PTAC's Draft White Paper:

Transforming Health Care Delivery Through Value-Based Payment Models and Care: A Roadmap

PublicComments

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) received input from the public regarding PTAC's draft white paper, *Transforming Health Care Delivery Through Value-Based Payment Models and Care: A Roadmap*. PTAC has received two responses from the following stakeholders:

1. Deborah Ault, RN, CCM, CCP, AATMC, BCPA, MBA
2. Independent Coalition of Advanced Risk Entities (ICARE)

For additional information about PTAC's draft white paper, visit the ASPE PTAC website.

From: Deborah Ault <Deb.L.Ault@outlook.com>
Sent: Monday, September 7, 2026 3:24 PM
To: PTAC (OS/ASPE) <PTAC@hhs.gov>
Subject: Public Comment – Value-Based Payment Models and Care Roadmap

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Comments on PTAC Draft White Paper

Transforming Health Care Delivery Through Value-Based Payment Models and Care: A Roadmap

Submitted by:
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Nurse Deb Speaking, Media & Consulting, LLC
Healthcare Strategist • Patient Advocate • Speaker • Author

I appreciate the opportunity to comment on PTAC's draft roadmap for transforming healthcare delivery through value-based payment models and care.

I strongly support the paper's emphasis on patient-centered care, evidence-based practice, meaningful quality measurement, patient safety, usable data, and accountability for both quality and total cost of care. PTAC is also right to recognize that payment incentives alone do not constitute value-based care. Payment methods and performance measures must reinforce the care model we actually want patients to experience.

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My comments focus on several guardrails that I believe should be strengthened as PTAC finalizes its recommendations.

1. "Savings" must identify who actually saved money.

PTAC appropriately recognizes the importance of reducing spending while improving outcomes. The draft cites savings generated by ACO and other total-cost-of-care models and recommends accelerating value-based payment based in part on this emerging evidence.

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But **savings needs a first name.**

Medicare savings are not necessarily patient savings. Plan savings are not necessarily employer savings. Employer savings are not necessarily employee savings. And lower spending in one portion of the healthcare system can sometimes represent cost shifting rather than true reduction in total healthcare cost.

As value-based models mature, evaluations should explicitly identify **who saved, who paid more, whether costs moved elsewhere, and what happened to patients.**

This becomes especially important because PTAC recommends that CMS lead commercial payers toward greater alignment with value-based payment models.

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Employers and other healthcare purchasers should therefore be treated as active stakeholders in this transformation—not merely downstream recipients of payment models developed primarily for Medicare populations.

Medicare can lead. But commercial alignment should not mean simply copying Medicare. Working-age employees and their families have different populations, benefit structures, financial exposures and healthcare needs. Employers need transparent, purchaser-verifiable evidence demonstrating whether a model improves quality, patient outcomes, patient financial impact, and total healthcare cost.

2. Reduced utilization must not automatically be treated as improved value.

The draft appropriately recognizes under-provision of care and reduced access as potential risks of capitated payment approaches.

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That risk deserves to become an explicit design guardrail throughout the roadmap.

Value-based models must distinguish among:

- care avoided because it was unnecessary;
- care avoided because better upstream care made it unnecessary;
- care that did not occur because access became more difficult; and
- clinically appropriate care that was delayed, discouraged or denied.

Those events may look similar in utilization data. They are profoundly different for patients.

My guiding principle is:

Move the money around the care. Do not move the care around the money.

Payment reform should change how we finance clinically appropriate care. Financial incentives should not quietly redefine what care is considered appropriate.

PTAC uses the phrase “clinical appropriateness” when recommending flexibility for accountable entities. PTAC-Draft-White-Paper-July-2026.pdf I recommend strengthening that concept by explicitly grounding clinical appropriateness in **scientifically sound, current, evidence-based standards**, while preserving transparent patient-specific clinical exception pathways when the evidence-based starting point does not fit an individual patient.

3. Never divorce quality and cost.

I strongly support PTAC's conclusion that current performance measurement needs substantial improvement. The draft notes that an analysis of 24 Medicare programs found 618 performance measures, with 61 percent unique to a single program and 59 percent not endorsed by CMS's consensus-based entity—and little evidence connecting many measures to actual performance, outcomes, or burden.

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The objective should not be more measurement.

It should be **better measurement of what happened to the patient.**

PTAC appropriately recommends a balanced portfolio including clinical quality, population-health outcomes, patient experience, and patient-reported outcomes.

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I encourage PTAC to go further by ensuring that financial performance is never interpreted independently from clinical performance.

A lower-cost referral is not higher value if the patient receives poorer care. Fewer emergency-department visits are not necessarily evidence of success if appropriate emergency care became harder to obtain. Lower utilization is not inherently better utilization.

Quality and cost should remain linked throughout model design, performance measurement, referral strategy, and evaluation.

4. "Usable data" must also be trustworthy data.

I strongly support PTAC's recommendations for real-time, usable patient health and claims data. PTAC-Draft-White-Paper-July-2026.pdf The draft also correctly recognizes that merely providing patients and clinicians with large volumes of data does not create patient empowerment; information must be clinically useful and actionable.

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I would add another requirement:

Usable data must also be trustworthy.

For consequential healthcare decisions, data should carry sufficient identity and provenance to answer basic questions:

Who or what generated the information?

When was it generated or updated?

Which patient, practitioner and facility does it actually describe?

Has it been corrected, superseded or transformed?

What source supports it?

Interoperability without provenance can distribute error faster.

When data influence clinical care, referral, quality measurement, payment, patient navigation, or artificial intelligence, the underlying evidence and decision pathway should be reconstructable.

In plain language: **keep the receipts.**

5. AI accountability should follow clinical influence—not simply technology classification.

PTAC appropriately recognizes the growing role of AI and digital technology in clinical decision support, predictive care and patient empowerment. The draft also specifically cautions against technology being used to facilitate inappropriate denial of patient claims.

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I strongly support that safeguard, but recommend broadening it.

AI can influence healthcare without formally issuing a denial. It can influence navigation, triage, referral, prioritization, scheduling, outreach, benefit interpretation, utilization management and patient-facing recommendations.

Task completion is not an adequate healthcare-AI safety metric.

My recommended accountability principle is:

If technology can foreseeably influence whether, when, where, from whom, or what healthcare a person receives, somebody must be accountable for proving that it is safe enough for the influence it exercises.

Consequential AI should be grounded in curated, current evidence; preserve appropriate human clinical escalation; respect patient autonomy; and produce decisions or recommendations that can be reconstructed and audited.

Shared responsibility must never become unowned responsibility.

6. Patient safety should be elevated from a performance domain to a foundational requirement.

I particularly appreciate PTAC's patient-safety discussion. The draft recognizes that reported safety events may represent only the "tip of the iceberg," that diagnostic and medication errors and near misses remain underrecognized, and that safety measurement remains disproportionately focused on inpatient settings. It also calls for longitudinal data,

prospective identification of potential errors, and meaningful involvement of patients and families.

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PTAC further concludes that the current level of patient harm is unacceptable and that payment, performance measurement, and conditions of participation can all be used to drive improvement.

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I strongly agree.

However, any payment model tied to safety must be designed carefully so that financial incentives do not unintentionally encourage underreporting, coding manipulation, avoidance of high-risk patients, or movement of care into settings where adverse events are less visible.

Patient safety information should also follow the actual practitioner and facility responsible for care, with sufficiently persistent identity and provenance to prevent meaningful safety history from disappearing inside organizational changes, health-system hierarchies, or incomplete datasets.

7. Patient empowerment should reduce the burden placed on patients—not increase it.

PTAC correctly emphasizes shared decision-making and patient empowerment.

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But empowerment should not become another way of transferring responsibility to patients.

Patients should not have to become experts in medicine, insurance networks, benefit design, prices, quality measurement, payment models and healthcare navigation merely to receive appropriate care.

Move the knowledge, not the patient.

The healthcare system should bring trustworthy information, meaningful interpretation and appropriate professional assistance to the patient at the moment a consequential decision must be made.

Conclusion

I support PTAC's effort to move value-based care forward. But as these models become more widespread—and potentially more mandatory—the safeguards surrounding them become more important, not less.

The ultimate measure of value-based care should not be whether healthcare organizations successfully assumed risk or whether utilization declined.

It should be whether patients more reliably received the **Right Care, at the Right Time, in the Right Place, from the Right provider, at a defensible price—and whether the result was better health and genuine reduction in total healthcare cost rather than cost shifting or under-provision of care.**

Payment should support that objective.

Technology should support that objective.

Measurement should prove whether we achieved it.

And accountability should remain clear when we do not.

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INDEPENDENT COALITION OF
ADVANCED RISK ENTITIES

September 15, 2026

To: Physician-Focused Payment Model Technical Advisory Committee (PTAC)
U.S. Department of Health and Human Services

Re: Comments on Draft *Transforming Health Care Delivery Through Value-Based Payment Models and Care: A Roadmap*

Dear Members of the Advisory Committee:

The Independent Coalition of Advanced Risk Entities (ICARE) appreciates the opportunity to comment on PTAC's draft *Transforming Health Care Delivery Through Value-Based Payment Models and Care: A Roadmap*. ICARE strongly supports the draft and PTAC's recognition that the future of value-based care depends on expanding meaningful total cost-of-care accountability and ensuring that organizations accepting risk have the resources, information, and flexibility necessary to manage it.

ICARE represents independent, full-risk healthcare provider organizations participating in Medicare Advantage. Our members contract directly with Medicare Advantage organizations and accept responsibility for the total cost-of-care for their patients. They are not owned or operated by the health plans with which they contract.

From the perspective of organizations already accepting meaningful downside risk, ICARE strongly supports several of PTAC's recommendations. We believe the final Roadmap should make several of these principles more explicit and extend them to Medicare Advantage.

Overall, PTAC recommendations **3, 5, 6, 8, 10, 11, 12, 13, 14, and 15** establish a powerful framework for sustainable value-based care. ICARE recommends that PTAC make one overarching principle explicit in the final Roadmap:

> **Organizations should not be expected to accept meaningful total cost-of-care risk without the financial predictability, prospective resources, information, organizational accountability, operational flexibility, and transparency necessary to manage that risk.**

Independent providers should not have to choose between remaining independent and participating meaningfully in advanced value-based care. CMS policy should create a competitive environment in which organizations are judged by their ability to improve outcomes and manage total cost. Specifically, ICARE shares the following insights.

Rec. 3 & 10: Align Accountability with Organization Assuming Risk

ICARE strongly supports **Recommendation 3**, which states that accountability should be placed at the organizational level when organizations participate as accountable care entities.

We also support **Recommendation 10**, which calls for performance to be measured at the accountable-entity level.

These recommendations should be treated as complementary. When an organization accepts responsibility for total cost-of-care, it must be recognized as the accountable entity and have the ability to organize care, coordinate providers, manage utilization, and invest in interventions that improve outcomes.

This is particularly important for independent physician organizations. A model should not place financial accountability on an independent organization while leaving key elements of care management, information access, or operational control outside its reach.

ICARE recommends that PTAC explicitly state:

> **Financial accountability, performance measurement, and organizational accountability should be aligned at the level of the entity actually assuming total-cost-of-care risk.**

Rec. 5 & 6: Financial Predictability and Prospective Payment

ICARE strongly supports **Recommendation 5**, which calls for benchmarks that provide long-term predictability for payers, health plans, and accountable care entities.

We also strongly support **Recommendation 6**, which states that some portion of payment should be made prospectively to provide financial predictability and enable investment in infrastructure.

These are fundamental principles for organizations assuming genuine financial risk. An organization cannot effectively manage total cost of care if it cannot reasonably anticipate the resources available to manage its population. Care management staff, technology, data analytics, patient outreach, transitional care, home-based interventions, and other activities require investment before savings can be generated.

ICARE therefore encourages PTAC to go further and establish a broader principle:

> **Risk should be accompanied by sufficient financial predictability and resources to manage the risk being assumed.**

This principle is particularly important in Medicare Advantage, where independent organizations may accept significant downside responsibility while the payment they receive can be affected by withholds, administrative deductions, deferred amounts, quality adjustments, and subsequent reconciliation.

ICARE is not asking CMS to establish private contract rates. Rather, we believe CMS should establish basic transparency and predictability expectations so that organizations can determine whether they can responsibly accept and manage the risk being assigned to them.

Rec. 8: Create Explicit Pathways for Independent Practices

ICARE strongly supports **PTAC Recommendation 8**, which calls for new pathways to encourage greater participation in total cost-of-care models among “small and large independent practices and rural providers,” as well as integrated delivery systems. We encourage PTAC to place particular emphasis on the independent-provider component of this recommendation.

Independent physician organizations capable of accepting meaningful downside risk are not simply smaller versions of health systems. Many have developed sophisticated capabilities in care management, utilization management, data analytics, specialist coordination, and population health while remaining independent of health plans and hospital systems.

CMS should create pathways that allow these organizations to participate in advanced risk **without requiring consolidation or vertical integration as a prerequisite for success.** ICARE recommends that the final Roadmap explicitly states that CMS should:

- create pathways for independent physician organizations to enter advanced total cost-of-care models;
- provide appropriate transitional mechanisms for organizations building risk capacity;
- ensure that established risk-bearing organizations have a direct pathway to two-sided risk; and
- evaluate whether model design inadvertently favors vertically integrated organizations over independent competitors.

The goal should be to expand the number of organizations capable of accepting real accountability—not simply the number of organizations participating in contracts labeled "value based."

Rec. 11: Move Toward Meaningful Outcomes

ICARE supports **Recommendation 11**, which calls for a balanced portfolio of measures that include clinical quality, population health outcomes, and patient experience. We encourage PTAC to emphasize the importance of reducing reliance on measures that are not strongly connected to meaningful outcomes.

Organizations accepting substantial downside risk should be evaluated on whether they improve the health of their populations and reduce avoidable spending—not simply on whether they satisfy an expanding list of administrative or process requirements. **As financial accountability increases, measurement should become more meaningful, not merely more extensive.**

Rec. 12: Performance & Payment Must be Transparently Connected

ICARE strongly supports **Recommendation 12**, which calls for performance measures to be linked through transparent methods to payment at the accountable-entity level. We believe this principle should be expanded to encompass the broader financial structure of risk arrangements.

A provider assuming risk should be able to understand:

- what portion of its payment is prospective;
- what amount is withheld or deferred;
- what administrative or infrastructure deductions apply;
- what performance measures affect payment;
- how shared savings or losses are calculated;
- how and when reconciliation occurs; and
- what conditions must be met for withheld or deferred amounts to be released.

Transparency is not the same as rate regulation. CMS can require meaningful financial transparency without dictating the commercial rate negotiated between a health plan and a provider.

ICARE recommends that PTAC explicitly encourage CMS to establish minimum transparency expectations for organizations accepting meaningful total-cost-of-care risk.

Rec. 13: Data Access Must Match Accountability

ICARE strongly supports **Recommendation 13**, which calls for CMS to continue providing real-time, patient-level claims data to accountable entities. We believe this principle should be considered a fundamental condition of risk-bearing.

An organization cannot manage care that it cannot see. Organizations accepting total cost-of-care responsibility need timely access to information concerning:

- medical claims;
- pharmacy utilization;
- specialist utilization;
- emergency department visits;
- hospital admissions and discharges;
- transitions of care;
- risk-adjustment information; and
- performance and financial information used to determine risk settlements.

ICARE recommends that CMS develop **minimum data-access expectations** for any arrangement in which a provider organization assumes meaningful financial responsibility for total cost of care. This should apply regardless of whether the arrangement operates through Traditional Medicare or Medicare Advantage.

Rec. 14: Extend Alignment Principles to Medicare Advantage

ICARE supports **Recommendation 14**, which calls for greater alignment across public and private payers, including alignment in areas such as risk adjustment and performance measurement. We encourage PTAC to specifically identify Medicare Advantage as part of this alignment discussion.

The draft itself recognizes that supporting policies for total cost-of-care models include **reforming Medicare Advantage while strengthening value-based models as an alternative**. The final Roadmap should make the connection more explicit. CMS should evaluate whether Medicare Advantage arrangements create the same foundational conditions PTAC identifies as necessary for successful total cost-of-care models. If these conditions are necessary for successful value-based care in Traditional Medicare, they should not disappear when care is delivered through Medicare Advantage.

Rec. 15: Give ACOs Flexibility to Manage Care

ICARE supports **Recommendation 15**, which calls for waivers and flexibilities for accountable entities, including flexibilities analogous to those available to Medicare Advantage plans. We believe this principle should be applied consistently to independent accountable organizations.

If CMS expects an independent provider organization to accept total cost-of-care risk, it should have reasonable flexibility to determine how to organize care, coordinate services, engage patients, and invest in interventions appropriate to its population. **Risk-bearing organizations should have the operational flexibility necessary to manage the risk they have accepted.**

Reference Chart

PTAC Recommendation	ICARE Position	ICARE Comments
Rec. 3 – Organizational accountability	**Strongly support**	Accountability should rest with the organization actually assuming total cost-of-care risk.
Rec. 5 – Long-term predictability	**Strongly support**	Risk-bearing organizations need predictable economics to make long-term investments and remain viable.
Rec. 6 – Prospective payment	**Strongly support**	Providers need resources prospectively to manage the population for which they are accountable.
Rec. 8 – Pathways for independent practices	**Strongly support / expand**	CMS should create viable pathways specifically for independent organizations capable of accepting meaningful downside risk.
Rec. 10 – Entity-level performance	**Strongly support**	Performance should be measured at the same organizational level at which risk is assumed.
Rec. 11 – Meaningful outcomes measures	**Support**	Measures should emphasize outcomes and patient experience rather than excessive process measures.
Rec. 12 – Transparent link between performance and payment	**Strongly support / expand**	Providers need transparency into how performance translates into payment and financial settlement.
Rec. 13 – Real-time claims data	**Strongly support**	Data access must match the level of financial

PTAC Recommendation	ICARE Position	ICARE Comments
		accountability.
Rec. 14 – Alignment across payers	**Support / expand to MA**	CMS should apply these principles consistently across Traditional Medicare and Medicare Advantage.
Rec. 15 – Flexibilities for accountable entities	**Support**	Independent risk-bearing organizations need flexibility to organize care and manage risk.

In conclusion, ICARE strongly supports PTAC's draft Roadmap and agrees with the Committee's fundamental conclusion that Medicare should continue to advance value-based payment rather than retreat from it. We particularly support **Recommendations 3, 5, 6, 8, 10, 11, 12, 13, 14, and 15** and encourage PTAC to strengthen them by explicitly recognizing the role of independent, full-risk physician organizations.

The final Roadmap should make clear that successful value-based care requires more than transferring financial risk. **It requires creating conditions under which organizations accepting that risk can manage it and remain financially viable.** ICARE also urges PTAC to apply these principles to Medicare Advantage, where millions of Medicare beneficiaries receive care through risk-based arrangements.

Independent physician organizations are already demonstrating that they can accept meaningful accountability for total cost and outcomes. Medicare policy should create more opportunities for these organizations to succeed, compete, and expand.

Thank you for your consideration and for PTAC's continued leadership in advancing meaningful value-based care. If you have any questions regarding our comments or would like to speak with our members who can share their experiences, please contact me directly at (202) 253-7581 or at Robin.Goracke@ICAREforPatients.com.

Respectfully submitted,

Sincerely,



Robin Goracke
Executive Director