Engaging Specialists in Care Delivery Transformation: Applications from NAACOS Specialty Care Guidebook

Chair: Erin Hurlburt, Lumeris

Health Care Transformation Task Force

Specialty Integration in VBC

April 23, 2026

Partners in Promoting Value

Who We Are

Established in 2014, the Health Care Transformation Task Force is a multi-stakeholder collaborative committed to driving outcomes, access and affordability.

Providers | **Payers** | **Purchasers** | **Patients** | **Partners**

Long -Term Commitment

Needed to Fix the Health Care System

All Stakeholders Needed

For Effective Transformation

Policy Engagement

To Support Sustainable Investment

Industry Action

Grounded in Operational Expertise

Patient Perspectives

To Prioritize Lived Experiences

CMMI Specialty Portfolio

New Models with Specialty Engagement

LEAD

ACCESS

WISeR*

Ambulatory Specialty Model*

TEAM*

Four Pharmacy Models

LEAD includes voluntary CMS-administered risk arrangements (CARA) – nested bundles within an ACO – and options for primary & specialty sub-capitation

Anticipated CMMI Models

CKCC certification or follow-up model

MA Models

* Mandatory models for providers

LEAD

Voluntary

Specialist Engagement Options

1 CMS Administered Risk Arrangements (CARA)

- **Nested bundled payments** for procedures, acute medical & fall prevention (chronic medical to follow)
- Begins in 2028 and only available to Global Risk ACOs
- CMS sets episode definitions and benchmarks, but ACO may modify with CMS approval
- ACO establishes risk-based contracts with specialists, with retrospective reconciliation relative to target

2 Non-Primary Care Capitation (NPCC)

- **Capitation for specialists** within or outside the ACO (Participant or Preferred Providers, respectively)
- ACO establishes contracts with specialists
- CMS will reduce FFS payments between 1-100%, as set in contracts, which is replaced with capitated payments
- No retrospective reconciliation – meaning any ACO savings relative to benchmark is locked in

3 Advanced Payment Option (APO)

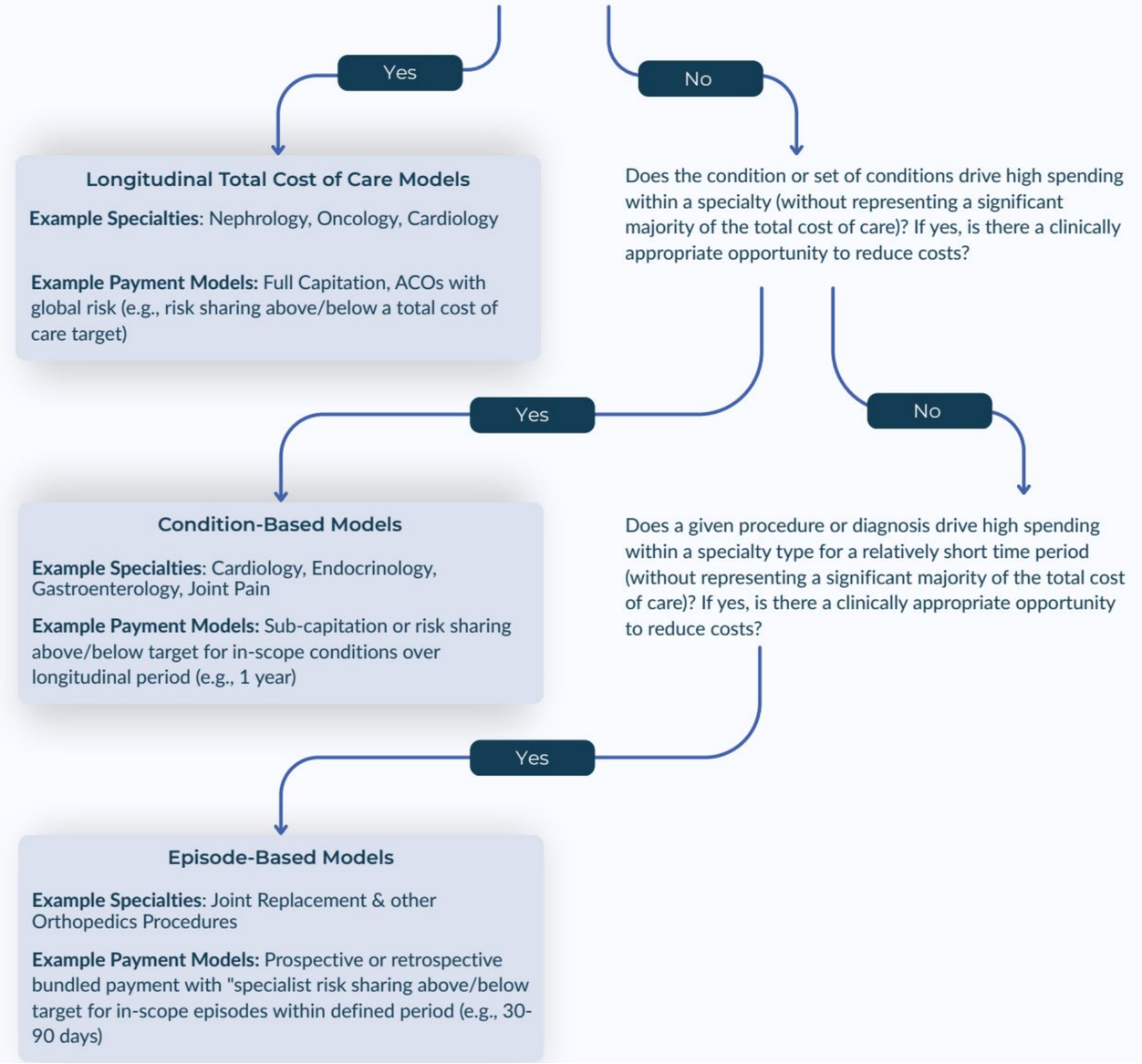
- **Advanced payment for specialists** within/outside ACO
- ACO establishes contracts with specialists
- CMS will reduce FFS payments between 1-100%, as set in contracts, which is replaced with capitated payments
- Includes retrospective reconciliation – so ACO specialty spend may be above or below benchmark

Decision Tree

Specialty incentives must be tailored to:

- Clinical opportunity to appropriately reduce costs
- The proportion of total cost of care represented by the clinical condition

Figure: Tailored Incentive Structures for Specialty Models



Source: https://hcttf.org/policy-recommendations-on-specialty-integration-in-value-based-care/

Key Questions for MA Arrangements

1. How are patients attributed – especially if patients are already attributed to a primary care arrangement?
2. How are benchmarks set (e.g., prospective vs. retrospective) and what is the comparison group?
3. How is financial risk defined (e.g., total cost of care vs. medical loss ratio)?
4. What quality measures are used and how will they adjust payment (e.g., quality gate vs. adjustment)?
5. How are payments operationalized (e.g., sub-capitation, retrospective reconciliation, incentives)?

Specialty Integration Case Studies

- MedStar Health participates in CMMI's Guiding an Improved Dementia Experience (GUIDE) Model
- GUIDE offers a monthly per beneficiary payment to support model implementation
- Care delivery: individualized care plans, referral coordination, caregiver support and respite care
- Keeping patients safely at home for longer is intended to reduce the total cost of care for dementia

- Camber Cardio contracts with MA plans and other risk-bearing entities like ACOs
- Financial arrangements include: Full capitation (TCOC risk), cardiac sub-capitation, and pay-for-performance
- Care delivery: real-time data sharing to support care coordination, care transitions & patient engagement
- Achieves savings through reduced inpatient and emergency department utilization

- Thyme Care participates in the Enhancing Oncology Model & MA contracts
- Total cost of care responsibility for attributed patients across models (including drugs)
- Care delivery: virtual navigation, care transitions, behavioral health, social support & palliative care
- Achieves savings through reduced ED/IP spend (60-70%) and reduced drug spend (30-40%)

Source: https://hcttf.org/advancing-value-based-oncology-through-24-7-integrated-virtual-cancer-care/
https://hcttf.org/driving-value-based-cardiology-care-at-scale/
https://hcttf.org/reimagining-dementia-care-lessons-from-implementing-the-guide-model/

Questions?

@HCTTF

@Health Care Transformation Task Force

Connect with me

Lehigh Valley Health Network

part of Jefferson Health

Specialty and Primary Care Collaboration in Value Based Care

Kevin McNeill, MD, MHA
Medical Director LVHN ACO

Together for the future of care

325+ years of health care, innovation and education

Top 15 nonprofit health system in the U.S.

65,000+ employees – among the top 5 largest nonprofit employers in PA

10 U.S. News national rankings

700+ sites of care

4,300+ physicians

2,500+ advanced practice clinicians

13,600+ nurses

4 Magnet® designated sites

1,400+ active clinical trials and research studies

10 colleges and **3** schools

200+ graduate and undergraduate programs

6 continents of global studies programs and collaborative research

8,400+ students

350,000+ health plan members

$1.6 billion in community benefit

Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE
+
Lehigh Valley Health Network

FY24 data; subject to change

LVHN ACO's MSSP

- **ACO Mission-**To foster a collaborative delivery of patient centered, high-value care to support individuals and groups in the achievement of better health and well-being.
- **ACO Vision-** To elevate the health and well-being of our beneficiaries and the communities we serve.
- Set up as a distinct legal entity (LLC)
- Founded in 2014, started program in 2015
- 50,000+ Medicare fee-for-service (FFS) beneficiaries are anticipated for attribution in 2026.

Agreement Period 1 (2015-2017)	Agreement Period 2 (2018-2021)	Agreement Period 3 (2022-2024)	Agreement Periods 4-5 (2025, 2026-2030)
• Track 1 (upside only) • Earned Shared Savings • Quality score above average • Philadelphia Area Wage Index (AWI) introduced	• Track 1 (upside only) • Newark AWI • MIPS increases	• Pathways to Success BASIC Track Level E • First agreement in up & down-side risk • aAPM bonus	• Early renewal, Pathways to Success BASIC Track Level E • Additional participants added (Northern tier) • Removed hospital TIN • Changed MSR/MLR

Cardiology Interventions

Program Component	Cedar Crest	Muhlenberg	Hazleton^	Schuylkill	Pocono	Carbon
Dedicated Nurse Navigator(s)						
Dedicated CHF Inpatient Unit						
Add on HF Order Set *FY26 to date	70.9% usage*	90% usage*	90.4% usage*	93.4% usage*	93.8% usage*	84.6% usage*
Meds to Beds/IV Lasix Kits						
TOC (ACBC)						
CARES-RPM						
Embedded Inpatient Pharmacist			Perhaps			
Home Health Care						
LVHI Tiger Connect						
ED Engagement						
LVHI Outpatient Pharmacist						
Urgent Heart Failure Clinic			Improving	Improving	Improving	Improving
7-day, 3-week Cardiology F/U			<14 days	<14 days	<14 days	<14 days
Advanced HF Program LVAD, ECMO						
Palliative Care						
Hospital Medicine Engagement						
Ambulatory HF Pathway						
Cardio Renal Clinic						

^Outpatient Cardiac Rehab Only

Multidisciplinary Collaborations

Cardio Renal- Dr. Ravi Bollu et al.	CC and MHC Consult if acute HF + GFR <50 AHA-Kidney Metabolic Center Pilot- signed 1/2026
Device Clinics –Ryan Kemp + Lehka Racharla	Facility definition of non-responders Workflow to advanced HF CardioMEMs- CC and MHC
Hospital Medicine	Cohorting HF patients outside the HFUs at CC and MHC US guided diuresis
Pulmonary medicine	CHF/COPD MHC Pilot • ID low risk for d/c • Drs. Boehmler and Love
Infectious Disease	Influenza Vaccine for all eligible HF patients Vaccination has been shown to decrease HF readmissions (-6%)

Cardiorenal Clinic Objectives

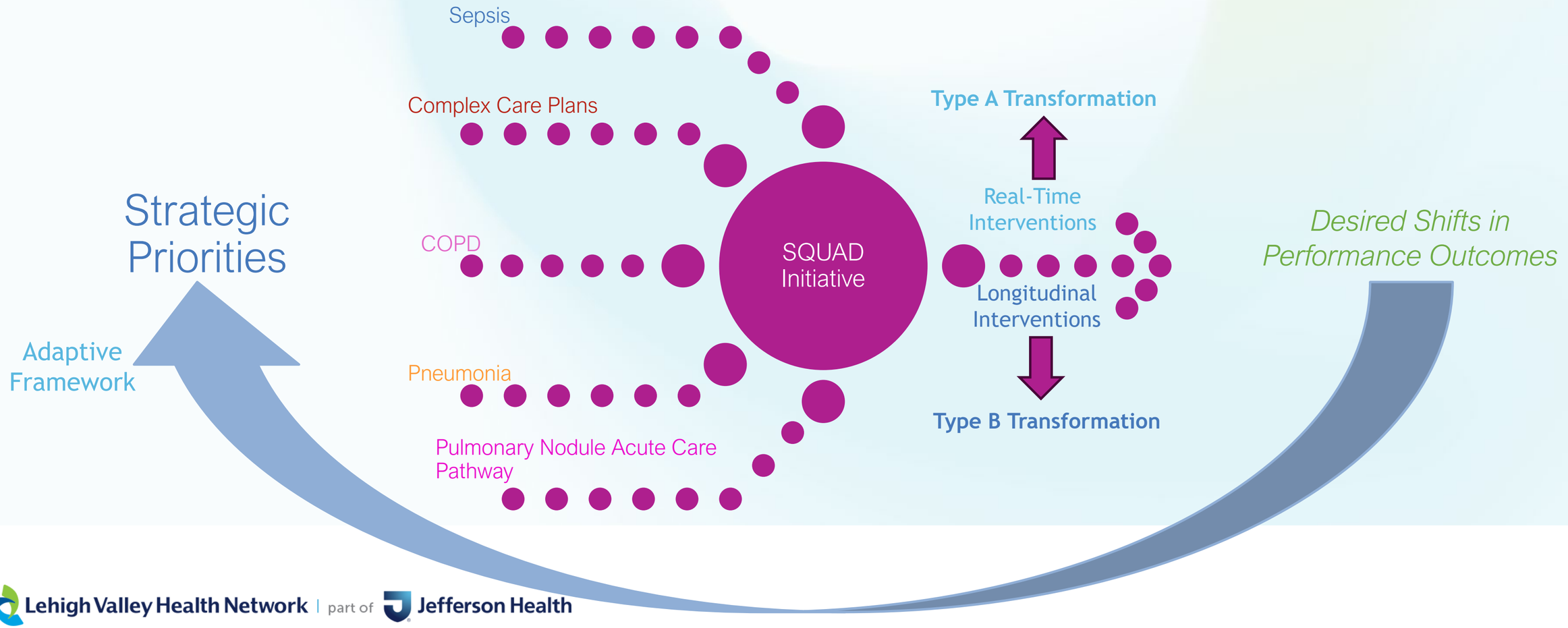
- Individualized and coordinated care with multidisciplinary approach
- Optimize and safely implement GDMT in CKD population
- Identify high risk groups and implement referral criteria
- Adequate follow-up w/prompt recognition of decompensation and implement appropriate intervention → avoid readmission/ED visits
- Reinforce lifestyle modification
- Provide guidance in treatment options
  - Advanced therapies
  - Palliative care
- Encourage patient involvement in care
  - Patient Education
  - Self monitoring

- Legacy LVHN sites are now part of AHA Cardiovascular-Kidney-Metabolic (CKM) Health Initiative
- 4-year national initiative to address fragmented siloed management to integrate whole person CKM care
- Improve early detection, care coordination and consistent use of evidence-based therapies.

SQUAD

Strategic Quality Utilization and Diagnostic

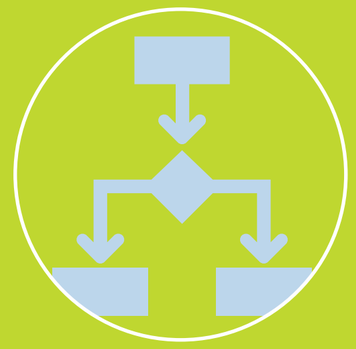
Quality Care Coordination Initiative



SQUAD Mission

The Strategic Quality Utilization and Diagnostic (SQUAD) initiative is a network-wide commitment to advancing patient outcomes and optimizing care delivery through cross-functional collaboration.

SQUAD offers an agile, sustainable framework for continuous improvement designed to accelerate and sustain performance gains aligned with strategic priorities identified by our colleagues.



Our approach integrates a dynamic set of proactive and reactive principles to drive meaningful, measurable transformation across the organization.

COLLABORATIVE CONTINUOUS IMPROVEMENT

SQUAD: Multidisciplinary Subject Matter Expertise

Care Management	Nursing	Virtual Nursing	Continuous Improvement	Quality	Access Coordination
Infectious Disease	Infection Prevention and Control	Department of Medicine	Pulmonary/Critical Care	Hospital Medicine	Emergency Medicine
TOC	Remote Patient Monitoring	Policy	Pharmacy	Infection Control	ACO
Family Medicine	Finance	Ambulatory	Informatics	Population Health	Respiratory

Growth

Lehigh Valley Health Network

part of Jefferson Health

HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Kevin McNeill, MD, MHA

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Engaging Specialists in Care Delivery Transformation: A Health System Perspective

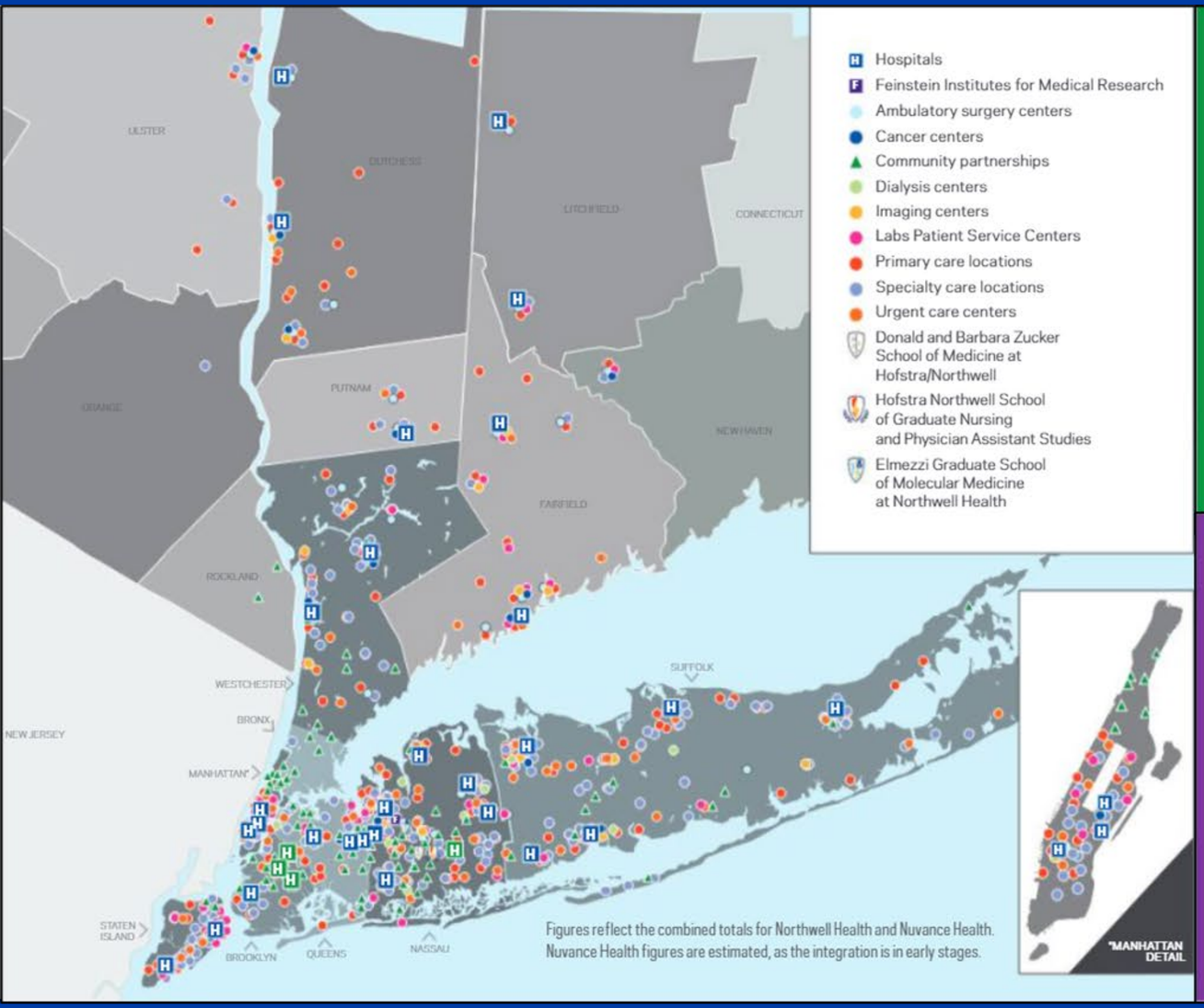
A Health System Perspective

NAACOS Spring Conference | April 23, 2026

Ramsey Abdallah, DHA, MBA, FACHE, PMP, CMQ/OE, CPHQ, CHFP, CPPS
Assistance Vice President, Operations

Northwell Health

Northwell Health At A Glance



ECONOMIC IMPACT

$22.6 billion annual operating budget

$1.6 billion capital budget

28 hospitals

11 Magnet-designated

1,050+ ambulatory facilities

104,000 employees

largest private employer in New York State

13.2 million service area population

CAREGIVERS

13,500 credentialed physicians

7,300 employed physicians

4,500 advanced care providers

Largest physician group in the New York metropolitan area

22,000 nurses

2,400 residents & fellows in 220+ programs

3,700 volunteers

COMMUNITY IMPACT

$2.7 billion in community benefit **(15.6% of operating expenses)**

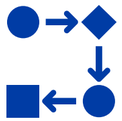
6,000 community health programs

60,100 health professionals in training

1. MSSP ACO
2. ACO REACH
3. GUIDE Model
4. Medicare Advantage & Commercial Contracts
5. State Medicaid Programs

The Core Problem

What VBC requires from specialists



Standardized workflows

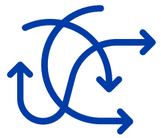
Population-level accountability

Cross-continuum coordination

Data-driven behavior change

What specialists experience

"This isn't my scope"



Workflow disruption concerns

Misaligned incentives

Fragmented data and feedback

Specialist Engagement Is a Change Management Problem

Specialist engagement is not a contracting problem you solve with incentives alone. It is a behavior-change problem you solve with infrastructure, trust, and operational alignment.

You cannot mandate adoption; you have to design for it

Pick a change framework that fits your culture and commit to it

Address both the clinical objection and the operational objection simultaneously

The Goal: Screen 2M+ patients for depression annually across all ambulatory settings including specialty offices

Only 29% of Northwell patients receive primary care at Northwell

If screening lives only in primary care, the majority of patients are never reached

Specialists had to be part of the solution

Two Objections That Had to Be Solved Together

01

Infrastructure: Behavioral Health Access Center

- Centralized navigation hub for all positive screens
- Licensed counselors triage by acuity (emergent

02

Incentives: Multi-Layered, Role-Specific

- *Physicians & operational leaders*: financial bonus tied to depression screening performance
- *Frontline staff*: recognition program with certificate, leadership communication, and team visits with lunch

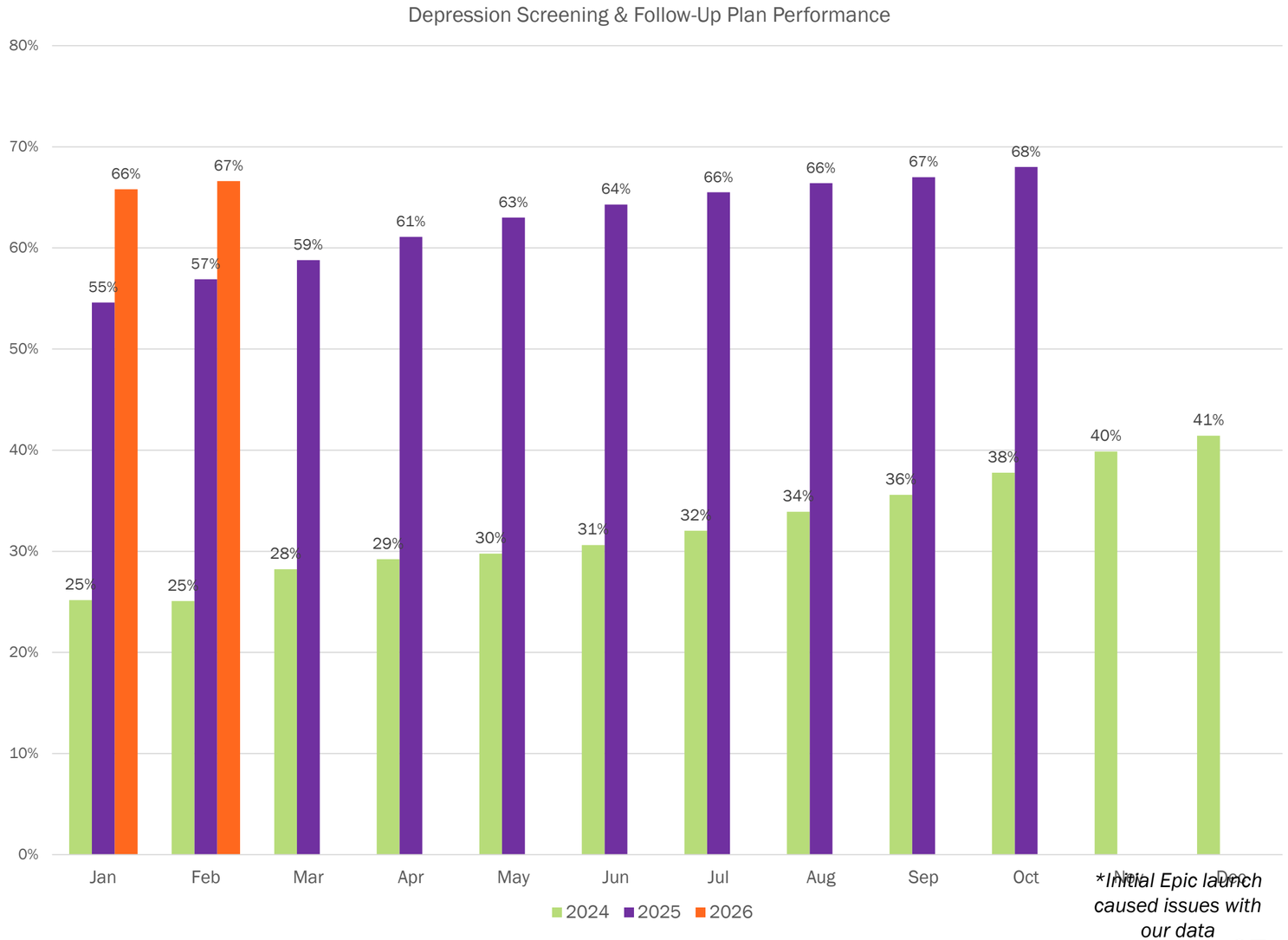
03

Champions & Governance

- Ambulatory Quality Improvement Champions embedded in practices
- Cross-functional governance: quality, regional operations, clinical service lines, data, IT
- Physician sponsors for credibility and peer

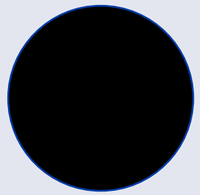
Results: Screening Expanded Across Specialty Offices Enterprise-Wide

- 76 foundational touchpoints
- 369 champion-based touchpoints
- 7 in-house training sessions
- 34 meetings
- 25 email communications



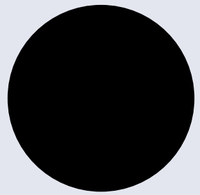
**Initial Epic launch caused issues with our data*

Principles for Specialist Engagement: What We Learned



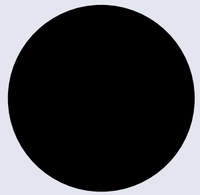
Solve the clinical and the operational objection at the same time.

Build the infrastructure before you ask for the behavior.



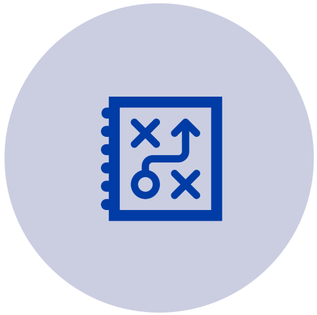
Layer incentives by role. One incentive model does not fit all roles.

Invest in peer-to-peer influence. Credibility comes from shared clinical identity.



Measure relentlessly, but lead with transparency.

What's Next: The Road Ahead



Expanding the Playbook to Cardiometabolic Disease

Building Specialty-Specific Performance Visibility

Designing for Shared Accountability Across the Continuum

Key Takeaway

Specialist engagement succeeds when you make participation easy, make performance visible, and make the work theirs.

Thank you

Northwell Health

Made for this™

Engaging Specialists in Care Delivery Transformation: The Time is Now

Erin Hurlburt, MD

Chief Medical Officer, Population Health Services, Lumeris

4/23/2026

Lumeris™

Lumeris is a physician-first healthcare transformation company dedicated to improving primary care.

ESSENCE HEALTHCARE®

Medicare Advantage plan founded by physicians in 2003 and built on patient-first care.

Value Based Care Enablement™
Lumeris

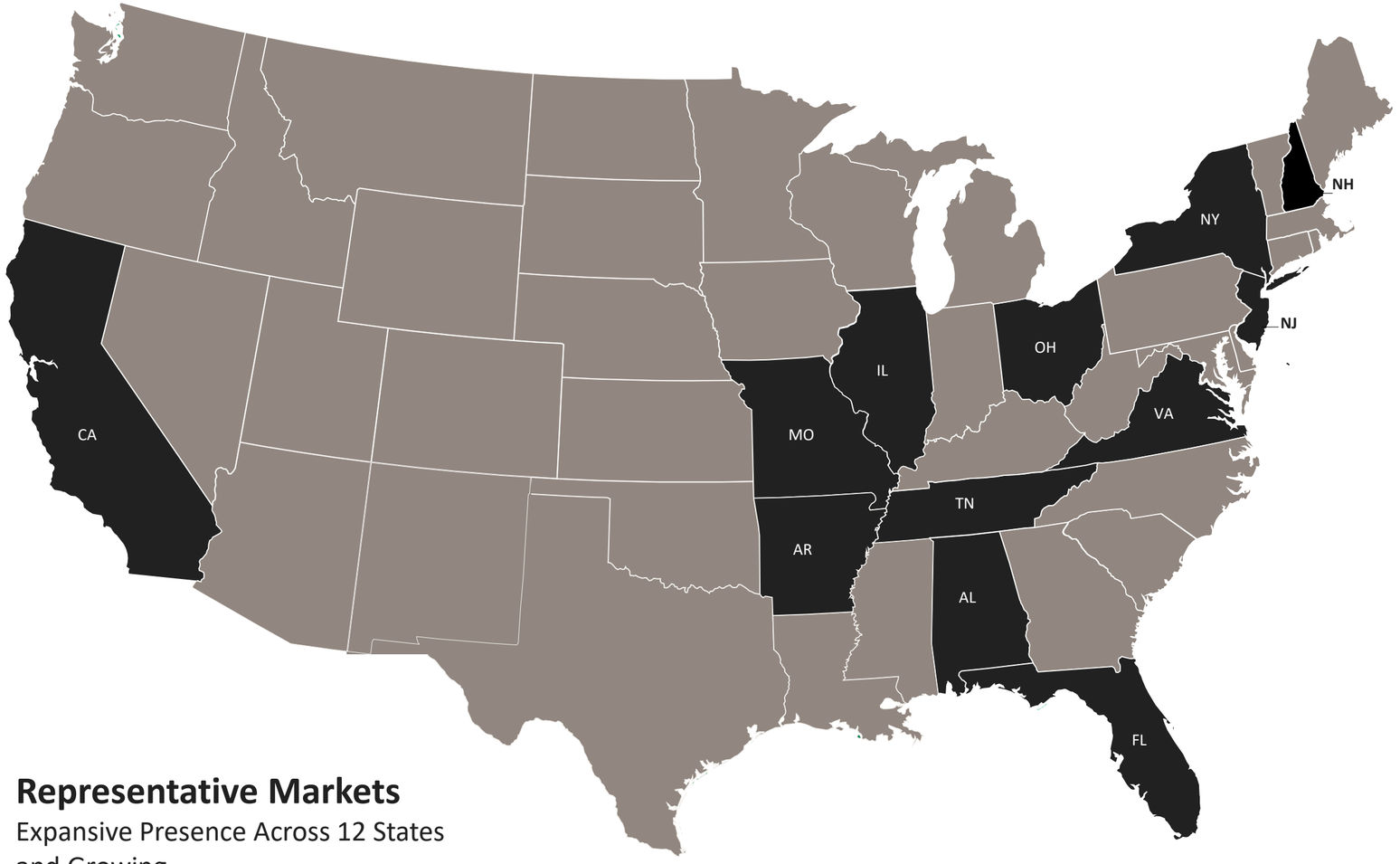
Health systems and provider partnerships navigating the complexities of VBC to maximize investment, ensure long-term sustainability, and improve patient outcomes.

Tom™
Lumeris

AI platform for value-based and primary care designed to enhance care coordination, reduce administrative burden, and optimize both clinical and financial performance.

Enablement Partnerships: National Scale, Diverse Business Lines

15+ Years Focused Value-Based Care Experience

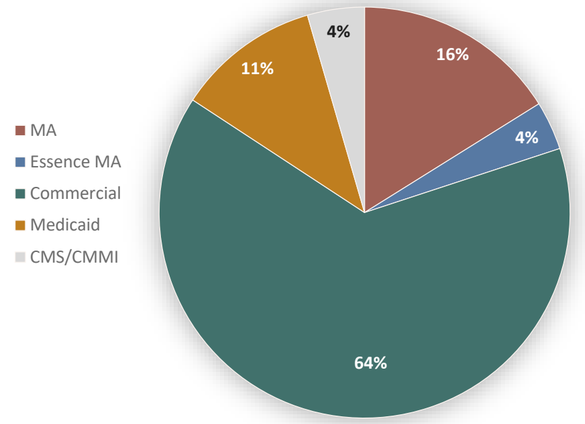


Representative Markets
Expansive Presence Across 12 States and Growing

1.2M+
Total Value-Based Lives

>$10B
Medical Spend Under Management

2026 Lives Under Management By LOB



We believe that value-based care is the foundation of a stronger, more sustainable health system—and that every individual deserves access to the kind of proactive, personalized care we'd choose for those we love.

This belief isn't just aspirational—it's operational

94%+
Quality Scores
*ACO REACH RESULTS

$1,000+
Yearly savings per patient*
*PY23 ACO REACH RESULTS

~60%
High Risk Patients Proactively Identified before Admissions

32%
Decrease in SNF Length of Stay
Current Partner Representative Group

3.8x
More Favorable Contract Economics than FFS

4.5+ Star
CMS Rating for Essence Healthcare 5 years running

Lumeris™

Specialists in VBC: Why Now?

Specialty spending is a leading contributor to the increase in overall healthcare spend

TCOC for patients seeing orthopedics, oncology, cardiology, women's health, behavioral health and nephrology made up 68% of commercial and Medicare spend in 2023[1]…and costs are growing

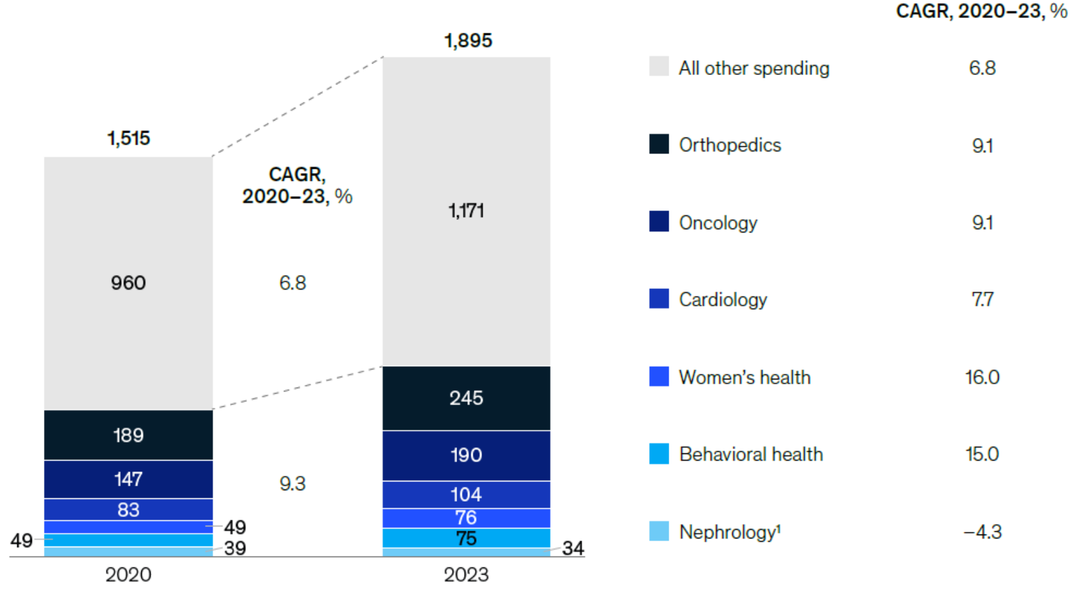
Health systems are focusing on:

- Evidence-based care pathways to improve quality ratings, reduce clinical variation & readmissions penalties, and contain variable costs
- High-value network development for direct-to-employer strategy
- Network care consolidation as competitive advantage in a consumer-driven landscape

Exhibit 1

Spending on six specialty-care segments is growing 35 percent faster than all other Medicare and commercial spending.

Total Medicare and commercial spending, 2020–23, $ billion



Note: Figures may not sum to totals, because of rounding.
¹Decrease in spending was driven by expanded Medicare eligibility in 2021, leading to a shift in coverage for end-stage renal disease from commercial to Medicare.
Source: CareCUBE by McKinsey; Centers for Medicare & Medicaid Services Limited Data Set (2020–23); Merative MarketScan Commercial Dataset (2020–23)

McKinsey & Company

[1] McKinsey and Company: "Specialty risk: The next frontier of value-based care" Kunte, Patel, Abou-Atme, July 2025

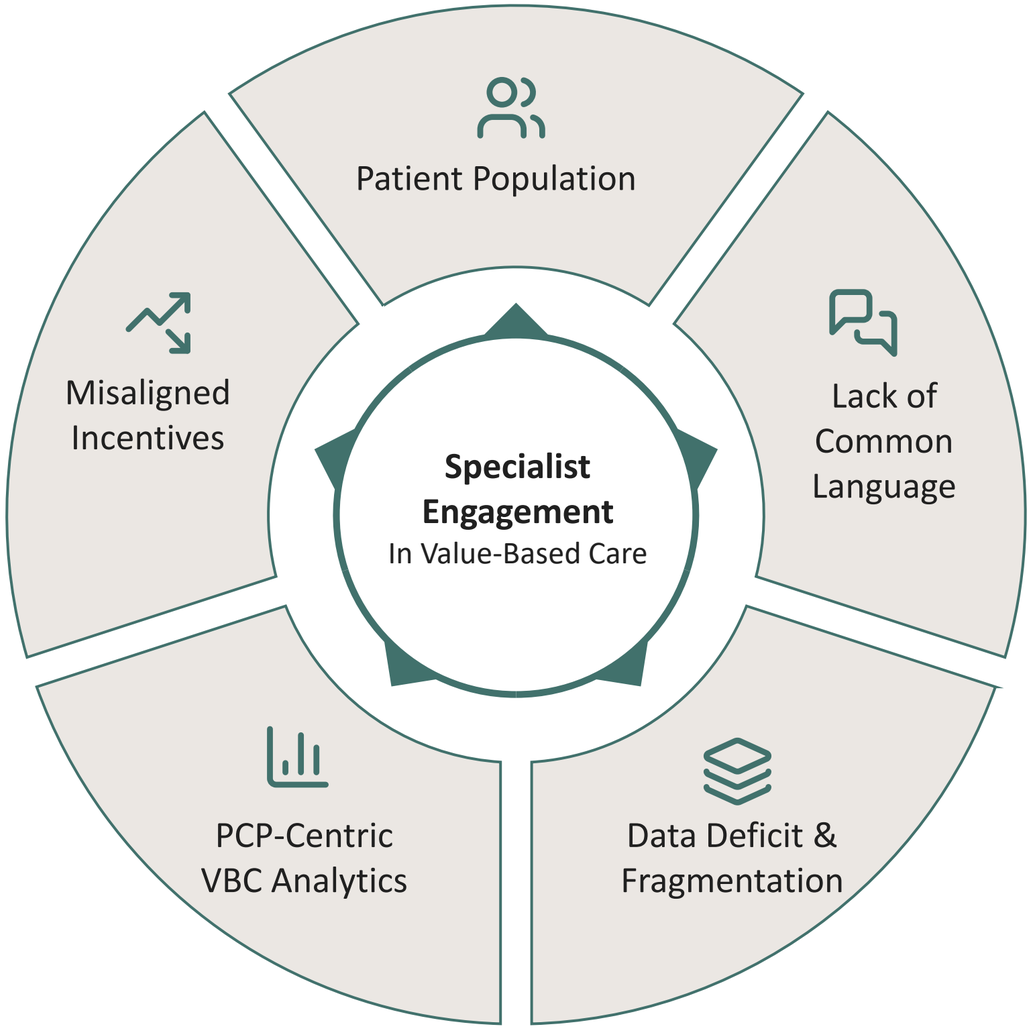
Programmatic Tailwinds

The traditional view of VBC focusing solely on **primary care** transformation is evolving

Recent CMMI initiatives incorporate elements that encourage or require direct involvement from specialty care:

- Ambulatory Specialty Model (**ASM**)
- Advancing Chronic Care with Effective, Scalable Solutions (**ACCESS**)
- Transforming Episode

The Core Challenges



Specialist Patient Population:
Smaller, higher-acuity cohorts lead to variability in costs and outcomes

Common Language, Shared Goals:
It's challenging to have productive conversations without a shared set of relevant metrics and a common objective

Incentives:
FFS models do not reward and often disincentivize the coordination and efficiency that VBC requires

Fragmented Data:
Multiple EHRs, delayed claims, and small populations lead to the skepticism specialists have towards "black box" analytics

Analytics:
Lack of a specialty-focused analytics strategy makes it difficult to draw credible, actionable insights

Bridging the Gap with Data

Building a foundation for performance: Balanced scorecard

Efficiency: Timeliness of consult notes, referral acceptance rate

- Ensures coordinated care and accountability between PCPs and specialists

Clinical Quality: 30-day readmission rate, evidence-based therapy adherence

- Reflects clinical outcomes specialists directly influence

Utilization: ED visits per 1,000 patients, imaging appropriateness

- Identifies opportunities to manage costs and reduce unnecessary care

Patient Experience: Appointment wait times, Net Promoter Score

- Drives engagement and trust, crucial for loyalty and adherence

Referrals: The Front Door to Engagement

Referrals indicate trust

Anchor referral patterns in transparent, shared data

Fix the referral experience first

Co-design referral pathways with specialists

Learn from out-of-network referrals

Best Practices: Implementing for Impact & Trust

Prioritize for strategic impact

Focus on 3-5 specialties with highest costs, volume, or variation

Segment patient populations by condition and acuity to target the most meaningful opportunities

Engage early and consistently

Involve specialists from the start in defining value and validating metrics

Identify physician champions to lead adoption and build credibility

Develop structured, transparent governance

Establish peer-review processes, regular meetings, and clear charters for accountability

Present benchmarks in clear, visual formats, and share multi-payer data at the provider level

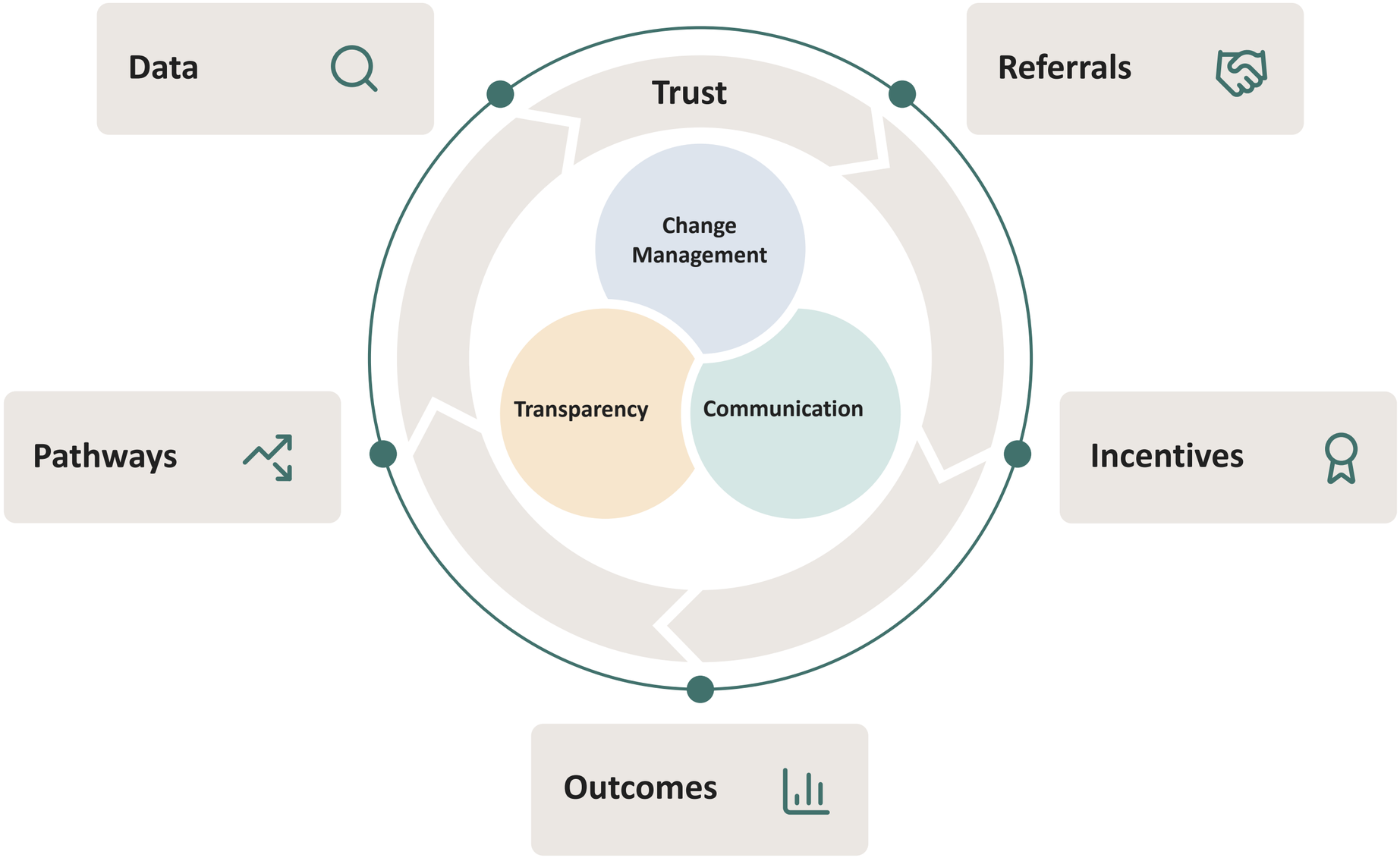
Sustain collaborative dialogue

Use scorecards as a foundation for ongoing, peer-to-peer conversations

Address patient experience, consult expertise, and referral patterns in discussions

Continuously evolve scorecards to remain relevant

A Framework for Success



Thank you!

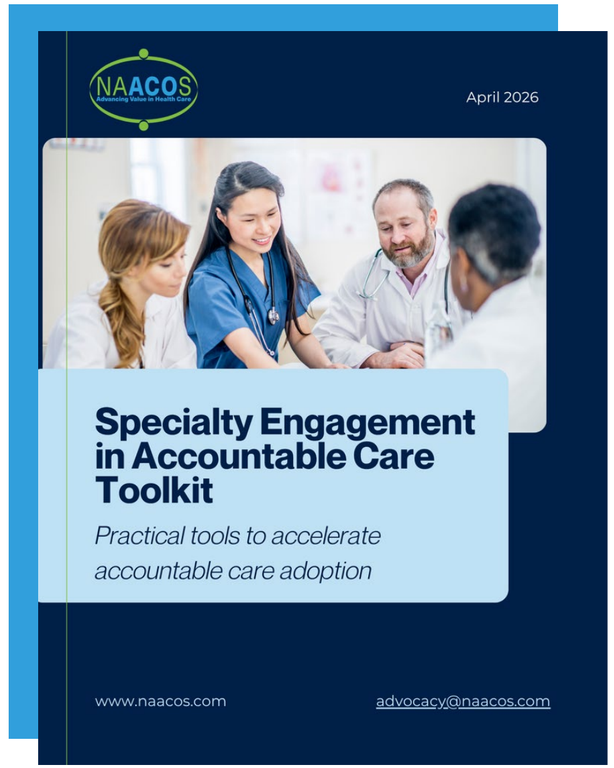
NAACOS Specialty Engagement in Accountable Care Toolkit Webinar

April 23, 2026

Specialty Engagement in Accountable Care Toolkit

NAACOS released the *Specialty Engagement in Accountable Care Toolkit* to support meaningful specialty engagement across the continuum of care.

- ✓ Voluntary best practices
- ✓ Step-by-step guidance
- ✓ Practical, adaptable tools



Download your free copy of the toolkit and resources now!

Purpose

The Specialty Engagement Toolkit serves as a comprehensive resource designed to bridge the gap between accountable care entities, primary care, and specialty providers. It enables organizations to move beyond fragmented approaches toward coordinated, team-based care that delivers measurable results for all stakeholders.

Share What Works

Distill successful strategies for organizations to adapt to their unique market conditions and patient populations.

Provide Guiding Principles & Best Practices

Offer stepwise approaches to align incentives, improve coordination, and strengthen shared accountability across the care continuum

Align Incentives & Strengthen Accountability

Create shared goals that align financial and clinical incentives across care teams, improving coordination between primary care and specialists while reinforcing mutual accountability for patient outcomes.

Approach

The Toolkit represents findings from:

- An advisory workgroup including specialists, VBC providers, clinical and operational leaders, payers, and quality and analytical experts. Workgroup members were selected from NAACOS' membership to ensure diverse representation across national and regional industry organizations
- NAACOS staff coordinated additional literature reviews, environmental scans, and interviews with subject matter experts

Learn What's Working

Stakeholders expressed strong interest in understanding what works and what doesn't in specialist engagement. They wanted proven strategies and real-world examples that can be adapted to their unique care settings.

Incentive Structures

There is significant desire for both financial and non-financial incentives with scalable examples. Organizations seek flexible models that align specialist rewards with value-based care outcomes across diverse populations.

Practical Outcomes & Transparency

Stakeholders emphasized the need for practical, attainable outcomes supported by transparency and data-driven insights.

Practical Tools for Specialty Engagement

Structured and actionable
Strategic guidance and practical tools include dashboards, assessments, and templates

Practical framework
Domains and tools can stand alone or integrate as a full toolkit

Works for many audiences
Written for executives, clinicians, specialists, strategic & operational leaders, and analysts

Developed for every stage
Works for entities engaging specialists in early efforts to those with advanced models

Adaptable guidance
Reflects the diversity of specialties, populations, and organizational readiness levels

Foundational Themes

Leadership and governance

Data transparency

Operational integration

Incentive alignment

Equity and access

1. **Data, Analytics, and Dashboards**
2. **Patient Entry, Attribution, and Clinical Pathways**
3. **Specialist Engagement & Referral Network Planning**
4. **Developing and Aligning Meaningful Incentives**
5. **Episodes of Care Payment Models**
6. **Advanced Specialty Care Payment Models**

Acknowledgements

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Erin Hurlburt, MD
Chief Medical Officer, Population Health Services, Lumeris

Sophia Kim
Chief Growth Officer, Heartbeat Health

David Klebonis
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David Lim, MD, PhD
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Robert Mechanic, MBA
Executive Director, Institute for Accountable Care

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Questions?

THANK YOU!

Stay engaged with us.

Share your experiences with dchen@naacos.com

Appendix

Tool 1: Specialist Performance Index

Example Specialist Performance Index -- Key Domains and Example Measure Concepts

Measure Concepts	Specialty	Target/Benchmark	Measure Concept Details and Benchmark Source
Efficiency			
Referral acceptance rate	All specialties	≥ 90%	Tracking referral completion, often called "closing the loop," is an important measure of care coordination. It captures the percentage of referrals that are scheduled, completed, and result in a report back to the referring provider. This metric aligns with national quality guidance and ensures accountability between primary care and specialists. CMS data for Closing the Referral Loop (Measure 374) show that high-performing organizations average about 77% completion after workflow improvements. Setting a target of 80% is both realistic and ambitious, exceeding the national mean while remaining achievable with strong processes in place. https://pmc.ncbi.nlm.nih.gov/articles/PMC4510221/
Timeliness of consult notes (<72 hrs)	All specialties	≥ 90%	Timely turnaround on consult notes is essential for safe, coordinated care. While CMS quality measures focus on receipt of a specialist report, many eConsult programs commit to responding within 72 hours or less, ensuring that actionable guidance quickly reaches primary care providers. Evidence from a Duke University study found that 91% of eConsult notes were completed within 72 hours, showing that this standard is achievable with effective workflows. A benchmark of at least 90% aligns with best practices, supporting referral loop closure and giving primary care teams the timely information they need to guide follow-up care. https://dukespace.lib.duke.edu/server/api/core/bitstreams/9cf5 5e2c-d500-4843-b3b4-255ec207536c/content
Average episode expense	Oncology, Orthopedics, Cardiology, Nephrology	≤ regional or national average for that episode type (risk-adjusted).	Episode-level cost visibility is critical for understanding and managing the total cost of care, particularly in bundled and sub-capitation arrangements. CMS' Bundled Payments for Care Improvement (BPCI) and other models establish target prices based on regional averages and adjust for patient risk. Using regional or national benchmarks provides a clear standard for comparison and ensures alignment with value-based purchasing frameworks and payer expectations. Note that cost can depend on case mix as different lines of business may have different costs. Expenditures would be subject to adjustments when weighing payer utilization management and contractual requirements. https://pmc.ncbi.nlm.nih.gov/articles/PMC5365411/
Quality of Care			
Evidence-based therapy adherence (%)	All specialties	≥ 80%	Specialty dashboards should reflect not only cost but also clinical quality measures that specialists directly influence. Healthcare Effectiveness Data and Information Set (HEDIS) offers condition-specific adherence and therapy metrics -- such as statin use for cardiovascular disease or diabetes and medication adherence for chronic conditions -- that provide meaningful insights into quality of care. Including a few guideline-backed measures in the core

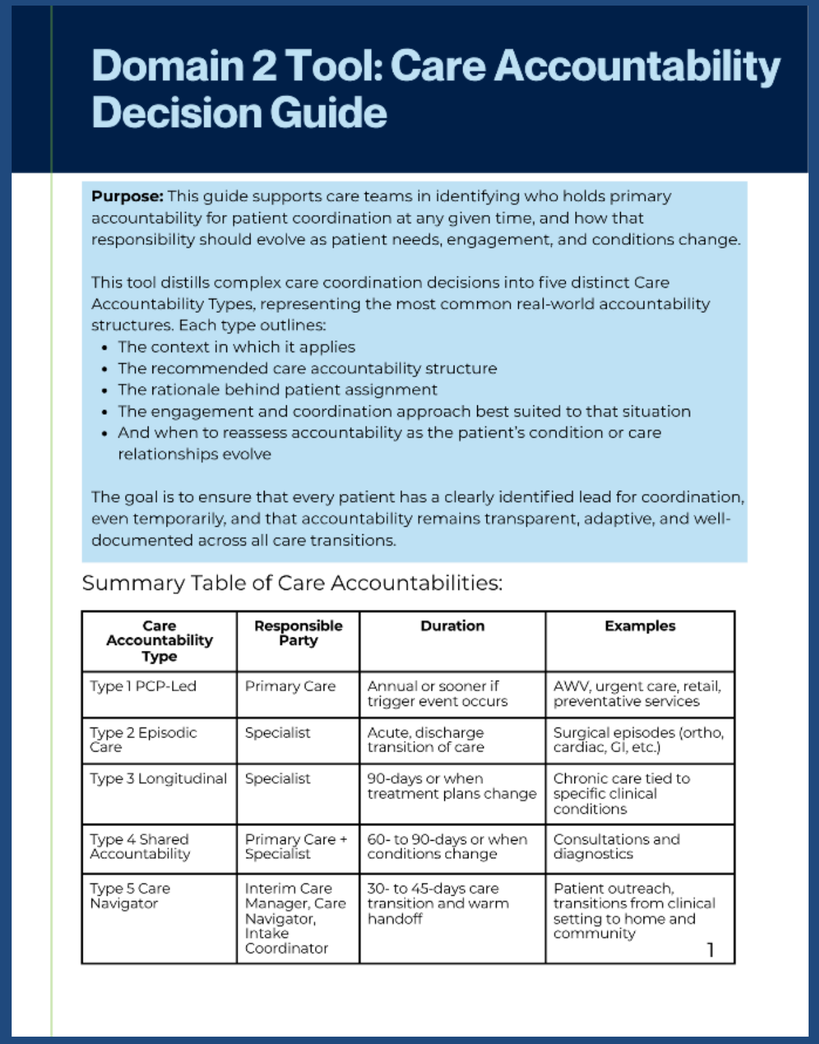
Challenges

- Data fragmentation
- Education on the use of performance data
- Patient attribution

Built for actionable transparency

- Excel-based, customizable, and flexible
- Organizes metrics into efficiency, quality of care, utilization, and patient experience categories
- Focuses on measures specialists can influence
- Aligns with broader total cost of care goals
- Actionable details drives conversation toward meaningful insights

Tool 2: Care Accountability Decision Guide



Domain 2 Tool: Care Accountability Decision Guide

Purpose: This guide supports care teams in identifying who holds primary accountability for patient coordination at any given time, and how that responsibility should evolve as patient needs, engagement, and conditions change.

This tool distills complex care coordination decisions into five distinct Care Accountability Types, representing the most common real-world accountability structures. Each type outlines:

- The context in which it applies
- The recommended care accountability structure
- The rationale behind patient assignment
- The engagement and coordination approach best suited to that situation
- And when to reassess accountability as the patient's condition or care relationships evolve

The goal is to ensure that every patient has a clearly identified lead for coordination, even temporarily, and that accountability remains transparent, adaptive, and well-documented across all care transitions.

Summary Table of Care Accountabilities:

Care Accountability Type	Responsible Party	Duration	Examples
Type 1 PCP-Led	Primary Care	Annual or sooner if trigger event occurs	AWV, urgent care, retail, preventative services
Type 2 Episodic Care	Specialist	Acute, discharge transition of care	Surgical episodes (ortho, cardiac, GI, etc.)
Type 3 Longitudinal	Specialist	90-days or when treatment plans change	Chronic care tied to specific clinical conditions
Type 4 Shared Accountability	Primary Care + Specialist	60- to 90-days or when conditions change	Consultations and diagnostics
Type 5 Care Navigator	Interim Care Manager, Care Navigator, Intake Coordinator	30- to 45-days care transition and warm handoff	Patient outreach, transitions from clinical setting to home and community

1

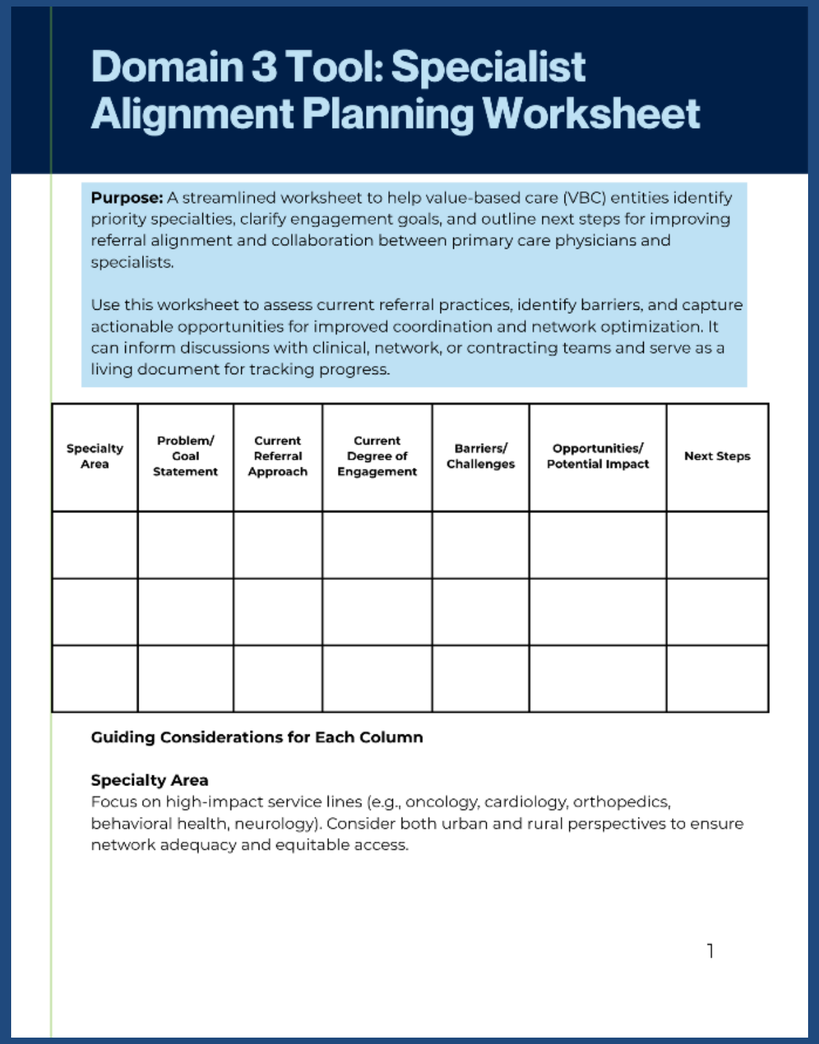
Challenges

- Fragmented patient entry pathways
- Limitations of attribution algorithms
- Duplication and overlapping care
- Communication and patient engagement gaps
- Barriers to integrating evidence-based clinical pathways
- Securing specialist buy-in and identifying clinical champions

Defines accountabilities as care needs evolve

- Supports smoother coordination across PCP and specialists
- Organizes real-world scenarios into distinct care accountability types
- Ensures patients have a consistent, coordinated point of care
- Clarifies when and how responsibility could shift across care settings
- Informs clear, clinical and operational workflows that build trust and reinforce credibility

Tool 3: Specialist Alignment Planning Worksheet



Domain 3 Tool: Specialist Alignment Planning Worksheet

Purpose: A streamlined worksheet to help value-based care (VBC) entities identify priority specialties, clarify engagement goals, and outline next steps for improving referral alignment and collaboration between primary care physicians and specialists.

Use this worksheet to assess current referral practices, identify barriers, and capture actionable opportunities for improved coordination and network optimization. It can inform discussions with clinical, network, or contracting teams and serve as a living document for tracking progress.

Specialty Area	Problem/ Goal Statement	Current Referral Approach	Current Degree of Engagement	Barriers/ Challenges	Opportunities/ Potential Impact	Next Steps

Guiding Considerations for Each Column

Specialty Area
Focus on high-impact service lines (e.g., oncology, cardiology, orthopedics, behavioral health, neurology). Consider both urban and rural perspectives to ensure network adequacy and equitable access.

1

Challenges

- Identifying barriers to coordination, access, efficiency, and quality
- Complex market conditions and populations
- Lacking data-driven insights and transparency

Actionable insights for building specialty networks

- Structured framework to understand referral patterns and clarify the goals driving engagement
- Surface barriers and opportunities that inform coordination and performance
- Defines actionable next steps for network optimization
- Data-informed foundation for strategic planning

Tool 4: Specialist Incentive Development Framework

Domain 4 Tool: Specialist Incentive Development Framework

Purpose: Provide a structured guide for Value-Based Care entities collaborating with specialists to co-design credible, transparent, and actionable incentive programs that align specialists with quality outcomes and patient experiences.

Step 1. Define Target Condition or Service Line
Identify areas with high potential for quality improvement and cost savings.

Examples: Cardiology, Orthopedics, Oncology, Behavioral Health, Chronic Disease, Neurology, Pulmonology

Prompts:
- What condition or specialty area are we targeting?
- What measurable outcomes or savings opportunities exist?
- What population size/volume supports implementation?

Step 2. Select Model Type
Whether considering pay-for-performance or other payment model types such as bundles, sub-capitation, or population-based specialty care models, designing and implementing the right incentive structure requires a nuanced understanding of clinical patterns/care accountabilities, stakeholder roles, and available data.

Key Considerations:
- Nature of specialty care types: longitudinal/chronic conditions, episodic care
- Roles of key players: payers, VBC/risk-bearing entities, clinical practices
- Incentive program participants: individual clinicians such as specialists or other physicians, clinical practices, other providers (clinical and/or social care)
- Exploring referral patterns across networks
- Availability and reliability of cost and quality data

Step 3. Establish Metrics and Data Sources
Translate measurable metrics into performance goals that inform distribution logic. The chart below includes examples from the Section 1 Toolkit – Specialty Performance Index measure concepts.

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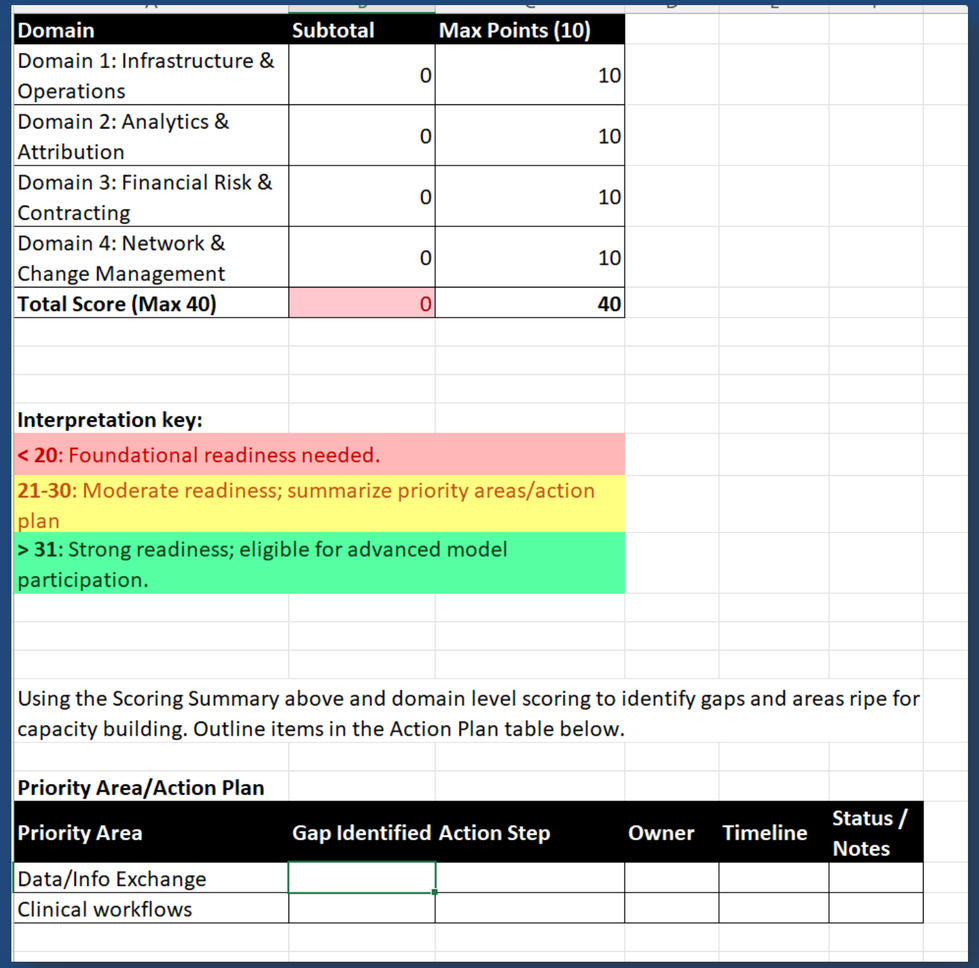
Challenges

- Balanced ownership of financial risk and incentives
- Attributable savings, impact, and distribution
- Aligned incentives across complex populations and payers

Aligning clinical goals, incentives, and accountability

- Stepwise guidelines to co-designing incentive programs alongside specialists
- Defines how measurable goals and quality gates align to financial and non-financial incentives
- Ensures incentives remain achievable and transparent
- Reiterates importance of accountability and governance (e.g., clinical champions)

Tool 5: Bundle Contracting Readiness Assessment



Domain	Subtotal	Max Points (10)
Domain 1: Infrastructure & Operations	0	10
Domain 2: Analytics & Attribution	0	10
Domain 3: Financial Risk & Contracting	0	10
Domain 4: Network & Change Management	0	10
Total Score (Max 40)	0	**40**

Interpretation key:

< 20: Foundational readiness needed.

21-30: Moderate readiness; summarize priority areas/action plan

> 31: Strong readiness; eligible for advanced model participation.

Using the Scoring Summary above and domain level scoring to identify gaps and areas ripe for capacity building. Outline items in the Action Plan table below.

Priority Area/Action Plan

Priority Area	Gap Identified	Action Step	Owner	Timeline	Status / Notes
Data/Info Exchange					
Clinical workflows					

Challenges

- Constrained participation and attribution complexity
- Savings and benchmark “ratcheting”
- Fragmented data insights

Preparing for Episodic Risk

- Realistic self-assessment to evaluate preparedness before entering or expanding bundled arrangements
- Organizes across 4 domains infrastructure & operations, analytics & attribution, financial risk & contracting, network & change management
- Scoring system informs priority areas in creating strategic and action plans
- Findings can influence episode selection, risk glidepaths, and operational decision-making

Tool 6: Practice Engagement Readiness Assessment

Category	Dimension	Evaluation Criteria / Questions	Scoring Guidance (1–5)	Score	Guidance
Quality & Outcomes	Clinical Performance	Does the specialist/specialty group meet or exceed quality benchmarks (e.g., HEDIS, PROMs, readmission rates, complication rates)?	**1:** No tracking or below benchmark **2:** Tracks but inconsistent or below targets **3:** Meets benchmark performance **4:** Exceeds benchmarks on key measures **5:** Consistently top quartile with demonstrated outcomes improvement		🔴 Require formal corrective action plan before partnership; defer contracting until validated improvement or external quality reporting available. 🟡 Review metrics with the group and identify specific measures below target; establish a short-term quality improvement plan with quarterly review. 🟢 Ready for partnership or performance-based contracting.
Quality & Outcomes	Care Pathway Adherence	Does the specialist/specialty group have standardized, evidence-based clinical pathways in place and consistently used across care sites?	**1:** No standardized pathways **2:** Pathways exist but not consistently used **3:** Basic pathway use in core areas **4:** Broad use with strong adherence monitoring **5:** Fully embedded, evidence-based pathways with outcomes tracking		🔴 Prioritize technical support and training to build baseline pathway structure; limit engagement to consultation or non-risk arrangements until standards are met. 🟡 Share example pathways from peer groups and offer technical assistance for alignment; monitor pathway adherence semi-annually. 🟢 Ready for partnership or performance-based contracting.
Cost & Utilization	Cost Efficiency	How does the specialist's/ specialty group's total episode cost compare to relevant benchmarks or peer averages?	**1:** Above benchmark with no cost controls **2:** Some awareness but limited action **3:** At or near benchmark **4:** Consistently below benchmark through management strategies **5:** Demonstrated sustained cost savings through effective utilization management.		🔴 Exclude from downside or shared-risk models until cost variation addressed; reassess after cost-control measures implemented. 🟡 Conduct joint review of cost drivers and implement a cost improvement roadmap; include shared savings incentives tied to progress. 🟢 Ready for partnership or performance-based contracting. Continue to monitor for cost saving opportunities.
Cost & Utilization	Utilization Management	Does the specialist/specialty group actively manage unnecessary tests, admissions, and post-acute utilization?	**1:** No UM processes **2:** Ad hoc or manual reviews **3:** Basic UM protocols in place **4:** Active, data-driven UM with measurable results **5:** Advanced predictive UM integrated with care management		🔴 Provide direct support to establish utilization management workflows; participation limited to data-sharing pilots until consistent controls are in place. 🟡 Collaborate to standardize UM protocols and connect to ACO care management; review utilization trends quarterly. 🟢 Ready for partnership or performance-based contracting.

Challenges

- Data integration complexity
- Financial risk tolerance and impact
- Variation in readiness and significant infrastructure requirements
- Newer, growing area

Specialist readiness for advanced models

- Decision-making tool to assess readiness and timing for advanced specialty models
- Organizes across quality, cost efficiency, risk readiness, data & analytics, cultural alignment, and engagement timing
- Evaluates infrastructure requirements, operational maturity, and risk considerations