Session 2: *Expert Input on PTAC's Recommendations on Value-Based Care: Part 2*

Presenters:

Subject Matter Experts

- **Hoangmai (Mai) Pham, MD, MPH** – President and Chief Executive Officer, Institute for Exceptional Care (IEC)
- **Paul Krakovitz, MD, FACS** – Chief Executive Officer, Cone Health
- **Emily Brower, MBA** – President and Chief Executive Officer, National Association of ACOs (NAACOS)

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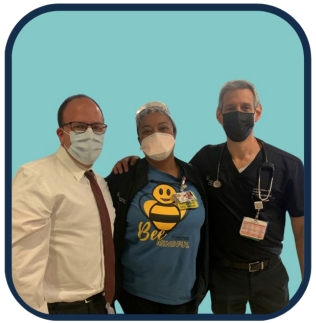
Hoangmai (Mai) Pham, MD, MPH

President and Chief Executive Officer,
Institute for Exceptional Care (IEC)

IEC



Recommendations to PTAC

Hoangmai Pham, MD, MPH

Background

- Founder and current CEO of Institute for Exceptional Care, a nonprofit focused on making healthcare better and safer for people with intellectual/developmental disabilities.
- Former Chief Innovation Officer, CMMI.
- Architect of CMMI's original ACO and primary care models.
- Led Elevance's valuebased care initiatives.
- General internist, safety net primary care physician.

PTAC’s Recommendations to the HHS Secretary

Areas for Particular Emphasis

- Hidden value of VBP: Provides ballast against the undertow of volume incentives.
- Recommendation 2:
  - Strong patient empowerment and engagement.
  - Reducing disparities in care/outcomes; addressing social needs.
- Recommendation 8:
  - Encourage greater participation among integrated health systems.
- Recommendation 11:
  - Measures should include a balance of clinical quality, population outcomes, patient experience.

Recommendations to PTAC

Limited VBP Participation Limits Gains and Undermines Overall Market Balance

- Voluntary models →Under-representation of high-cost, high-growth providers.
  - Only one-third of hospitals participate in Medicare VBP models.
  - Limits gains for Medicare and Medicaid (including if Medicare tries to lure providers with regional or administrative spending benchmarks).
  - Limits gains for high-performing VBP participants.
  - Does little to counter growth of private sector prices for “must-have” providers →political pressure to raise Medicare prices to address self-induced gap in public vs. private prices.

Increasing Broad VBP Participation Requires Removing Arbitrage Opportunities

- Distortions in underlying Medicare prices.
- Risk adjustment in both VBP models and Medicare Advantage.
- Facility fees.

The Medicare Physician Fee Schedule Can Be A VBP Model Too…..

- Pervasive influence of the MPFS that underpins prices and outcomes in all VBP models:
  - Distortions in relative prices over time →Overvalued and undervalued services that run counter to goals of VBP programs in both what drives fixed costs and where volume incentives are greatest.
  - Impossible for individual organizations in VBP programs to counter distortions in clinical labor markets, market competition for high-margin services.
  - Facility fees, unbundled services, multiple codes and prices for similar procedures, upcoding.
- CMMI, CM, and other CMS components can collaborate to experiment with the fee schedule:
  - Alternative data sources for pricing.
  - Simplifying and redesigning payment codes to reduce arbitrage opportunities.
  - Testing changes under CMMI authority.

Thank you.

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Paul Krakovitz, MD, FACS

Chief Executive Officer,
Cone Health

Cone Health PTAC

Expert Opinions on Value-Based Care Recommendations

Paul Krakovitz, MD
CEO, Cone Health

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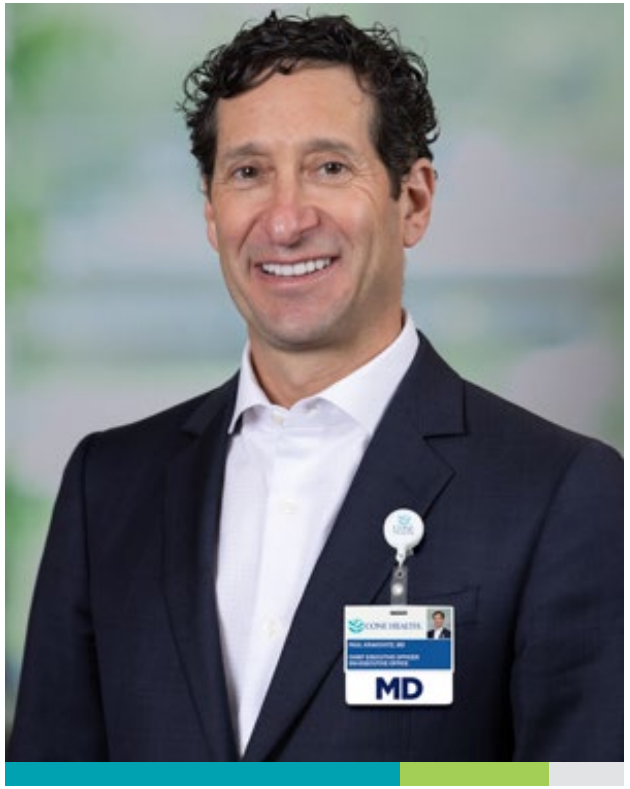
About Paul Krakovitz, MD, FACS

- Has more than two decades of experience leading nationally recognized health systems.
- Transformed **Intermountain Health** (a fully functioning VBC organization) Desert Region from a $1.2B medical group in Nevada to a $2.5B integrated region (Arizona, Nevada and Utah).
- Served as an Executive-in-Residence at **Cressey & Company**, an investment firm with a mission to innovate and improve America's health care system, where he was integral in helping with strategy and improving clinical excellence.
- Is a nationally recognized **pediatric otolaryngology physician**.



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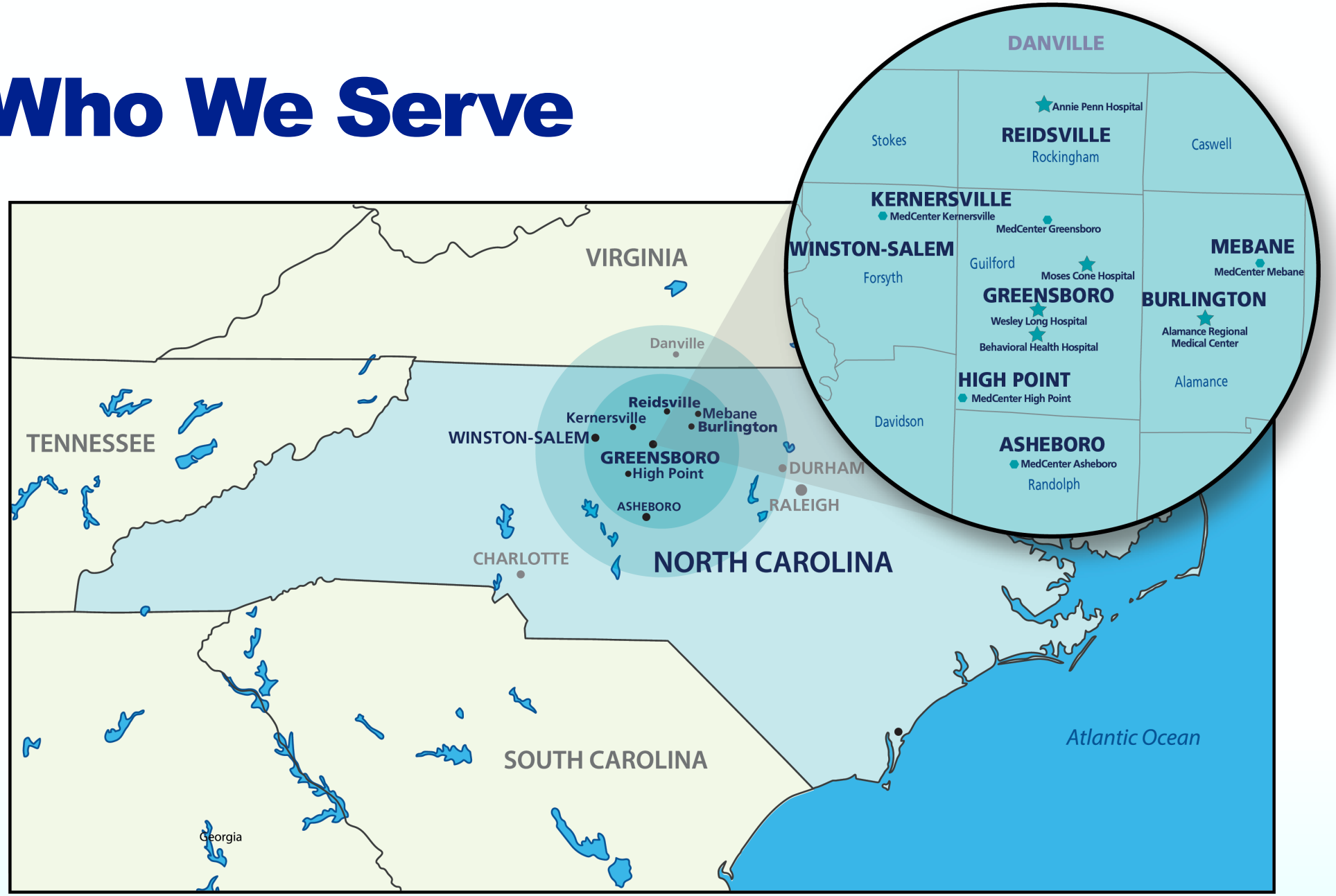
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SOUTH CAROLINA
Georgia
Atlantic Ocean

Strengths of the Recommendations

(Part 1)

Multi-Payer Alignment: Recommendation 14 remains highly relevant.

- Provider organizations continue to struggle with:
  - Different quality measures;
  - Different risk methodologies;
  - Different attribution approaches; and
  - Different reporting requirements.
- Greater alignment remains one of the most significant opportunities to reduce administrative burden while accelerating value-based care adoption.

Strengths of the Recommendations

(Part 2)

Strong Primary Care Foundation: Recommendation 2 appropriately places advanced primary care at the center of TCOC strategy.

- The framework includes team-based care, care coordination, patient engagement, population-level interventions and health-related social needs.
- These remain central characteristics of high-performing accountable care organizations nationwide.
- **Criticality of this recommendation:** The recommendations recognize primary care as the principal organizing structure for population health management.

Opportunities of the Recommendations

Modernize Provider Performance Management

- The recommendations emphasize accountability without adequately addressing clinician-level engagement.

Recommended Expansion of Value-based TCOC Models:

- Physician performance reporting
- Referral pattern transparency
- Utilization benchmarking
- Quality outcome dashboards

This would improve alignment between organizational and provider incentives.

Emerging Value-Based Care Considerations

Recommended Addition: *Behavioral Health Integration*

- TCOC models should require:
  - Integrated behavioral health within primary care, substance use disorder management, behavioral health quality metrics and shared accountability between behavioral and physical health providers.
- National impact of behavioral health integration may represent one of the largest untapped TCOC opportunities.

Recommended Addition: *Avoid Distracting Piecemeal Models*

- Elevate idea from conclusion into a recommendation: “Models based on episodes of care, that are disease-specific, or that test payment for specific types of services, should be limited to those that implement shadow bundles and support TCOC through evidence creation.” *(last paragraph, page 27)*

(Part 1)

Critical Gaps

Several major topics are insufficiently addressed.

Artificial Intelligence Lacking:

- Predictive analytics
- Clinical decision support
- Population risk forecasting

Workforce Sustainability Missing:

- Clinician burnout
- Workforce shortages
- Care team redesign
- Administrative simplification
- Workforce limitations may become one of the greatest barriers to TCOC success.

(Part 2)

Critical Gaps

Several major topics are insufficiently addressed.

Social Determinants Financing Missing:

- Community investment models
- Shared savings reinvestment
- Social impact funding approaches

Medicaid-Specific Value-Based Care Missing:

- Medicaid beneficiary engagement
- Pediatric TCOC strategies
- Maternal health integration
- State Medicaid alignment
- As Medicaid programs increasingly adopt value-based models, this gap becomes more significant.

Thank you.

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Emily Brower, MBA

President and Chief Executive Officer,
National Association of ACOs (NAACOS)

Opportunities to Modernize Accountable Care

Emily Brower

September 14, 2026

NAACOS

The National Association of Accountable Care Organizations (NAACOS) is a member-led nonprofit representing value-based care providers in Medicare, Medicaid, and commercial insurance as they improve the quality of care while reducing costs.

472
ACO MEMBERS

10.2 M
BENEFICIARY LIVES IN MEMBER ACOS

81%
OF ACOS ARE NAACOS MEMBERS

137
PARTNER ORGANIZATIONS

LEADERSHIP

EDUCATION

ADVOCACY

ACOs Save Money and Attract Clinicians

Through 2024 Medicare ACOs have generated **$37.4 billion in gross savings** with an average of **$710 gross saving per beneficiary**.

We continue to see strong health outcomes in patients in accountable relationship, as well as high-quality care delivered by **700K physicians and other clinicians**.

Modernize ACOs

The success of accountable care is built on the innovations in care delivery and operations that are only possible with a strong financial foundation.

Modernizing ACOs will accelerate innovation, deepen engagement with patients across the health care continuum, and drive greater long-term value.

Sustainability	Burden Reduction	Innovation
Strengthen the financial foundation of ACOs	Ease burdensome requirements so clinicians can direct resources into patient care	Embrace innovation to sustain impact
Address benchmark ratchet for long-term participants and create stronger fraud protections	Modernize quality reporting, ease ACO voluntary alignment to promote choice	Engage specialists and support tech-enabled care

Sustainability

ACO participation is voluntary. CMS must design benchmark policies that reflect the financial realities organizations face. By designing budgets that improve participants' savings potential, we can maintain and grow participation in value-based care models.

Recommendation	Feedback
5	Emphasize ***sustainability*** in benchmark approaches to achieve long-term goals. Without this critical piece, long-term value proposition is absent.
3 and 4	Put accountability on the ACO, with model flexibility to make downstream arrangements, depending on the network and goals.
7	Organizations are increasingly willing to take on risk, with on-ramp to encourage new participation.
8	Continue moving beyond one-size-fits-all; participants can benefit from benchmarking approaches specific to certain types of clinical teams and populations that can be part of existing models, vs. creating new models.
14	Invest in infrastructure. Implementing value-based payment across all lines of business is more economical and creates deep, multi-payer sustainability. • Use available tools, like NAACOS' playbooks developed with AMA and AHIP to promote multi-payer alignment. • Overcome anti-trust concerns that hinder sharing of payment model best practices; CMS can disseminate MA model best practices. • Incentivize accountable care within MA as originally intended with MACRA, but through more direct means such as a STARS measure. • Do not constrain state-based innovation (e.g. state-based waivers and state-directed payments).

Burden Reduction

ACOs' regulatory burdens have grown. While well intentioned, requirements for quality measurement and waiver processes have created burden and operational challenges that are untenable and pull physicians, clinicians, health systems and other providers away from this opportunity to provide high-quality care.

Recommendation	Feedback
11, 19	Address ***burden reduction*** *by* shifting to greater interoperability and enhanced data sources that help create a balanced portfolio of meaningful measures.
14, 15	Promote ACOs as patient choice through easing voluntary alignment and allowing more beneficiary-focused waivers.
16, 17	Structure mandatory models for success; current mandatory models are largely payment cuts.
20	Capture patient safety within ACO quality metrics.
21, 22	Rely on hospital-based programs to address hospital safety.

Innovation

ACO participants make long-term investments in population health to change care models and clinical workflows. These physicians, clinicians, health systems and other providers need new ways to continue to build on their success delivering high-quality care while reducing costs.

Recommendation	Feedback
6	Reduce dependence on fee-for-service through capitation and establish a foundation for equipping primary care providers with the resources and incentives to deliver comprehensive, coordinated preventive care for their full patient population. This approach can improve population health through a stronger focus on evidence-based prevention and outcomes, alleviate cash flow challenges that practices face when adopting new care delivery models, and sharpen risk adjustment to ensure fair compensation across diverse patient populations.
9	Develop flexible approaches for engaging specialists in TCOC models by aligning incentives and advancing shared accountability. Let the accountable entity choose what works for their network, their community.
15	Expand waivers to eliminate or reduce cost-sharing for high-value and preventive services. This would increase tools that support patient access, choice, and prevention, as well as ACO partnerships with community-based organizations to address upstream drivers of health. Policymakers can support these efforts by creating a transparent process to accept public nominations for new waivers and simplifying implementation and reporting processes to reduce burden and promote broad use of waivers.

Additional Feedback

Celebrate ACO Success

Don’t hedge – in fact, celebrate – ACO success!

Use common language

Advance and connect to HCP-LAN taxonomy and concepts, including the goal of 100% of Medicare FFS beneficiaries in accountable care.

Drop old constructs

Physician vs hospital ACOs and who remains on the sidelines

Promote flexibility

The accountable entity should choose the model, track and downstream arrangements that match their transformation thesis.

Thank you!

Emily Brower
President & CEO
202-350-3488
ebrower@naacos.com

www.naacos.com