

Specialty Contracting Playbook

Health Care Transformation Task Force

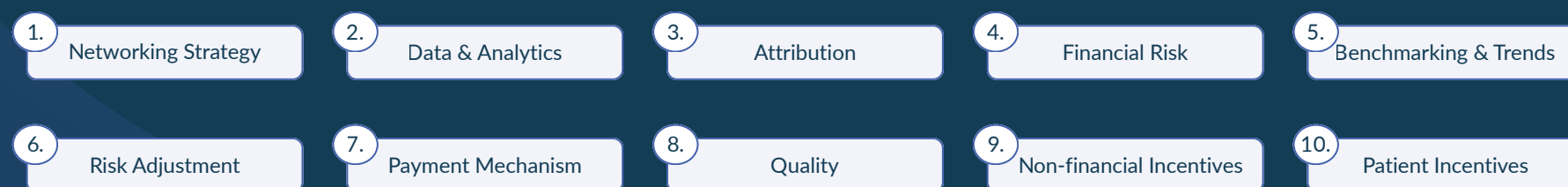


As **value-based care** (VBC) continues to grow – with risk-based contracts representing 29% of all health care spending – specialty care has become a primary focus for many payers and accountable care organizations (ACOs).¹ While specialty care is a major driver of US health care spending, specialists are 40-50% less likely to participate in value-based payment models compared to primary care providers.² Integrating specialists into VBC arrangements is vital to improving outcomes, managing costs, and reducing fragmentation for the highest-risk patients.

Effectively engaging specialists requires strong partnerships. In addition to contract design, successful specialty partnerships depend on organizational readiness, leadership commitment, and a shared willingness to adapt. Identifying partners with a genuine appetite for change is an important first step. Even with strong alignment, these arrangements take time to mature. To build trust, refine care processes, and establish effective workflows, partnerships often require multiple performance periods and sustained investment. Partners must also have a shared understanding of the data and analytics available to support the arrangement, as well as how these capabilities are evolving, to make informed decisions and adapt over time.

HCTTF developed this playbook for specialty care organizations, ACOs and payers to negotiate and implement contracts that support meaningful transformation of specialty care delivery. Drawing on subject matter experts throughout the field, this resource highlights the key considerations for developing successful specialty contracts and partnerships.³

Specialty Contracting Domains



¹ AHIP. (2026, February 2). 2025 APM Measurement. <https://www.ahip.org/resources/2025-apm-measurement>

² Winberg, D.R., Baker, M.C., Hu, X., Horvath, K.A. (2024). Who participates in value-based care models? physician characteristics and implications for value-based care. Health Affairs Scholar, 2(8). <https://academic.oup.com/healthaffairsscholar/article/2/8/qxae087/7714277?login=false>

³ This work builds on HCTTF's [specialty landscape paper](#) and NAACOS' [specialty engagement toolkit](#).

Table 1: Networking Strategy

	Goals	Solutions & Decisions
Payer	- Identify high-value specialists to improve outcomes & reduce avoidable costs. - Ensure access across rural and urban areas – both statewide and nationally – to meet CMS and/or NCQA network adequacy requirements.	- Partner with high-value specialists within their existing network while ensuring opportunities for independent practices. To create scale, partner with specialty groups that aggregate practices to standardize contracting and relieve administrative burden. - Navigate anti-steering clauses with large provider systems that impact referral pathways. → DECISION <i>In-network provider vs. vendor vs. hybrid</i> In-network: Leverage established infrastructure to drive volume to high-value specialists, and may layer additional incentives on top. Vendor: Enable non-covered services and benefits, allow for PMPM, and eliminate cost sharing. Hybrid: Establish in-network contracts with cost-sharing waiver.
ACO	- Identify high-value specialists to improve outcomes & reduce avoidable costs. - Manage total cost of care accountability under CMS models, often focusing on specific catchment areas (e.g., metros or sub-state regions).	- Partner with high-value specialists currently seeing the ACO's attributed patients, whether they are employed or part of existing referral networks. - Align activities with existing programs (e.g., CMMI models) and across markets to better manage resources and drive sustainability. - Navigate administrative burden of integrating referral preferences into provider workflows and steering patients to preferred sites of care. → DECISION <i>ACO participant lists vs. preferred provider networks vs. downstream financial risk arrangements</i> ACO participant lists: Allow for the strongest financial incentives between ACOs and specialists, but create operational challenges depending on the specialist's EHR and their willingness to capture population health measures. Preferred provider networks: Leverage established referral patterns to drive volume to high-value specialists. Downstream risk arrangements: Create financial incentives for stronger alignment, but operationally complex and often limited to shared savings opportunity under CMS models.
Specialist	- Deliver care with more flexibility and be rewarded for outcomes. - For independent specialists, retain independence while reducing administrative burden through an aggregator.	→ DECISION <i>(Payer Contracts): In-network provider vs. vendor vs. hybrid</i> In-network: Contract as in-network with a plan – including self-insured employers – but this may create complexity in patient cost-sharing unless billing FFS. Vendor: Simpler contract option for wrap around services, and may reduce patient cost-sharing since they do not bill claims. Hybrid: Allow for in-network contracts with cost-sharing waiver.

Table 2: Data & Analytics

Goals		Solutions & Decisions
Payer	- Share data with specialists to support patient identification, chronic condition management, and outcomes. - Seek EMR data from providers to supplement claims.	- Generally not able to provide customized data feeds but may offer regular claims feeds for attributed patients. - Perform financial calculations internally while allowing third-party validation if negotiated in the contract. - May incorporate the EHR into analytics if available from the provider. → DECISION <i>Determine what data to share and when.</i> Data types: Claims data (medical and/or pharmacy), member eligibility and attribution, ADT feeds, prior authorization, lab, and pharmacy data. Format: May offer claims data for attributed patients and/or develop dashboards for providers. Timing: Widely variable by data type and payer. May be daily, weekly, monthly, or quarterly. Real-time availability will grow with forthcoming interoperability rules.⁴
ACO	- Share data with specialists to support patient identification, chronic condition management, and outcomes. - Evaluate provider performance, utilization, and outcomes using EHR and claims data.	- Test whether the specialty practice can receive and return patient-level information needed for population health management, quality measurement, and CMS reporting. May include EHR connectivity, patient matching, data-use permissions, workflow integration, and responsibility for resolving data-quality issues. - Use analytic platforms to integrate claims and EHR data for risk stratification and population management. ACOs will need to incorporate actuarial expertise, which is often cost prohibitive for small practices with fewer than 30 physicians. - Leverage CMS monthly or quarterly reports while recognizing limitations for proactive care management and performance improvement due to extended data lag. - Compare specialist performance internally within the ACO and relative to external benchmarks (if available). → DECISION <i>Determine what data to share with downstream specialist (e.g., data types, format & timing).</i>
Specialist	- Access timely and actionable data to manage performance under risk arrangements. - Adjust data requirements based on level of financial risk.	- Obtain access to claim-level data either as a standard feed or in cases where contract calculations differ significantly from provider expectations. - Conduct independent propensity-matched analyses with actuarial partners when retrospective benchmarking is not used or when additional validation is needed. → DECISION <i>Determine analytic needs and capacity either internally or with consultant support.</i> Frequency of claim-level data needed to manage a risk-based contract (e.g., monthly). Capacity to process claims, given need to validate and variability across payers.

⁴89 FR 8758 (February 8, 2024).

Table 3: Attribution

	Goals	Solutions & Decisions
Payer	• Maintain primary care attribution while developing additional incentives for specialists. • Create a hierarchical attribution methodology across specialties.	• Most payers use claims as a source of attribution but may incorporate member selection. • Most payers use the following attribution hierarchy: (1) oncology, (2) nephrology (ESRD and advanced CKD, with specific staging up for negotiation), and (3) cardiology. → DECISION <i>Establish an attribution logic for PCPs vs. specialists.</i> • Carve out: Most payers prohibit overlap between PCP and specialist attribution. Patients may be carved out of primary care attribution for specific specialties (e.g., oncology, nephrology). Patients with other conditions may be attributed to specialists if not seeing primary care. • Shared savings: Maintain primary care attribution while concurrently assigning the patient to a specialist. A portion of savings attributed to the specialists could be charged back to primary care or controlled for to measure differential savings between PCP/specialist attribution.
ACO	• Encourage primary care providers to manage specialty types through targeted referrals or co-management.	• Maintain attribution methodology under CMS models (e.g., primary care attribution takes precedence, with attribution to select specialties if patient is not seeing primary care). → DECISION <i>Determine subsets of the attributed patient population that would benefit from a formal referral pathway to a specific specialty group (while maintaining the precedence of primary care attribution).</i>
Specialist	• Identify patient population with opportunity to better manage specialty cost and utilization.	• Identify patient population based on specific diagnoses and in some cases geographies. → DECISION <i>Negotiate which patient populations to take accountability for and how much scale.</i>

Table 4: Financial Risk

	Goals	Solutions & Decisions
Payer	Achieve successful long-term partnerships by establishing appropriate levels of specialist risk.	- Place specialist fees at risk based on clinical outcomes and cost savings relative to the benchmark, while tailoring the level of risk to the specialist's experience and scale. - Determine whether and how pharmacy spend is included in the financial methodology, particularly in instances when drug costs represent a significant share of the total cost of care (e.g. biologics). → DECISION <i>Establish an attribution logic for PCPs vs. specialists.</i> Start with non-financial incentives: Implement referral pathways to triage clinically appropriate patients to non-operative care first, consistent with shared decision-making. Once these pathways are mature and proven, consider introducing risk-sharing for condition-based risk. Glide path to risk: Offer upside risk arrangements and a glide path toward risk as specialists demonstrate cost reduction and quality improvement. Immediate downside risk: Prioritize specialties with more experience in VBC and greater opportunities for savings (e.g., nephrology).
ACO	Implement incentives for downstream specialists to improve outcomes and reduce avoidable costs.	- Maintain attribution methodology under CMS models (e.g., primary care attribution takes precedence, with attribution to select specialties if patient not seeing primary care). → DECISION <i>Determine whether financial incentives for specialists are needed.</i> Financial incentives for ACO participant list: Some ACOs offer financial incentives to those on the ACO participant list including incentives based on a percent of shared savings and/or changing compensation plans for employed specialists. However, due to low attribution, incentives based on aligned lives may not be meaningful. Financial incentives for preferred provider network: Some ACOs use financial incentives to align with high-value specialists (either through employment contracts or gainsharing agreements with affiliated specialists). The LEAD model will offer additional financial risk options (e.g., CARA & non-primary care capitation). Non-financial incentives: Many ACOs pursue complementary engagement strategies such as preferred provider networks to drive referrals or benchmarking specialist performance (publicly or privately). → DECISION <i>Determine appropriate level of risk (upside, glide path, downside). Under CMS models, downstream financial arrangements must be funded through shared savings, limiting the size of the incentive pool and is not known in advance.</i>
Specialist	Seek financial incentives for improving outcomes and lowering cost within the specialist's control.	- When contracting with risk-bearing ACOs, may be required to involve the payer who is delegating risk. → DECISION <i>Determine what level of financial risk to take on (shared savings, full risk, fee arrangements). If assuming downside risk, determine guardrails such as minimum volume, stop-loss protection, and catastrophic cases.</i> - Example: Begin by managing a defined percentage of an ACO's population (e.g., 1-3%) before transitioning to arrangements with shared savings and greater financial accountability.

Table 5: Benchmarking & Trends

	Goals	Solutions & Decisions
Payer	Determine benchmarking and trend methodologies to demonstrate savings over shorter time horizons.	- May purchase external benchmarks. Reset benchmarks no longer than every two years for greater accuracy. - Anchor specialty models to broader TCOC metrics to counter incentives for providers to do more episodes to maintain revenue. - Monitor for underuse, delayed referrals, or selection against complex patients, and measure patient experience. → DECISION Define the <u>time horizon</u> for a given arrangement <u>based on the clinical condition</u> Episodes: Time-limited responsibility for cost and outcomes (e.g., 30 days), often TCOC. Conditions: Longitudinal responsibility for a specific condition, generally not TCOC. Longitudinal TCOC: Long term responsibility (e.g., 1 year) of outcomes with full risk. → DECISION Medical Loss Ratio (MLR) vs. Total Cost of Care (TCOC) under longitudinal risk MLR: Specialist is assessed based on how the plan performs on MLR, which factors in both cost and revenue. TCOC: Specialist is assessed based on total actual spending, without factoring in changes in revenue. → DECISION Select the most appropriate trend methodology for the specialty population. Retrospective trend is often preferred for greater accuracy, especially post-COVID. Must establish a counterfactual, which may leverage propensity matching relative to a payer's other markets, or external data sources (e.g., CMS 5% sample). Tradeoff: Lag time in knowing financial performance. Prospective trend is known in advance, allowing for more real-time understanding of performance. May include material adverse change clauses to allow retrospective benchmark adjustments during the performance period. Tradeoff: Cannot account for unforeseeable market shifts unless retrospective adjustment is applied. Concurrent trend may be most appropriate for high-risk patient populations (e.g., oncology). Tradeoff: While these have been tested in CMS' REACH high needs population, this is a newer methodology and may not be most appropriate for a general patient population.
ACO	Align downstream specialists with CMS benchmarking methodologies.	→ DECISION If the ACO decides to offer downstream financial risk to specialists, determine how to link this to cost and quality benchmarks (often different for employed vs. affiliated specialists). Employed specialists: May link cost and/or quality targets to a bonus structure in the physician's contract. Affiliated specialists: May link cost and/or quality targets to a percent of shared savings.
Specialist	Establish feasible benchmark & trend that accounts for elements under specialist control.	→ DECISION Negotiate for benchmark & trend methodologies that represent clinical factors under the specialist's control. - Limit exposure to "insurance risk" related to changes in enrollment or pricing. If assuming downside risk, determine guardrails such as minimum volume, stop-loss protection, and catastrophic cases. - Negotiate access to data needed to validate the results.

Table 6: Risk Adjustment

Goals		Solutions & Decisions
Payer	Accurately capture patient risk to ensure appropriate performance comparisons.	- Prioritize transparency in risk adjustment calculations to build provider trust.  DECISION <i>Determine the most appropriate risk adjustment methodology.</i> Claims-based risk adjustment: Generally V28 HCCs, but may use alternatives (e.g., internally developed models, MARA, Optum's ERG). Concurrent risk adjustment: Alternative approach for claim-based risk adjustment that may be appropriate for high-needs populations (e.g. ACO REACH methodology). Specialty specific: May be more clinically appropriate if EHR data is available to support (e.g., staging data for oncology models).
ACO	Accurately capture patient risk to ensure appropriate performance comparisons.	 DECISION <i>Determine what risk adjustment methodology to use with downstream specialty providers (same options as above).</i> Employed specialists: May link cost and/or quality targets to a bonus structure in the physician's contract. Affiliated specialists: May link cost and/or quality targets to a percent of shared savings.
Specialist	- Take accountability for clinical care delivery while controlling for differences in patient risk. - Limit exposure to elements of "insurance risk" outside provider's control, such as changes in enrollment or pricing.	 DECISION <i>Negotiate the most appropriate risk-adjustment methodology for the patient population. If using specialty-specific methodologies, determine the necessary data exchange needed to support it.</i>

Table 7: Payment Mechanism

Goals		Solutions & Decisions
Payer	Offer flexible payment timing to support care delivery.	→ DECISION <i>Determine when to deliver incentives.</i> Upfront: PMPM or case rates to provide cash flow to specialists for care delivery efforts with retrospective reconciliation. Retrospective reconciliation: Calculate and deliver shared savings after the performance period.
ACO	Offer payment mechanism in alignment with CMS rules.	→ DECISION <i>Determine best available option to deliver financial incentives.</i> MSSP ACOs cannot offer upfront cash flow through specialty sub-cap arrangements but can offer gainsharing arrangements to downstream specialists. LEAD ACOs will also have the option to offer upfront cash flow through non-primary care capitation and may also offer nested bundles through CMS-Administered Risk Arrangements (CARA).
Specialist	Obtain upfront cash flow to support care delivery and operations.	→ DECISION <i>Negotiate cash flow options that best support care delivery and operations, with a general preference for an upfront option:</i> PMPM/case rate: Often a standardized amount per patient, reconciled retrospectively. Sub-capitation: Full amount delivered upfront, but greater financial risk as true capitation is not retrospectively reconciled.

Table 8: Quality

	Goals	Solutions & Decisions
Payer	- Align quality measures with care delivery and outcomes. - Reward providers for delivering improved outcomes.	- Prioritize measures that align with established quality programs including HEDIS and Medicare Star Ratings measures. → DECISION <i>Develop a quality payment approach.</i> How to link payment to quality: Pay for reporting vs. pay for performance (e.g., often calculated as a multiplier on existing incentive structures for improvement over time or performance relative to peers). How to set benchmarks: Minimum threshold vs. external benchmark (e.g., set in advance based on historic data or calculated retrospectively relative to the current performance year). → DECISION <i>Determine quality measure selection.</i> - Process vs. outcomes - Specialty specific (not available for all specialties) - Patient reported outcomes & experience
ACO	Reward providers for delivering improved outcomes.	- ACOs often prioritize measures established by CMS, but have flexibility on measure selection for downstream specialty arrangements. → DECISION <i>Develop quality metrics in partnership with ACO leadership and specialty provider.</i> - ACOs may select quality measures that are separate from those used by CMS, particularly since EHR data allows for more specialty-specific quality measures than are available in claims. - While incentive structures may vary for employed vs. affiliated incentive structures, ACOs generally prefer to standardize quality measures by specialty type to enable consistent evaluation across providers. → DECISION <i>Determine a quality payment methodology</i> Sliding scale: Increase payments as specialist performance improves. Threshold: Pay specialists if they meet a minimum threshold. → DECISION <i>Determine how to collect population health measures to meet ACO requirements.</i> - For patients attributed to the ACO through their specialist, determine specialist ability and willingness to capture population health metrics.
Specialist	Get credit for quality measures that specialists can directly influence.	→ DECISION <i>Negotiate quality measures.</i> - Propose measures that are clinically appropriate and under specialists' control. - Balance measure selection with potential administrative burden related to data sources and reporting.

⁵ Examples include: Oncology (ED visits during chemotherapy, timely hospice enrollment); nephrology (optimal dialysis starts, home dialysis rate, unplanned starts); cardiology (30-day HF readmissions, & GDMT adherence)

Table 9: Non-financial Incentives

Goals		Solutions & Decisions
Payer	Engage specialists through relatively low-cost interventions.	→ DECISION <i>Identify the most effective non-financial levers for the network before delegating risk. Make high-value choices the path of least resistance through product design and administrative ease. For example:</i> Waive prior authorization or implement gold carding program for specialists taking on downside risk. Eliminate downcoding (e.g., changing claims to a lower-cost service code than the provider initially billed). Reduce or eliminate patient cost-share to drive volume to high-value providers.
ACO	Engage specialists through relatively low-cost interventions.	→ DECISION <i>Determine whether to set up a preferred provider network to increase referrals. Offer opportunities for preferred pricing on operational tools, such as electronic medical record platforms.</i>
Specialist	- Build reputation through partnerships - Reduce administrative burden.	→ DECISION <i>Negotiate for opportunities to increase referrals, reduce administrative burden, obtain preferred pricing.</i>

Table 10: Patient Incentives

Goals		Solutions & Decisions
Payer	Encourage patients to receive care through the preferred specialist.	- This is an area where more work is needed, as payers are not uniformly applying patient incentives. Payers should explore opportunities for effective patient incentives to drive meaningful clinical outcomes. Waive patient cost-sharing for members who engage with preferred specialty providers. Offer supplemental benefits to incentivize preventive care and address non-medical drivers of health. Example: One payer implemented a pilot finding that offering an Amazon Prime subscription achieved higher patient engagement than offering an HSA contribution.
ACO	Encourage patients to receive care through the preferred specialist.	- ACOs have fewer opportunities than MA plans to incentivize patients under current regulations. - However, ACOs with access to patient cost-sharing waivers can explore opportunities for effective patient incentives to drive meaningful clinical outcomes (subject to applicable waivers and beneficiary inducement rules). Target waivers to high-impact populations (e.g., Original Medicare patients without supplemental coverage). Create patient incentives for using AI-powered referral systems. Example: An ACO offered zero cost-share to patients who used their AI system that triages patients and routes them to the most appropriate care
Specialist	Encourage patients to receive care through their organization.	- Implement patient incentives and access standards to drive meaningful clinical outcomes. Reduce wait times by offering initial appointments within days rather than months from referral. Offer holistic wraparound care that addresses patients' whole health. Use tech and AI to make accessing care easy for the patient.