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What is Value-Based Specialty Care, and Why Should Health Plans, Employers, and Health Systems Care?

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The following review is the first in a series focused on value-based specialty care. The objective of this series is to educate health plan and health system leaders on the importance of specialty care as it relates to overall performance in value-based arrangements.

Key Takeaways

1. The success of value-based health care is of critical importance to health insurance plans, self-insured employers, and many provider organizations/health systems
2. Primary care providers have central role in value-based programs by ensuring their patients are healthy and only utilize healthcare services that improve health
3. An overwhelming majority of healthcare expenditures are beyond the control of primary care providers, with one such cost driver being specialty care
4. Risk bearing organizations – health plans, employers, and providers – must engage specialists in order to be successful in value-based care
5. Specialist engagement includes many factors, such as inclusion in decision-making, alignment of financial incentives, education, and operational integration

> **Risk-bearing organizations – health plans, employers, and provider groups - must ask themselves: "What are we doing to improve value-based specialty care?". If the answer is not clear, then there is much work to be done…**

Introduction

Spearheaded by the Affordable Care Act [1], value-based health care has taken center stage in American health care. The traditional payment environment of fee-for-service care has resulted in

1. https://www.commonwealthfund.org/publications/2022/apr/impact-payment-and-delivery-system-reforms-affordable-care-act#:~:text=The%20Affordable%20Care%20Act%20introduced,low%2Dincome%2Dserving%20hospitals.

insurmountable costs to health plans and self-insured employers, which bear financial risk for their members and beneficiaries. Payment reform that priorities value (high quality outcomes with low costs of care) has enjoyed largely bipartisan support[2] due to the importance of such programs in controlling the excesses of healthcare expenditures.

According to the famous equation by Porter, the key to delivering value in healthcare is either through improvement of outcomes (with unchanged costs), reduction costs of care (with preserved quality), or – ideally - both. Most value-based programs do reward quality improvements in a variety of ways, but typically, performance is dictated by cost reduction (quality metrics in value-based care will be discussed in a later article!). Therefore, RBOs must first understand what drives costs of care before they can reduce these costs in meaningful ways.

Specialty Care: a Major Cost Driver of Total Cost of Care (TCOC)

When considering value-based care, the term "total cost of care" is often used. This is straightforward and refers to the overall costs related to a given patient/member or the population. In many value-based programs, such as through accountable care organizations (ACOs), clinically integrated networks (CINs), and some Medicare Advantage arrangements, the primary care providers (PCPs) have taken on the financial risk for costs of care. This seems reasonable, as PCPs are the "gatekeepers" of care and help guide what specialty referrals or other non-medical services may be needed. However, not only do PCPs control very little of the expenditures overall, but patients are also increasingly going directly to specialists for their non-primary care needs. This creates a vulnerability in which PCPs that own risk are not fully able to control performance.

In the table below, obtained in an article from JAMA Network by Martin et al.[3], you can clearly see this in action. There are two things worth nothing from this table. First, as of 2016, primary care expenditures only counted for 5.4% of the total expenditures. Secondly, primary care expenditures represent an even smaller amount – 4.2% - of the growth in spending.

Table. Change in Medical Expenditures, 2002-2016[a]

	Spending (billions), $		% Of total		Difference, 2002 to 2016	
	2002	2016	2002	2016	Amount (billions), $	% Of total
Overall spending						
Total	810.7	1617.5	100.0	100.0	806.8	100.0
Inpatient	256.1	415.0	31.6	25.7	159.0	19.7
Office based	180.0	400.0	22.2	24.7	219.9	27.3
Prescription	150.6	381.1	18.6	23.6	230.5	28.6
Outpatient	78.9	139.1	9.7	8.6	60.1	7.5
Dental	64.3	101.3	7.9	6.3	37.0	4.6
Home health	34.8	87.4	4.3	5.4	52.6	6.5
Emergency	27.9	62.5	3.4	3.9	34.7	4.3
Other	18.1	31.2	2.2	1.9	13.1	1.6
Office based and outpatient, by clinician type						
Subspecialist	122.3	266.4	15.1	16.5	144.1	17.9
Other nonphysicians	65.3	129.3	8.1	8.0	64.0	7.9
Primary care	53.1	87.1	6.5	5.4	34.0	4.2
RNs/NPs/PAs	14.4	45.8	1.8	2.8	31.4	3.9
Behavioral health	3.8	10.3	0.5	0.6	6.5	0.8

Abbreviations: NP, nurse practitioner; PA, physician assistant; RN, registered nurse.

[a] Data from the Medical Expenditure Panel Survey, 2002-2016 (https://www.meps.ahrq.gov/mepsweb/).

2. https://www.ama-assn.org/practice-management/payment-delivery-models/new-bipartisan-bill-crucial-boost-medicare-value-based
3. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2765245#:~:text=Specialty%20care%20was%20the%20third,%25%20in%202016%20(Table)

None of this is “new news” to primary care providers who are already engaged in value-based contracting. However, to risk bearing organizations, this should be a wake-up call that true performance improvement in value-based care will require not only helping PCPs manage their own spending (and quality measures) but also by proactively optimizing high cost drivers, such as specialty care.

Within specialty care, there are a few conditions that consistently cost the most. In another notable study from JAMA[4], musculoskeletal (MSK) conditions were the most expensive, followed by diabetes (and related) conditions and cardiovascular conditions (see table from their study below). **Another important finding from the study was that the highest expenditures for commercially insured individuals was for those between 60-64 years old, with MSK conditions representing the highest cost conditions in this cohort.** There was a shift to publicly funded insurance in individuals 65 and older, which is not surprising given that this is the age that qualifies for Medicare coverage.

Table 1. Total Estimated Spending and Aggregated Health Categories for 2016

Aggregated Health Category	Category Code	Health Care Spending, 2016 $Billion (95% CI)	Estimate, %[a] Aggregated Age Group, y <20	20-64	≥65
Musculoskeletal disorders	A	380.9 (360.0-405.4)	3.6	61.3	35.2
Diabetes, urogenital, blood, and endocrine diseases	B	309.1 (292.4-328.4)	4.5	57.5	38.0
Cardiovascular diseases	C	255.1 (233.4-282.6)	1.7	38.8	59.5
Communicable diseases[b]	D	241.7 (226.5-258.6)	29.3	47.7	23.0
Other noncommunicable diseases	E	240.2 (231.3-249.5)	17.1	48.8	34.1
Injuries	F	231.1 (211.7-250.7)	9.9	57.8	32.3
Mental and behavioral disorders	G	180.7 (172.8-189.7)	14.7	71.8	13.5
Neurological disorders	H	173.9 (161.2-186.9)	4.7	36.4	58.9
Well care	I	167.0 (158.0-175.4)	28.3	64.0	7.7
Digestive diseases	J	135.6 (127.9-144.3)	7.8	60.6	31.5
Neoplasms	K	123.8 (114.9-132.8)	6.7	53.7	39.6
Chronic respiratory diseases	L	117.0 (110.8-123.2)	15.6	50.8	33.5
Treatment of risk factors	M	117.0 (109.3-125.7)	0.8	52.1	47.1
Cirrhosis	N	32.5 (27.0-40.4)	3.6	67.9	28.4
All categories (total)		2705.6 (2705.6-2705.6)	10.7	54.2	35.1

4. https://pubmed.ncbi.nlm.nih.gov/32125402/

from birth until aged 64 years. The highest amount of private insurance spending in 2016 was for women and men aged 60 to 64 years. For these ages and among both sexes, the highest spending was for musculoskeletal disorders. In per-person

Implications for Value-Based Care Programs

In value-based specialty care, specialist providers are aligned with the risk bearing organizations with regards to the fundamental incentives of delivering higher quality care at lower overall costs. Given the high proportion of expenditures related to specialists, it would be natural to include these providers in value-based initiatives, but reality proves to be much more difficult.

For specialist providers, revenue is still earned in a fee-for-service fashion. Given that approximately 80% of revenue comes from surgical procedures, there is a strong incentive for specialists to prioritize volume over all else, even outcomes and value-based delivery. This of course creates a natural misalignment between the specialists and the RBO. Value-based specialty care programs overcome these challenges by re-aligning incentives (or through sheer operational force, as discussed later).

So how to overcome this misalignment of incentives? Risk-bearing organizations can do so in multiple ways:

1. **Specialist education and engagement:** Not only do specialists need to be aware of their impact on value-based performance, but these providers must also have leadership roles in designing new delivery models. Moreover, there must be open communication between specialist providers and leaders with their counterparts in clinical operations, population health, and primary care.

2. **Operational integration:** Most provider groups that participate in value-based programs care for a variety of patients. Some of these patients are in risk-bearing arrangements, but others are traditional fee-for-service. How do providers know which patients are in value-based arrangements? What do they do with this information? What can be done on “auto-pilot” in the background to ease provider burden? When should the specialist get involved – early or late?

3. **Data visibility:** as mentioned above, there are two key drivers of value: cost and outcomes. Does the organization have clear dashboards that report on each? How are they reported, and where? How is the data shared and discussed? Most importantly, how is it acted upon?

4. **Financial incentives:** has the organization put into place shared incentives for specialists that will promote behavior change? Will these be meaningful enough considering the potential salary drop from reduction of surgeries and procedures? What other non-financial incentives are available to promote behavior change?

5. **Utilization management:** the most controversial method of cost control comes with utilization management, in which third party companies evaluate appropriateness of surgeries, procedures, treatments, and imaging requests, and subsequently denying those requests that fail to meet certain qualifying criteria. This process can be very effective at lowering costs of care for a given population but come with significant patient/member abrasion as well as physician dissatisfaction.

As can be seen, some of these strategies involve realigning incentives, particularly financial, such that programmatic success yields financial success to the participating specialists. Often, these "bonus" payments may be insufficient– when considering the potential loss of revenue from decreasing surgical volume – to singlehandedly change behavior. Therefore, organizations must employe a variety of strategies to get specialists to the table. Some of these may involve voluntary behavior change, while others may be applied "invisibly" (through operational changes) or by force (see utilization management below). Likely, organizations must do a combination of these.

This list is not exhaustive but represents some key areas to consider when formulating specialty value-based care strategies. Some of these, such as operational integration, may be more easily attained by the delivery organization (e.g., health system) than through the health plan or employer. Alternatively, health plans may be in better position to provide cost performance data. Employers may have significant power in affecting financial incentives through mechanisms such as direct contracting. We previously gave some summary advice on the topic in a prior post that may also be worth reviewing. In future posts, we are going to dive deeper into each of these topics. Our goal is to provide a toolbox of actionable articles that will help healthcare leaders enhance specialty care.

About Protera Health

Protera Health helps health plans, employers, and provider groups improve value-based MSK specialty care through a clinically integrated virtual approach. Our team is committed to helping risk-bearing organizations enhance their specialty value-based care programs and initiatives, particularly with MSK conditions. If you are interested in learning about how our unique virtual specialty care model can help your group, please contact us here, and a member of our team will help you schedule a planning session.