



Specialty Engagement in Accountable Care Toolkit

*Practical tools to accelerate
accountable care adoption*



The National Association of Accountable Care Organizations (NAACOS) is a member-led, member-governed nonprofit of nearly 500 ACOs and value-based care entities in Medicare, Medicaid, and commercial insurance working on behalf of physicians, health systems, and other providers across the nation. These accountable care providers seek to improve the quality of care while reducing costs. NAACOS represents more than 10 million beneficiary lives through Medicare's population health-focused payment and delivery models.

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Acknowledgements

The Toolkit was prepared by the NAACOS team through expert guidance and work group discussions. NAACOS wishes to acknowledge and thank the following specialty care work group members who generously offered their time and expertise.

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Special thanks to **Coral Health
Advisors** for their support in preparing
the toolkit.

Introduction

Specialty care continues to account for the majority of total health care spending. Its integration into value-based care (VBC) is essential for achieving equitable, efficient, and sustainable care transformation. Yet specialists often face barriers to participation: fragmented data, unclear attribution, and limited visibility into how their performance connects to overarching cost and quality outcomes.

This resource presents guiding principles and best practices for VBC organizations looking to develop and implement models for optimizing specialty care engagement. The stepwise approaches outlined in the Toolkit were developed based on feedback from a wide range of industry experts and thought leaders, including specialists, VBC providers, clinical leaders, operational experts, payers, and quality and analytical experts. These leaders have built programs to align incentives, improve coordination, and advance shared accountability across specialties. Organizations can use the framework and best practices to quickly test and scale coordinated, data-driven, and equitable models of specialty care that strengthen payer-provider relationships, improve patient outcomes, and sustain VBC transformation across the care continuum.

Why Specialty Care Engagement Matters

Persistent cost pressures, declining reimbursement, and provider workforce shortages have intensified the need for models that reward collaboration and capture value.

Specialty care is central to improving cost, quality, and outcomes in accountable care, as specialists have a significant role in the care of patients with complex and chronic needs, whose care can be the most costly and difficult to coordinate. Unfortunately, many specialists struggle to engage in VBC arrangements or to see clearly defined roles within accountable care frameworks, as many risk arrangements are built around primary care attribution and incentives. Additionally, specialists often lack visibility into how their decisions influence total cost of care or how they can contribute to performance and savings opportunities. Integrating specialty care into accountable frameworks allows organizations to extend value-based principles across the full continuum of care and ensure that transformation efforts have the potential to drive the greatest opportunity for improvement by effectively reaching populations who could benefit the most.

Scope

This toolkit provides a flexible foundation that primary care physicians (PCPs), accountable care organizations (ACOs), value-based care (VBC) providers and enablers, payers and specialists across disciplines can use to inform planning, alignment, and implementation efforts. It does not prescribe a single model or policy approach. Rather, it offers adaptable guidance that reflects the diversity of specialties, patient populations, and organizational readiness levels.

The resource is structured to support both those beginning specialty engagement and those refining mature programs. Each section includes guiding principles, practical tools, and voluntary best practices that can be adapted to local contexts and market dynamics.

Toolkit Domains

The Specialty Engagement in Accountable Care Toolkit is organized into six domains that form a comprehensive framework for specialty engagement in VBC. Each domain builds upon the last, moving from foundational design to advanced implementation. Each domain has a corresponding toolkit resource that highlights useful approaches or illustrative examples for organizations to consider when developing and implementing specialty care VBC programs or models.

1. **Data, analytics, and dashboards** details the data infrastructure needed to credibly engage specialists. It explains how to integrate claims, electronic health records (EHRs), and registry data; and design meaningful specialty care dashboards that guide actionable performance and quality improvement.
2. **Patient entry, attribution, and clinical pathways** explores how patients enter the care system and methods for assigning accountability across primary and specialty care. It outlines strategies for defining attribution, clarifying roles between PCPs and specialists, and improving care coordination through shared accountability.
3. **Specialist engagement and referral network planning** focuses on referral management and network optimization. It highlights how to engage specialists in defining “value,” balance access and performance, and design data-driven referral systems that strengthen trust and collaboration across care teams.
4. **Developing and aligning meaningful incentives** describe how to develop incentive programs. It also explores strategies for managing specialty drug costs and sustaining engagement through non-financial incentives.

5. **Episodes of care payment models** provide a structured approach to developing and evaluating bundled or episode-based payment programs, including emerging infrastructure that supports standardized episode-based contracting. It introduces readiness assessments, risk glidepaths, and governance frameworks to help organizations design fair, scalable, and data-driven bundles.
6. **Advanced specialty care payment models** examines next-generation arrangements such as sub-capitation and total cost of care (TCOC) specialty care risk models. It includes a readiness and partnership assessment framework for evaluating potential collaborators and aligning financial, clinical, and cultural capabilities.

Foundational Themes for Specialty Transformation

Throughout the toolkit, several cross-cutting themes recur:

- Leadership and governance: Success requires clear executive sponsorship and clinical champion engagement to sustain credibility and alignment.
- Data transparency: Multi-source data and shared analytics build trust and enable continuous performance improvement.
- Operational integration: Pathways, referral systems, and handoffs must be standardized to support seamless care coordination.
- Incentive alignment: Financial and non-financial incentives should reinforce evidence-based practice and reward collaboration.
- Equity and access: Strategies must address disparities, ensuring equitable participation and patient access across specialties and geographies.

These themes frame the practical tools and approaches introduced throughout the toolkit. The [Playbook of Voluntary Best Practices for VBC Payment Arrangements](#), developed by NAACOS with AHIP and the American Medical Association (AMA), also provides an overview of voluntary best practices related to VBC payment arrangements that align payment with performance on quality, cost, and patient experiences.

Using This Resource

Each section of the toolkit is accompanied by a tool, like a template or sample framework that can be customized by ACOs, payers, or specialty groups. These include tools such as the Specialist Performance Index, Care Accountability Decision Guide, Specialist Alignment Planning Worksheet, Specialist Incentive Development Framework, Bundle Contracting Readiness Assessment, and Practice Engagement Readiness Assessment.

INTRODUCTION

By following the voluntary best practices and frameworks presented here, organizations can move beyond isolated pilots toward a coordinated, data-driven, and equitable models of specialty care that strengthens provider relationships, improves patient outcomes, and sustains value-based transformation across the continuum.

The integration of specialty care into value-based models is no longer optional: it is essential to the sustainability of accountable care. This toolkit provides the structure, language, and practical examples needed to bring specialists into the value-based ecosystem as full partners.

Domain 1: Data, Analytics, and Dashboards

Overview

Engaging specialists requires granular and condition-specific data because specialists often treat narrower patient populations with higher acuity, so variations in costs and outcomes are magnified. The data needed to illuminate these variations is fragmented. EHRs are siloed across provider groups, claims data are delayed, and specialty cohorts may be smaller than PCP patient cohorts. All three challenges make it difficult to draw credible insights. A specialty-focused data and analytics strategy is essential for overcoming barriers, ensuring that insights are organized in ways that resonate with specialists and reflect the realities of their practice.

Dashboards play a critical role in compiling specialty care data in a usable format. Specifically, they:

- Create structured reporting tools that compile cost, quality, utilization, and patient experience metrics into a consistent, comparable format,
- Serve as a bridge between raw analytics and practical decision-making by turning disparate data into actionable insights,
- Support performance monitoring, highlight opportunities for quality improvement, and foster more productive engagements with specialists, and
- Align financial accountability, clinical performance, and patient experience.

Depending on the design, dashboards can also inform referrals, shape network design, anchor peer-to-peer performance conversations, or serve as the foundation for new payment models.

Goals and Opportunities

Key goals include:

- Ensuring each measure captures what matters most to specialists and supports system-wide improvement.
- Focusing on measures specialists can directly influence, such as timeliness of consult notes or adherence to evidence-based therapies. By doing so, they become credible tools that support performance monitoring in TCOC frameworks.

- Highlighting opportunities for coordination between PCPs and specialists, focusing on metrics where collaboration is straightforward, such as timely communication or referral completion, while acknowledging that areas like shared accountability for outcomes can be more complex. This coordination sets the stage for higher level population health management that bridges roles across the care continuum.
- Supporting broader system goals, such as guiding referral decisions by illustrating specialists who consistently deliver high quality and cost-effective care. For example, dashboards can also play a role in network design, helping identify and engage providers across specialties.
- Anchoring performance conversations by giving providers a shared understanding to discuss progress and areas for improvement, and address case mix and appropriate quality measurement.

Challenges

- **Data fragmentation** across claims, EHRs, registries, and admissions, discharge, and transfer (ADT) feeds remains a persistent barrier. A delayed availability of claims data undermines timeliness, while incomplete data around specialty-specific measures weaken credibility when presenting performance dashboard results.
- **Education on the use of performance data** as a quality improvement tool may be needed as specialists gain familiarity with the metrics. It should be stressed that data review is not punitive.
- **Patient attribution** can be difficult to ascertain when multiple providers treat the same patient. Duplication of care management across payers and providers may stem from unclear attribution and complicated care accountabilities.

Without careful design, these challenges can erode trust and limit the utility of dashboards.

Leveraging Data for Market Analysis

Organizations must determine which specialties represent the greatest strategic priorities for engaging in VBC and whether dashboards are the right tool for driving change in those areas. Segmenting patient populations by condition, acuity, and comorbidity is critical. High-cost, high-variation cohorts (those where spending is both significant and inconsistent across providers) often represent the best opportunities for targeted improvement.

Data-driven market analysis can serve as a foundation for building a successful specialty strategy. Outlined below are key elements to integrate into a market analysis.

- Analyzing claims and clinical data to reveal which conditions show wide variation in treatment patterns, resource use, and outcomes, and are ripe for deeper intervention.
- Using data to understand local practice patterns and regional cost drivers (i.e., data from shadow bundles, etc.).
- Drawing on data from payer initiatives such as participation in bundles, ACO contracts, or sub-capitation pilots from public payer announcements, contract documents, or market intelligence reports.
- Factoring in provider consolidation (e.g., merger and acquisition filings) and workforce capacity data (e.g., state licensure counts, Health Resources and Services Administration (HRSA) databases) to more deeply understand where opportunities and risks lie.
- Establishing consistent data standards for defining and refining episodes across vendors and payers to avoid dissent and ensure accountability. In some conditions, attribution may appropriately begin with specialist (particularly when acuity or chronicity requires their involvement) before extending to primary care.

Specialties with significant spending and outcomes

- Orthopedics (e.g., physical therapy and pain management)
- Oncology
- Cardiology
- Behavioral health
- Nephrology (e.g., stages 3-4 chronic kidney disease and end-stage renal disease)

Derived from Specialty risk: The next frontier of value-based care (Kunte, et al)

Leveraging Data for Developing a Dashboard

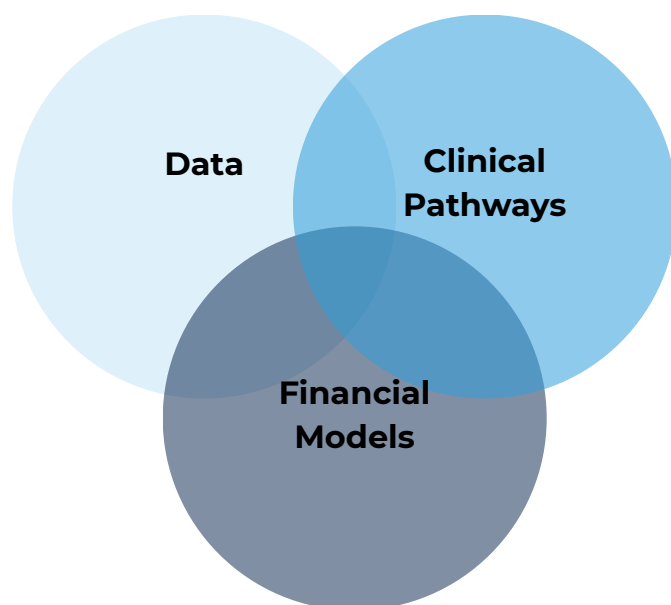
Effective dashboards or indexes rely on strong data sources. Claims across Medicare fee-for-service (FFS), Medicare Advantage (MA), and multi-payer populations form the foundation of specialty indexes. The Playbook of Voluntary Best Practices for Advance Data Sharing, a resource NAACOS developed with AHIP and AMA, covers the fundamental building blocks of data sharing for VBC models.

Supplemental Data Sources for Indexes

- **Shadow bundles** – analytic constructs that simulate bundled payments using claims data are useful for tracking longitudinal episodes of care. To be effective, they should not focus on cost alone but also incorporate measures of quality and outcomes, ensuring that high-value specialists are identified and recognized for delivering efficient, evidence-based care within these episodes.
- **Membership extracts** – files from payers that provide eligibility, enrollment, and demographic information.
- **ADT feeds** – near-real-time notifications that flag patient movement and care transitions.
- **Registries** – condition- or procedure-specific databases (e.g., oncology or cardiology) that provide richer clinical detail.
- **EHRs** – provider-level clinical data that includes elements such as lab values, clinician notes, and treatment decisions.

Operational competencies are equally important. Strong partners should provide access to disparate data systems, understand specialist workflows, apply risk modeling to account for high-risk patients and churn, and support evaluation of contracts and risk levels. Several integration points between data, financial

Components Essential for Building Meaningful Dashboards



models, and clinical pathways are essential to make dashboards credible and actionable. Attribution logic and financial accountability must be mapped into specialty pathways, so the data used in indexes aligns with true drivers of cost and quality. Each pathway should be tied to an attribution model (such as TCOC, episodic, or condition-based) so performance can be tracked consistently and transparently across providers. Finally, clear guardrails should define when care shifts between PCPs and specialists and where accountability lies, ensuring that financial responsibility matches the data being reported.

Specialist Performance Index

The Specialist Performance Index can be used as a template for illustrating elements that populate a specialty care dashboard or index. End users can pick from the referenced measures to create their own indexes based on market analytics and access to data. This index is particularly valuable as a tool for initiating performance conversations. This dashboard includes measurement concepts categorized into core domains of efficiency, quality of care, utilization, and patient experience. Whenever possible, leverage measures used in existing programs, such as the [core measure sets](#) curated by the Core Quality Measures Collaborative (CQMC), to drive alignment and limit measurement burden. Implementation requires integrating multi-payer data to address leakage, using shadow bundles to ensure credibility, standardizing reporting cadences, and enabling drill-down to the provider level to drive behavior change.

Use Cases for Dashboards

Dashboards enable VBC organizations to translate data into shared understanding and collective action. When designed for transparency and engagement, they shift conversations toward meaningful insights that specialists can use to improve care. Shared openly, these tools build trust, reinforce credibility in identifying opportunities, and support a culture of continuous improvement. Dashboards can be applied across multiple use cases as seen below – from network design to referral management, governance formation, program design, and performance measurement – all to anchor collaborative, data-driven decision-making.

Network Design	Referral Management	Governance
identify and engage value-focused specialists	guide primary care providers toward high-performing specialists	anchor peer-to-peer performance conversations in neutral, data-driven facts
Program Design	Practice-level Measurement	Individual Measurement
serve as adaptable tools for bundles, sub-capitation, or pathway-based models	facilitate group accountability and peer benchmarking	support targeted outreach and identify areas of opportunity

Best Practices for Implementation

Engagement	Engage specialists early and consistently. <ul style="list-style-type: none"> • Involve them from the start and identify physician champions to lead adoption. • Provide multi-payer data at the provider level, and present benchmarks in clear, visual formats. • Balance leadership dashboards with focused indexes tailored to specialists.
	Identify priority specialties and patient segments. <ul style="list-style-type: none"> • Use claims and clinical data to select specialties that drive the highest costs or show wide variation in outcomes. • Segment populations by condition, acuity, and comorbidity so indexes target the most meaningful opportunities.
Governance	Align attribution and accountability. <ul style="list-style-type: none"> • Map attribution logic and financial accountability into specialty pathways so index metrics match true drivers of cost and quality. • Define clear guardrails for when accountability shifts between PCPs and specialists.
	Govern with structure. <ul style="list-style-type: none"> • Establish structured peer review processes, regular meeting cadences, and defined charters to maintain accountability. • Use forums and workgroups to resolve operational issues, monitor progress, and reinforce expectations for provider “citizenship.”
	Balance community and individual accountability. <ul style="list-style-type: none"> • Use practice-level dashboards to mitigate volatility, foster peer accountability, and encourage team-based improvement. • Provide individual-level views for coaching, professional development, and recognition of high performers.
Sustainability	Sustain ongoing peer-to-peer conversations. <ul style="list-style-type: none"> • Evolve indexes over time to keep the tool relevant, timely, and action-oriented. • Build in discussions on patient experience, consult expertise, and referral patterns. • Deliver transparent, credible, and meaningful data.

Best Practices for Implementation

Operations	<p>Decide on analytics capacity and partners.</p> <ul style="list-style-type: none"> Determine whether analytics will be built in-house or outsourced. Strong partners should integrate disparate data systems, understand specialist workflows, apply risk modeling, and support evaluation of contracts and risk levels.
	<p>Embed actuarial intelligence.</p> <ul style="list-style-type: none"> Conduct an actuarial review of claims, cost drivers, and projected risk impact across geographies and conditions. Use risk stratification to segment patients into high-cost, rising-risk, and manageable groups. Derive benchmarks from actuarial data, historical claims, regional prices, and contractual requirements, and track actionable key performance indicators (KPIs) such as cost per episode or referral conversion ratios. Actuarial expertise can also strengthen engagement by comparing actual vs. expected costs at the episode level, identifying measures or episodes prone to adverse selection, and pressure-testing multiple risk adjustment methods, recognizing that Risk Adjustment Factor (RAF) or any single approach may be insufficient.
	<p>Standardize operational touchpoints.</p> <ul style="list-style-type: none"> Define workflows, minimum data sets for handoffs, and shared accountability across PCPs and specialists. Standardization reduces friction, closes communication gaps, and ensures consistent data sharing.
	<p>Leverage multi-payer data and analytic tools.</p> <ul style="list-style-type: none"> Integrate multi-payer claims to address leakage. Use shadow bundles to validate insights. Standardize reporting cadences. Enable provider-level drill-downs to drive behavior change.
	<p>Address volatility in smaller specialty populations.</p> <ul style="list-style-type: none"> Aggregate data across years, pooling multi-payer sources, and applying rolling averages or confidence intervals. These methods help smooth variation, increase credibility, and highlight meaningful performance patterns.

Domain 2: Patient Entry, Attribution, and Clinical Pathways

Overview

Clearly defining patient entry points, attribution, and clinical pathways is foundational for optimizing specialty care within VBC models. Attribution determines which provider or organization is accountable for cost, quality, and outcomes, while entry points define how patients enter the system and where they first interact with care teams. Together, these factors influence everything from care coordination to financial accountability.

The Playbook of Voluntary Best Practices for VBC Payment Arrangements also provides an overview of voluntary best practices related to patient attribution, benchmarking, and financial accountability. In specialty care, determining when and which conditions are best suited for participating in risk arrangements and developing appropriate and effective clinical pathways require special consideration.

In most markets, payers play a central role in assigning attribution, determining coverage and benefit design, and supporting patient navigation.

However, without clearly defined clinical pathways and shared accountability, care often becomes fragmented, duplicative, and reactive, especially for patients with chronic or complex needs. Clinical pathways provide a structured mechanism for standardizing evidence-based care while leaving room for specialty-specific leadership and innovation.

Goals and Opportunities

The overarching goal of a specialty care attribution strategy is to clarify care accountability, establish clear clinical pathways, and increase streamlined coordination between PCPs and specialists. This begins with defining where and how patients enter the system and ensuring that methodologies and care accountability structures align with real-world clinical workflows and patient behavior.

Establishing consistent, transparent approaches to entry, attribution, and clinical pathway design ensures that patients are **connected to the right level of care at the right time, while streamlining care management** between PCPs, specialists, VBC entities, and payers.

Key goals include:

- Clarifying patient entry points to strengthen coordination between PCPs, specialists, and payers,
- Aligning attribution methodologies and care accountability expectations with patient needs, clinical complexity, and provider capabilities,
- Avoiding duplication of care management across the continuum by ensuring patients have the appropriate number of touchpoints and care managers are equipped with the information they need to streamline care transitions,
- Balancing financial accountability across TCOC, pay-for-performance, and episodic, and sub-capitation models to minimize tension and promote shared ownership, and
- Embedding evidence-based clinical pathways into practice to improve quality and consistency of care.

Challenges

- **Fragmented patient entry pathways** could create inconsistencies in accountability. Without a unified approach, organizations struggle to determine who is “responsible” for care, leading to gaps in coordination and duplicative services and outreach.
- **Limitations of attribution algorithms** often fail to capture provider relationships. Algorithm methodologies may misalign accountability, overlook patient engagement levels, and result in misinformed care accountability, inaccurate data, and delayed care transitions.
- **Duplication and overlapping care** management efforts between payers and providers could result in inefficient processes, delayed early interventions, and patient confusion. Early and accurate diagnostics prevent unnecessary downstream utilization and allow patients to enroll in timely clinical programs.
- **Communication and patient engagement gaps** hinder smooth care transitions, especially for patients with chronic or complex conditions. Patients who might be disconnected or disengaged from routine care often remain invisible in data systems until they present in acute care settings.
- **Barriers remain in integrating evidence-based clinical pathways into EHR** systems and workflows, ensuring real-time data connectivity and aligning pathway use with efficiency goals and improved patient outcomes. Even after adoption, scaling pathway use requires coordinated alignment across IT, staffing resources, and workflows to balance efficiency with the infrastructure needed to reduce burden and streamline processes.
- **Securing specialist buy-in and identifying clinical champions** often require workflow and cultural changes but are crucial to pathway development and sustainability.

Key Patient Entry Points

Patients may enter the system through multiple channels which may create.

Understanding patient entry pathways helps organizations design interventions and care models that meet patients where they are. These pathways can include:

- Assignment to a PCP or VBC entity through payer enrollment.
- PCP referral to a specialist for consultation or ongoing management.
- Referrals from other providers, such as home- and community-based services or community-based organizations.
- Patient self-referrals, often driven by online directories, reviews, or proximity.
- Triggering events, such as emergency department (ED) visits, hospitalizations, screenings, or community outreach activities.
- Integrated service-line entry points through programs like cardiac care, obesity/weight loss, women's health, or chronic disease management.

Each pathway carries different implications for accountability, data capture, and coordination. Mapping these entry points ensures that engagement strategies are inclusive of real-world patient journeys.

Attribution Dynamics

In specialty care, attribution can vary widely depending on the duration and nature of the relationship.



Short-term attribution

typically applies to discrete episodes or one-time procedures (such as orthopedic surgeries or cardiac interventions) where accountability begins and ends within a defined window.



Longitudinal attribution,

applies to chronic or comorbid conditions where specialists may have the most regular interactions with a patient for extended periods of time and therefore may become the patient's source of routine care and take on responsibilities for care coordination.

Ensuring effective patient pathways and consistent adherence to clinical pathways requires strong clinical infrastructure as well as attribution methodologies that recognize varying patterns of patient engagement. From a patient-engagement perspective, attribution should reflect how patients interact with their care teams, acknowledging that many patients maintain meaningful, ongoing relationships with both their primary care clinicians and specialists, while others may engage episodically based on changing health needs. Current attribution methods often fail

to capture these nuances, which can lead to misaligned incentives, gaps in data accuracy, and challenges in maintaining clear accountability.

Patient and Provider Engagement

The patient-provider relationship is an important partnership. Engagement ensures that accountability is understood, information is shared, and transitions happen smoothly. When roles are unclear or communication is inconsistent, coordination breaks down, especially for patients with chronic or complex conditions.

Across the broader clinical care team, including the patient, these four elements should be considered for effective engagement:

- **Clear role definition:** Identifying which provider leads to coordination at distinct points in time (e.g., PCP, specialist, or care manager) and making that role known and visible to the full team.
- **Bidirectional communication:** Maintaining timely, consistent information exchange between PCPs, specialists, and care managers.
- **Patient education:** Helping patients understand their care plan, provider roles, and what to expect during transitions.
- **Ongoing Reassessment:** Regularly reviewing who holds primary coordination responsibility as conditions or engagement levels change.

The Care Accountability Decision Guide supports these efforts by providing a structured process for defining and updating accountability. It organizes common real-world scenarios into distinct care accountability types (e.g., PCP-led, specialist-led episodic, shared accountability) and outlines when and how accountability should shift. This decision-guide is a tool to help teams determine who is responsible for coordination, how responsibility may shift, and when reassessment is needed to stay aligned with patient needs. Used within broader engagement strategies, the tool turns shared accountability principles into clear workflows to reduce duplication, improve communication, and ensure every patient has a consistent point of coordination across settings.

Benchmarking and Financial Accountability

Balancing ownership of financial risk across PCPs and specialists is one of the most complex aspects of attribution and varies by the type of accountability model. The central complexity often lies in defining “who gets the credit and who takes the risk” for managing patient outcomes and costs. Factors, such as provider infrastructure, treatment duration, and patient acuity help determine which approach is appropriate.

Clarity in workflow is also essential: early disease stages may be managed by PCPs with specialist consult support, while advanced or complex stages could transition to specialist-led management with some engagement or monitoring from PCPs. Aligning incentives through shared accountability models can reduce conflict and promote collaboration, especially when both PCPs and specialists see value in joint success and in caring for complex patients with multiple comorbidities.

Accountability Often Varies by Disease Stage of Condition or Setting

CONDITION

Early chronic kidney disease (CKD), care management rests with advanced PCPs.

- As the disease stage progresses, longitudinal management typically rests with nephrologists, supported by wraparound services as patients progress through stages 3B and 4 toward end-stage renal disease (ESRD).

Cardiac care for congestive heart failure is managed by advanced PCPs within a value-based framework.

- Specialists are leveraged as input is needed.

Oncology accountability is more highly integrated between PCPs and specialists due to the prevalence of comorbidities and supportive care needs that extend beyond the oncologist's scope.

SETTING

Screening, testing, and diagnostic pathways

- Require close PCP–specialist coordination
- Ensures patients are guided efficiently to the right level of care.

Regional attribution strategies reflect local dynamics, such as specialist availability and referral patterns.

Rural or underserved areas require flexibility in attribution rules to account for provider shortages and patient travel patterns.

Developing Clinical Pathways

Clinical pathways translate evidence into actionable workflows that enhance consistency and reduce unnecessary variation. Clinical pathways could be leveraged for acute, episodic models as well as longitudinal clinical areas such as cancer, kidney, dementia, and chronic diseases overall, where structured evidence-based guidance can simultaneously improve outcomes and generate savings.

Integration with EHRs and related data systems allows real-time tracking of pathway adherence and performance on quality, utilization, and cost measures, giving clinicians an option for immediate feedback on care delivery.

Real-time data connectivity helps:

- Identify and diagnosis patients more quickly and enroll them into clinical pathways.
- Streamline care transitions to improve patient and clinician experiences.
- Ensure continuity across the care continuum from teams spanning acute, post-acute, home, and palliative care settings.

Once established, pathways serve as the foundation for performance dashboards that complete data flows, highlight adherence, reveal gaps, and promote care accountability among specialists.

Role of Clinical Champions and Executive Sponsors

Leadership plays a pivotal role in developing and sustaining clinical pathways. Together, clinical champions and executive sponsors bridge clinical and operational execution with strategic oversight.

- **Clinical champions**, because of their role as respected leaders in their specialty, can be tapped to lead design and implementation of clinical pathways, foster peer trust, model evidence-based practice, and advocate for change among peers.
- **Executive sponsors** ensure alignment with organizational priorities, secure budget and resources, and maintain visibility across administrative leadership.

This joint involvement strengthens credibility of pathways, accelerates cultural adoption, and ensures that performance efforts, particularly those related to care transitions, quality, and patient experiences, remain both feasible and meaningful.

Best Practices for Implementation

Implementing effective entry and attribution frameworks requires a blend of analytics, workflow standardization, and relationship management.

Key Patient Entry Points	Conducting risk stratification using cost, attribution history, acuity, and comorbidities, and leveraging multiple data systems such as clinical records, care-management data, and social health datasets (e.g., Community Needs Index or area deprivation metrics) to identify patients who would most benefit from proactive coordination.
	Positioning care managers to guide patients across settings, with clear delineation of payer and provider roles, so as to avoid duplications.
	Standardizing referral and handoff workflows across organizations to ensure consistent navigation regardless of entry point.
Attribution Dynamics	Establishing shared workflows that define PCP and specialist responsibilities by condition and treatment stage.
	Integrating data systems for timely communication and feedback loops between PCPs, specialists, and payers.
	Defining communication protocols , such as turnaround times for consult notes or secure-messaging expectations, to reinforce accountability alignment.
	Building trust by involving specialists early in attribution design discussions, reinforcing transparency and shared accountability.

Patient and Provider Engagement	Providing patient education to improve engagement, whether episodic (e.g., pre-surgical patient education) or longitudinal (e.g., chronic illness management).
	Delivering clinician education and joint training opportunities to improve collaboration and alignment.
	Leveraging complementary strengths across payer and provider care teams to help reduce patient and caregiver confusion, improve outreach consistency, and strengthen engagement, especially in employer-based or shared-risk arrangements where multiple care-management entities may operate concurrently.
Benchmarking and Financial Accountability	Facilitating collaboration between payers and providers to align care-management resources, avoid duplicating services, and prevent unnecessary charges back to providers who already employ advanced care managers.
	Aligning incentive structures through shared accountability models that reduce conflict and promote collaboration between PCPs and specialists.
	Ensuring transparency in financial risk ownership by linking attribution design to care-management capacity and data visibility.

Developing Clinical Pathways	Prioritize high-value conditions where pathways yield the greatest clinical and financial impact.
	Pair pathway adherence with outcome measures across quality, cost, and patient experience
	Ensure alignment between organizational goals, executive sponsor leadership, and clinical champions to secure resources and maintain visibility at the leadership level.
	Align pathway priorities with organizational goals and available patient volume to manage risk effectively.
	Maintain clear governance through defined leadership roles and oversight responsibilities, standing meetings, and structured performance review processes.
	Involve specialists early on in co-designing and leading clinical pathways.
	Promote multi-specialty collaboration across acute, post-acute, and community-based teams to ensure seamless care transitions.
	Reinforce engagement through regular feedback and performance recognitions.
	Integrate pathways into EMRs to enable real-time adherence tracking and continuous feedback loops.
	Provide transparent performance data through scorecards and dashboards to reinforce accountability.
	Assess clinical pathways and incentive designs regularly using data and evolving evidence.

Domain 3: Specialist Engagement and Referral Network Planning

Overview

Effective referral management and network design are foundational to achieving success in VBC. These components are critical for guiding patients to specialists who provide evidence-based, patient-centered, and cost-effective care and ensuring the patients receive the right care, in the right setting, at the right time. As health care organizations expand from informal provider referral relationships to include more structured, data-driven systems, leveraging referral analytics and building optimal networks will become essential tools for improving patient outcomes and managing costs.

Provider organizations in accountable care and VBC arrangements across payers are increasingly using structured programs to inform, guide, and support access to high-value care. These efforts balance two critical priorities:

- Aligning referral patterns with clinical and quality goals; and
- Maintaining credibility with the specialist community.

While optimizing networks and referral patterns can enhance workflows and lead to quality outcomes, doing so without transparent data or clinician engagement risks eroding trust and limits patient access. In rural areas, trust and care coordination is even more important due to access challenges, including specialist availability and locality. Achieving sustainable alignment requires thoughtful design and innovative care delivery approaches, grounded in analytics but guided by collaboration.

Goals and Opportunities

The primary goals of a robust referral management and network design strategy are to strengthen alignment among PCPs, specialists, and patients while maintaining access, choice, and trust.

Transparent referral pathways, supported by credible data and analytical tools, can help identify high-value care and support coordination across the continuum.

Key goals include:

- Improving alignment between PCPs, specialists, and patients through clear referral pathways and consistent communication.
- Leveraging credible analytical tools and data, including performance dashboards, to identify appropriate specialists and inform referral decisions.
- Ensuring timely access to care while balancing patient choice and network adequacy requirements.
- Building trust buy-in and shared expectations between PCPs and specialists by co-developing definitions of value and pathway design.
- Addressing equity and access by incorporating the needs of rural and underserved populations into network design strategies.

Challenges

- Entrenched referral patterns and long-standing provider relationships often resist change.
- Complicated market conditions are an additional obstacle. Urban areas may have an abundant supply of specialists, while rural areas face scarcity and access barriers.
- Misaligned incentives and restrictive insurance structures, such as narrow networks or prior authorization requirements, can hinder timely and equitable referrals. Maintaining adequate network coverage while optimizing referral networks also adds operational complexity.

Engaging Specialists in Referral Processes

Leading organizations treat all specialists as potential partners in value-based alignment.



Engagement begins with transparency. Specialists are more likely to participate in referral improvement efforts when data is credible, peer-validated, and reflective of clinical realities. Building shared accountability also requires involving specialists directly in defining what constitutes value within their field and how it should be measured.



Communication and trust are equally crucial. When specialists understand how referral expectations align with patient needs, quality improvement goals, and broader system performance, they are more receptive to collaboration. A clear and consistent approach to communication (e.g., using terminology that resonates across specialties) helps sustain participation and engagement.

Key Elements in Referral Decision-Making

Referral decisions depend on a mix of clinical, logistical, and patient-centered factors. Successful organizations design systems that standardize these elements while leaving room for clinical judgment and patient preference.

- **Logistical parameters** influence timely access to care and include specialty type, office locations, proximity, appointment availability, and wait-times.
- **Performance indicators** form the backbone of objective, data-driven referral decision-making. They include outcomes, readmissions, complication rates, cost efficiency, and patient experience scores.
- **Insurance and benefit design** affect patient access, cost-sharing, and in-network vs. out-of-network status, shaping both provider participation and patient choice.
- **Referring dynamics amongst provider types** can reveal key distinctions in referral patterns and care accountabilities (e.g., PCPs referring to specialist(s), specialists referring amongst one another, and PCPs/specialists referring to care sites). Provider setting can also factor in referral processes, whether the specialist practices in small, independent, multi-specialty medical practices or within a health system or academic medical center.
- **Patient engagement and education** ensure individuals understand their provider options and participate in decision-making through transparent communication and benefit design that support informed choices.
- **Existing relationships** include local dynamics amongst clinician community and “word of mouth” credibility. These intangible dynamics are important to understand as they could influence referrals or be leveraged to support communication and transparency.

Organizations can use the [Specialist Alignment Planning Worksheet](#) to support structured analysis of these elements. The worksheet helps teams document current referral approaches, identify barriers, and define actionable next steps for specialist engagement. This planning tool identifies priority specialties, clarifies the goals driving engagement (e.g., improving access or reducing unnecessary utilization), and documents the current referral environment. It also prompts teams to capture barriers, opportunities, and next steps for improvement. When completed, the worksheet includes a summary of the most promising areas for optimizing relationships, referral pathways, and network design, creating a data-informed foundation for strategic planning. The tool also supports data-driven network optimization by identifying patterns in specialty care delivery that can be shared with PCPs to strengthen coordination and inform referral decisions. By analyzing regional referral trends and specialty performance data, organizations can better align specialists across value-based networks and promote transparency around where high-value care is being delivered.

Best Practices for Implementation

Engagement and Referrals	<p>Understand local dynamics and existing referral patterns. Providers can leverage a strong understanding of local dynamics and existing referral patterns to optimize care coordination. By assessing market capacity and specialist availability, they can identify opportunities to adjust referral pathways and use existing relationships to streamline communication and increase transparency.</p>
	<p>Set mutually agreed upon expectations. Providers should collaborate using mutually agreed upon terms and expectations, such as sending consult notes in standardized data formats and in a timely way, attending meetings, sharing data, outlining care team roles and responsibilities, and coordinating patient outreaches and plan follow-ups.</p>
	<p>Engage specialists early and consistently. VBC providers should involve PCPs and specialists in defining value, shaping pathways, and validating referral data. This level of engagement helps build credibility.</p>
	<p>Offer aligned incentives. Combine financial and non-financial motivators such as leadership roles, public recognition, or streamlined workflows.</p>
	<p>Pilot targeted referral initiatives. Use small pilots in specific specialty (e.g., oncology, orthopedics, cardiology) to refine pathways and demonstrate impact before scaling.</p>
	<p>Reinforce accountability. Establish mechanisms for PCP-specialist data sharing and jointly review performance metrics to ensure continuous feedback. Adopting intentionality and cultural transformation will help promote peer-to-peer conversations about quality and patient experiences. A specialist clinical champion in the same clinical area as their peer leading discussions about patient care pathways, quality, performance, and patient experiences can lend credibility.</p>
	<p>Document rationale for out-of-network referrals. Documenting why patients are referred out-of-network provides a clear picture of unmet needs and operational barriers. By sharing this information openly, providers can collaborate more effectively with network partners to improve access, reduce friction points, and build trust through transparency.</p>
	<p>Engage consumers and incorporate community and employer partnerships. Promote informed referral decisions through condition-specific education campaigns reaching patients, employers, and the public.</p>

Optimal Networks	<p>Define clear network objectives. Determine whether the goal is broad access or a narrowed high-value network, then align strategies accordingly. Within either option, clear care accountabilities and data-backed provider performance are necessary to build robust networks.</p>
	<p>Set transparent specialist selection criteria that balances access needs, performance opportunities, and partnership stability. Establish referral guidelines based on clinical standards.</p>
	<p>Balance coverage and collaboration by including required specialties for adequacy, engaging specialists with improvement potential, and maintaining strong relationships with aligned high performers.</p>
	<p>Ensure compliance with CMS and payers by applying adequacy standards while still tailoring networks to local population needs.</p>
	<p>Leverage multidisciplinary teams. Combine analytics, contracting, and managed care expertise to manage provider rosters and updates.</p>
	<p>Align medical, surgical, and sub-specialty networks with risk tolerance, cost profiles, and site-of-care considerations.</p>
	<p>Use transparent, data-based guidance to support referrals while respecting patient choice.</p>
	<p>Keep incentives simple and easy to understand. Reduce administrative burden by focusing on a few meaningful, measurable goals.</p>
	<p>Use performance analytics and feedback loops to align incentive designs and continue performance progression.</p>
	<p>Start small and scale deliberately. Expand from condition-specific pilots or pay-for-performance programs to broader alignment efforts as readiness grows.</p>
	<p>Track clinical and financial outcomes to ensure referral and network strategies achieve their intended impact, adapting as needed.</p>

Domain 4: Developing and Aligning Meaningful Incentives

Overview

Incentives are critical levers for aligning specialists around shared goals of improving quality, reducing variation, and rewarding value-based outcomes. Success depends on designing incentives that are not only financial but can also include non-financial incentives that are meaningful, transparent, and support reinvestments into infrastructure and program development. Stakeholders consistently emphasize the importance of trust and credibility in developing any incentive framework.

Health Care Transformation Task Force (HCTTF) published the [Next Frontier in Specialty Integration in VBC](#) that spotlights various case studies from payers, providers, and VBC entities that addresses aligning incentive programs across specialties and payment model types.

Goals and Opportunities

Key goals include:

- Aligning specialist incentives with value-based outcomes such as quality, utilization, and patient experience.
- Reinvesting savings into high-value services and support that benefit both specialists and patients.
- Using incentives to help strengthen collaboration across payers, providers, and specialists through shared quality and financial accountability.

Challenges

- **Balanced ownership of financial risk** across PCPs and specialists when determining “who bears the right and who gets the credit,” which can vary by condition, disease stage, and care model. Misalignment can create tension, erode trust, and weaken incentives and collaboration for joint success.
- **Accurately attributed savings to specialist actions and impact remains difficult**, particularly in multi-specialty settings and for complex, comorbid populations.
- **Eroded shared-savings potential** from specialty drug costs and operational complexity. There must be a balance between managing high-cost drugs without restricting access or compromising adherence.
- **Sufficient allocated financial incentives** through bonuses to overall revenue for specialists.
- **Aligned incentives across populations and payers** can motivate behavioral change, reduce burden, and create more significant financial incentives.

Developing Incentive Programs

Incentive models align measurable results to financial and non-financial rewards. Data and analytics are essential for attributing incentives accurately, linking improvements in quality, utilization, or TCOC to the specialists most responsible for those changes.

Understanding when to use outcome-based metrics vs. process measures will help to tie metrics to transformative behavior and ultimately, aligned incentives that feel meaningful and rewarding. Programs are generally most effective when they focus on a targeted number of actionable measures that providers can directly influence. For example, outcome-based metrics may be better suited for providers coordinating the overall care of the patient and attributed the patient's outcome. Process metrics are helpful for specialists to ensure access, adhere to clinical pathways, and perform on condition-specific measures. In either instance, effective incentive programs use condition-specific, risk-adjusted targets that fall within each provider's sphere of influence. Clear operational structures (e.g., leadership oversight, standing meetings, and transparent reporting) help sustain accountability and trust.

It is within this context that organizations can employ the **Specialist Incentive Development Framework**. This tool guides organizations through defining measurable goals, establishing quality gates, and determining how savings generated through pathway adherence or utilization improvements are attributed and distributed among participating providers. Financial incentives may include meaningful bonuses tied to quality performance, evidence-based utilization, or achievement of defined value-based outcomes under established quality thresholds, while non-financial incentives can include care-management support, technology investments, reduced reporting burden, or reinvestment into specialty programs that strengthen practice infrastructure. By combining step-by-step guidance with examples of both financial and non-financial incentives, the framework helps ensure incentives remain transparent, achievable, and aligned with both individual specialist contributions and broader value-based entity goals.

Getting Started

- Starting with **upside-only arrangements** can help build engagement and generate baseline data before introducing shared-risk elements.
- **Piloting approaches** with specialty clinical champions allows organizations to refine incentive parameters, validate fairness, and gain early credibility.

Funding and Savings Pool Design

Financial incentives can take different forms. Establishing a sustainable funding source, through savings as an example, is one path for maintaining credibility and longevity in any incentive program. The funding source could also exist as a virtual “risk pool” where positive and negative results are factored into the overall performance of the pool. Other instances could include paying incentives to a specific group of specialists for co-managing a population or condition cohort. A clear methodology for identifying, capturing, and allocating incentive payments ensures that distribution logic remains fair and financially sound.

Each type of VBC model offers distinct opportunities and challenges, requiring organizations to carefully assess partner capabilities, financial readiness, and data infrastructure. Layering these models can align incentives across specialties and broader provider incentive programs that improve outcomes and advance the integration of specialty care into VBC frameworks.

Organizations can find savings opportunities by quantifying reductions in avoidable or inefficient spending across key levers of care delivery. Common savings drivers include:

- **Cost-effective therapeutic alternatives** such as lower-cost medications or less-invasive procedures that maintain clinical effectiveness.
- **Shifting care to lower-cost settings** when clinically appropriate, such as ambulatory surgery centers or home-based care.
- **Preventing complications and readmissions** through adherence to evidence-based pathways and proactive follow-up.

Because these levers vary by specialty, estimating savings potential requires a detailed understanding of both specialty-specific spending and TCOC. Incentive programs should clearly define how risk is quantified and applied as well as how bonus payments are calculated, attributed, and distributed to participating specialists. Transparent formulas that link measurable improvements in cost, quality, or utilization to pay-out thresholds help minimize disputes and strengthen accountability.

Finally, organizations should determine how shared savings will be reinvested. Some groups have returned portions of earned incentives to support collective investments in areas such as care management, community health workers, or information technology. This approach reinforces sustainability by channeling shared gains back into system improvements that benefit patients and providers alike.

Pay-for-Performance (P4P) Incentive Models

Performance incentive models, often structured as pay-for-performance (P4P), reward specialists for achieving specific quality, cost, or patient experience metrics, usually in upside-only arrangements. While they involve less financial risk, they provide a pathway for specialties that are not yet ready to assume full accountability. These models can support broader engagement by aligning incentives with VBC goals and encouraging collaboration across specialties such as radiology, gastroenterology, and orthopedics. These arrangements are foundational to building trust, establishing evidence-based pathways, and serving as transitional models toward more advanced specialty care models that bear full risk.

Managing Specialty Drug Spend

Specialty drugs represent a growing share of healthcare expenditures and pose unique challenges in P4P models. Lessons from CMS specialty-focused payment and innovation models highlight that medication adherence, appropriate utilization management, and early specialist engagement are critical levers for balancing quality and cost. Balancing cost containment with equitable patient access requires coordinated strategies across payers, providers, and pharmacy partners.

Effective approaches leverage formularies and utilization management policies that promote evidence-based prescribing while preventing unnecessary administrative burden. Engaging specialists in adherence and medication-optimization initiatives helps avoid disease progression and supports better patient outcomes. Incentives can further reinforce evidence-based use of lower-cost but clinically appropriate therapies. Clear agreements between payers and providers on how specialty drug costs are treated in shared-savings pools prevent disputes and preserve alignment.

Best Practices for Implementation

Leveraging Aligned Incentives	Pilot upside-only or limited-risk arrangements before advancing to shared-risk models.
	Offer both financial and non-financial rewards , such as leadership opportunities, public recognition, or reinvestment into specialty programs.
	Coordinate incentive terms across contracts to ensure alignment and prevent conflicting metrics.
	Develop transparent incentive structures with clear, credible metrics.
	Reinforce engagement through regular feedback and performance recognition.
Funding and Savings Pool Design	Share payment methods, risk levels, and funding source opportunities so that participants can know the role they play in achieving savings, areas they can influence, and value they can add.
	Streamline models by focusing on a limited set of high-impact conditions and performance metrics.
	Scale gradually from pilots to broader service lines , including bundles or sub-capitated arrangements, as readiness grows.
	Evaluate clinical and financial outcomes regularly, sharing transparent and timely opportunities for expansion and programs updates as needed.
	Reinvest savings into clinical, operational, and infrastructure supports that improve care delivery and ease administrative burden.
Managing Specialty Drug Spend	Embed evidence-based formularies and utilization management to prioritize clinical effectiveness and patient access.
	Clarify how specialty drug expenses factor into savings calculations and incentive pools to support transparency.

Domain 5: Episodes of Care Payment Models

Overview

Bundled Payments, or Episodes of Care (EOCs), are episode-based payment arrangements that align incentives across services delivered for a defined condition, procedure, or time period. Within broader TCOC models, nested bundles allow organizations to target specialty performance on discrete, high-impact episodes, linking clinical outcomes to financial accountability for certain conditions. Bundles typically begin with a triggering event, such as a hospitalization or procedure, and cover all related services for a fixed period, commonly 30, 60, or 90 days. By integrating bundle data into TCOC analytics, organizations can pinpoint variation in utilization and post-acute care costs, identify actionable levers for quality and efficiency, and strengthen collaboration among specialists, PCPs, and post-acute partners.

Bundled payments can be leveraged as a powerful mechanism for aligning clinical and financial goals, particularly when used within TCOC models or as a transitional step toward testing population-based models. These models promote shared accountability and may involve downside risk for total costs during an episode period. When executed well, bundled payments provide a practical bridge between fee-for-service and more advanced VBC arrangements.

Bundles drive specialists to lead care improvement within their areas of influence and incentivize specialists to improve care coordination, reduce post-acute spending, and adhere to evidence-based pathways.

As bundled payment models continue to evolve, newer CMS initiatives are reinforcing the role of episode-based accountability within broader value-based care strategies. For example, the Long-term Enhanced Accountable Care Organization (LEAD) Model introduces CMS-supported episode-based risk infrastructure through CMS-Administered Risk Arrangements (CARA), allowing ACOs to contract with specialists using standardized episode frameworks. Together, these approaches reflect growing alignment between episodic payment design and broader accountable care strategies.

Goals and Opportunities

Bundled payment programs aim to establish clear accountability for both cost and quality within a defined clinical episode.

Key goals include:

- Defining clear clinical and financial accountability among specialists, PCPs, and facilities.
- Linking evidence-based practice and measurable outcomes to financial reward.
- Standardizing episode definitions, inclusion/exclusion criteria, and attribution logic.
- Building scalable models that can operate across multiple payers and populations.
- Preparing for next-generation, chronic-condition bundles that emphasize longitudinal management, particularly the onset of mandatory episode models.

Challenges

- **Sustained participation is discouraged** by benchmark “ratchet effect,” in which annual rebasing reduces future savings potential.
- **Limited insights and delayed reconciliation** from fragmented data across claims, EHRs, and ADT feeds.
- **Constrained participation or risk pressures on providers** from limited episode volume, attribution complexity and eligibility concerns.
- **Reduced statistical credibility and slow progress** due to the need for up-front investments in analytics or contracting capacity.

Episode Design and Selection

Thoughtful **episode selection** is foundational to EOC program success. Targeting high-volume, high-variation clinical areas (e.g., musculoskeletal (MSK), cardiac, renal, gastrointestinal (GI), and behavioral health) enables organizations to capture the greatest impact early.

Selecting an appropriate **episode window** balances comprehensiveness and feasibility: 30-day windows work for limited procedures, while 60–90 days better capture post-acute utilization, site of service opportunities, and readmissions. Programs must define **inclusion and exclusion criteria**, establish attribution rules to clarify which provider “owns” the episode, and apply stop-loss and case-mix adjustments to manage volatility and maintain fairness.

Episode Selection

Episode Window

**Inclusion and
Exclusion Criteria**

Episode Ownership

**Specialists’ Area of
Control**

Clear definitions of **episode ownership** are essential for both clinical and financial accountability. On the front end, ownership connects to clinical or operational “quarterbacking,” where the lead provider (often a specialist) coordinates care, ensures pathway adherence, and manages transitions across sites and settings. On the back end, ownership ties to how savings and performance are reconciled within broader shared savings or bundled payment arrangements. Clarifying how clinical ownership aligns with financial responsibility and care accountabilities ensures alignment between who directs the episode’s care and who shares in its financial outcomes.

Specialists play an important role in post-acute care referrals, utilization management, and care management decisions that directly influence episode cost and quality. Defining what is within the **specialist’s control or purview to change** (e.g., clinical decisions, drug use, and referral patterns) helps determine fair attribution and prevents misaligned incentives across the care team.

Operational Readiness

Operational readiness determines whether organizations can manage episodes effectively across settings. Successful programs rely on:

- Robust care coordination infrastructure with clear cross-site workflows
- Timely data exchange between inpatient, post-acute, home-health, and community providers. ADT alerts and EHR flags enable real-time tracking of patients through the episode, while standardized discharge planning and readmission review workflows maintain continuity. It is essential to have a minimum viable data set (MVDS) for handoffs between PCPs, specialists, and post-acute care (PAC) partners. These structured exchanges reduce information loss, streamline transitions, and allow for accurate monitoring of outcomes across the care continuum.
- Establishing a PAC roster of preferred partners, such as skilled nursing facilities (SNFs) and home-health agencies (HHAs), with service-level agreements (SLAs) ensures consistency in performance.

Contracting and Financial Alignment

Contracting and financial design help define bundled models. Transparent collaboration with payers is critical to establish target price methodologies, validate baseline periods, and ensure that rebasing assumptions are understood by all parties.

Risk-sharing arrangements typically evolve through a glidepath from shared-savings models to two-sided risk and, eventually, prospective payment. Incentives

must be tied to both cost and quality gates, with rewards triggered only when both are met. Clear reconciliation rules, attribution logic, and gain-sharing formulas prevent duplication of savings between EOC and TCOC models.

Multi-payer participation further stabilizes episode volume and risk pools, while governance policies formalize oversight roles, fair-market-value (FMV) compliance, and decision-making authority.

New federal models are also beginning to support standardized episode-based contracting infrastructure. Under the LEAD Model, CARAs provide ACOs with a framework to establish episode-based risk arrangements with specialists. These approaches may reduce operational barriers for organizations seeking to operationalize bundles within broader accountable care strategies.

Once preliminary bundle design parameters have been established, including episode selection, duration, and ownership, organizations can apply the **Bundles Contracting Readiness Assessment**, a structured self-assessment that helps evaluate readiness across four domains:

- Infrastructure and Operations: Care coordination capacity, workflow integration, and data interoperability
- Analytics and Attribution: Episode definitions, benchmarking methods, data timeliness, and attribution clarity
- Financial Risk and Contracting: Risk tolerance, glidepath design, quality linkage, and compliance safeguards
- Network and Change Management: Specialist engagement, referral optimization, and leadership support

These domains help organizations structure internal readiness conversations across clinical, operational, analytic, and contracting functions. The assessment helps organizations evaluate readiness across key domains and identify areas that may require additional development before pursuing bundled contracting. By scoring readiness items and identifying domain-level gaps, organizations can determine whether to begin with retrospective or prospective models, nested bundles, or sub-capitation. The tool produces a color-coded readiness score and a strategic action plan summary to close gaps, ensuring that bundled payment participation begins from a position of strength.

Measurement and Data Integration

Accurate measurement is the backbone of bundled payment success. Combining claims, EHR, and ADT data through an episode grouper enables consistent definitions and visibility across care settings.

Key performance indicators typically include:

- Post-acute utilization and site-of-care mix,
- Readmissions and avoidable ED visits,
- Adherence to evidence-based pathways, and
- Functional recovery metrics (e.g., mobility scores) or disease-control indicators (e.g., eGFR trends).

Organizations often pilot shadow bundles, analytic-only versions that track costs and outcomes without financial reconciliation, to test definitions and validate risk models before full implementation.

Regular performance reporting reinforces accountability. Quarterly reconciliation reports and monthly trend dashboards help teams connect daily practice to eventual financial outcomes. Integrating episode-level metrics into TCOC dashboards provides a holistic view of performance across specialties and care settings.

Sustainability and Future Models

Sustaining bundled payment models requires balancing simplicity with adaptability. Organizations with robust data and sufficient volume can test prospective bundles in areas such as orthopedics and cardiology, while those with more advanced data integration may explore sub-capitation arrangements for chronic conditions, like kidney care or oncology.

Beyond financial incentives, programs can reinforce participation through non-financial motivators such as autonomy, transparency, and peer recognition. Annual reviews with payer partners ensure that targets, benchmarks, and quality measures remain current while addressing the effects of rebasing.

Emerging efforts to develop chronic-condition bundles (e.g., for congestive heart failure (CHF), chronic kidney disease (CKD), or chronic obstructive pulmonary disease (COPD)) are expanding the concept beyond procedural care. Initially, these can be implemented as analytic or “shadow” bundles before transitioning to full financial risk.

Ultimately, bundled payments should be viewed as a stepping stone toward advanced risk-sharing arrangements and cross-payer alignment.

Best Practices for Implementation

Episode Selection	Select and design episodes that align with organizational goals or meet regulatory requirements.
	Pilot one or two episodes to validate definitions and workflows before scaling.
	Involve specialists early in model design, metric selection, and attribution to build trust.
	Maintain consistent episode parameters year over year and exclude pandemic-distorted baselines.
	Match episode length to the clinical scenario using shorter length for procedures and longer for post-acute capture.
	Apply fairness guardrails , such as outlier protection, case-mix adjustment, and minimum volume thresholds.
Operational Readiness	Integrate ADT and EHR systems to enable timely alerts and care tracking.
	Formalize partnerships with SNFs and HHAs through SLAs and shared metrics.
	Standardize discharge and follow-up workflows for consistent transitions and rapid readmission review.
	Implement MVDS for information handoffs across providers.
Contracting and Financial Alignment	Tie incentives to quality gates , rewarding savings only when cost and quality thresholds are met.
	Establish risk glidepaths to transition from shared-savings to prospective models as confidence builds.
	Maintain governance oversight with defined roles, policies, and FMV compliance review.

Measurement and Data Integration	Combine EOC and TCOC metrics to view episode-level and population-level performance together.
	Test definitions and data integrity using shadow bundles before assuming financial risk.
	Deliver monthly and quarterly performance dashboards with actionable metrics.
Sustainability and Future Models	Conduct annual reviews with payers to update targets and address rebasing for fairness.
	Recognize clinical leadership, peer mentorship, and transparency alongside financial incentives.
	Use bundles as a bridge to prepare for longitudinal, condition-based, or population-level risk models.

Domain 6: Advanced Specialty Care Payment Models

Overview

Specialists can engage in VBC in many ways: they can belong to VBC entities that hold risk arrangements, participate directly in specialty care VBC payment models, or hold specialty care accountability for a patient's TCOC. Risk arrangements complement the clinical and operational efforts by offering measurable incentives tied to patient outcomes, adherence, performance, and cost containment.

Advanced specialty care arrangements represent the next phase of VBC, shifting greater risk and accountability to specialty care groups for cost, quality, and outcomes within defined clinical populations. These models are best suited for high-cost, high-variation conditions such as kidney disease, oncology, GI, MSK, cardiac care, and behavioral health. These specialties provide clear opportunities to improve outcomes and reduce costs through coordinated management because of measurable differences in practice patterns and spending.

More so than traditional episode-based payments, advanced models in specialty care require deeper data integration, stronger financial alignment, more risk tolerance, higher value and ROI expectations, and more seamless clinical handoffs between PCPs, specialists, and payers. As such, they demand more sophisticated governance, analytics, and operational maturity than earlier phases of value-based transformation to manage the longitudinal patient population assigned and more aggressive risk track.

Types of Advanced Specialty Models



Joint Venture or Joint Operating Agreements (JV/JOAs) establish shared governance between VBC entities (e.g., ACOs, payers, or enablement firms) and specialty groups. They align incentives through joint ownership and operational collaboration, allowing organizations to test shared-risk structures before full delegation. JV and JOA models are particularly useful when both sides seek deeper partnership without transferring total control. These arrangements foster trust, data sharing, and aligned incentives.

Sub-capitated Models provide fixed per-member-per-month (PMPM) payments covering all specialty-related costs for a defined population. These models delegate both upside and downside risk but can vary in structure. In some arrangements, risk is held directly by specialty care groups or integrated provider entities that own clinical assets and manage total specialty spend. In others, wraparound or enablement organizations assume financial risk and partner or affiliate with specialty practices to manage performance collaboratively. Sub-capitated models work best for chronic, predictable conditions supported by well-defined clinical pathways.

Specialty Care TCOC/Population-based Models extend care and financial accountability beyond discrete episodes to encompass longitudinal TCOC for patients with complex or chronic conditions. Examples include Kidney Care Choices (CKCC) and Enhancing Oncology Model (EOM), which assign specialists responsible for managing overall cost and outcomes across extended periods of time and across care continuums. These models often blend global budgets, partial capitation, and hybrid fee-for-service structures – all requiring robust data integration and enhanced care management. Specialty care TCOC models are particularly effective in conditions where the specialist becomes the patient's primary point of contact for long-term chronic disease management.

Goals and Opportunities

Advanced specialty care models create a pathway to expand VBC by shifting accountability to specialists for cost, quality, and outcomes.

Key goals include:

- Improving outcomes for high-cost conditions where coordinated care management reduces variation and improves patient outcomes across populations.
- Strengthening collaboration between PCPs, specialists, and payers through shared governance, advanced financial risk management, integrated care management, and aligned incentives.
- Leveraging more integrated claims, utilization, clinical, and financial data to identify risk tolerance, predictive modeling, performance variation, and opportunities for improvement.
- Scaling more advanced specialty care risk models for expansion, growth, and sustainability in risk-bearing structures.

Challenges

While advanced specialty models offer significant promise, they also present operational and strategic challenges:

- **Data Integration Complexity:** Requires seamless connectivity across claims, EHRs, and care management systems to support real-time performance monitoring.
- **Financial Risk Tolerance:** Specialty groups must be prepared for downside risk, cash flow volatility, and the need for stop-loss protections.
- **Attribution and Benchmarking Issues:** Transparent attribution logic and risk adjustment methodologies are essential to avoid misaligned incentives and credibility gaps. Long-term viability depends on careful management of rebasing and evolving benchmarks to prevent erosion of incentives.
- **Variation in Readiness:** Not all specialists or provider groups have the infrastructure, scale, or cultural alignment to succeed in risk-bearing arrangements.
- **Operational Maturity Requirements:** Advanced models require higher levels of analytics, care coordination, and financial management than transitional P4P and episode-based payments.
- **Governance and Trust:** Advanced specialty care contracts demand strong governance, compliance oversight, and FMV alignment to maintain trust among partners.
- **Equity and Access Concerns:** Ensuring adequate patient scale, network adequacy, and equitable access in underserved areas or for complex, vulnerable populations remains a persistent challenge.

Readiness and Risk Assessment

Determining readiness for participation must be prioritized as an integral step prior to entering into advanced specialty risk arrangements. Organizations should evaluate internal capacity, partner preparedness, external market signals, and existing program structures.

Many payers already operate national or regional specialty models (e.g., oncology, kidney care, or condition-specific bundles), while PCP-centered frameworks such as patient-centered medical homes, Total Cost of Care (TCOC) models, or ACO arrangements may shape expectations for specialty participation. State and employer priorities can further influence which specialties or conditions are most viable for advanced arrangements.

Across all stakeholders, alignment on quality measures, incentive structures, and pathway expectations is essential. Organizations should use data on cost

variation, quality performance, and referral patterns to determine which conditions are best suited for advanced specialty models versus other approaches, ensuring that pathway design and model selection reflect real-world utilization and outcomes.

Organizations can apply the **Practice Engagement Readiness Assessment**, a structured assessment tool that can help identify specialists or specialty groups that are best positioned to participate in advanced arrangements. The tool evaluates potential partners across specific dimensions within broad categories.

- **Quality Performance and Patient Outcomes**
 - Clinical performance – clinical and operational capacity, availability of specialists, clinical throughput, and continuous quality improvement workflows
 - Care pathway adherence – alignment with standardized, evidence-based clinical pathways that are embedded into workflows and EHRs
- **Cost Efficiency and Utilization Management**
 - Cost efficiency – total episode cost, peer and regional benchmarks, financial risk, and savings opportunities
 - Utilization management – waste reduction and avoidable care, areas of opportunity, peer review, utilization dashboards, appropriateness and step-down criteria
- **Infrastructure Maturity and Risk Readiness**
 - Contracting capability – actuarial support, risk tolerance, stop/loss considerations, cash flow resilience, access to working capital, and sufficient patient volume to distribute risk and enable statistical credibility
 - Care coordination infrastructure – workforce readiness, resource allocation across people and systems, and population health and tech system capabilities
- **Data, Analytics, and Reporting Capabilities**
 - Data integration – clinical data exchange, automated interfaces with VBC entity, interoperability, connectivity standards, and ability to support closed-loop communications and coordinated care
 - Reporting maturity – ability to produce timely, actionable, risk-adjusted reports, displays variation reduction, benchmark comparisons, and longitudinal specialty performance tracking
- **Cultural Alignment and Partnership Orientation**
 - Mission and collaboration – shared accountability norms, commitment to patient-centered care and transparency, communication habits, openness to feedback, and willingness to collaborate across teams
 - Prior partnership performance – partnership experiences with VBC models, measurable improvements in quality, cost, and outcomes, and demonstrated scalability of specialty care initiatives
- **Engagement Timing and Decision Gate**
 - Stage of relationship – assess readiness to enter or advance specialist partnership pipeline, relationship maturity and past experiences, shared values and goals, and commitment to accountable care
 - Duplication check – demonstrates unique or complementary expertise, identify any duplications with existing partnerships, and adds value to overall network.

The assessment helps organizations categorize potential partners by readiness level and determine appropriate timing for engagement or additional development. The tool uses a stoplight framework to support decision-making around which specialists are ready for early participation in sub-capitated or JV arrangements and which may require additional support or staged engagement. This approach allows VBC and specialty leaders make data-informed partnership decisions grounded in operational reality.

Contracting and Financial Model Design

Across all model types, variation exists in financial accountability, delegated functions (such as utilization management, care management, and billing), capital requirements, and data integration needs.

Understanding who the key players are and how they operate is essential when evaluating potential partners or structuring new arrangements. Payers, risk-bearing entities, integrated delivery networks (IDNs), and enablement or wraparound companies each contribute distinct capabilities:

- Payers typically provide attribution, claims data, and payment infrastructure
- Risk-bearing entities or ACOs manage population-level performance and financial risk and reconciliation
- Integrated Delivery Networks (IDNs) offer scale and clinical integration
- Enablement firms often supply analytics, clinical operations and care management technology, or operational capacity to support provider groups.

Recognizing these roles helps organizations distinguish which partners can fill capability gaps, offer complementary services, and jointly achieve desired cost and quality outcomes.

Key contracting considerations for advanced specialty care arrangements:

- Contracting requires both technical rigor and mutual trust.
- Contracts must clearly specify the scope of delegated risk, population definitions, and payment flow.
- Transparent benchmarks, risk-adjustment methodologies, and attribution logic are critical to maintaining credibility with all parties.
- Financial models often include prospective care management fees to ensure steady cash flow during ramp-up, combined with gainsharing provisions that distribute savings among conveners, specialty providers, and downstream partners.
- Stop-loss corridors and outlier protections help mitigate volatility, while defined reconciliation schedules align expectations between payers and providers.

- Robust governance policies should establish oversight roles, decision-making protocols, and compliance reviews to maintain integrity, particularly in areas such as FMV compliance and data use agreements.

Measurement and Data Infrastructure

Data transparency and integration are prerequisites for advanced specialty arrangements. Combining claims, cost, and utilization data provides a comprehensive view of specialty performance, while predictive models identify risk tolerance, variation, and opportunities for improvement.

Key outcome domains include:

- **Clinical:** Measures such as remission rates, dialysis adequacy, or functional recovery.
- **Process:** Indicators like care pathway adherence and timely follow-ups.
- **Patient Experience and upstream drivers of health:** Factors such as access, patient outreach and engagement, and barriers to care.
- **Financial:** Indicators include PMPM spend, variation, risk management, and stable return on investment (ROI).

Dashboards that deliver real-time performance insights to PCPs, specialists, and payers support collaboration and accountability. The ability to drill down by provider, condition, or care setting allows teams to translate insights into concrete improvement actions.

Evolving Models and Innovation Pathways

As specialty risk models evolve, organizations are expanding their scope to include social and community factors that shape outcomes. Integrating community resources and supports for upstream drivers of health enables VBC entities to coordinate wraparound services and address non-medical drivers of cost, particularly for complex, high-risk populations.

Recent innovations in specialty risk models increasingly incorporate palliative and end-of-life care for high-cost, complex populations, ensuring care that is both compassionate and efficient. Sustainability, however, requires careful management of rebasing and benchmark drift to preserve long-term viability while maintaining network adequacy and patient access.

Best Practices for Implementation

Starting Point	Start with limited service lines (one or two focus areas) before expanding.
	Pilot joint-venture or sub-capitated arrangements to test risk readiness before full delegation.
	Align partner roles clearly (payer, ACO, or enablement entity) to avoid overlap.
Readiness and Risk Assessment	Conduct structured readiness assessments early using the Practice Engagement Readiness Assessment tool.
	Validate sufficient patient scale and attribution before entering risk contracts.
	Build financial cushions and stop-loss protections to support liquidity during ramp-up.
Condition and Population Focus	Select conditions with measurable variation and actionable improvement levers.
	Use reliable baselines and risk-adjusted PMPM targets to balance fairness and accountability, if relevant.
	Re-evaluate population definitions annually to prevent benchmark drift.
Clinical Integration and Handoff Protocols	Define referral, transition, and return-to-PCP workflows with clear accountability.
	Use shared care pathways and ADT alerts for timely coordination.
	Reinforce communication between PCPs and specialists through joint case reviews.

Contracting and Financial Model Design	Document benchmarks, attribution logic, and risk-adjustment methodologies transparently.
	Combine prospective care-management fees with gainsharing and stop-loss protections.
	Establish joint governance and compliance oversight to maintain trust and FMV alignment.
Measurement and Data Infrastructure	Integrate claims, cost, and clinical data for full performance visibility.
	Track outcomes, processes, experience, and financial results in parallel.
	Deploy dashboards with provider-level transparency and drill-down capabilities.
Evolving Models and Innovation Pathways	Integrate community and SDOH data to address non-medical drivers of cost.
	Incorporate palliative and end-of-life care into complex-population models.
	Plan annual rebasing and benchmark evolution to sustain fairness and engagement.

Conclusion

Specialty care accounts for a large and growing share of health care spending and is central to improving outcomes for patients with complex and chronic needs. Integrating specialty practice into VBC is therefore an essential path for achieving equitable, efficient, and sustainable care delivery transformation. Specialists still face barriers that limit deeper engagement in VBC models, including fragmented data, unclear care accountabilities, overly burdensome sets of measures, and clinical workflows that are not yet integrated into broader VBC infrastructure. This toolkit offers practical, adaptable approaches to help organizations meaningfully engage specialists as partners in accountable care.

Several areas merit continued deeper dives, experimentation, and cross sharing:

- **Managing specialty drug costs:** With specialty drugs representing a rapidly rising share of total cost, VBC contracts should adopt payment and utilization levers that acknowledge this reality. Focus areas could include aligning medication-related measures, clearly defining financial accountability, and balancing clinical appropriateness and responsible cost management.
- **Integrating community-based support:** Embedding community-based organizations and addressing upstream drivers of health can reduce avoidable admissions and better coordinate care, particularly for underserved populations. Early screening, community partnerships, and advanced care-management models that pair community care navigation with clinical accountability are essential components of effective specialty engagement.
- **Rural health access and infrastructure:** Rural communities face persistent shortages of specialty clinicians, network adequacy gaps, and limited care coordination infrastructure. Specialty telemedicine, flexible contracting arrangements, and standardized pathways adapted for rural workflows can help mitigate these disparities and expand access.

By applying the voluntary best practices and tools presented in this toolkit, payers, VBC enablers, PCP and specialty groups can build coordinated, data-driven, and equitable specialty models that strengthen payer-provider relationships, improve outcomes and patient experiences, and sustain value-based transformation across the continuum. Embedding specialty care into TCOC frameworks ensures that the populations with the highest clinical complexity are fully aligned with systemwide goals for equity, efficiency, and patient experience. This toolkit provides the structure, strategic framework, and best practices needed to make that engagement meaningful, scalable, and lasting.

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