

Specialty Contracting Playbook: **Payer Worksheet**

This is a quick reference companion to the full specialty contracting guide, serving as a worksheet for payers seeking value-based contracts with specialty providers. The worksheet outlines decisions across 10 contracting domains.

Counterparty: _____

Completed by: _____

Date: _____

1. Networking Strategy *Identify high-value specialists*

What approach to specialty arrangements will the payer use?	☐ In-network ☐ Vendor ☐ Hybrid ☐ Undecided
If in-network: How will established infrastructure be used to drive volume to high-value specialists and/or layer additional incentives?	
If vendor: What payment approach will be used?	☐ PMPM ☐ Case rate ☐ Other: _____
If hybrid: Will the arrangement combine in-network contracts with reduced or waived cost sharing?	☐ Yes ☐ No ☐ TBD

2. Data & Analytics *Share & receive data*

Which data types will be shared with specialty partners?	☐ Claims ☐ Member eligibility ☐ Attribution ☐ ADT feeds ☐ Lab results ☐ Pharmacy ☐ Other: _____
How will data be shared?	☐ Claims data for attributed patients ☐ Provider dashboards ☐ Both ☐ Other: _____
What refresh timing has been agreed, by data type?	



3. Attribution *Develop attribution logic across primary & specialty care*

Which attribution approach will be used for PCPs vs. specialists?	☐ Carve out from primary care ☐ Concurrent primary care & specialist assignment with shared savings ☐ Other: _____
If carve out: Which specialties or populations may be removed from primary care attribution <i>(e.g., oncology, nephrology)?</i>	
If shared savings: How will specialist savings be charged back to primary care or controlled for when measuring differential savings?	

4. Financial Risk *Incentivize specialists with appropriate levels of risk*

What level of risk will be offered to specialists?	☐ Start with non-financial incentives ☐ Upside risk with glide path toward risk ☐ Immediate downside risk ☐ TBD
If starting with non-financial incentives: Which referral pathways will triage clinically appropriate patients to non-operative care first, consistent with shared decision-making?	
If using a glide path: What cost reduction and quality improvement milestones will trigger progression toward risk?	
If immediate downside risk: Which experienced VBC specialties with greater savings opportunities are prioritized <i>(e.g., nephrology)?</i>	

5. Benchmarking & Trends *Establish sustainable methodologies*

What time horizon best matches the clinical condition?	☐ Episode - time-limited responsibility, may include TCOC risk (e.g., 30 days) ☐ Condition - longitudinal responsibility for a specific condition (and associated costs) ☐ Longitudinal TCOC - long-term responsibility for all costs (e.g., 1 year)
Which financial performance basis will be used?	☐ Medical loss ratio (MLR) ☐ Total cost of care (TCOC) ☐ Other: _____
Which trend methodology will be used for the specialty population?	☐ Retrospective trend ☐ Prospective trend ☐ Concurrent trend
If retrospective: What counterfactual will be used?	☐ Propensity matching to payer markets ☐ External data source ☐ Other: _____
If prospective: Will material adverse change clauses allow retrospective benchmark adjustments during the performance period?	☐ Yes ☐ No ☐ TBD

6. Risk Adjustment *Accurately capture patient case mix*

Which risk adjustment methodology will apply?	☐ Claims-based (generally V28 HCCs) ☐ Concurrent (e.g., ACO REACH methodology) ☐ Specialty-specific ☐ Other: _____
If specialty-specific: Is EHR data available to augment claims-based risk adjustment?	☐ Yes ☐ No ☐ TBD
If available: Which providers or specialties have EHR data available to integrate into risk adjustment?	

7. Payment Mechanism *Establish appropriate payments*

When will incentives be delivered?	☐ Upfront - PMPM or case rate with retrospective reconciliation ☐ Retrospective reconciliation - shared savings after performance period ☐ Other: _____
If upfront: What PMPM or case-rate structure will provide cash flow for care delivery efforts?	

8. Quality *Reward clinically appropriate measures*

How will payment be linked to quality?	☐ Pay for reporting ☐ Pay for performance ☐ Other: _____
How will quality benchmarks be set?	☐ Minimum threshold ☐ External benchmark ☐ Other: _____
Which types of quality measures will be used?	☐ Process ☐ Outcomes ☐ Specialty-specific (where available) ☐ Patient-reported outcomes & experience
Which measures apply, by specialty <i>(e.g., Oncology (ED visits during chemotherapy, timely hospice enrollment); nephrology (optimal dialysis starts, home dialysis rate, unplanned starts); cardiology (30-day HF readmissions, GDMT adherence))</i>	

9. Non-financial Incentives *Reduce burden*

Which non-financial levers will make high-value choices the path of least resistance before delegating risk?

- ☐ Waive prior authorization / gold carding
- ☐ Eliminate downcoding
- ☐ Reduce or eliminate patient cost-share for high-value providers
- ☐ Other: _____

10. Patient Incentives *Support patient choice*

Which patient incentives will be used to drive meaningful clinical outcomes?

- ☐ Waive patient cost-sharing
- ☐ Provide supplemental benefits
- ☐ Other: _____

Which populations or clinical pathways will these incentives target?