

Current Value-Based Care Models Need Greater Emphasis on Specialty Care

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ABSTRACT

As we expand value-based care, specialty care, which slows chronic disease progression and reduces complications, deserves as much—if not more—attention as primary care. Patients with chronic conditions account for the vast majority of US healthcare expenditures, and specialists are incredibly well positioned to implement new payment models to stem the progression of these conditions and actively maintain patient health and engagement.

Specialists are already participating in disease- or condition-focused value-based care models with success in achieving quality-of-care measures, improved patient outcomes, and cost-effectiveness. The path to developing a specialty accountable care organization (ACO) begins with analyzing a particular patient population's health status, then deciding which services and providers can help improve its health while also eliminating waste. Certain prerequisites such as seamless data sharing may increase the likelihood of success of specialty ACOs. Numerous possibilities exist for reimbursement structures and whether to focus on condition- and/or episode-based payments. Given the impact of specialty care as a whole, it is logical to consider how to expand these models whether in parallel with or as an alternative to ACOs in the near future.

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The consistent, inexorable move to value-based care in the United States is failing to fully achieve the Quadruple Aim of improving patient engagement, the health of a population, and clinician engagement while reducing the total cost of care.¹ This failure may be due, in part, to current accountable care models, which focus on primary care and ignore specialty care. Specialty care accounts for the majority of healthcare activity (doctor visits and medical spend) among Medicare beneficiaries. In fact, in 2009, specialty care accounted for more than half of office visits to physicians and nearly 70% of healthcare expenditures.² In this new paradigm of value-based care, specialty care, which slows chronic disease progression and reduces complications, deserves as much—if not more—attention as primary care. Thus, we suggest that specialty care becomes the principal driver of accountable care.

In this paper, we examine results achieved by current specialty care models and review considerations for constructing specialty care vehicles, including alternative payment models (APMs) that more directly involve specialty, value-based care.

Benefits of a Specialty-Focused Accountable Care Environment

Medicare covers a large population of patients with multiple chronic conditions. In 2010, approximately 21.4 million Medicare beneficiaries had at least 2 chronic conditions and accounted for the bulk of healthcare services provided under Medicare.³ There are multiple chronic conditions that require not only management by specialty and primary care physicians, but also data exchange and a common understanding between patients and physicians of treatment goals and monitoring. A specialty accountable care organization (ACO) environment would be best suited to address the complexities of those with chronic conditions and may achieve the following outcomes.

Improved clinical results. Specialists know their areas of health-care and delivery systems better than generalists. Additionally, as key lead physicians for their patients, specialists can likely better improve patient experience and outcomes, especially when using the evidence base of their specialty to inform care.

Reduced cost of care. Specialty care drives the bulk of Medicare spending. Patients with chronic conditions account for approximately 75% of US healthcare expenditures, and 96 cents of each Medicare dollar fund chronic disease treatment and management.⁴ There is an opportunity to save more money with specialty care, not only because that is where the majority of the healthcare costs are, but also because precision medicine and most new and innovative treatments are in the province of specialty care. Thus, specialists need to be more at the center of efforts to control costs in ACOs.

Enhanced patient engagement. The average Medicare fee-for-service (FFS) patient visits 2 primary care clinicians and 5 specialists annually. Patients with multiple chronic conditions visit even more specialists and fewer primary care clinicians.⁵ Thus, the greatest opportunity to enhance patient engagement is with the specialist. However, most ACOs diminish contact with specialists by encouraging primary care physicians and patients to use them only when truly necessary and to find specialists who use fewer resources—and therefore, keep costs low—in their practices.⁶

Increased specialist accountability. Leaving specialists out of ACOs and other value-based constructs creates division and a lack of accountability on their part to participate in the necessary changes to achieve better outcomes and lower costs. In the process of redesigning value-based care, specialists—not only primary care physicians—need to be fully engaged. Developing ACO constructs that include or are led by specialists positions both the ACOs and the specialists to effectively deliver on the whole Quadruple Aim.

Evidence Suggesting That Specialty Providers Can Achieve the Objectives of ACOs

Current care models that provide intensive, specialty-focused, value-based care have succeeded in delivering on the Quadruple Aim. These models have a reimbursement structure different from

traditional Medicare FFS; they also are specialty-focused, but borrow significantly from the ACO construct in other ways. Four examples of this care model are described here.

Chronic Condition Special Needs Plans (C-SNPs). C-SNPs are coordinated care plans offered under Medicare Advantage with enrollment limited to individuals with specific severe or disabling chronic conditions, including, but not limited to, chronic heart failure, diabetes, cancer, and end-stage renal disease (ESRD).⁷ For patients with chronic illness, 132 C-SNPs were available throughout the United States in 2018.⁸ C-SNP beneficiaries experienced increased value—including cost-sharing reductions for Medicare-covered services—in 2018 relative to 2017, while premiums stayed relatively flat during this time frame.⁹ We present 2 examples of C-SNPs that have added value through improved outcomes:

- CareMore is a Medicare Advantage plan that focuses on changing the care delivery model for chronically ill patients through its C-SNPs. CareMore Health Plan of Arizona Inc operates multiple SNPs in the United States, including CareMore Diabetes, which has more than 3100 enrollees. Through its operations in 6 states, CareMore has demonstrated success in improving patient outcomes and reducing medical costs. For example, in 2015, members had 20% fewer hospitalizations, 23% fewer hospital days, and a 4% shorter length of stay than beneficiaries covered under FFS Medicare.¹⁰
- Certain C-SNPs managed by DaVita Integrated Kidney Care have shown similar success, with a hospital admission rate among the C-SNP patients that is 25% lower than the national ESRD average. Moreover, these C-SNPs have a central venous catheter (CVC) rate of 6% versus the national ESRD average of 18.6%—the CVC is a vascular access associated with a higher infection rate and poorer outcomes than other access types (DaVita, unpublished data, 2016).

ESRD Seamless Care Organizations (ESCOs). In the United States, patients with ESRD make up approximately 1% of the Medicare population and account for 7% of Medicare spending due to disease complications, comorbidities, and high rates of hospital admissions.¹¹ In 2015, CMS introduced the Comprehensive ESRD Care (CEC) Model to help address the complex needs of these patients. The CEC Model established ESCOs consisting of dialysis centers, nephrologists, and other providers to coordinate care for patients on dialysis. In contrast to other ACOs, beneficiary attribution occurs through the dialysis center and ESCOs are accountable for both Part A and Part B Medicare expenditures for ESCO beneficiaries.

The ESCOs have demonstrated improvements in care quality and a reduction in per-patient medical expenses compared with Medicare FFS. The 13 ESCOs, in year 1, decreased unnecessary healthcare

utilization through reductions in hospitalizations, ambulatory visits, and use of CVCs, while generating \$75 million in savings.¹² In fact, as shown in the **Table**, the ESCOs in year 1 outperformed other ACOs in terms of savings. General enthusiasm for the model led to expansion to a total of 37 ESCOs in year 2 of the CEC Model. This model is slated to conclude at the end of 2020. The Center for Medicare and Medicaid Innovation (CMMI) has recently proposed a series of new models built on the CEC to further encourage use of integrated care in the populations with chronic kidney disease and ESRD.

Table. Performance Year 1 Comparison of CMS ACOs

	ESCO	Pioneer ACO	Next-Generation ACO	MSSP
Average savings (benchmark minus aligned expenditures as % of benchmark)	5.3%	1.2%	0.9%	0.5%
Percentage generating savings (vs benchmark)	100%	56%	61%	54%
Percentage earning shared savings payment	92%	41%	61%	24%
Nominal savings per patient*	\$4670	\$138	\$102	\$64

ACO indicates accountable care organization; ESCO, ESRD [end-stage renal disease] Seamless Care Organization; MSSP, Medicare Shared Savings Program.

*Total number of Medicare fee-for-service beneficiary-years were included in final reconciliation.

The ESCOs have achieved these results through various structures and interventions. These include the introduction of care managers for patients; improved analytics to risk stratify an already high-risk, high-need patient population; and strategies to better coordinate care for patients, whether through more efficient patient scheduling or medication therapy management. Learnings from the ESCOs have informed the proposed models in the recently announced Advancing American Kidney Health Initiative.¹³ This initiative has identified new clinical objectives for kidney care and several new reimbursement models to advance kidney health.

Oncology Care Model (OCM). In 2018, there were an estimated 1.7 million new cases of cancer diagnosed in the United States and an estimated national expense exceeding \$147 billion.¹⁴ Patients with cancer are medically complex and often require extensive specialty care. In 2016, CMMI announced the OCM, a 5-year, multipayer model established to test innovative payment strategies promoting high-quality and high-value cancer care.¹⁵ The OCM demonstration runs through June 2021. Medicare FFS beneficiaries who receive chemotherapy are automatically attributed to this type of care entity through a participating Medicare-enrolled physician group practice. Participating practices receive an up-front payment to manage

beneficiary care and performance-based payments. Beneficiaries attributed to the OCM continue to receive all Medicare Part A and Part B services, partial Part D services, integrated care, and required enhanced services, such as 24/7 access to an appropriate clinician with access to the patient's full medical record. CMS reports that the OCM covers 25% of Medicare FFS chemotherapy-related cancer care, with 190 practices and more than 6500 practitioners as of December 30, 2016. In the first 6-month performance period, Part D costs increased for both OCM and nonparticipating practices. OCM practices were most likely decreasing medical expenses but not enough to offset OCM practice payments. Also, no significant changes in quality occurred during this time frame.¹⁶ Acknowledging that these results cover only the first 6 months of OCM performance, it is probably too soon to ascertain its effect on cost and quality.

Other specialty care coordination solutions. One digital care coordination solution called SonarMD—a specialty-focused population health entity offered to patients with Crohn disease by participating gastroenterologists—reduced hospitalizations and outpatient visits, which led to savings of \$6500 per patient annually. With input from the patient—a way of integrating patient-reported outcomes—the information technology and care management platform allows clinicians to track disease severity and intervene when appropriate. Using the technology platform to identify potential flares and condition- and treatment-related problems early, providers can take action to prevent hospitalizations. As a result, patients feel guided through their illness by the technology and more connected to their doctors.¹⁷

Constructing New Specialty Accountable Care Vehicles

As demonstrated by the aforementioned specialty care models and solutions, new specialty ACOs could successfully enhance outcomes and reduce costs for chronic populations—and, through a specialized focus, could do so more effectively than a traditional primary care ACO. These clinicians are able to provide consistency of care in managing specific disease states, making it a better fit medically than primary care and potentially leading to improved patient experience and support.¹⁸ Specialty ACOs involve integrating care coordination and transitions of care, coordinating condition-specific medications with specialty pharmacies, leveraging knowledge related to guideline-specific specialty care, and enhancing patient navigation for appropriate services to add value.¹⁸

The path to developing a specialty ACO begins with analyzing a particular patient population's health status, then deciding which services and providers can help improve its health while also eliminating waste. This methodology contrasts the current health status with the ideal health of that population. Managing several patients with the same underlying disease and comorbid complications can help an ACO perform care coordination and use common solutions for similar problems.¹⁸

To incentivize payers, a specialty ACO must be large, have an established number of patients, and have access to an extensive managed care population, usually within a major metropolitan area. All patients must present with very similar conditions. If the ACO does not have access to the requisite population, it must create a significant base through aggregation or collaboration with other providers.¹⁸ The ACO needs to be cognizant of referral and practice patterns and not be inadvertently penalized (eg, through changes in patient referral or loss of other contractual agreements) for aggregating these patients into a new care structure.

Seamless data sharing is important for specialty ACO success. The appropriate exchange of information among primary care physicians, specialists, and hospitals is essential to properly manage patients with complex care needs. Technology solutions, such as SonarMD, allow patient data to be shared with specialty physicians and can improve outcomes. However, tracking and monitoring a condition-specific population also requires transparent benchmarks and disease-specific quality reporting. Developing new metrics and accountability for a broader set of conditions and performance of specialty practices are needed to help inform practice improvement and transformation. With knowledge of evidence-based medicine related to their specific area of practice, specialists are the best choice for developing quality-of-care measurements in their respective areas, and the organizations with which they work can help create efficiency and operational metrics.

APMs. To engage specialists in building an ACO or integrating with an existing ACO, payments must be linked to physician- and specialty organization–defined care processes and outcome metrics. The challenges of shared savings models and their lack of success to date suggest that APMs, such as those being undertaken in the OCM, should be tested in these structures. This is consistent with the alignment of new kidney care models as potential APMs in the recently announced Advancing American Kidney Health Initiative.¹³

One option is to add financial components in stages and increase risk over time. For large entities, a 2-sided risk arrangement may be used initially, with a limit to downside risk (or repayment penalties) for a defined period of time. In this scenario, participants would be eligible for bonuses by holding spending below defined targets while meeting quality metrics, and they would have a cap on the amount of repayment penalties for spending more than expected during the first performance year. For small entities, a 1-sided risk arrangement, in which they are eligible for bonus payments but not repayment penalties, would be used for the first year. Then, in years 2 and 3, these participants would migrate to a 2-sided risk arrangement.¹⁹

Alternatively, CMS could establish a waiver process for individual specialty ACOs to continue a 1-sided risk arrangement beyond the agreed-upon time period. A prerequisite to be included

in this payment mechanism would be a risk transition plan, which should define when the new organization would adopt 2-sided risk and how it will achieve that goal. This adaptable, but predictable, approach could effectively transition organizations to greater risk over time while also recognizing that some organizations have unique circumstances requiring flexibility to achieve success. By instituting this through a formal waiver process, CMS could achieve its goal of transitioning providers to more financial risk while retaining the interest and participation of those willing to provide more value.¹⁹

APMs for episode- or procedure-based care. Payment reform models are being designed around episodes of care or clinical conditions not necessarily confined within a single specialty. These clinical circumstances offer opportunities for better coordination by involving providers across multiple specialties and across the care continuum for a particular condition. The goal of episode- or procedure-based payment reform models is to incentivize providers to coordinate evidence-based medicine and patient-preferred treatments across the care continuum whenever possible.²⁰ This type of payment reform could improve clinical results and lower costs by focusing on episodes of care or clinical conditions that increase Medicare expenses and do so in part through variations in the amount, type, and quality of care for the clinical problem.

Many have suggested that APMs meet the prerequisites to manage conditions through a continuum. Smarter Management and Resource Use for Today's Complex Cardiac Care (SMARTCare), designed by the American College of Cardiology, was developed to improve the management of chronic coronary artery disease by increasing the percentage of patients with stable ischemic heart disease with optimal risk factor modification. This model aims to increase quality and reduce costs by improving decision making through (1) rational use of noninvasive cardiac imaging; (2) logical use of medical therapy, stenting, and bypass surgery when appropriate; and (3) addressing medication and lifestyle-change adherence. The SMARTCare model has been estimated to reduce resource utilization by 10% to 30%, according to CMS data, over the course of treatment for a cardiac episode of care.²⁰

In addition to cardiology, other specialty areas could readily achieve episode-based payment reform,²⁰ including gastroenterology, specifically inflammatory bowel disease; neurology, specifically Alzheimer disease; and rheumatology, specifically rheumatoid arthritis. These are condition-specific situations that require follow-up, management, and intervention to achieve clinical stability and prevent exacerbations of the clinical conditions.

Other specialties are suitable for developing payment models around procedure-based conditions or episodes of care,²⁰

including cardiology, specifically atrial fibrillation and transcatheter aortic valve replacement; orthopedic surgery, which already has the bundled payment care initiative in joint replacement; ophthalmology, specifically cataract removal, treatment for macular degeneration, glaucoma, and diabetic retinopathy; urology, specifically treatment for benign prostatic hyperplasia and prostate cancer; and vascular surgery, specifically peripheral vascular disease and hemodialysis access.

Methodologies are needed to attribute episodes of treatment to practices or providers. A 2015 study examined 2 approaches for attributing episodes in a payment model for specialty oncology services: (1) a retrospective approach, in which the episode was attributed to the practice responsible for the plurality of cancer-related visits for evaluation and management services, and (2) a prospective attribution rule that attributed episodes to the practice responsible for the claim triggering chemotherapy initiation. This analysis found that the prospective rule successfully attributed a higher percentage of episodes.²¹ However, further research is needed regarding attribution rules, as it is unclear whether this study's findings would apply to other specialty areas.

Conclusions

As the healthcare system continues to incorporate more value-based models, specialty ACOs represent a unique approach toward achieving the Quadruple Aim. Each of the aforementioned constructs has the ability to uniquely activate specialists. Moreover, in the specialty ACO, the specialists have a greater obligation to lead care while improving outcomes and cost-effectiveness of the care delivered. This is consistent with the approach defined in the executive order signed on July 10, 2019, to launch Advancing American Kidney Health.¹³ Although this encourages innovation, it also exposes the need to improve information systems that can risk-stratify patients and provide timely integration of clinical, operational, and financial data. The impact of training in population health management and team-based approaches to care can only enhance the likelihood of success of these models, with potentially greater impact when paired with practice transformation tools.

Specialty ACOs are also likely to succeed in adding value for other reasons. Most importantly, managing several patients with the same underlying disease and comorbid complications can help an ACO perform care coordination and use common solutions for similar problems. Regardless of certain inherent challenges—such as specialty–primary care interaction, patients moving between 2 types of accountable care entities, and appropriate information transfer—specialty ACOs deserve greater consideration as we strive to deliver better results for patients, for the clinicians caring for them, and for all payers.

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