Physician-Focused Payment Model
Technical Advisory Committee

January 2026

PTAC Highlights on Value-Based Care: Recommendations & Key Takeaways, 2020–2025

OVERVIEW

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to: 1) review proposed physician-focused payment models (PFPMs) submitted by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary. PTAC reviews submitted proposals using criteria established by the Secretary in regulations at 42 CFR §414.1465. As of 2025, PTAC has reviewed 35 proposals.

Within this context, it is beneficial for PTAC to reflect on PFPM proposals that have been submitted to the Committee to provide further advisement on pertinent issues regarding effective payment model innovation in Alternative Payment Models (APMs) and PFPMs. With that in mind, the Committee began a series of theme-based discussions on this topic in September 2020. A key focus for the Committee has been population-based total cost of care (PB-TCOC) models, a specific type of APM that involves providers having full accountability for the quality and costs of a specific patient population.[1] Through PTAC's research and advice provided by stakeholders, PTAC's public meetings provide valuable and detailed information and advice to the Secretary on important payment model issues.[2]

This document includes some of the major issues that PTAC has explored during the past five years, along with a brief summary of the Committee's key recommendations and takeaways on each topic.[3]

[1] PTAC uses the following working definition of a PB-TCOC model: "A population-based total cost of care (PB-TCOC) model is an Alternative Payment Model (APM) in which participating entities assume accountability for quality and TCOC and receive payments for all covered health care costs for a broadly defined population with varying health care needs during the course of a year (365 days). Within this context, a population-based TCOC model would not be an episode-based, condition-specific, or disease-specific specialty model. However, these types of models could potentially be 'nested' within a population-based TCOC model."

[2] A complete list of PTAC's theme-based discussion public meetings, including meeting recordings and supporting documents, can be accessed on the ASPE PTAC website.

[3] Additional information on many of these topics is provided in PTAC's Issue Brief series.

VISION FOR PB-TCOC MODELS

- Six concepts relate to the desired vision for population-based total cost of care (PB-TCOC) models: 1) a culture of accountability; 2) high-touch, proactive care; 3) eliminating health care disparities; 4) care coordination for underserved populations; 5) evidence-based practices, risk stratification, and data-driven care; and 6) dissemination and uptake of best practices.
- Ten features characterize the ideal care delivery system: 1) multidisciplinary, team-based, patient-centered care; 2) well-coordinated care; 3) seamless management of care transitions; 4) meeting patients where they are; 5) high touch or advanced primary care; 6) balanced use of, and coordination between, primary care and specialty care; 7) targeted population-based interventions to prevent or mitigate populations' risk of developing adverse health outcomes; 8) reducing disparities in care and outcomes; 9) identification of health-related social needs (HRSNs) and connection to appropriate resources; and 10) empowering patients to participate in their care.
- Supporting policies related to payment, performance measurement, specialty integration, risk adjustment and attribution, accessible and actionable data, infrastructure investments, and multi-payer alignment will be critical in the development and implementation of PB-TCOC models.
- There is a need to strengthen a sense of urgency and inevitability surrounding the transition to value-based care. However, some providers may be better equipped than others to take on the costs related to the transition.

PAYMENT METHODS AND FINANCIAL INCENTIVES

- The paradigm shift toward value-based care necessitates careful consideration of various payment arrangements, phased transitions, voluntary and mandatory participation, and multi-payer alignment.
- Clear financial accountability at the organization level and strong financial incentives at the provider level are needed. Payment arrangements, such as episode-based payment, capitation, and fee-for-service (FFS) with shared savings models, have demonstrated potential in reducing total cost of care (TCOC).
- Policy considerations for payment in population-based total cost of care (PB-TCOC) models include determining who receives payment from Medicare, how benchmarks for payments are established and updated over time, and the role of episode-based payments in PB-TCOC models.
- Several payment features are desirable for PB-TCOC models, including determining accountability, attribution, and actuarial risk; using glide paths and incentives for increasing financial risk and participation over time; providing up-front investments to support desired care delivery transformation; caring for socially disadvantaged patients through HRSNs screening and risk adjustment; and encouraging multi-payer alignment on model design components.

PRIMARY AND SPECIALTY CARE INTEGRATION

- Categorizing providers by their primary function within their specialty rather than by their specialty alone, developing care pathways, and clearly defining workflows can help to address challenges related to understanding the roles and responsibilities of primary care providers (PCPs) and specialists at different stages in a patient's disease progression.
- Coordination and communication between PCPs and specialists can be improved by adopting technology that facilitates bidirectional, synchronous, and asynchronous communication, including e-consultations and telehealth.
- Sharing timely data on quality, cost, and utilization can improve care decisions and coordination between PCPs and specialists. Sharing these data can also inform patients' decisions when searching for specialists who deliver high-value care.
- Providing practices with up-front funds to invest in infrastructure and technology not only improves the exchange of timely data between providers and settings, but also encourages participation in value-based care models.
- Nesting specialty condition models and acute episode-based payments within larger population-based total cost of care (PB-TCOC) models can address all aspects of specialty care spending; allow specialists to provide longitudinal, comprehensive specialty care management; and promote the sustainability of care coordination.
- Designing models to incentivize specialists to adopt a whole-person, value-based care approach can encourage specialists to participate in PB-TCOC models.
- Different approaches to patient attribution, including proactive attribution and multi-attribution methods, can be used to attribute patients to providers held accountable for their care.
- Creating performance metrics relevant to specialty care in PB-TCOC models and identifying metrics that can be linked to payment can help address challenges related to the lack of standard metrics on the needs of and care for patients managed by specialists.
- One approach to setting meaningful benchmarks that promote high-value care involves creating empirically derived benchmarks based on a provider's own historical spending for the applicable patient population, adjusting the target to account for national or regional cost growth trends, and risk-adjusting the target to account for the provider's unique patient population.
- Developing models to include entity-level risk for quality and total cost of care (TCOC) while allowing flexibility for organizations to determine how to structure provider-level risk can improve specialty integration in PB-TCOC models.

RURAL PARTICIPATION IN APMs

- Rural providers lack capital to finance the up-front costs of transitioning to APMs. Providing up-front payments to support the adoption of health information technology (health IT) infrastructure and data analytics, increasing the percentage of the overall spend on primary care, and establishing glide paths to sustainable participation in value-based care can encourage rural providers to participate in population-based total cost of care (PB-TCOC) models.
- Low patient volume in rural areas can challenge providers' willingness to take on financial risk. Low volume can also impact patient attribution, benchmarking, and performance measurement. Promoting collaboration among rural providers in a region to spread fixed costs and create a greater pool of patients to balance downside risk can help address challenges related to low volume.
- Rural providers face unique challenges related to caring for rural patients. For example, rural patients commonly have complex health care and social needs. Implementing team-based reimbursement can help to increase the use of high-touch, proactive, multidisciplinary, team-based care across professions (e.g., nurses, community health workers) and organizations to promote care coordination and case management.
- Beyond payment policy solutions, additional supporting policies can help to address health care challenges common in rural areas. For example, strategies to address rural provider workforce shortages include improving rural provider recruitment and training opportunities, increasing the role of rural academic medical centers, and increasing the supply of non-physician rural health providers.

CARE COORDINATION & TRANSITION MANAGEMENT

- Effective care coordination and management of care transitions require further improvements to electronic health record (EHR) interoperability, data sharing, and the use of digital tools.
- Shared decision-making—when the patient and their clinicians work together to make informed decisions about the patient's health care—is an important component of care coordination.
- A process should be developed that would identify providers accountable for each stage of a patient's care transitions.
- The use of Transitional Care Management (TCM) codes is associated with substantial improvements in patient outcomes and cost savings.
- Process and patient-centered outcome measures are needed to adequately measure occurrences of care coordination and care transition management.
- Long-term funding and sizeable financial incentives are needed to encourage care coordination and effective management of care transitions.
- Multi-payer alignment is necessary to effectively achieve care coordination across a patient's full health care journey.

PERFORMANCE MEASUREMENT

- A balanced performance measure portfolio that includes different types of performance measures is needed. It is important to focus on broader, system-level, and long-term measures. Macro-level measures, such as TCOC, may be particularly important in helping to drive system transformation and achieve the goals of value-based payment.
- Specific measures to include in PB-TCOC models are those focused on access, timeliness, and appropriateness of care; patient safety; team-based care, including collaboration and communication; care improvement; and patient-reported measures.
- It is important to include patient-reported outcome measures (PROMs) in PB-TCOC models as these measures provide key insights to the outcomes of care and can provide important information on the benefits and risks of a particular treatment and identify unmet needs or gaps in patients' health.
- Performance measures should be tied to payment. Further, the entity or organization should be responsible for bearing financial risk; providers within the organization should not be at financial risk but should be incentivized to meet the performance measures set at the organization level.

EMPOWERING PATIENTS AND SUPPORTING PROVIDERS TO MAKE INFORMED DECISIONS

- Ensuring access to patient health data is critical to empower patients and support providers.
- Synthesis of health data is needed for patients and physicians to meaningfully use health information to support shared decision-making and care improvements.
- Data from patient wearables and other digital health tools should be integrated with clinical data to promote patient empowerment, early identification of health changes, and proactive care.
- APMs and other incentives can promote use of health data and patient empowerment.
- Health data should not be used in ways other than improvement of patient health, supporting high-quality and cost-effective patient care.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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