How to Achieve High Quality Value Based Specialty Partnerships

A Getting Started Guide for Healthcare Purchasers and Specialty Providers

Dave Terry

Table of Contents

Introduction

Value based care has come a long way in the last decade, but substantial improvements in quality and cost won't happen without more proactive and innovative partnerships between primary and specialty care providers. High quality value based (HQVB) partnerships between risk-takers—Accountable Care Organizations (ACOs), payors, employers, etc.—and specialty providers will become increasingly important as primary care providers (PCPs) and other risk-takers consolidate and take on more responsibility for managing care and risk. Historically, it's been challenging to develop these cooperative relationships, but as healthcare data transparency improves and specialty episode definition sets become more common, HQVB partnerships between risk-takers and specialty providers can be effective and successful.

Define high quality value based (HQVB) specialty care

Specialty providers in the top 30th percentile in their market for risk-adjusted, specialty specific outcome metrics; and episodic costs that are in the top 50th percentile for risk-adjusted total cost of care.

In this guide, I outline five models for structuring effective HQVB specialty partnerships.

1. **Selective Fee-for-Service**
2. **Specialty Specific Pay-for-Performance**
3. **Shadow Bundles**
4. **Bundled Payment**
5. **Carve-Outs**

In addition, purchasers and providers can use a three-phased approach to successfully facilitate the development of HQVB partnerships.

Phase 1: Assessment → **Phase 2: Engagement** → **Phase 3: Execution**

As long as providers and purchasers are motivated to move toward HQVB specialty care, the process of developing a partnership can be straightforward. The key is to simply get started.

The State of High Quality Value Based Specialty Care

As primary care continues to consolidate, provider organizations are getting better at using data to risk-stratify patients, build patient specific care plans, work in care teams, and standardize practices. However, over 70%1 of healthcare spending is driven by specialty care, and alarmingly, performance among specialty providers varies dramatically on every measurable metric—including quality outcomes, patient experience, and cost of care on an episodic basis. In this environment, it is increasingly important for purchasers and risk-taking providers to find ways to deliver HQVB specialty care to patients with specialty needs that PCPs can't effectively meet.

Two examples of specialty specific quality metrics include:

Lung Cancer

- Time from diagnosis to treatment;
- Emergency room (ER) & hospital utilization during chemo treatment
- Hospice utilization outside the last 3 days of life
- 24/7 access to care.

Hip & Knee Surgery

- Skilled nursing facility (SNF) days per surgery
- Post-surgical ER visits & hospitalizations
- Physical function (HOOS/KOOS measures)

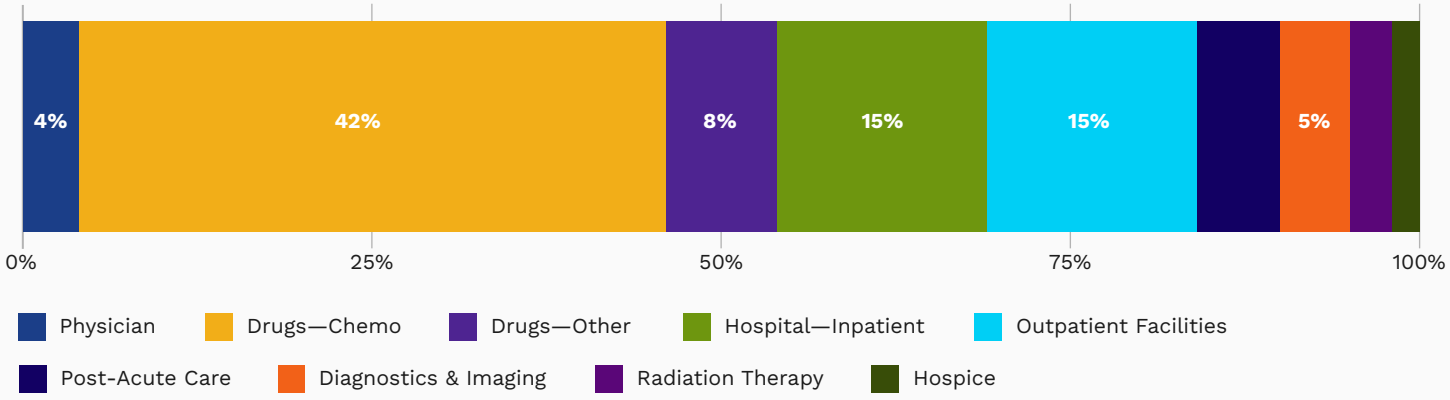
Despite various efforts from the Center for Medicare & Medicaid Innovation (CMMI), the vast majority of specialty care—which includes visits to specialty physicians, diagnostic testing, hospitalizations, and post-acute care–is still paid through the traditional fee-for-service (FFS) model. Also, specialty care is fragmented and characterized by poor communication and coordination between primary care doctors, specialists, and other providers along the continuum. In fact, when talking to PCPs, they express frustration about the limited information they have about the relative quality, cost, and value of care delivered by the specialty providers to whom they refer.

The good news: Progress has been made on several fronts. In the last few years, the healthcare industry has entered a new era of cost and quality transparency. Now, Medicare, healthcare providers, and insurers are sharing troves of data that we can all use to better understand what it takes to provide high quality care and who is delivering it. CMMI's bundled payment programs have also created a universal framework that we can use to define specialty episodes and evaluate risk-adjusted performance for all types of specialty providers. This is particularly crucial as specialty care is extraordinarily nuanced and variable—what's important in one clinical specialty, like orthopedics, is very different from what's important in cancer, diabetes, cardiology, or cardiac surgery episodes.

When evaluating provider quality and cost performance within and across specialties, it's important to understand the elements of care that are included in a specialty episode, including who is involved in the process, the drivers of variability in performance, and how referral channels and the alignment, or misalignment, of reimbursement incentives impact performance. The specialty physician is the most important person in the process, but they usually generate less than 10% of the cost of an episode, and often underutilize their influence over other aspects of the care process.

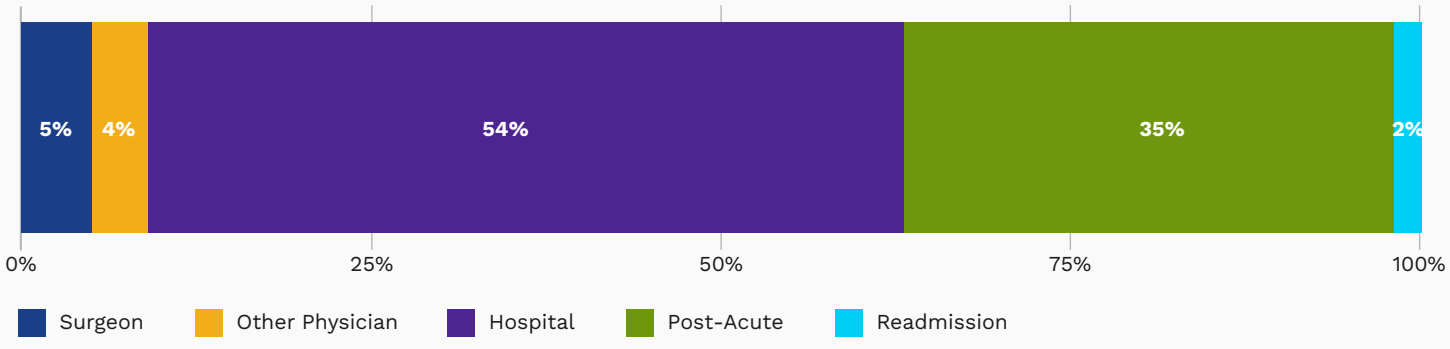
Figures 1-3 highlight the clinical components and cost distribution in oncology, joint replacement, and diabetes episodes, respectively.

Figure 1. Medicare Oncology Episode Cost Distribution.
Total Average Cost = $38,400.



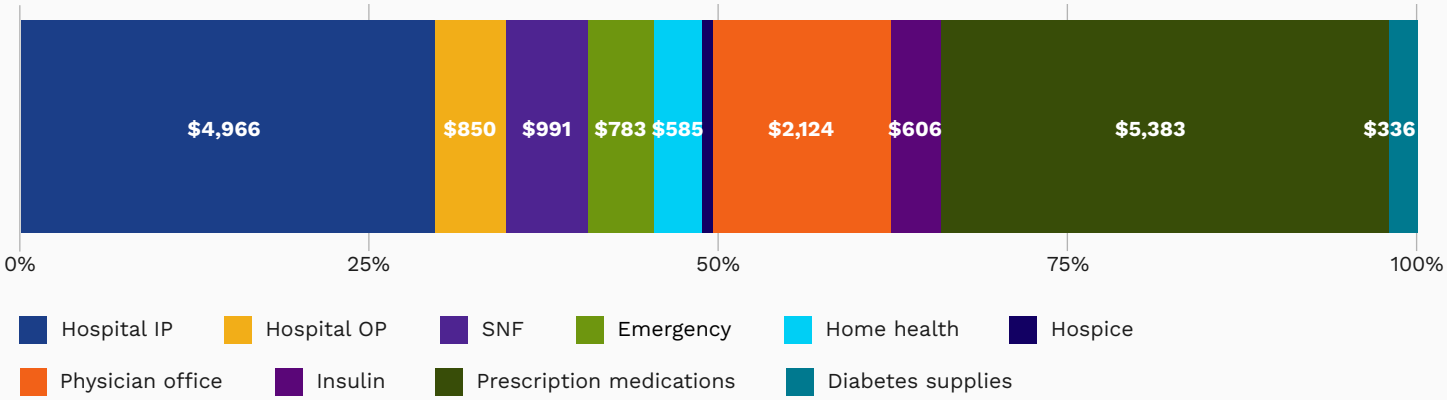
Note. Adapted from: Share of Oncology Versus Non-Oncology Spending in Episodes Defined by the Centers for Medicare & Medicaid Services Oncology Care Model. DOI: 10.1200/JOP.18.00309 Journal of Oncology Practice 14, no. 11 (November 01, 2018) e699-e710.

Figure 2. Medicare Major Joint Replacement Episode Cost Distribution.
Total Average Cost = $25,600.



Note. Adapted from: Bundled payments in total joint arthroplasty and spine surgery. Current Reviews in Musculoskeletal Medicine. 2017 Jun; 10(2): 218–223. Published online 2017 Mar 31. doi: 10.1007/s12178-017-9405-8.

Figure 3. Diabetes Episode Cost Distribution Across All Payers.
Total Average Cost = $16,753.



Note. Adapted from: Economic Cost of Diabetes in the US in 2017; Diabetes Care Volume 41, May 2018.

In my experience, true HQVB specialty providers embody the following characteristics: expertise, as represented by significant annual volume in the targeted clinical area; strong performance in specialty specific quality metrics; rapid return to home; low rate of follow-up ER visits and hospital readmits; low complication rates; and low costs, relative to the competition, all on an episodic basis. With this information becoming increasingly available, it's important to use it to identify HQVB specialty providers in communities across the country.

In the Oncology Care Model (OCM), Medicare's medical oncology bundled payment program, top-performing participating practices have improved care by expanding office hours, adding nurse triage lines, creating patient-centered care plans, developing care navigation initiatives, and creating programs for evaluating and utilizing biosimilars where appropriate. Overall, the OCM program led to modest improvements in quality and cost, but the most committed HQVB oncology practices helped their patients avoid unnecessary ER visits and reduce hospitalizations while saving over $3,000 per episode,2 compared to a program average savings rate of less than $300 per episode.3

In Medicare's joint replacement bundled payment program, average savings were higher at over $1,300 per episode,4 while top performing HQVB providers saved over $2,500 per surgical episode.2 In addition to cost savings, there were significant improvements in quality and patient experience, including a more rapid return to home, faster ambulation after surgery, SNF avoidance, and improved post-acute access to the surgeon's team. In both bundled payment models—oncology and orthopedics—independent practices outperformed hospital-based providers.

To make positive HQVB outcomes more common, it's necessary to develop specialty reimbursement models that drive greater collaboration and better alignment of incentives among risk-taking organizations and all of the providers along the continuum—including PCPs, specialists, hospitals, and post-acute providers.

The next chapter outlines the five models for structuring these arrangements. While each model uses the perspective of a purchaser, specialists and other provider types along the continuum can initiate the process.

The Five Models for Structuring HQVB Specialty Partnerships

Generally, the options to pay for HQVB specialty care have been limited and complex. However, over the last 12 years, my colleagues and I have worked with dozens of specialists in all types of clinical categories to identify ways to move the needle toward better care quality and value. As a result of these discussions, we have identified five models for structuring a HQVB specialty partnership.

1. Selective Fee-for-Service.

In this model, purchasers can use the tools previously described—data transparency and episodic analysis—to identify the top performing specialists in key categories in their markets. From there, they can simply channel as many patients as possible to those providers and continue to pay prevailing FFS rates. With this approach, a referring PCP's patients will receive top-tier specialty care and purchasers will incur relatively low costs on an episodic basis.

The main benefit of this model is simplicity—there's no need to negotiate new prices or contracts, nor does it require a new type of payment structure. The main downside is it's a surreptitious approach that doesn't lead to a coordinated, improvement-oriented partnership between PCPs and their local specialists. It also may be difficult for patients and their PCPs to gain access to top HQVB specialists through this method.

2. Specialty Specific Pay-for-Performance (P4P).

All of these specialty payment models start with the same first step—use claims data and episodic analytics to identify the top HQVB specialists in your market or markets. In this model, risk-bearing purchasers reach out to the top specialty providers with the goal of developing a preferred, value based referral and reimbursement partnership. The two main incentives for specialty providers to engage and participate are increased referrals and performance-based bonuses that allow them to make more money than in a traditional FFS model. In exchange, the purchaser and/or referring PCP expects several things: enhanced access to specialty appointments, information sharing, collaboration around establishing specialty specific performance goals, commitment to help manage episodic cost, and an orientation toward continuous improvement in quality and cost performance.

Simplicity is also a core benefit of the P4P model. Specialists continue to earn traditional FFS and bonuses can be processed and paid by the risk-taker once performance data is available, ideally, at least quarterly throughout the performance year. The key is to create a small set of relatively simple performance metrics that are specific to each specialty and drive better alignment and performance improvement. For example, SNF avoidance in orthopedics, hospice and biosimilar utilization in oncology, radial catheterization in interventional cardiology, home dialysis in kidney care, etc.

3. Shadow Bundles.

In a shadow bundle, HQVB specialty provider quality and cost performance are monitored within an established episodic definition, but the risk is still held by the purchaser or global risk taker. This structure is similar to P4P because the specialty provider can earn upside bonuses for truly being a HQVB specialist based on superior quality and cost performance as measured by empirical data. However, the metrics are generally more comprehensive and longitudinal than in P4P. Shadow bundles don't require a risk transfer and are easier to set up and administer than a traditional bundled payment program, but there are still complex issues to resolve, such as choosing which episode definitions to use, establishing quality and cost benchmarks, and tracking performance across an episode.

4. Bundle Payment.

In a full bundled payment model, episodic risk is transferred from the purchaser or global risk-taker to a specialty provider. This can be attractive as specialists are fully accountable for delivering quality outcomes at a value based cost, otherwise they owe money back to the purchaser.

However, there are several downsides to this model, including: complexity—bundled payment programs have proven quite challenging to set-up and administer. Finding providers who are both HQVB and have the appetite and ability to take risk can also be challenging; when in doubt, I prefer HQVB care over risk tolerance. Bundled payment models can also lead to excess value transfer—in some cases HQVB specialists earn more in a bundled model than they expect or would otherwise accept in a P4P or Shadow Bundle structure.

5. Specialty Carve-Out.

In a carve-out structure, all of the responsibility and risk for a broad set of specialty services for a full population is shifted from the purchaser or global risk-taker to a specialty provider. This can be attractive to the purchaser as they will have a partner who is fully accountable for delivering all aspects of care within a specific specialty at a fixed per member cost over the course of the performance period.

While this model may be a good fit for some, particularly in high-cost, complicated specialty areas, the complexities of defining and pricing the services, and risk-adjusting the population that is included in the carve-out are quite challenging. A carve-out structure also limits the choice for referring providers and their patients. Lastly, unless the service is priced accurately, this model can lead to economic imbalances, like excessive transfer of value from the risk-taker to the specialty provider, or undue risks and losses taken on by the specialty organization.

Figure 4 outlines the characteristics of specialty providers that fit into each of the five payment models.

Figure 4. Specialty Partner Characteristics by Payment Model

Payment Model	Specialty Partner Characteristics
Selective FFS	• Little to no experience with Value Based Care (VBC) • Hard to engage • Easy to get appointments
Specialty Specific P4P	• Limited risk experience • Eager to move into VBC • Wants to collaborate and improve
Shadow Bundle	• Eager to move into VBC • Risk averse • Has influence over downstream providers
Bundled Payment	• VBC experience • Risk-tolerant • Financial strength
Carve-Out	• Significant VBC experience • Large, full-service specialty organization • Financial strength • Data analytics capabilities

A Three-Phased Approach to Initiating HQVB Partnerships

To date, HQVB partnerships between global risk-takers and specialists have been rare. However, there is a straightforward three-phased process that can help initiate these types of partnerships and make them more common, with the goal of improving care for patients and reducing costs for those who foot the bill.

Phase 1 | **Assessment.**

The first step in Phase 1 is to analyze where your patients have historically gone to get specialty care, and how much money is being spent with high volume referral partners in key acute and chronic care categories, such as oncology, medical cardiology, orthopedics, general surgery, CHF, COPD, diabetes, hospital, post-acute care, etc. It's also important to assess the clinical outcomes and customer service your patients experience with those providers.

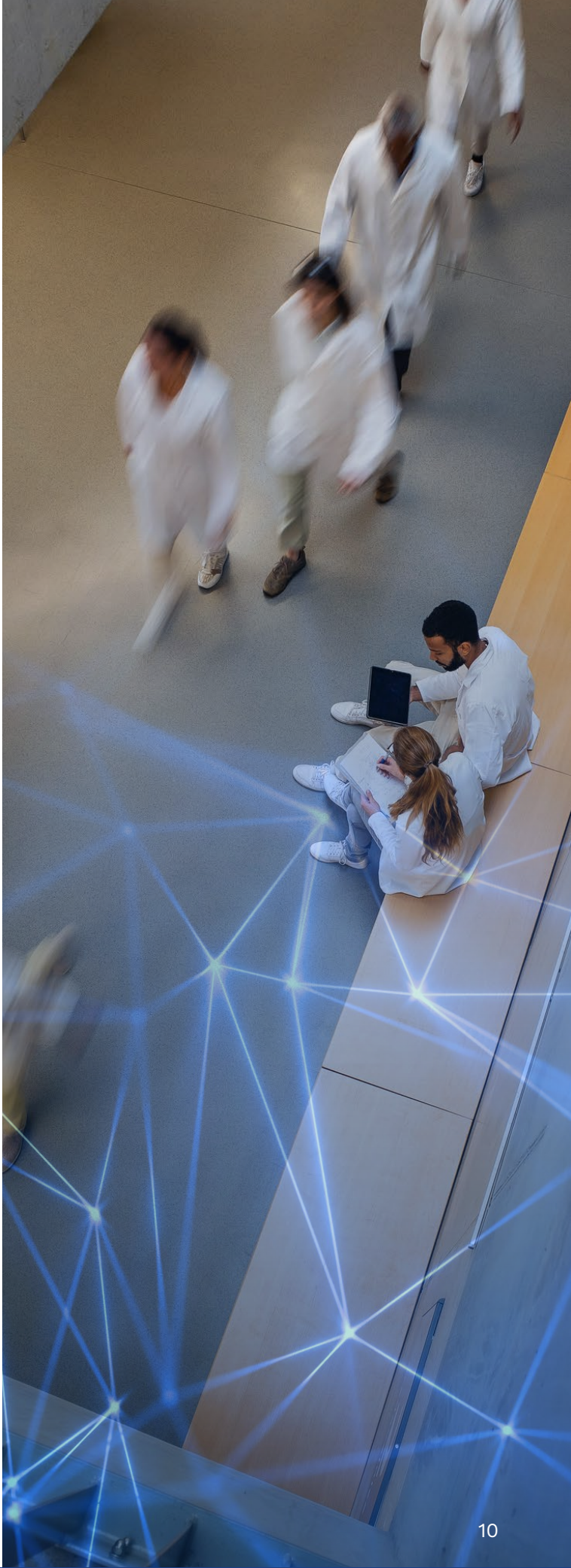
In one situation my colleagues and I experienced, a large primary care group we

were working with was surprised to learn they were sending close to $1 million per year of Medicare Part B spending to a single local oncologist. While they knew the doctor to be a referral partner, they didn't know how many patients and Medicare dollars they were sending him, or much about the outcomes achieved by the patients they had referred to this physician. They also weren't aware of the quality, customer service, and cost performance of the downstream surgeons, therapists, and institutional providers utilized by the oncologist, all of which is key to understanding the full episodic experience of the patients.

The second step in Phase 1 is to gain an understanding of the episodic quality and cost performance of every specialty provider in your market. In my experience, this type of analysis exposes striking variability in risk-adjusted provider performance in the key areas discussed above including expertise as determined by volume, quality outcomes based on specialty specific metrics, follow-up ER visits and hospitalizations, complication rates, and total cost of care. It's crucial to have all the information about current and potential specialty providers in your referral network, and overall market, before moving into Phase 2.

Phase 2 | **Engagement.**

Once you're armed with all the data, the first step in Phase 2 is to reach out and engage specialty providers and health systems with whom you'd like to have a preferred provider partnership. In my experience, most providers are almost completely blind to their episodic quality and cost performance relative to others in the market. They are also often unaware of exactly how many patients they care for from a particular referral source or purchaser. It's very powerful to have this information in hand when



engaging with potential partners and initiating preferred referral partner discussions and value based reimbursement negotiations.

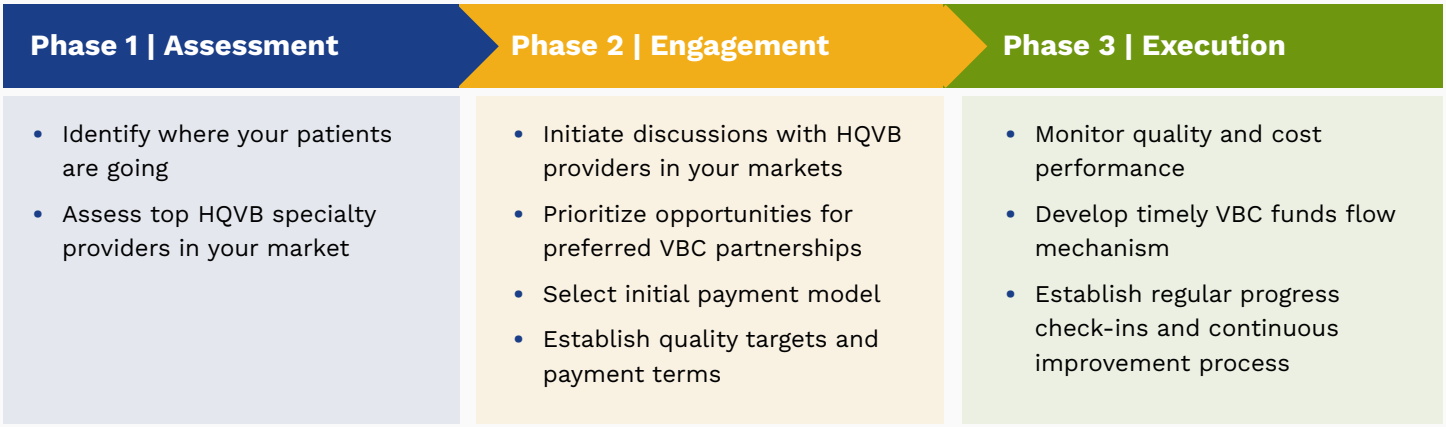
The best preferred specialty partners are provider organizations who share your interest in pursuing value based care models, and who want to utilize new reimbursement models to improve quality and outcomes while also reducing costs. The second step in Phase 2 involves a series of discussions focused on sharing volume and performance data, identifying opportunities for improvement, outlining shared goals, and discussing partnership options and payment models. In my experience, these discussions are most productive when a diverse group of administrators and clinicians—such as PCPs, specialists, and nurses—can use real episodic performance data to assess where breakdowns in care are happening, design specific ways to help patients recover faster, and eliminate the use of underperforming providers and low value-added services. The ultimate goal of these discussions is to design the parameters of a preferred provider arrangement that includes specialty specific quality metrics, utilization goals for various services within an episode, identification of downstream preferred providers or products to use within an episode (PTs, Home Health, Generics, etc.), and episodic cost ranges and targets.

Once a prioritized set of preferred HQVB specialty partners are identified, the next steps include selecting the most appropriate payment model from the five options in the previous chapter, developing an agreed upon set of performance metrics, and negotiating payment terms.

Key steps that lead to success in Phase 2 include:

- **Start with like-minded providers and leaders** in your market who are motivated to make the relationship work.
- **Keep it simple—**there's no need to start with a complicated bundle model if neither party has done this before.
- **Get started—**don't let "perfect" be the enemy of "good."
- **Focus on using data and collaboration** to drive improvements in care (who can argue with that?).
- **When structured and managed well**, care quality should improve for patients, and compensation should increase for both specialty provider partners and global risk-takers.

Figure 5. Three-Phased Specialty Partnership Process



Phase 3 | **Execution.**

The first step in Phase 3 is to establish a method for how to pay preferred provider partners based on the agreed upon payment model. In programs like ACO REACH, where REACH entities have access to prospective capitation payments from Medicare, the preferred provider compensation model can be designed and implemented relatively easily. In sub-cap arrangements with Medicare Advantage plans or commercial purchasers, the health plan or TPA will need to be included in the process. If this is the case, I recommend starting with more progressive purchasers in your market and bringing them into the process early. In some situations, preferred provider compensation models may need to start with an annual retrospective reconciliation process, similar to how Medicare designed their Shared Savings ACO and Bundled Payment models—these structures are a reasonable way to get started if real-time models are unavailable in the short term.

The last step is to design a process for regular ongoing communication with clinical and administrative leadership across the participating parties. There are a few big-picture goals for the partnership, including: continuously evaluating progress against established quality, cost, and customer service goals; building relationships you can depend on to solve problems and make course corrections as needed; continuously identifying opportunities for improvement; and laying the groundwork for an updated agreement in Year 2. Figure 5 outlines the key steps in each of the three phases.

HQVB Partnership Matrix

In the future, the best performing risk-holders in value based programs will ultimately be able to develop an HQVB matrix model and use it to meet their preferred provider partners where they are on their journey towards value. The key to this approach is a flexible tool kit that facilitates contract structures and payment capabilities across the spectrum of the five payment models for all types of specialty care providers—acute, chronic, procedural, and medical. For example, there may be a straightforward P4P arrangement with a group of oncologists, and a sophisticated Carve-Out model with a group of cardiologists who have significant VBC experience. Figure 6 provides an illustration of how the matrix model works.

Figure 6. Value Based Specialty Payment Model Matrix **Illustrative**

	Selective FFS	Specialty Specific P4P	Shadow Bundle	Bundled Payment	Carve-Out
Oncology Group A		X			
Oncology Group B	X				
Cardiology Group C			X		
Cardiology Group D	X				
Orthopedic Group E		X			
Orthopedic Group F					X
Hospital G		X			
SNF H	X				
Hospice I			X		

It's Time to Get Started

The healthcare purchaser landscape is changing—driven by progressive global capitation models, like ACO REACH and Medicare Advantage sub-capitation arrangements, and the increasing availability of provider cost and quality performance data. These trends create new opportunities for progressive providers and purchasers to be more proactive in how they improve care and reduce costs for their patients. The most successful participants in these global risk arrangements will not only manage care within their own organizations, but they will also need to ensure their downstream partners are delivering care that is truly HQVB. While establishing these relationships can be challenging, this guide provides a straightforward process. All that's left for you to do is get started.

If you have questions about how to get started or would like to discuss anything outlined in this guide, feel free to email the author, Dave Terry at dterry@hqvbc.com.

About the Author

Dave Terry is a healthcare delivery and reimbursement expert with over 20 years of experience working with provider organizations of all types to help them develop successful risk arrangements. Most recently, Dave was CEO and Co-Founder of Archway Health, a convener in multiple Medicare bundled payment programs, and an innovative underwriter of stop-loss insurance products for providers taking risk. Previously, he was COO and Co-Founder of Remedy Partners, a Partner at the Chartis Group, and a risk management Executive within the Partners Healthcare System (now Mass General Brigham). Dave holds a BA from Columbia University and an MBA from Harvard.

Notes

[1] Data from the Medical Expense Panel Survey, 2002 – 2016 (www.meps.ahrq.gov/mepsweb) Specialty driven care includes direct visits to specialists, plus prescriptions and inpatient hospitalizations directed or managed by specialists.

[2] Based on the author's experience with high performing participants in the OCM and BCPI-Advanced programs.

[3] Evaluation of the Oncology Care Model: Performance Periods 1-6 – OCM Impacts on Payments. December 2021.

[4] CMS Bundled Payments for Care Improvement Advanced Model: Third Evaluation Report. February 2022.