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

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This article provides an overview of the impact of specialty care and the opportunity for it to leapfrog primary care as a lead focus for accountable care.

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**ABSTRACT**

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

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

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The consistent, inexorable move to value-based care in the United States is failing to fully achieve the Quadruple Aim of improving patient engagement, the health of a population, and clinician engagement while reducing the total cost of care.[1] This failure may be due, in part, to current accountable care models, which focus on primary care and ignore specialty care. Specialty care accounts for the majority of healthcare activity (doctor visits and medical spend) among Medicare beneficiaries. In fact, in 2009, specialty care accounted for more than half of office visits to physicians and nearly 70% of healthcare expenditures.[2] In this new paradigm of value-based care, specialty care, which slows chronic disease progression and reduces

complications, deserves as much—if not more—attention as primary care. Thus, we suggest that specialty care becomes the principal driver of accountable care.

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

**Benefits of a Specialty-Focused Accountable Care Environment**

Medicare covers a large population of patients with multiple chronic conditions. In 2010,



treatment goals and monitoring. A specialty accountable care organization (ACO) environment would be best suited to address the complexities of those with chronic conditions and may achieve the following outcomes.

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

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

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

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

**Evidence Suggesting That Specialty Providers Can Achieve the Objectives of ACOs**

Current care models that provide intensive, specialty-focused, value-based care have

succeeded in delivering on the Quadruple Aim. These models have a reimbursement structure different from traditional Medicare FFS; they also are specialty-focused, but borrow significantly from the ACO construct in other ways. Four examples of this care model are described here.

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