



Specialty Recommendations for CMMI Models

In May 2025, the Center for Medicare and Medicaid Innovation (CMMI) released an updated [strategy](#) to Make America Healthy Again by investing in preventive care, empowering patients, and driving choice and competition. CMMI [discussed](#) two key opportunities for specialty care, including:

- New models or tracks within models that focus on complex care and specialty populations for Original Medicare patients.
- Specialty-focused longitudinal care within Medicare Advantage and Medicaid.

HCTTF strongly supports CMMI's interest in increasing specialty engagement across lines of business, which reflects a key area of innovation among payers and providers in the private sector.

Because specialty care is the principal driver of total health care spending, policymakers cannot meaningfully reduce costs without finding opportunities to address specialty care. Specialty groups – including physicians and multidisciplinary care teams – are essential front-line partners in identifying opportunities to improve patient outcomes while reducing waste, fraud, and abuse. This policy brief outlines our recommendations for CMMI investment in specialty models, in alignment with the CMMI strategic pillars.

Specialty care represents a broad spectrum of complex health care needs, which requires models to be tailored to specific conditions and patient populations. HCTTF members – including payers, Accountable Care Organizations (ACOs), and specialty groups – are developing innovative longitudinal specialty arrangements in the private sector. Private payers are creating tailored financial incentives for specialties with the greatest opportunity to impact clinical outcomes and the total cost of care (**Figure**). Specialty groups are partnering with risk-bearing entities (both payers and ACOs) to take financial accountability for clinical and financial outcomes, as shown in HCTTF [case studies](#). ACOs are implementing population health infrastructure to address chronic conditions, including care management, post-discharge follow-up, and data analytics and reporting.

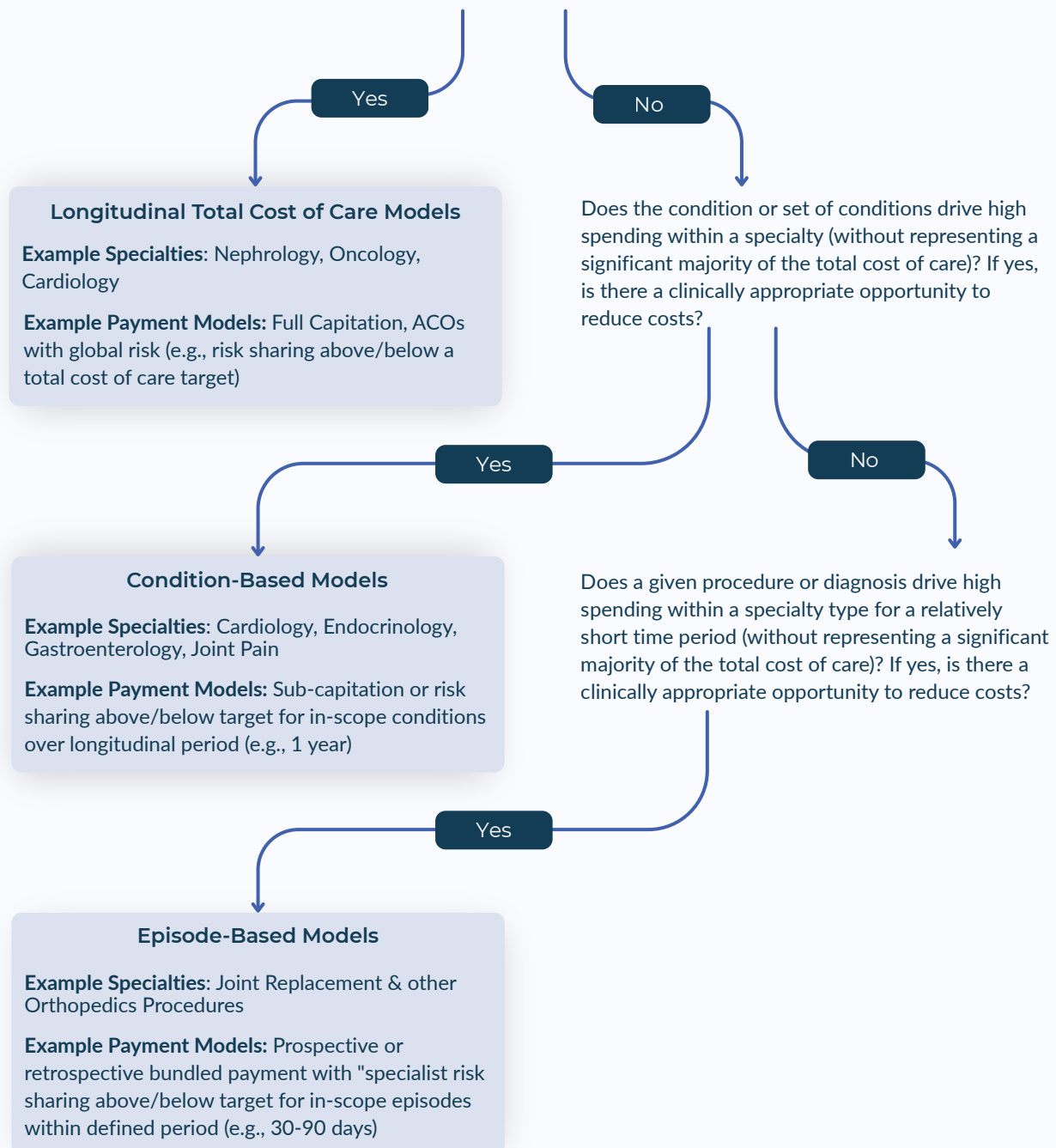
CMMI currently uses two key approaches to address total cost of care (including specialty costs):

- **Population-based models.** Most ACOs and other population-based models are built on primary care attribution, making the ACO (not specialty groups) responsible for all specialty care. The exception is the Comprehensive Kidney Care Contracting (CKCC) model, which attributes patients to nephrologists.
- **Episode-based models.** CMMI has implemented both voluntary and mandatory episode-based models for a range of procedural and medical specialties. Patients are generally attributed to the hospital or outpatient facility (not specialty groups) and model design elements are generally uniform across all conditions and procedures (e.g., standardized 30-day episodes, even for procedures with 6-week clinical follow up requirements). CMMI is now innovating in this space with the mandatory [Ambulatory Specialty Model](#), announced in July 2025, which attributes patients with low back pain and heart failure directly to individual specialists.

HCTTF recommends that CMMI build upon this foundation, by creating **additional voluntary opportunities for specialty groups to assume downside risk for longitudinal care – both by participating directly in CMMI models and as downstream providers in global risk models.** This would fill a gap in the CMMI portfolio for condition-based, longitudinal specialty models, and would create additional opportunities to leverage private-sector innovation.

Figure: Tailored Incentive Structures for Specialty Models

Does the condition represent a significant majority of beneficiaries' total cost of care (both for individual patients and in aggregate for the payer)? If yes, is there a clinically appropriate opportunity to reduce costs?



HCTTF Recommendations

HCTTF has developed specialty recommendations that align with CMMI's strategic pillars of promoting prevention, empowering patients, and driving choice and competition. We believe that increased opportunities for specialty engagement in value-based care will spur investment in prevention, empower patients to improve their own care (supported by wearables and other tech-enabled tools), and increase competition among providers to deliver the highest-value care.

Specialty Total Cost of Care Models

HCTTF recommends that CMMI create additional opportunities for specialty groups to participate in total cost of care models for three specialties:

- **Nephrology:** HCTTF supports CMMI's strong ongoing investment in nephrology total cost of care models, as demonstrated by the recent decision to extend CKCC by one year through 2027. Nephrology is an excellent example of a specialty that drives total cost of care for individual nephrology patients, as well as for the Centers for Medicare & Medicaid Services (CMS) overall. HCTTF members currently bear longitudinal risk under CKCC. To strengthen this model, HCTTF recommends that CMMI: (1) **promote prevention by expanding the patient population** to include people with stage 3 chronic kidney disease, (2) **increase participation in the global track** by reducing the CMS discount, and (3) **increase the geographic reach** by loosening the core-based statistical area restrictions.
- **Oncology:** HCTTF supports the refinement of the Enhancing Oncology Model (EOM). Like nephrology, oncology also drives the total cost of care for individual patients, as well as for CMS. However, most oncology spending is driven by treatment regimens – such as chemotherapy and biologics – which are determined based on the patient's cancer type, stage, and biomarkers. Therefore, most [private sector oncology models](#) are tied to clinical pathways that take stage and biomarkers into account. However, EOM does not [fully risk adjust](#) for these factors, instead [adjusting](#) only for metastatic cancer for three cancer types and one biomarker for breast cancer. HCTTF recommends that CMMI: (1) **expand EOM to incorporate all actively treated cancers** to provide care improvement to all patients, (2) **create a mechanism for advanced shared savings** to more closely align incentives with clinical care and operations, similar to the options offered to ACOs, (3) **introduce risk corridors** to mitigate practices' financial exposure, (4) **improve the risk adjustment within cancer types by using available clinical data** on stage and patient biomarkers, and (5) **reduce the administrative burden** by requiring practices to only report clinical data that is used in EOM financial and quality methodologies.
- **Cardiology:** There is currently no CMMI model focused on total cost of care for cardiology patients, despite cardiology being the largest driver of costs in the US. **HCTTF supports the development of a voluntary longitudinal total cost of care model for patients with Congestive Heart Failure, potentially expanding to other major cardiovascular conditions.** This would supplement the mandatory episode-based approach in the Ambulatory Specialty Model by increasing specialist engagement in global risk.

Specialty Models Embedded in ACOs

In addition to the longitudinal total cost of care models, HCTTF recommends that CMMI create opportunities for ACOs to engage specialists inside of population-based models through:

- **Sub-capitated arrangements:** All ACOs bearing global risk should have the opportunity to establish sub-capitated arrangements with specialty groups – especially those with high-cost chronic conditions (e.g., cardiology, endocrinology, gastroenterology, and joint pain). ACOs are in the best position to comprehensively address the clinical needs for the patients they serve, particularly related to high-cost conditions and specialty episodes that are expensive but may not represent the significant majority of a patient's total cost of care. While ACOs currently have the authority to gainshare with specialists by establishing up- or downside incentives attached to quality metrics, sub-capitation would expand upon this authority and provide stronger incentives. This flexibility would give ACOs new tools to incentivize specialty groups to provide longitudinal care for high-cost chronic conditions.
- **Patient cost-sharing waivers:** All ACOs bearing global risk should have the flexibility to waive patient cost-sharing for specific services or conditions. This would allow ACOs to incentivize longitudinal specialty care by creating predictable patient cost-sharing for a given chronic condition. In addition, this would allow ACOs to waive cost-sharing that may be prohibitively expensive for patients, in cases where the ACO identifies opportunities for chronic condition prevention and management.
- **High-needs risk track:** All ACO models should include tracks for participants serving high-needs populations, such as homebound patients and those living in nursing homes. These highly complex patients generally have multiple chronic conditions that require specialty care, as well as high levels of support with activities of daily living. Because these populations are high-cost but relatively low-volume compared to the general Medicare population, these risk tracks require specialized risk adjustment models, quality measures, and financial safeguards. As [recommended](#) by the [Complex Care Alliance](#), HCTTF recommends that future high-needs models should (1) **drive patient and caregiver choice and transparency** by allowing ACOs to offer cost-sharing waivers and benefit enhancements, (2) **increase access for high-needs patients – including rural patients** – by allowing ACOs to participate at the organization level and treat all beneficiaries as high needs if a high enough percentage meet eligibility criteria, (3) **improve benchmark stability and accuracy** by using a regional rate book similar to MA that is calibrated for high-needs patients, and (4) **deepen Medicare-Medicaid integration** for long-term services and supports through partnerships with ACOs and Medicaid risk-bearing entities.

Key Elements for All CMMI Models

In addition, all CMMI model participants – especially those bearing global risk – require clear model requirements and guidance from CMMI, including:

- **Elimination of fraud, waste, and abuse** spending from benchmarks, as seen with skin substitutes and catheters.
- **Consistent benchmarking methodologies** that do not change suddenly mid-model (e.g., attribution methodology, CMS discount, outlier exclusions, quality adjustment).
- Reduced administrative burden, such as **exemption from Merit-based Incentive Payment System (MIPS) reporting requirements** – a key non-financial incentive for participants in advanced alternative payment models.
- Appropriate **risk adjustment for patient-level factors that drive clinical decisions and patient outcomes**, including chronic conditions that inform treatment patterns and non-medical drivers of health such as nutrition and transportation that influence patient choices.
- A parsimonious set of **clinically relevant quality measures**, including patient-reported outcome and experience measures, which for specialty models should be directly linked to a given specialty.
- **Complete, accurate and timely data** to identify gaps in care and inform referrals, with clearly communicated data standards to support interoperability.
- **Safe harbor laws and guidance** for value-based care (VBC) contracts and patient engagement.
- **Stakeholder engagement – especially of patients and caregivers** – to ensure that models effectively meet patient needs and support prevention.
- **Multi-payer alignment opportunities** to reduce fragmentation, support practice transformation, and amplify the impact of VBC incentives across patients and payers.

HCTTF looks forward to supporting the CMMI as it implements the new strategy to drive prevention, empower patients, and promote choice and competition.



Tailored Incentive Structures for Specialty Models

Specialty care represents a broad spectrum of complex health care needs, which requires models to be tailored to specific conditions and patient populations. HCTTF members – including payers, Accountable Care Organizations (ACOs), and specialty groups – are developing innovative longitudinal specialty arrangements in the private sector. As discussed in our [specialty care brief](#), **payers are creating tailored financial incentives for specialties with the greatest opportunity to impact clinical outcomes and the total cost of care (Figure)**. These models support specialty groups as they partnering with risk-bearing entities (both payers and ACOs) to take financial accountability for clinical and financial outcomes, as shown in HCTTF [case studies](#).

Figure: Tailored Incentive Structures for Specialty Models

Does the condition represent a significant majority of beneficiaries' total cost of care (both for individual patients and in aggregate for the payer)? If yes, is there a clinically appropriate opportunity to reduce costs?

Yes

No

Longitudinal Total Cost of Care Models

Example Specialties: Nephrology, Oncology, Cardiology

Example Payment Models: Full Capitation, ACOs with global risk (e.g., risk sharing above/below a total cost of care target)

Does the condition or set of conditions drive high spending within a specialty (without representing a significant majority of the total cost of care)? If yes, is there a clinically appropriate opportunity to reduce costs?

Yes

No

Condition-Based Models

Example Specialties: Cardiology, Endocrinology, Gastroenterology, Joint Pain

Example Payment Models: Sub-capitation or risk sharing above/below target for in-scope conditions over longitudinal period (e.g., 1 year)

Does a given procedure or diagnosis drive high spending within a specialty type for a relatively short time period (without representing a significant majority of the total cost of care)? If yes, is there a clinically appropriate opportunity to reduce costs?

Yes

Episode-Based Models

Example Specialties: Joint Replacement & other Orthopedics Procedures

Example Payment Models: Prospective or retrospective bundled payment with "specialist risk sharing above/below target for in-scope episodes within defined period (e.g., 30-90 days)