dialysis centers</p> <p><b>Payment Mechanism:</b> Episode-based model</p>	<p>Within condition, single specialty within episode; coordination among medical specialists and with dialysis providers</p>	<p>Episode-based model with continued FFS payments and an additional payment for transplant; one- and two-sided risk options</p>

\* At least sixteen proposals addressed issues related to improving specialty integration in advanced primary care models and episode-based or condition-specific models. These proposals received a PTAC rating of “Meets” or “Meets and Deserves Priority Consideration” for Criterion 7, Integration and Care Coordination.

### **APPENDIX 3. ADDITIONAL RESOURCES RELATED TO PTAC’S THEME-BASED DISCUSSIONS ON IMPROVING CARE DELIVERY AND INTEGRATING SPECIALTY CARE IN POPULATION-BASED MODELS**

The following is a summary of additional resources related to PTAC’s theme-based discussions on improving care delivery and integrating specialty care in population-based models. These resources are publicly available on the ASPE PTAC website:

#### **Environmental Scan**

[Environmental Scan on Improving Care Delivery and Integrating Specialty Care in Population-Based Models](#)

#### **Request for Input (RFI)**

[Improving Care Delivery and Integrating Specialty Care in Population-Based Models Request for Input \(RFI\)](#)

#### **Materials from the Public Meetings**

*Materials from the Public Meeting on March 2, 2023*

[Presentation: Improving Care Delivery and Integrating Specialty Care in Population-Based Models Preliminary Comments Development Team Findings](#)

[Presentation: Panelist Introduction Slides](#)

[Presentation: Subject Matter Expert Listening Sessions](#)

[Panelist Biographies](#)

[Panel Discussion Guide](#)

[Listening Session Facilitation Questions](#)

*Materials from the Public Meeting on March 2, 2023*

[Presentation: Panelist Introduction Slides](#)

[Presentation: Subject Matter Expert Listening Sessions](#)

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## APPENDIX 4. SUMMARY OF PTAC COMMENTS ON IMPROVING CARE DELIVERY AND INTEGRATING SPECIALTY CARE IN POPULATION-BASED MODELS

The Committee’s comments have been summarized in the following broad topic areas:

- Topic 1: General Principles for Improving Primary and Specialty Care Integration;
- Topic 2: Care Delivery Model Features to Support Primary and Specialty Care Integration;
- Topic 3: Enablers to Support Desired Care Delivery Feature;
- Topic 4: Payment Model Features to Support Improving Primary and Specialty Care Integration; and
- Topic 5: Enablers to Support Payment Features.

<b>Category 1: General Principles for Improving Primary and Specialty Care Integration</b>	
1A	The objectives for improving primary and specialty care integration include facilitating prospective, longitudinal, whole-person care, including anticipatory symptom management and disease management.
1B	There are many nuances related to categorizing primary and specialty care providers and the different aspects of their care delivery. Providers may be better categorized by their main function in their specialty (e.g., screening, acute care, chronic longitudinal care) rather than only by the specialty itself.
1C	Efforts to improve primary and specialty care integration should focus on disease- or condition-specific approaches.
1D	The potential for improvements in care coordination can encourage specialist engagement with population-based models.
1E	Providers need to receive timely data on quality, cost, and utilization to facilitate patient care management and manage financial risk.
1F	Because practice transformation takes time, in addition to considering short-term return on investment (ROI), efforts to improve specialty integration in APMs should also focus on long-term improvements and infrastructure development.

<b>Category 2: Care Delivery Model Features to Support Primary and Specialty Care Integration</b>	
2A	<p>Desired care delivery model features for improving primary and specialty care integration include:</p> <ul style="list-style-type: none"> <li>• The use of a patient-centered approach (focusing on patients and their diseases or conditions, rather than on providers and their specialties).</li> <li>• The use of risk screening to capture medical, behavioral, and social determinants of health (SDOH) data, and develop proactive patient care plans.</li> <li>• Incorporating and expanding the use of technology-enabled care (i.e., through telehealth, e-consultations, and remote monitoring) to facilitate patient care and extend the reach of a limited health care workforce.</li> <li>• Monitoring and addressing issues related to overutilization and underutilization of services.</li> <li>• Accounting for “preference-sensitive” care that will improve a patient’s overall health, given that patients have multiple conditions and different priorities, and, improve care at the end of life in particular</li> </ul>
2B	<p>It is important for providers to collectively understand which patients the primary care and specialty team is accountable for managing. Proactive attribution of patients to accountable providers can be facilitated by using information on a patient’s preferences, utilization patterns, and needs, as well as the specific role that each provider should play at a given point in the patient’s care journey independent of provider specialty.</p>
2C	<p>There is a need to develop care pathways and clearly-defined workflows indicating when it is appropriate to make a specialty referral, what information the referring provider needs from the specialist, and who will be responsible for managing the patient’s care at various points during the care journey.</p> <ul style="list-style-type: none"> <li>• Conversations between the primary care and specialty care management teams should begin early through a pre-consultation exchange to determine if a specialty consultation is appropriate, and what tests should be ordered before the patient sees the specialist.</li> </ul>
2D	<p>More information is needed on how models can measure and value the communication and collaboration between primary and specialty care providers necessary for providing high-value care, determine when that coordination should occur, and identify which providers should be accountable.</p>

<b>Category 3: Enablers to Support Desired Care Delivery Feature</b>	
3A	<p>The use of practice assessments can help to identify readiness and encourage participation in value-based care models.</p>
3B	<p>Robust data analytics and data sharing are necessary to facilitate coordination among providers. This includes:</p> <ul style="list-style-type: none"> <li>• Improving access to timely data that can be used to identify opportunities to derive more value from referrals to specialists and services provided by specialists.</li> <li>• Creating shadow bundles and providing that data to ACOs.</li> </ul> <p>It is also important to consider potential biases of artificial intelligence programs in data sharing that might disadvantage patients traditionally underserved by health care resources.</p>

<b>Category 3: Enablers to Support Desired Care Delivery Feature</b>	
3C	It is important to support the future physician workforce by reducing administrative burden, promoting relationship building, and providing education and training for providers participating in integrated primary and specialty care models.

<b>Category 4: Payment Model Features to Support Improving Primary and Specialty Care Integration</b>	
4A	The use of disease- or condition-based care models may be more effective than models focused on all care provided by a given specialty to incentivize primary and specialty integration. Disease- or condition-specific utilization and cost data can help identify appropriate financial incentives and areas of potentially avoidable cost to inform the development of these models, with the caveat that the historical data may reflect inequity in the health care system.
4B	To support effective integration between primary and specialty care, payment for care delivered by specialists should be “carved in,” or nested within population-based APMs, instead of being “carved out.”
4C	<p>It is important to reward providers for preventing disease progression that will lead to higher costs. One option could involve developing nested, condition-specific models with sub-capitation payments to specialists to support longitudinal care management for chronic conditions, as well as acute and surgical episodes.</p> <p>Other potential payment model features for disease-based models include:</p> <ul style="list-style-type: none"> <li>• Disease-specific buckets of risk based on the desired services;</li> <li>• Payments based upon functions, including bundles for acute care and bundles for chronic and longitudinal care;</li> <li>• Expanded payment for managing an underlying (base) chronic condition to enable specialists to have time to engage in care coordination activities that are generally not reimbursed within the current relative value unit (RVU)-based systems used in FFS;</li> <li>• Longitudinal episodes for payment; and</li> <li>• Per member per month (PMPM) payments for the cognitive, risk-adjusted component and market-based procedure payment, with protections to avoid stinting on necessary procedures.</li> </ul>
4D	The increased use of capitated payments could help to support the upfront costs needed to develop the infrastructure needed to support integrated primary and specialty care models, and enable more organizations and providers to participate in these models.
4E	<p>It is important to ensure alignment of financial and non-financial incentives to encourage specialists to participate in integrated primary and specialty care models rather than remain in FFS. With the right incentives and participants, providers will want to participate, and there could potentially be “healthy competition” among providers for managing care for given patient populations.</p> <ul style="list-style-type: none"> <li>• It is difficult for specialists to have time to engage in care coordination activities that are generally not reimbursed within the current relative value unit (RVU)-based systems.</li> </ul>
4F	Financial risk should be at the entity level in integrated primary and specialty care models, whether the entity is an ACO, hospital, or group practice, with financial incentives at the provider level.
4G	Payment interventions should focus on the local level and ACO level. It is challenging to dictate care at a national level. The risk-bearing entity can develop a process with the appropriate

	balances and protective measures. Pilot models can potentially be used to test the effectiveness of various payment models.
4H	The use of prospective attribution can enable proactive care coordination in integrated primary and specialty care models. To ensure that patient preferences are considered in alignment, patients can be given an opportunity to affirm the provider relationship. Weighted attribution models can also be considered so that attribution is not solely based on a single relationship, which does not typically reflect actual care delivery.

<b>Category 5: Enablers to Support Payment Features</b>	
5A	The provision of technology-enabled care can be incentivized by providing funds to the accountable entity, and making the accountable entity responsible for digitizing records, supporting telehealth, and other processes and resources.
5B	Participation in nested, condition-specific models could evolve from being voluntary to being mandatory for certain types of providers, such as hospital-affiliated ACOs, to increase participation in value-based care and encourage sustainable improvement.
5C	It is important to identify appropriate performance metrics that can be linked to payments, while acknowledging that some providers may not have experience in value-based models, particularly specialists. Examples of potential performance measures include: <ul style="list-style-type: none"> <li>• Patient-reported outcome measures (PROMs) such as pain, functional status, and patient satisfaction;</li> <li>• Process measures such as engagement rates across different kinds of patients;</li> <li>• Population health measures related to panel management to incentivize team-based care; and</li> <li>• Equity-related measures, improvement plans, and reports to ensure health equity.</li> </ul>
5D	The use of a multi-payer strategy is important to ensure that enough patients in a provider’s panel are in value-based programs to encourage participation and engagement.