WHITE PAPER

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

Recommendations of PTAC Based on 10 Years of Operation

Prepared by

the Physician-Focused Payment Model Technical Advisory Committee (PTAC)

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CURRENT PTAC MEMBERS

PTAC's current members (as of October 2026) contributed to and endorse the contents of this white paper.

Current PTAC Members	
Henish Bhansali, MD, FACP, Chief Medical Officer, Meridian Health Plan of Illinois, Centene Corporation	**Walter Lin, MD, MBA,** Chief Executive Officer, Generation Clinical Partners
Lindsay K. Botsford, MD, MBA, Regional Medical Director, One Medical	**Terry L. Mills, MD, MMM,** Chief Medical Officer, Aetna Better Health of Oklahoma; Owner, Strategic Health, LLC
Lauran Hardin, MSN, FAAN, Chief Integration Officer, HC^2 Strategies	**Soujanya R. Pulluru, MD,** President, CP Advisory Services; Co-Founder, My Precious Genes
Lawrence R. Kosinski, MD, MBA, Founder, VIOVOC	**Krishna Ramachandran, MBA, MS,** Chief Information Officer, UnitedHealth Group
Joshua M. Liao, MD, MSc, National Associate Vice President of Clinical Transformation, Ascension	**David C. Tyson, MA,** Senior Director, Policy & Regulatory Affairs, Public Affairs & Government Relations, Novant Health

PREFACE

The United States continues to face the need and opportunity to significantly improve the value of the health care system. The latest projections have health care reaching 20 percent of the gross domestic product by 2033, while health outcomes remain disappointing.[1] In recognition of these issues, Medicare and other stakeholders have tested and implemented Alternative Payment Models (APMs)—so termed because they represent alternatives to historical volume-based fee-for-service (FFS) payment and instead seek to incentivize value-based care. While many of these value-based payment models have shown promise, substantial opportunities for their expansion and improvement remain.

The aim of this white paper is to articulate a set of recommendations or a roadmap for policy that further incentivizes and supports the transformation of the U.S. health care system to one that produces high-value, patient-centered care. These recommendations draw on the Physician-Focused Payment Model Technical Advisory Committee's (PTAC's) 10 years of experience. They intend to build on the significant progress that Medicare and other payers have made in implementing APMs.

PTAC was established under the Medicare and CHIP (Children's Health Insurance Program) Reauthorization Act of 2015 (MACRA). The statutory mission of PTAC is to make comments and recommendations to the Secretary of Health and Human Services (the Secretary, HHS) on proposals for physician-focused payment models (PFPMs)—specifically, those in which Medicare is a payer—submitted to PTAC by individuals and stakeholder entities. 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 innovation in PFPMs and APMs. With that in mind, the Committee began a series of theme-based discussions on this topic in September 2020. Since 2015, the Committee has received 37 proposals for PFPMs and has deliberated and sent recommendations to the Secretary on 28 of the 37 proposals.[2]

One emphasis in PTAC theme-based meetings has been population-based total cost of care (PB-TCOC) models. Recognizing that payment and care transformation through these models will involve a complex set of policy choices that will need to be harmonized, the Committee has focused on fielding testimony about and deliberating on these arrangements as a foundational element in the value-based payment and care landscape. In turn, the roadmap and recommendations contained in this white paper are largely directed toward expanding these models.

In producing this white paper, the Committee is aware of both the growing urgency to address rising health spending and the need to carefully drive transformation of a $6 trillion health care system using deliberate, evidence-based strategies and processes. The vision for the future of patient care and recommendations for moving toward it that are presented in this paper attempt to balance these competing needs. The Committee also acknowledges the debate regarding the impact of value-based payment models to date, and the fact that disappointment about their impact has led some to recommend terminating value-based payment model efforts in favor of other strategies, such as

[1] Keehan SP, Fiore JA, Poisal JA, Cuckler GA, Sisko AM, Smith SD, et al. National Health Expenditure Projections, 2022-31: Growth To Stabilize Once The COVID-19 Public Health Emergency Ends. *Health Affairs*. 2023;42(7):886-98. doi:10.1377/hlthaff.2023.00403

[2] One proposal is currently under review by PTAC at the time of completion of this report.

modifying fee schedules and other payment systems. For reasons fully described in this paper, the Committee strongly disagrees with this approach.

As reflected in its recommendations, PTAC believes that it is most prudent to use what has been learned to date to evolve and refine, rather than discard, efforts to implement value-based payment models. Through models developed by the Center for Medicare and Medicaid Innovation (the CMS Innovation Center) and created by statute (e.g., Medicare Shared Savings Program [MSSP]), the Centers for Medicare & Medicaid Services (CMS) has made important progress toward transforming the delivery system using value-based arrangements. The Committee believes that this work should continue. Indeed, the recommendations contained in this white paper are meant to support and accelerate efforts to drive delivery system transformation through value-based purchasing and APMs.

The first (draft) version of this White Paper was sent to invited reviewers in July 2026. It was made available to the public in August 2026. PTAC held a public meeting on September 14–15, 2026, at which the invited reviewers presented their comments. Additionally, four public commenters provided either written comments and/or oral comments delivered at the public meeting. PTAC has considered all reviewer input and public comments in revising and producing this final version of the white paper. Many of the comments made during the public meeting will also inform future directions for the Committee's work.

This white paper has two main objectives with regard to moving forward with value-based care and delivery system transformation. First is to provide a vision or "North Star" for what patient-centered, high-value care should look like in the near future. Second is to present a set of policy recommendations for moving the system toward this North Star. These recommendations reflect general policy directions rather than detailed implementation strategies. PTAC's future agenda will be directed to adding details where it is possible to build on these recommendations.

SUMMARY OF PTAC RECOMMENDATIONS

Through its public meetings, discussions with expert presenters, and Committee deliberations, PTAC has explored a wide range of topics related to value-based payment and care, with emphasis on TCOC arrangements. Based on these discussions and emerging research, the Committee has developed a vision for TCOC models and explored various topics to realize this vision: policy recommendations for incentivizing TCOC models, supporting policies for successful TCOC models—enablers and flexibilities, the focus on patients—enhancing patient empowerment and patient safety in TCOC models, TCOC models in rural areas, and maximizing participation in TCOC models. PTAC recommendations in each of these areas are summarized in Exhibit 1.

Exhibit 1. Summary of PTAC Recommendations

LOOKING BACK AND MOVING FORWARD	
Recommendation 1 The Commitment	Through communications, model design, and implementation strategies, policymakers should continually reinforce a sense of urgency around and commitment to value-based care and payment as the principal policy tool for transforming the delivery system to moderate spending growth while improving population health outcomes.

THE NORTH STAR: PTAC'S CORE RECOMMENDATIONS AND VISION FOR PATIENT-CENTERED, HIGH-VALUE CARE	
Recommendation 2 Shared Vision	Across all payers, there should be a shared vision for the care delivered by TCOC models, encompassing the following success factors: • Multidisciplinary team-based, high-touch, proactive, patient-centered care; • Seamless, well-coordinated care, including during care transitions; • Strong patient empowerment and engagement; • Balanced use of, and coordination between, advanced primary care and specialty care; • Targeted population-based interventions to prevent or mitigate populations' risk of developing adverse health outcomes; • Emphasis on reducing disparities in care and outcomes; and • Identification of health-related social needs and connection to appropriate resources. Payment methods and performance measures should continually evolve to reinforce the shared vision for care.
Recommendation 3 TCOC is Primary	TCOC should be the primary model for resourcing and incentivizing this vision for care and ensuring organizational accountability for its provision.
Recommendation 4 Cascading Accountability	For TCOC models, risk and accountability should be placed at the level of the organization, with flexibility to design value-based incentives at the provider level. Assuming regulatory and clinical appropriateness, accountable entities should be afforded flexibility in how they manage and organize care in accordance with the vision described in Recommendation 2.
POLICY RECOMMENDATIONS FOR INCENTIVIZING TCOC MODELS	
Payment Approach	
Recommendation 5 Benchmarks	Regardless of the specific payment approaches implemented, CMS should continue to make progress in establishing benchmarks that engender long-term predictability for payers, health plans, and accountable care entities.
Recommendation 6 Prospective Payments	Regardless of the specific payment approaches implemented, some portion of payment should be made prospectively to provide financial predictability and enable investments in infrastructure needed for the transformation to value-based care.
Performance Measurement	
Recommendation 7 Accountability	Performance should be measured at the level of the accountable entity in TCOC models, with emphasis on performance measures that reflect key attributes of the vision for TCOC models detailed in Recommendation 2.

Recommendation 8 Measures	Measures used in TCOC models should be a balanced portfolio that reflects domains such as clinical quality, population health outcomes, and patient experience. They should include patient-reported outcomes and experience with care, and: • Include structure, process (if strongly linked to outcomes), and outcome measures; • Be derived from claims, electronic medical record data, or surveys; and • Include measures that are meaningful to patients with frailty, complex chronic conditions, and serious illness and to their caregivers, recognizing comfort, function, symptom burden, and care consistent with the patient's stated goals.
Recommendation 9 Transparency	Performance measures should be linked using transparent methods to payment at the level of the accountable entity in TCOC models.
SUPPORTING POLICIES FOR SUCCESSFUL TCOC MODELS: ENABLERS AND FLEXIBILITIES	
Recommendation 10 Standardization	CMS should continue its efforts to standardize and democratize health care data and ensure timely access to all who need it.
Recommendation 11 Flexibility	CMS should provide accountable entities with waivers and flexibilities, including those that could be analogous to those allowed for Medicare Advantage plans, to ensure that accountable entities can achieve the vision for care under TCOC models.
THE FOCUS ON PATIENTS: ENHANCING PATIENT EMPOWERMENT AND PATIENT SAFETY IN TCOC MODELS	
Patient Empowerment	
Recommendation 12 Patient Engagement	Patients and their clinicians and health care organizations should be provided with access to real-time, usable patient health data to promote patient engagement. • Digital health tools should be used to promote real-time data collection, sharing, and integration of these data. • Artificial intelligence (AI) and other new technologies should be used to synthesize data to produce actionable insights, support provider clinical decision-making, identify changes in patient health, and personalize care. • Engagement strategies should include family caregivers and authorized surrogate decision-makers where patients rely on them, and should preserve accessible non-digital pathways so that patients without digital access or capacity are not excluded from the benefits of these models.
Recommendation 13 Incentivization	Through both payment methods and performance measures, APMs should strengthen incentives for providers to use the vast amount of usable data to generate actionable insights and empower patients through shared decision-making. Models should also incentivize patients to participate in decision-making and engage in health-promoting behaviors. For example, ACOs could be provided with waivers to allow for structuring out-of-pocket payments in ways that incentivize patient engagement.

Patient Safety	
Recommendation 14 Patient Safety	For current and newly implemented APMs, incentives to significantly improve patient safety efforts should be emphasized and strengthened through new performance measures and payment methods. The CMS Innovation Center should consider developing a patient safety-specific model that includes incentives for new methods of reducing patient harm, such as investing in new information systems, changing system-level culture, and inducing greater transparency. As an alternative to a new model, the CMS Innovation Center might initiate a new version of the Health Care Innovation Awards for ground-level development and implementation of a patient safety model. For example, an award might be provided to organizations willing to form an alliance that shares longitudinal patient safety data and produces evidence of best practices.
TCOC MODELS IN RURAL AREAS	
Recommendation 15 Rural Health Providers	Rural provider participation in TCOC models should be encouraged by multiple strategies, including providing consistent, sustainable funding streams through capitation and upfront payments. Upfront payments are important to support the adoption of health information technology infrastructure and data analytics. Another strategy involves establishing longer participation glide paths for rural providers to take on risk in TCOC models.
Recommendation 16 Rural Health Data Integration	Rural providers should be encouraged to collaborate with other providers in their region to aggregate the volume of patients under value-based payment models.
MAXIMIZING PARTICIPATION IN TCOC MODELS	
Payment Pathways and Medicare Participation	
Recommendation 17 Flexible Pathways	While CMS has made progress toward increasing incentives to participate in TCOC models, new pathways are needed to encourage greater participation among: • Small and large independent practices and rural providers; and • Integrated delivery systems. These pathways would involve several different payment mechanisms and two-sided risk arrangements. Some of these methods might be considered transitional and may have to be supplemented with mandatory model development. For clinicians and organizations new to value-based payment, a clear, simple, predictable, multi-year glide path should be implemented to enable capacity building, for example, by beginning with upside-only risk (potential for savings but not losses) and moving toward two-sided risk (potential for either savings or losses) over time.

Recommendation 18 Specialty Care Integration	For all potential payment pathways (described in Exhibit 8), CMS should develop methods to incentivize integration of high-value specialty care with advanced primary care. Potential methods include the development of episode-based models that: • Incentivize specialists to provide high-value, coordinated care; • Nest cascading accountability into TCOC models as part of total payment to the organization; • Involve data that can be used by accountable entities for internal payment and performance purposes; and • Involve data that can curate referrals from primary care to high-quality specialists.
Multi-payer Alignment	
Recommendation 19 Multi-payer Alignment	To the extent possible under current authority, CMS should lead the way for commercial payers to encourage participation in value-based payment models. CMS should use its leadership position to help public and private payers align both their commitment to value-based care and payment, and their methods (e.g., risk adjustment, performance measures) for implementing these strategies.

Additionally, the Committee has considered several policies that can support TCOC models and value-based payments more broadly. These supporting policies include reforming Original Medicare while strengthening value-based models, creating a more level playing field between Original Medicare and Medicare Advantage (MA), shifting from voluntary to mandatory models, and limiting the CMS Innovation Center portfolio.

INTRODUCTION

The United States is now in its sixth decade of actively pursuing policies to contain the rising costs of health care. At various times, these policies have focused on the supply side of markets, the demand side, establishing volume limits, implementing fee schedules, and improving competition. The degree to which any of these policies have been successful is uncertain, and it is clear that neither the cost of health care nor its outcomes are satisfactory. Health care spending is on the rise and is projected to reach nearly one-fifth of the nation's gross domestic product by 2033.[3] By many measures, quality and health outcomes have not risen along with spending. Life expectancy in the United States was 76.4 years in 2021, roughly four years below the average of Organisation for Economic Co-operation and Development (OECD) countries, while per capita health care spending was $12,500, almost 2.5 times the average in OECD countries.[4] In addition, numerous studies suggest that 25 percent or more of the spending is wasteful.[5]

[3] Keehan SP, Fiore JA, Poisal JA, Cuckler GA, Sisko AM, Smith SD, et al. National Health Expenditure Projections, 2022-31: Growth To Stabilize Once The COVID-19 Public Health Emergency Ends. *Health Affairs*. 2023;42(7):886-98. doi:10.1377/hlthaff.2023.00403

[4] Organisation for Economic Co-operation and Development. OECD Health at a Glance 2023 Country Note: The United States. https://www.oecd.org/content/dam/oecd/en/publications/reports/2025/07/health-at-a-glance-2023_39bcb58d/united-states_1bd99de8/4268c3ef-en.pdf

[5] Shrank WH, Rogstad TL, Parekh N. Waste in the US Health Care System: Estimated Costs and Potential for Savings. *JAMA*. 2019;322(15):1501-1509. doi:10.1001/jama.2019.13978

In recent years, policies have focused on value—both containing costs and improving health care quality and outcomes. These policies fall under the umbrella of value-based or accountable care.[6] In general, value-based care is a term often used to describe health care that is designed to focus on quality of care, provider performance, and patient experience. Value-based care is commonly associated with characteristics such as having an advanced primary care foundation; addressing population health management; emphasizing the provision of well-coordinated, patient-centered care; and focusing on wellness and prevention. The key strategy for achieving value-based care is moving away from FFS payment to APMs that provide strong incentives for providers and patients to focus on quality and outcomes over quantity of services. The Center for Medicare and Medicaid Innovation (the CMS Innovation Center) was established under the Affordable Care Act (ACA) for the purpose of testing innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care. The ACA also authorized the Medicare Shared Savings Program (MSSP) as an Accountable Care Organization (ACO) option for Original Medicare (i.e., traditional fee-for-service [FFS] Medicare). The CMS Innovation Center and MSSP have become key engines for implementing and testing Alternative Payment Models (APMs), providing evidence, and driving changes.

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established by the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act of 2015 (MACRA) to: 1) review proposed physician-focused payment models (PFPMs), in which Medicare is a payer, submitted by individuals and stakeholder entities;[7] 2) prepare comments and recommendations regarding whether such proposed models meet criteria established by the Secretary of Health and Human Services (the Secretary, HHS); and 3) submit these comments and recommendations to the Secretary. The process provides stakeholders with an opportunity to bring proposed PFPMs to the attention of policymakers and to be evaluated by independent experts.

The Committee received the first PFPM proposal in December 2016. By January 2021, PTAC had deliberated and sent recommendations to the Secretary of HHS on 28 proposals for APMs. After making recommendations concerning specific payment models proposed by the public, the Committee began conducting theme-based public meetings to make recommendations related to specific topics relevant to the development and testing of APMs. These theme-based meetings have focused on providing advice and recommendations to the Secretary and the CMS Innovation Center on a variety of topics relevant to the submitted proposals and crucial to developing, implementing, and expanding APMs that involve Medicare, most notably Original Medicare. Theme-based public meetings also provide key health system stakeholders with the opportunity to inform policymakers by bringing their expertise, experience, and ideas into the policy process. PTAC's theme-based topics have included a vision for total cost of care (TCOC) models, payment strategies, performance measures, patient empowerment, patient safety, rural issues, maximizing participation, and multi-payer alignment.

PTAC's operations over the past 10 years have produced a wealth of information for informing policymakers and the public on key issues concerning APMs and delivery system transformation. The information is derived from several sources. First, Committee members have brought considerable first-

[6] In general, these policies have also been labeled as value-based purchasing, value-based payment, and value-based contracting.

[7] PFPMs are APMs in which Medicare is a payer and eligible clinicians play a core role in implementing the payment methodology, and which target the quality and costs of services that eligible professionals participating in the APM provide, order, or can significantly influence.

hand expertise and extensive hands-on experience with value-based care to public discussions on the topic. Second, the Committee's deliberations and recommendations have been informed by presentations and discussions with a variety of subject matter experts at public meetings. At its theme-based meetings, the Committee has listened to over 250 presentations from experts across a wide range of perspectives, including providers, patient groups, academics, the insurance industry, performance measurement, organizations, health information technology, and conveners, among others. Finally, the content and structure of each public meeting is informed by extensive environmental scans and original data analyses requested by Committee members. All the presentations, research reports, and environmental scans are available on the ASPE PTAC website.

In this white paper, PTAC presents its vision for patient-centered, high-value health care along with recommendations for moving forward with value-based policies. These recommendations are based on all the Committee has learned in producing this body of information described above. They also build on the learning and successes of the CMS Innovation Center models, MSSP, and value-based efforts of other payers. The white paper is structured to present and describe recommendations in key topic areas that have arisen through the Committee's meetings and deliberations. After a brief description of evidence to date and the potential directions for moving forward with value-based models, the white paper describes the Committee's definition for a population-based TCOC model and its vision for care under such a model. The recommendations for payment, performance measurement, and other relevant policies are largely focused on resourcing and incentivizing these TCOC models.

LOOKING BACK AND MOVING FORWARD

As described earlier, the United States has a long history of health care cost containment efforts. Although there is no comprehensive evaluation of the individual or collective impacts of these efforts, an overall assessment of current spending and outcomes suggested a different approach was needed. There are many reasons past efforts were likely not fully successful at containing cost or improving quality, but one key reason is that they were mostly designed to operate without substantially changing the fragmented system for care delivery. The value-based care efforts that began more than 15 years ago had a different approach—moving away from FFS as the principal payment method and in doing so fundamentally transforming the delivery system to one that provides value.

In developing the recommendations for this paper, the Committee has considered all the evidence concerning APMs and value-based care—quantitative and qualitative—presented to it over its 10 years of operation. As briefly described in this section, the evidence includes participation trends in APMs, savings estimates from TCOC models, and, of equal importance, the hands-on experience with value-based care as described to the Committee by the variety of its public meeting expert presenters.

The emerging evidence suggests that ACOs—the principal TCOC model—are achieving savings that are growing over time. A recent review estimates that the CMS Innovation Center's ACO models have lowered spending by $2.8 billion.[8] In addition, MSSP was estimated to reduce gross spending by $6.6 billion and increase net savings by $2.5 billion in 2024.[9]

[8] Nyweide DJ. The First Decade of ACO Model Evaluations in the Medicare Program: A Systematic Review. *Med Care Res Rev*. 2026;83(1):3-19. doi:10.1177/10775587251325914

[9] Centers for Medicare & Medicaid Services. Medicare Shared Savings Program Accountable Care Organizations: Updated Performance Year 2024 Financial and Quality Results. September 29, 2025. https://www.cms.gov/files/document/fact-sheet-ssp-py24-financial-quality-results.pdf

Based on all of the information presented to date, the Committee believes that these estimated savings considerably understate the impact of value-based care initiatives. They do not fully capture the delivery system changes that have occurred because of these models being implemented. For example, one study suggests that CMS Innovation Center models and MSSP have had spillover effects—that is, reduced spending for beneficiaries not participating in the models.[10] Of equal importance, there is qualitative evidence of changes in underlying care patterns occurring as a result of the models being implemented.[11] Indeed, recent reports have detailed a more comprehensive framework for evaluating these efforts.[12,13] With spending impacts trending in the right direction, PTAC strongly supports applying this broader evaluation context to drawing conclusions from past and emerging results.

PTAC has now heard public presentations from a wide variety of experts across the health care system. The consensus from these presentations is that there is acceptance and willingness among stakeholders to adopt accountable care as the model for moving into the future. The Committee has also been impressed with care innovations being implemented by provider organizations as a result of value-based payment arrangements. The Committee has not heard any strong statements suggesting a retreat from value-based care. Indeed, expert presenters have made many constructive suggestions about policies that would accelerate the adoption of accountable care, such as benchmark changes, upfront investments for specific providers, and data sharing. In addition, model participants are looking for assurance and certainty about future value-based care policy directions.

Subject matter experts have expressed both an urgency to move forward aggressively with value-based care and a need for further testing and evaluation of models. The Committee believes that the CMS Innovation Center has taken a well-considered test-and-modify approach to fielding new models that incorporate learning from previous models. At the same time, the Committee believes that the time is right to use current evidence to take an increasingly aggressive approach to scaling value-based care across the health system. At some point, difficult decisions will need to be made about limiting testing and maximizing participation in value-based arrangements. The Committee also recognizes that there are obstacles to substantial participation growth in TCOC models, such as for ACOs, so that these decisions will need to consider mandatory models and aggressive multi-payer strategies.

PTAC has also considered the role of Medicare's current fee schedules in the transition to accountable care. Although FFS should ultimately be made substantially less appealing than value-based care and payment, targeted fee schedule modifications can be a pathway to value-based contracting. For example, the Committee has been provided with examples of fee schedule modifications that would encourage advanced primary care and better integration of primary care and specialty services. Moreover, as discussed in the following sections, using fee schedules in various ways as the basis for

[10] Office of the Assistant Secretary for Planning and Evaluation (ASPE). The Impact of Alternative Payment Models on Medicare Spending and Quality, 2012-2022, (Issue Brief No. HP-2025-04). https://aspe.hhs.gov/sites/default/files/documents/331ef819085bf78627bfd59e3bcdbce0/The-Impact-of-Alternative-Payment-Models-2012-2022.pdf

[11] Fowler E, Rawal P, Calloway R. The Spillover Effect of the CMS Innovation Center. *NEJM Catalyst*. January 21, 2025. https://catalyst.nejm.org/doi/full/10.1056/CAT.24.0427

[12] Office of the Assistant Secretary for Planning and Evaluation. A Framework for Evaluating the Impact of the Center for Medicare and Medicaid Innovation, (Issue Brief No. HP-2024-28). December 2024. https://aspe.hhs.gov/sites/default/files/documents/c12af0d1d154868f25b9257fd478cf69/value-cmmi-ib.pdf

[13] Sheingold S, Ghosh K, Samson LW. How to Evaluate the Innovation Center's Impact on Delivery System Transformation. *Health Affairs Forefront*. September 24, 2024. https://www.healthaffairs.org/content/forefront/evaluate-innovation-center-s-impact-delivery-system-transformation

value-based contracting can help policymakers to recognize different business models of provider organizations and maximize the attractiveness of accountable care as entities transition from FFS to value-based care.

Recommendation 1

Through communications, model design, and implementation strategies, policymakers should continually reinforce a sense of urgency around and commitment to value-based care and payment as the principal policy tool for transforming the delivery system to moderate spending growth while improving population health outcomes.

THE NORTH STAR: PTAC'S CORE RECOMMENDATIONS AND VISION FOR PATIENT-CENTERED, HIGH-VALUE CARE

The Committee strongly believes that a shared vision of patient-centered, high-value care should be the foundation for policies intended to transform the delivery system. The Committee also believes that TCOC should be the principal framework for achieving this vision. What might be called the "North Star" vision should include basic principles for care delivery under accountable care arrangements and become a core element in designing policy for TCOC models. That is, the critical policies to resource and incentivize this care vision—such as payment parameters, performance measurement, and waivers—should be fully aligned with these principles. The Committee also believes that provider organizations should have considerable flexibility to implement these principles in ways that best serve the needs of their patient populations.

PTAC is using the following working definition of TCOC in the context of population-based models:

> *TCOC is a composite measure of the cost of all covered medical services delivered to an individual or group. In the context of Medicare APMs, TCOC typically includes Medicare Part A and Part B expenditures [representing Medicare Part A and Part B expenditures only], and is calculated on a per-beneficiary basis for a specified time period.*[14]

PTAC is using the following working definition of population-based TCOC (PB-TCOC) models:

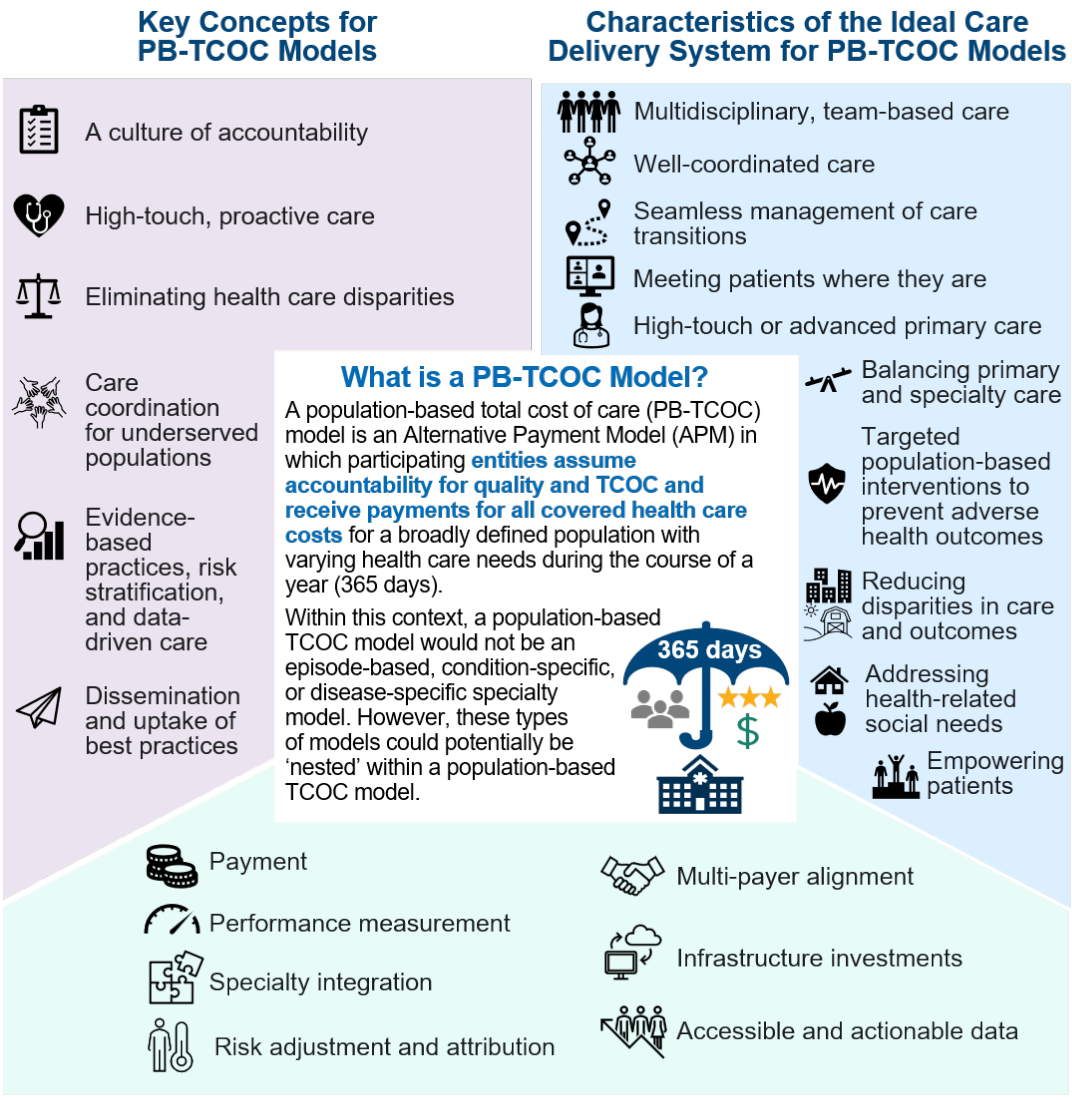
> *A population-based TCOC model is an APM in which participating entities assume accountability for quality and TCOC and receive payments for all covered health care costs for a broadly defined population with varying health care needs during the course of a year (365 days).*
>
> *Within this context, 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.*

The Committee believes that it is important to consider the desired vision and culture for future PB-TCOC models before identifying the desired care delivery and payment features of these models. Exhibit

[14] Around the time when PTAC developed the working definition for how TCOC should be defined in the context of PB-TCOC models, the Committee questioned whether Part D expenditures should be included in TCOC calculations or whether the exclusion of Part D expenditures leads to unintended consequences related to shifting therapies between Part B and Part D options. This topic was discussed in the March, June, and September 2022 Report to the Secretary.

2 summarizes the key concepts, characteristics of the ideal care delivery system, and supporting policies needed for the development and implementation of PB-TCOC models.

Exhibit 2. Definition and Vision for Population-Based Total Cost of Care (PB-TCOC) Models



Committee members identified six concepts relating to the desired vision and culture for PB-TCOC models:

- A culture of accountability;
- High-touch, proactive care;
- Eliminating health care disparities;
- Care coordination integrated into all populations;
- Evidence-based practices, risk stratification, and data-driven care; and
- Dissemination and uptake of best practices.

Thus, from all the information presented to the Committee, members identified several important features of the ideal care delivery system for PB-TCOC models, which constitute Recommendation 2.

Recommendation 2

Across all payers, there should be a shared vision for the care delivered by TCOC models, encompassing the following success factors:

- Multidisciplinary team-based, high-touch, proactive, patient-centered care;
- Seamless, well-coordinated care, including during care transitions;
- Strong patient empowerment and engagement;
- Balanced use of, and coordination between, advanced primary care and specialty care;
- Targeted population-based interventions to prevent or mitigate populations' risk of developing adverse health outcomes;
- Emphasis on reducing disparities in care and outcomes; and
- Identification of health-related social needs and connection to appropriate resources.

Payment methods and performance measures should continually evolve to reinforce the shared vision for care.

In addition:

Recommendation 3

TCOC should be the primary model for resourcing and incentivizing this vision for care and ensuring organizational accountability for its provision.

The Committee notes that this vision for care, or North Star, is key to increasing value for the health care system and the economy. More importantly, patient-centered care should be taken literally to mean care centered around the patient and their family, that is, care which prioritizes their needs, values, and preferences for their health and health care. The care model is intended to create value for patients in terms of how they experience the health care system, their health outcomes, and their financial exposure. That is why specific recommendations below stress the importance of patient-reported experience and outcome measures.

It is also critical to recognize that PTAC's vision for the care in TCOC models was significantly influenced by how many of the key elements apply to patients with the highest needs—those with complex conditions and serious illnesses. The Committee held two separate public meetings that focused on care and care transitions for these patients in TCOC models. The top 5 percent most expensive beneficiaries account for nearly half (44 percent) of spending under Original Medicare.[15] A significant portion of these

[15] MedPAC. A Data Book: Health Care Spending and the Medicare Program. July 2023. https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_SEC.pdf

top-spending beneficiaries are those with complex chronic conditions or serious illnesses. Discussion at PTAC's public meetings focused on the need for an advanced primary care foundation, coordination by multidisciplinary teams, and taking a holistic view of accountability for ensuring effective care transitions, such as to an appropriate mix of therapeutic and palliative care services.

Recommendation 4

For TCOC models, risk and accountability should be placed at the level of the organization, with flexibility to design value-based incentives at the provider level. Assuming regulatory and clinical appropriateness, accountable entities should be afforded flexibility in how they manage and organize care in accordance with the vision described in Recommendation 2.

The Committee notes that ACOs, hospitals, and integrated delivery systems (IDSs) have more resources and infrastructure to assume risk compared with individual providers. The purpose of contracting with organizations is to pool risk into larger populations and encourage organizations to do what clinicians cannot—such as organizing care practices, making joint decisions about capacity, and managing the workforce—noting that devolving risk from the group to the clinician level defeats that purpose. Nonetheless, clinicians are key to implementing value-based changes. Accountable organizations should ensure that individual practices that contribute to increasing value realize a significant financial share to promote their continued participation in value-based care.

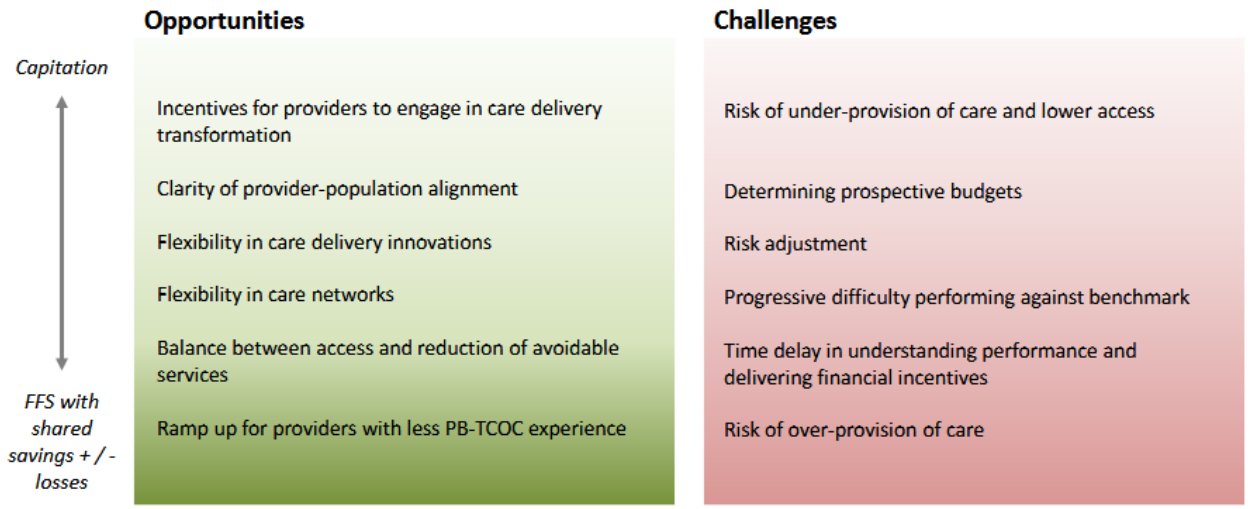
POLICY RECOMMENDATIONS FOR INCENTIVIZING TCOC MODELS

Payment Approach

The Committee's basic payment concept for TCOC models is that they are APMs 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 throughout the year (365 days).

These APMs might be implemented as FFS payment with shared savings, partial capitation, or full capitation. In addition, particularly where FFS payment is used, payment should be prospective and retrospective. That is, at least some upfront payments should be made to allow for investments needed to ensure that infrastructure is consistent with value-based care. A variety of PTAC's expert presenters have advised the Committee that FFS payment with shared savings can be structured (e.g., two-sided risk) to produce similar incentives for value-based care as for capitation. Nonetheless, as represented in Exhibits 3 and 4, the Committee recognizes different policy challenges and opportunities based on these choices. Most importantly, the Committee believes that to maximize participation in TCOC models, payment policy must recognize the organizational structures and business models, both current and post-transition, of accountable entities (Exhibits 7 and 8). Finally, presenters have frequently emphasized the need for timely, predictable payments and the ability to benefit from achieved spending reductions, both at the accountable entity level and at the level of the entity's individual providers. For example, eliminating the "ratchet effect" in calculating ACO benchmarks has often been raised with the Committee. PTAC recognizes the CMS Innovation Center's progress in addressing this issue as reflected in the implementation of the Long-term Enhanced ACO Design (LEAD) Model.

Exhibit 3. Opportunities and Challenges Associated with Selected Payment Methodologies (Continuum)



Abbreviations: FFS, fee-for-service; PB-TCOC, population-based total cost of care

Exhibit 4. Opportunities and Challenges Associated with Selected Payment Methodologies

Methodology	Opportunities	Challenges	Example
Full Capitation	Increased incentives to engage in care transformation; flexibility in care networks; clarity about provider-population alignment	Risk of under-provision of care and lower access; determining prospective budgets	Medicare Advantage
Partial Capitation	Flexibility in care delivery innovations; facilitate transition to increased risk	Risk adjustment; progressive difficulty performing against benchmark	Global and Professional Direct Contracting Model (now ACO REACH)
FFS with retrospective shared savings + / - losses	Balance between access and reduction of avoidable services; ramp up for providers with less PB-TCOC experience	Time delay in understanding performance and delivering financial incentives (from reconciliation); risk of over-provision of care	Medicare Shared Savings Program

Abbreviations: FFS, fee-for-service; PB-TCOC, population-based total cost of care

Recommendation 5

Regardless of the specific payment approaches implemented, CMS should continue to make progress in establishing benchmarks that engender long-term predictability for payers, health plans, and accountable care entities.

Benchmarks should allow for a sustainable projected spending path for the Medicare program while allowing accountable entities to continuously benefit financially from achieving savings. Benchmarks should not automatically adjust to actual spending experience for individual accountable entities.

Recommendation 6

Regardless of the specific payment approaches implemented, some portion of payment should be made prospectively to provide financial predictability and enable investments in infrastructure needed for the transformation to value-based care.

In addition, TCOC models must have tools, resources, and infrastructure to enable providers to access real-time data and to facilitate data sharing between providers and risk-bearing entities. For some provider organizations (e.g., those that are low-volume, rural providers), upfront payment strategies may be necessary to ensure that these investments can be made.

Performance Measurement

The Committee believes that, along with payment benchmarks, developing the appropriate performance measure portfolio is critical for incentivizing the provision of North Star care. While provider organizations should have full flexibility for organizing care, the measure set should hold them accountable for its quality and outcomes, especially as experienced by patients and their caregivers.

Research presented to the Committee demonstrated that there was an extensive inventory of performance measures being used across value-based programs in Medicare.[16] An analysis of information in the Centers for Medicare & Medicaid Services (CMS) Measures Inventory Tool (CMIT) performance measure database for 24 Medicare pay-for-reporting and pay-for-performance models and programs found that:

- 618 current performance measures were used by the 24 models/programs;
- 375 measures (61 percent) were unique to a single model/program; and
- 366 measures (59 percent) were not endorsed by the CMS consensus-based entity (CBE).

The Committee observed that there was little evidence that these measures were related to actual performance, outcomes, or providers' concerns about burden and complexity. Also, despite the number of measures, specific specialties have very few meaningful measures from which to choose.

The Committee does note the progress that CMS has made to address these issues through the National Quality Strategy, which includes the Meaningful Measures Initiative and the Universal Foundation effort. In addition, the CMS Innovation Center launched the Quality Pathway initiative to strengthen the focus on quality in APMs.

The Committee's recommendations for building on these initiatives have a primary focus: that performance measures should be closely aligned with the vision for care in TCOC models detailed in Recommendation 2. The payment benchmarks and risk-sharing arrangements for TCOC models would

[16] Welch J, Weiss A, Ahmed A, Moiduddin A. NORC at the University of Chicago. Overview of Current Performance Measures Included in Selected Medicare Payment Programs. Final Report. March 2024. https://aspe.hhs.gov/sites/default/files/documents/8c2ca9395d740c409e14234f8b97b93d/PTAC-Mar-25-Perf-Meas-Report.pdf

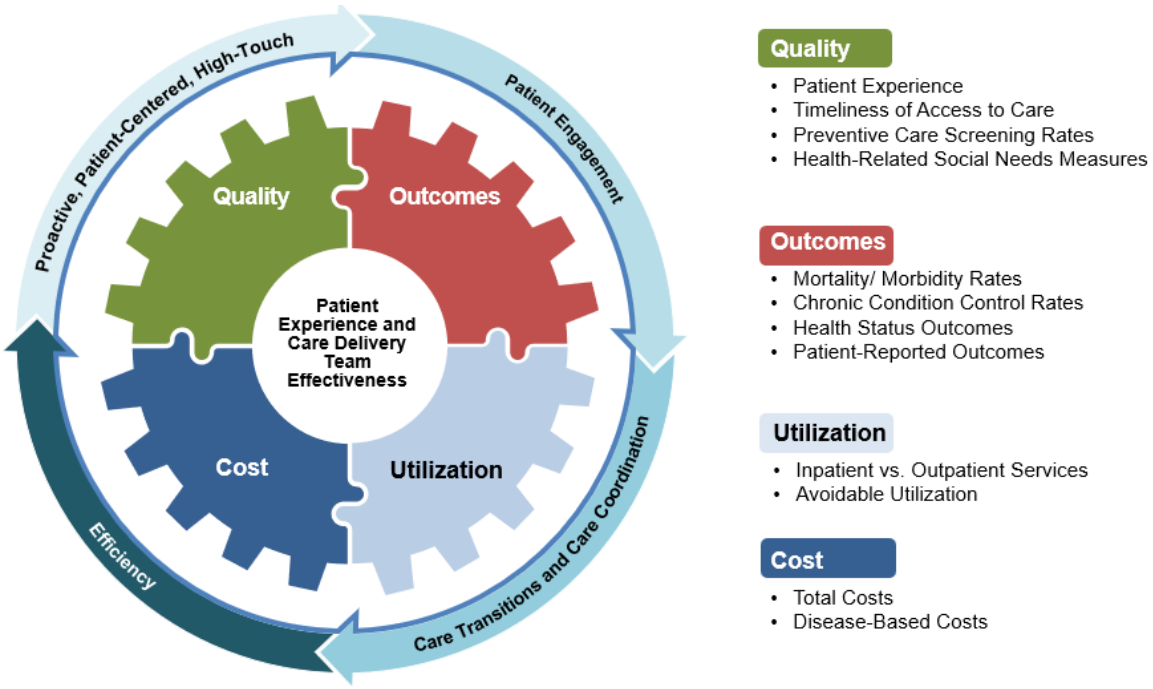
be designed to incentivize efficiency while the performance measures, when tied to payment, would incentivize efficiency achieved through well-coordinated, patient-centered care processes.

The Committee's conceptual framework for TCOC performance measurement is displayed in Exhibit 5. When identifying appropriate performance measures for PB-TCOC models, PTAC believes that it is important to consider several guiding principles, including:

- Providing proactive, patient-centered, high-touch care;
- Encouraging, seeking, and maintaining patient engagement;
- Managing multiple care transitions and complex care coordination; and
- Improving efficiency, including reducing the amount of time needed to develop and test new measures, which can take two to three years.[17]

The guiding principles can be used to identify appropriate types of performance measures that can be used to evaluate participating PB-TCOC organizations and ultimately improve patient experience and care delivery team effectiveness. Exhibit 5 shows the relationship between the guiding principles and the types of quality, outcome, utilization, and cost measures that can be used to evaluate performance related to the guiding principles.

Exhibit 5. Relationship Between Guiding Principles and the Types of Performance Measures for PB-TCOC Models



There was consensus among the Committee members and expert presenters at PTAC's public meetings that current measures do not adequately capture the desired performance characteristics for TCOC

[17] Goldwater J, Silverman N, Johnson K, Roiland R. Using the NQF Measure Incubator to Develop Patient-Reported Outcome Performance Measures in Palliative Cancer Care. *AJMC*. 2026;22(SP8).

models. The Committee strongly endorses developing measures that are patient-centered; therefore, patient-reported experience and outcome measures should be a significant portion of the eventual TCOC model measure portfolio. These measures may need to be tailored to specific patient populations to ensure the measures are meaningful and the patient's care plan is consistent with their preferences and goals. For example, meaningful measures for high-needs patients and their caregivers may focus on receiving desired help for pain, feeling heard and understood, achieving patient-centered outcome goals, and caregiver burden. All measures should be consistent with the vision for care in TCOC models—for example, including indicators of care coordination, team-based care, and patient engagement.

There was also consensus that driving transformation is best served by macro-level measures, that is, measures developed at the system or accountable organization level rather than for individual providers within the system. Micro-level measures (e.g., by specialty) should be used by accountable organizations for internal measurement, payment, and reward policies.

Recommendation 7

Performance should be measured at the level of the accountable entity in TCOC models, with emphasis on performance measures that reflect key attributes of the vision for TCOC models detailed in Recommendation 2.

Recommendation 8

Measures used in TCOC models should be a balanced portfolio that reflects domains such as clinical quality, population health outcomes, and patient experience. They should Include patient-reported outcomes and experiences with care, and:

- Include structure, process (if strongly linked to outcomes), and outcome measures;
- Be derived from claims, electronic medical record data, or surveys; and
- Include measures that are meaningful to patients with frailty, complex chronic conditions, and serious illness and to their caregivers, recognizing comfort, function, symptom burden, and care consistent with the patient's stated goals.

Recommendation 9

Performance measures should be linked using transparent methods to payment at the level of the accountable entity in TCOC models.

The Committee notes that in 2024 the CMS Innovation Center announced the Quality Pathway strategy to align model design around quality goals; elevate outcomes and experience measures, particularly patient-reported outcomes; and ensure that evaluations have the ability to assess the impact of models on primary quality goals. CMS should aggressively pursue the Quality Pathway strategy in implementing the recommendations in this paper.

SUPPORTING POLICIES FOR SUCCESSFUL TCOC MODELS: ENABLERS AND FLEXIBILITIES

Optimizing payment and performance measurement policies is critical to expanding value-based care throughout the health system. In addition, expert presenters at PTAC public meetings have informed the Committee of several policy suggestions important to enabling, encouraging, and maximizing participation in value-based care. The following recommendations reflect these ideas.

Many PTAC public meeting presenters emphasized that access to real-time patient data (including clinical data and claims) from all sources of care is essential for provider success in TCOC models. Real-time data on patient health care utilization gives providers the information they need to be able to assume risk, since providers cannot influence patient outcomes if they lack information, for example, on the hospital or emergency room care their patients receive. Access to data is critical for enabling providers to adopt best practices, for example, related to medication management, palliative care, and advance care planning. Stakeholders also discussed how access to data is essential to improving coordination between specialists and primary care physicians.

To promote value-based care, health care data should be standardized and democratized, or readily accessible and in a format that is easily usable by everyone. For example, data should be in machine-readable or system-ready formats that facilitate access. Easily accessible data are essential for managing patient care, assessing provider performance, and driving value-based outcomes. Providing access to data with detailed APM attribution, benchmarking, and risk-adjustment logic could promote provider entry and participation in models. Additionally, providing access to data on health services utilization, cost, and quality of care could promote specialist engagement in models. CMS can play a central role in standardizing and expanding access to health care data.

Recommendation 10

CMS should continue its efforts to standardize and democratize health care data and ensure timely access to all who need it.

Recommendation 11

CMS should provide accountable entities with waivers and flexibilities, including those that could be analogous to those allowed for Medicare Advantage plans, to ensure that accountable entities can achieve the vision for care under TCOC models.

These waivers and flexibilities may include relaxing restrictions, such as the 3-day stay rule and inpatient-only list, and allowing cost-sharing modifications to incentivize use of high-value services.

THE FOCUS ON PATIENTS: ENHANCING PATIENT EMPOWERMENT AND PATIENT SAFETY IN TCOC MODELS

As described above, patient centeredness is critical to PTAC's vision of care delivered by TCOC models. One component of patient-centered care involves empowering patients to make informed medical

decisions and manage their own health. Another critical component is safety—the patient should feel confident that the care they access will not be subject to preventable medical errors.

Patient Empowerment

Findings from the Patient-Reported Indicators Survey (PaRIS) U.S. sample, which targets adults aged 65 years and older, indicated that 77 percent of adults reported feeling confident or very confident in managing their health and well-being, and 78 percent of adults reported definitely feeling involved in making decisions about their health.[18] However, over half (54 percent) of adults reported relying heavily on their health care providers to make medical decisions on their behalf. Health literacy may be a barrier to patients being more involved in making decisions about their health, as over one in five (22 percent) adults have difficulty understanding their health information.

To empower patients and support providers, the Committee's recommendations focus on ensuring that patients and providers have access to real-time, usable patient health data. Access to patient health data is critical to allowing patients to actively engage in their health and make informed decisions about their care. Patient health data can support shared decision-making, which is a model of care that encourages patients and clinicians to work together to make informed medical decisions that align with patients' health goals. The Committee also believes that digital health tools (e.g., wearable devices, patient portals) have an important role in collecting, sharing, and integrating patient health data to promote patient empowerment.

During PTAC's September 2025 public meeting, Committee members and expert presenters agreed that access to patient health data is not sufficient to promote patient empowerment; the data must also be usable to support shared decision-making and care improvements. Digital health tools generate large volumes of data, which providers must synthesize to produce actionable insights. Data should be condensed into clinically relevant formats with aggregated summaries so that clinicians can readily use and interpret the information.

Although there is great promise in the use of patient health data and digital health tools to promote patient empowerment, this strategy will not work for all patients. For example, patients who reside in rural areas that have poor broadband access or those with lower digital literacy may require alternative strategies to promote patient empowerment, such as using in-person visits as opportunities to support shared decision-making. Attention to this issue is particularly important to ensure that differences in digital access do not promote widening health disparities.

[18] Assistant Secretary for Planning and Evaluation (ASPE). Measures of Patient Empowerment for Medicare Beneficiaries: Evidence from the Patient Reported Indicators Survey (PaRIS). September 8, 2025. https://aspe.hhs.gov/sites/default/files/documents/5aa730d9f0018164e93674f92484063e/PTAC-Sep-2025-PaRIS-Findings.pdf

Recommendation 12

Patients and their clinicians and health care organizations should be provided with access to real-time, usable patient health data to promote patient engagement.

- Digital health tools should be used to promote real-time data collection, sharing, and integration of these data.
- Artificial intelligence (AI) and other new technologies should be used to synthesize data to produce actionable insights, support provider clinical decision-making, identify changes in patient health, and personalize care.
- Engagement strategies should include family caregivers and authorized surrogate decision-makers where patients rely on them, and should preserve accessible non-digital pathways so that patients without digital access or capacity are not excluded from the benefits of these models.

The Committee has discussed the growing role of technology, such as AI, in supporting providers with clinical decision-making and personalizing care. Use of new technologies to analyze and integrate large data sets can help shift the health care system from being symptom-based and reactive to proactive and predictive. For example, AI-enabled tools can identify patients with worsening conditions or at risk of needing treatment, and flag changes in patients' health patterns. Key to this approach is ensuring that patient-collected data from digital health tools are integrated with provider-collected clinical data and non-clinical data such as social drivers of health. Across multiple PTAC public meetings, Committee members and expert presenters have emphasized the importance of continuing data interoperability efforts to reduce data fragmentation and information blocking.

The Committee has cautioned that attention is needed to ensure that the use of patient health data and AI does not have unintended consequences. Use of technology should be purpose-driven and focused on improving patient health and not used for other purposes, such as facilitating the inappropriate denial of patient claims. The Committee recognizes a key step in this direction made by the CMS Innovation Center in developing the Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model, which tests an outcome-aligned payment approach to expand access to new technology-supported care options.

The Committee supports designing new APMs or modifying current efforts to incentivize providers to use patient health data and other empowering strategies. Additionally, APMs can use waivers that allow providers to offer patient engagement incentives that encourage patients to participate in their care. The Committee also supports designing APMs to empower patients by reducing barriers to health-promoting activities and care and by incentivizing the adoption of healthy behaviors and lifestyle changes. Patients should also be educated on the value of participating in APMs.

Recommendation 13

Through both payment methods and performance measures, APMs should strengthen incentives for providers to use the vast amount of usable data to generate actionable insights and empower patients through shared decision-making. Models should also incentivize patients to participate in decision-making and engage in health-promoting behaviors. For example, ACOs could be provided with waivers to allow for structuring out-of-pocket payments in ways that incentivize patient engagement.

Patient Safety

In exploring the role of APMs to improve patient safety across the health care system, PTAC heard from a broad range of stakeholders representing patients, providers, insurers, and academia. They had a common message: despite the efforts to date, medical errors remain a significant problem in health care. Following publication of the Institute of Medicine's *To Err is Human: Building a Safer Health System* report in 1999, a considerable amount of policy and measurement attention was placed on patient safety. There were noticeable improvements in selected measures of patient safety and hospital-acquired conditions. In recent years, progress seems to have stalled, and many of the poorest performing hospitals have not improved over time.

Perhaps more importantly, what is being measured is considered to be the "tip of the iceberg." That is, unreported errors such as diagnostic and medication errors, as well as near misses, represent a much greater patient safety problem. Moreover, current measures focus on inpatient care while many procedures are now provided in ambulatory settings. Currently, health system operations are geared to either retrospective quick fixes or hiding errors when they occur. Providers lack the data and information technology structure to prospectively identify potential errors. In addition, the current culture does not support a learning system in which identifying potential errors and implementing system fixes to address them is valued. Indeed, it appears that current policy does not foster an adequate business case for providers to address these challenges proactively, as opposed to less substantially dealing with errors after they occur.

Numerous changes should occur to eliminate preventable medical errors. The future state should be one in which the culture of health delivery values the identification of potential errors and modifies operations as needed to prevent those errors. In addition, data and information technology should be available to support this culture by providing timely and actionable information, as well as prospectively identifying potential errors. Moving to longitudinal data that can be accessed by patients, providers, and insurers is critical to capture the full care experience around a safety issue. As part of reporting and developing appropriate patient safety performance measures, patients and families should have a voice. Indeed, developing a set of patient-reported experience and outcomes measures may be an effective way of identifying errors and system problems that might otherwise not be visible.

The statutory responsibility of PTAC is to make recommendations to the Secretary concerning physician-focused APMs. Through expert presentations and public comments at its meetings, as well as responses to its Requests for Input (RFIs), PTAC is also informed about a variety of other potential policy alternatives to address a given issue. In the case of patient safety, the message from the public meeting

was clear: the current level of patient harm in our system is unacceptable, and, therefore, a strong and immediate policy response is required. Multiple levers at the Secretary's disposal—payment, performance measurement, conditions of participation—could be used to send a clear message across the health care community that significant improvement in patient safety is necessary, and that change is required.

The Committee also makes the following recommendation specific to improving patient safety through APMs:

Recommendation 14

For current and newly implemented APMs, incentives to significantly improve patient safety efforts should be emphasized and strengthened through new performance measures and payment methods.

The CMS Innovation Center should consider developing a patient safety-specific model that includes incentives for new methods of reducing patient harm, such as investing in new information systems, changing system-level culture, and inducing greater transparency.

As an alternative to a new model, the CMS Innovation Center might initiate a new version of the Health Care Innovation Awards for ground-level development and implementation of a patient safety model. For example, an award might be provided to organizations willing to form an alliance that shares longitudinal patient safety data and produces evidence of best practices.

One option for a new patient safety model is a hospital-level "earn-back" model in which hospitals would earn back payments withheld due to not meeting patient safety benchmarks or demonstrated improvement in specific patient safety-related performance indicators. Accountability should include ambulatory facilities and provider-owned or contracted hospitals and delivery systems. Entities implementing the withhold policy should account for and develop alternatives for financially vulnerable facilities.

TCOC MODELS IN RURAL AREAS

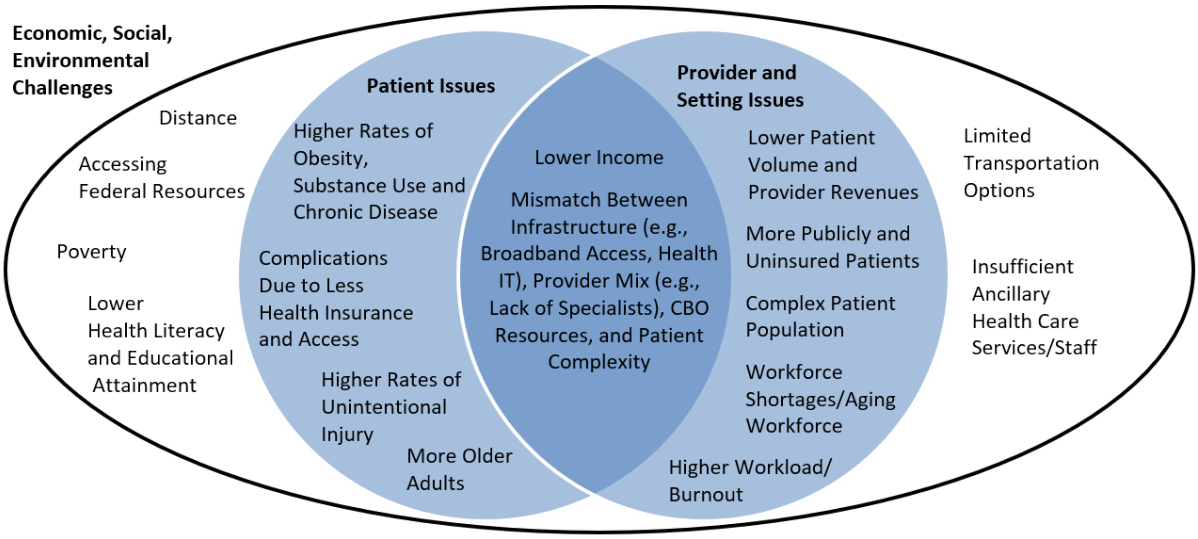
Committee members believe that increasing the adoption of value-based care in rural areas is critical. Rural areas can be defined based on different factors, such as population size and density, proximity to a metropolitan area, geography, and geographic remoteness. An analysis conducted for PTAC revealed that approximately 63 percent of U.S. counties are designated as rural areas and include approximately 15 percent of the U.S. population (46.3 million people).[19] Rural providers participate in PB-TCOC models

[19] Assistant Secretary for Planning and Evaluation (ASPE) and NORC at the University of Chicago. Environmental Scan on Encouraging Rural Participation in Population-Based Total Cost of Care (TCOC) Models. September 2023. https://aspe.hhs.gov/sites/default/files/documents/e33bac4e4801ea35363b6f8c8c8f1f59/PTAC-Sep-18-Escan.pdf

and ACOs at a lower rate than non-rural providers (roughly 12 percent versus 15 percent, respectively).[20]

The Committee members and public meeting expert presenters have identified a range of economic, social, and environmental challenges that affect rural patients, providers, and communities, which can adversely influence participation in APMs in rural areas (see Exhibit 6). Challenges may include limited transportation options, lower health literacy and educational attainment, poverty, higher rates of obesity and substance use, less health insurance coverage, and workforce shortages. Low patient volume can also contribute to challenges with APM participation related to patient attribution, benchmarking, performance measurement, and financial risk management.

Exhibit 6. Overview of Issues Affecting Rural Health Care Systems, Settings, Providers, and Patients



Abbreviations: CBO, community-based organization; Health IT, health information technology

The Committee believes that increasing provider participation in rural areas, and ultimately improving rural health care outcomes, requires a multipronged approach to strengthen rural infrastructure, increase sustainable funding, enhance recruitment and training of rural health providers, increase community health organization capacity, and address health disparities. Increasing rural participation in PB-TCOC models requires upfront funding, such as population-based prospective payments or global budgets, to aid rural providers in investing in high-quality care. Global budgets may be particularly useful as they typically include all payers, which could improve payment stability for rural providers. Additionally, because primary care is often underfunded in rural areas, a greater percentage of the overall spend on health care could be allotted to primary care in rural settings. The Committee also believes that it is important to provide a clear and simple glide path for rural providers with progressive risk (e.g., upside-only risk gradually transitioning to two-sided risk) to encourage participation in value-based care. Due to the heterogeneity of rural areas, each type of rural area may require a tailored solution to facilitate health care delivery transformation.

[20] Government Accountability Office. Information on the Transition to Alternative Payment Models by Providers in Rural, Health Professional Shortage, or Underserved Areas. GAO-22-104618. November 2021. https://www.gao.gov/assets/720/717649.pdf

PTAC's expert presenters also noted that given the unique characteristics of many rural areas, increasing value through TCOC models may require increasing spending to improve quality and outcomes. The Committee understands this approach is problematic for the CMS Innovation Center given the statutory requirements that models must reduce spending or be budget neutral. Nonetheless, a greater focus on quality improvement relative to spending in rural models might be prudent.

Recommendation 15

Rural provider participation in TCOC models should be encouraged by multiple strategies, including providing consistent, sustainable funding streams through capitation and upfront payments. Upfront payments are important to support the adoption of health information technology infrastructure and data analytics. Another strategy involves establishing longer participation glide paths for rural providers to take on risk in TCOC models.

Low patient volume in rural areas can lead to less predictable spending and utilization patterns, which increase financial risk for rural providers and may impede rural providers' participation in APMs. Low patient volume can also contribute to challenges related to patient attribution, benchmarking, and performance measurement. Regionalization and risk pooling may be potential strategies to reduce the risk of participation in value-based care for rural providers. Spreading fixed costs and ensuring a greater pool of patients can help balance downside risk.

Recommendation 16

Rural providers should be encouraged to collaborate with other providers in their region to aggregate the volume of patients under value-based payment models.

MAXIMIZING PARTICIPATION IN TCOC MODELS

Based on engagement in public forums with a variety of stakeholders and evidence presented to it, PTAC believes that maximum participation in TCOC models is essential for effective delivery system transformation. Several of PTAC's expert presenters have emphasized that a significant percentage of a provider organization's payment must be tied to value-based arrangements to incentivize the investments and practice changes needed to fully transform care. Thus, finding ways to both maximize participation in Medicare models and fully align other payers to similar arrangements is critical.

Payment Pathways and Medicare Participation

The recent growth in ACO participation, after a plateau from 2018 to 2022, is encouraging. Nonetheless, there are reasons for concern about obstacles to advance significant increases in participation under current policies. For one, because ACO models are voluntary, those providers and organizations that are less likely to succeed under shared savings arrangements are unlikely to participate. Physician-led organizations are now the predominant ACO type. This ACO type is able to achieve savings through effective care that results in reductions in hospital services such as admissions and emergency department visits. IDSs and hospital-based systems have little or no incentive to participate—they have fewer options for reducing utilization without reducing their own revenues in order to receive a lesser amount back in shared savings. At the other end of the provider spectrum, smaller and rural practices

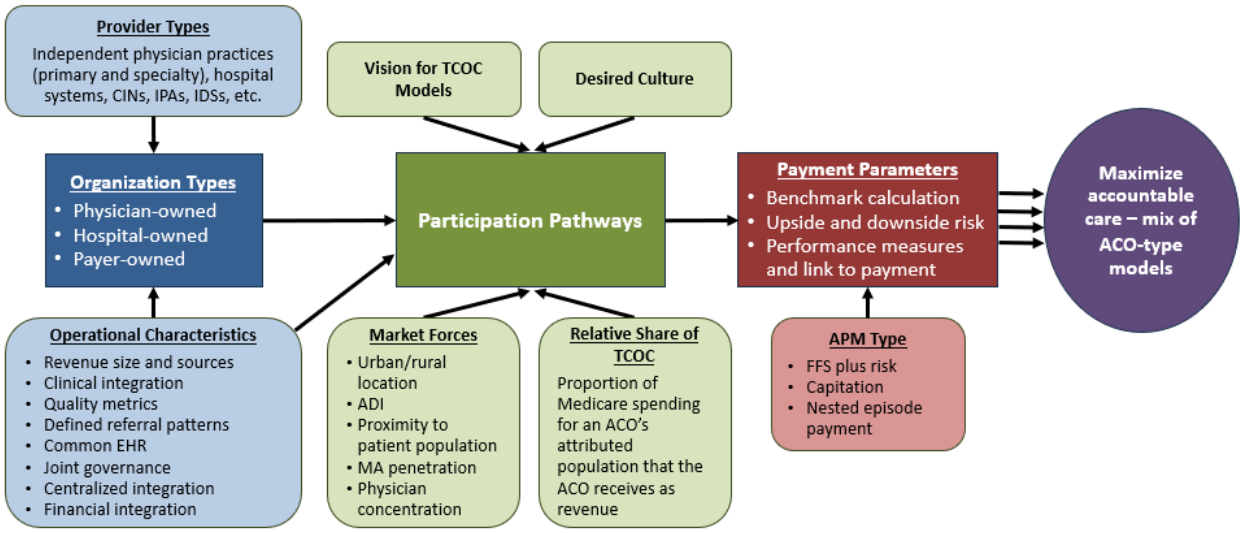
often do not have the resources to make the investments needed for value-based care and to undertake financial risk.

PTAC has sought research and public input for assessing how CMS might create multiple pathways that would incentivize the full range of provider organizations to enter value-based arrangements—especially TCOC models. The Committee has noted that how payment arrangements are structured is critical to maximizing participation in accountable care models. Payment models should recognize the business model of the practice and promote financial stability for providers through value-based care as opposed to FFS. Participation in value-based care must be financially viable for providers, and they must see a feasible path to savings to participate in APMs. For these reasons, the Committee has made the case that value-based payment arrangements should be consistent with the structure of provider organizations and their business models. However, payment models should not be designed to promote the current business model but rather one that requires a transition to value-based care. PTAC is using the following working definition of a "health care business model" for consideration of factors related to participation in PB-TCOC models:

> *A viable health care business model is one that allows a health care entity to provide health care services that meet patient needs and deliver value while ensuring financial returns that make it worthwhile to continue operating over time.*

Exhibits 7 and 8 summarize the important issues and factors for considering pathways to accountable care for multiple types of provider organizations. Exhibit 7 describes organizational and market factors that affect a provider organization's ability to undertake risk under different payment approaches. For example, large, integrated systems would have resources, both financial and for clinical integration, as well as management controls to potentially accept financial and performance risk and distribute payments throughout their system. Relative to large, integrated systems, physician-led ACOs have less ability to distribute payments and exert management control over other providers who care for their patients.

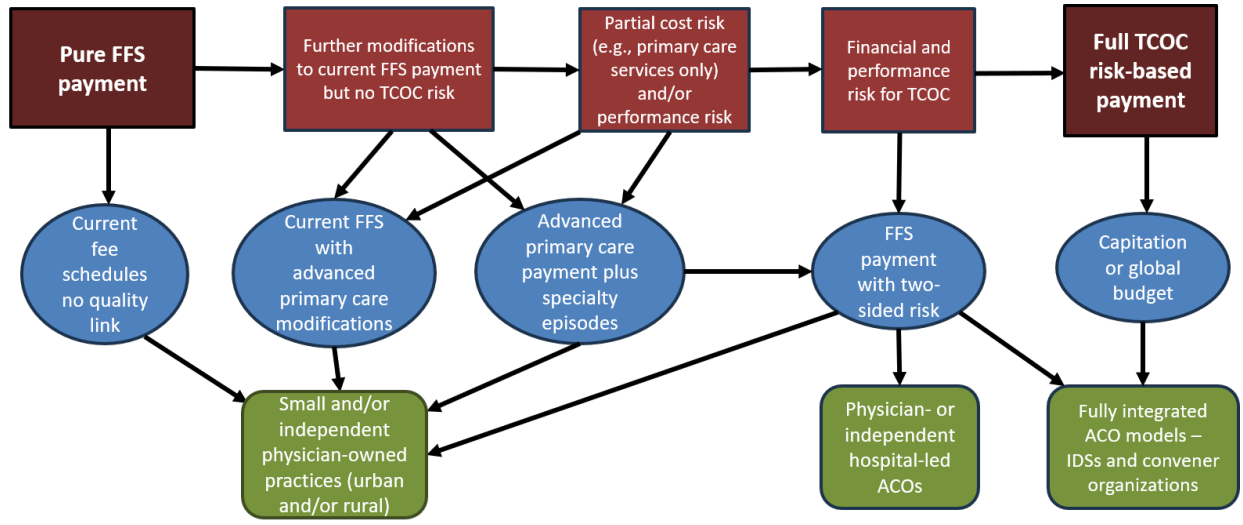
Exhibit 7. TCOC Model Pathways to Maximize ACO Participation



Abbreviations: ACO, Accountable Care Organization; ADI, Area Deprivation Index; APM, Alternative Payment Model; CIN, clinically integrated network; EHR, electronic health record; FFS, fee-for-service; IDS, integrated delivery system; IPA, independent physician association; MA, Medicare Advantage; TCOC, total cost of care

Exhibit 8 describes the types of payment arrangements that might be consistent with each type of organization that could participate as an ACO. For example, capitation or global payments might be appropriate for integrated systems and convener organizations, but most physician-led ACOs would likely rely on an FFS chassis for their payments. The Committee notes that payment arrangements that rely on modified fee schedules with little or no financial risk might be considered transitional models as they serve as pathways to full value-based arrangements.

Exhibit 8. Pathways and Payment Policies to Enhance Value



Note: The payment models in the first row of the diagram are aligned with the payment model categories in the HCP-LAN APM Framework.

Abbreviations: ACO, Accountable Care Organization; FFS, fee-for-service; IDS, integrated delivery system; TCOC, total cost of care

The Committee notes that the prior federal administration had set a goal of having all Medicare beneficiaries in TCOC relationships with providers by 2030. While the current administration does not have a specific participation goal, it has continued to expand ACO model opportunities based on the evidence produced to date. In considering all the evidence and presentations at PTAC's public meetings, the Committee believes that meaningful transformation of the delivery system requires maximum participation in value-based care across all patients and payers. Thus, pathways must be created and tested that allow for and incentivize participation of all provider types.

Recommendation 17

While CMS has made progress toward increasing incentives to participate in TCOC models, new pathways are needed to encourage greater participation among:

- Small and large independent practices and rural providers; and
- Integrated delivery systems.

These pathways would involve several different payment mechanisms and two-sided risk arrangements. Some of these methods might be considered transitional and may have to be supplemented with mandatory model development.

For clinicians and organizations new to value-based payment, a clear, simple, predictable, multi-year glide path should be implemented to enable capacity building, for example, by beginning with upside-only risk (potential for savings but not losses) and moving toward two-sided risk (potential for either savings or losses) over time.

For small and large independent practices and rural providers, models with fee schedules could be modified to encourage advanced primary care, coordination, and specialty integration with a glide path to risk-based models. Based on public testimony, the Committee recommends continued testing or models using capitated payments for primary care. Structuring these capitated rates to include current care coordination services (such as transitional care management and chronic care management services) could incentivize practitioners to both provide high-touch proactive primary care services and engage in longitudinal care coordination. These rates could offer both a pathway to accountable care for non-participating providers and a key portion of reimbursement for primary care in current ACOs.

For rural providers, spending reductions may be difficult to achieve from current levels. Thus, it may be necessary under current law to develop models geared toward maintaining spending or slowing its growth while making significant quality improvements.

For IDSs, new methods of payment may need to be developed and tested. For example, fully prospective, capitated payments could be implemented that allow net revenue gains from spending reductions when paired with improved quality. The Committee notes that many of PTAC's public meeting experts have stated that, in addition to new payment methods, maximizing participation may require mandatory models and/or changes in FFS payments that make FFS payments a much less attractive alternative to APMs. These issues are discussed in the "Other Supporting Policies for TCOC Models" section below.

The vision for care in TCOC models requires coordinated, team-based care across all services to meet a patient's health needs. A common theme discussed among expert presenters and the Committee has been the need to better engage and integrate specialists in TCOC models; there is concern that there has been little integration between primary and specialty care in current ACOs. Most specialists still practice in an FFS model. CMS-Administered Risk Arrangements (CARA) is a new initiative as part of the LEAD Model. CARA is designed to facilitate episode-based risk sharing between ACOs and specialists. By providing a digital platform, standardized contracts, and data-sharing capabilities, CARA enables specialists to share in risk-based payments, encouraging stronger partnerships with ACOs. These risk-based payments should be financially significant to encourage the transformation to value-based care.

The Committee believes that CMS can build on this important new feature to encourage integration for all the pathways to accountable care described above. It is likely that, for some time, there will be a variety of models reflecting the organizational and payment arrangements represented in Exhibit 8. Improved, patient-centered care might be incentivized by a combination of APMs in which there is shared financial risk between primary care physicians and specialists, episode-based payments for which specialists bear risk, or enhanced FFS payments incentivizing financial and performance accountability. By continuing to define, analyze, and share data on episodes of care, CMS can encourage coordination and high-value primary and specialty care regardless of the degree of formal management control, relationships, and shared financial incentives among participants in TCOC models.

Recommendation 18

For all potential payment pathways (described in Exhibit 8), CMS should develop methods to incentivize integration of high-value specialty care with advanced primary care. Potential methods include the development of episode-based models that:

- Incentivize specialists to provide high-value, coordinated care;
- Nest cascading accountability into TCOC models as part of total payment to the organization;
- Involve data that can be used by accountable entities for internal payment and performance purposes; and
- Involve data that can curate referrals from primary care to high-quality specialists.

Multi-payer Alignment

In several of PTAC's public meetings, expert presenters and Committee members stressed the importance of encouraging multi-payer alignment across PB-TCOC models. It is important to align payment approaches so that clinicians and organizations can focus on care transformation without the complexity of multiple payment structures, regulations, and performance metrics. There is a need for multi-payer alignment on data and quality measures to decrease administrative costs for accountable entities and to improve efficiency. One presenter stated that success in multi-payer alignment will require a shared vision across payers. Moreover, a critical mass of value-based revenues may be required to incentivize necessary infrastructure investments and changes in care patterns. Committee members also discussed the importance of multi-payer arrangements because of the challenge of

changing practice patterns only on a limited scale, noting that "one payer–one program" at a time approaches may not include enough patient or revenue volume to change practice.

The Committee believes that it is also important to align policies within the Medicare program; that is, between Medicare Advantage (MA) participants and accountable entities within Original Medicare. In particular, a number of waivers from statutory and regulatory requirements are necessary to allow entities the flexibility they need to focus on wellness and provide well-coordinated, patient-centered care. CMS has granted waivers on a model-specific basis.

In November 2020, as part of the Regulatory Sprint to Coordinated Care initiative, HHS issued final rules that, among other things, established new exceptions under the Stark Law and new safe harbors under the Anti-Kickback Statute (AKS) for certain value-based compensation arrangements. Expert presenters at PTAC's public meetings have expressed concerns about the application of exceptions and waivers, noting that uncertainty about legal risk still creates reluctance to take advantage of exceptions and waivers.

Recommendation 19

To the extent possible under current authority, CMS should lead the way for commercial payers to encourage participation in value-based payment models. CMS should use its leadership position to help public and private payers align both their commitment to value-based care and payment, and their methods (e.g., risk adjustment, performance measures) for implementing these strategies.

OTHER SUPPORTING POLICIES FOR TCOC MODELS

PTAC was established by statute to make comments and recommendations to the Secretary of HHS concerning PFPMs involving Medicare as a payer. 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 APMs and PFPMs. With that in mind, the Committee began a series of theme-based discussions on this topic in September 2020. During the Committee's public meetings, a variety of stakeholders have made potentially useful comments and suggestions about policies that are not directly related to development and testing of payment models but would support model participation and enhance the chances for success. In addition, expert presenters have raised potential topics that may be relevant to developing and testing payment models but the Committee does not yet have sufficient information for a formal recommendation. Because these topics have been raised in PTAC's public meeting, they are described below as considerations for policymakers as opposed to formal recommendations.

Reforming Original Medicare while strengthening value-based models—A common theme in public comments has been the problem and issues related to the predominantly voluntary nature of both MSSP and CMS Innovation Center models. For one, presenters have stated that FFS payment remains attractive relative to value-based arrangements to most providers, and, thus, they have no incentive to volunteer. Under these circumstances, it is unlikely that any objectives for maximum participation in accountable care can be met. In addition, organizations that tend to join and remain part of TCOC models under voluntary participation are in the best position to benefit from shared savings by

improving quality and efficiency, thus limiting the generalizability of findings to other organizations and providers.

Stakeholders believe that an approach containing both "carrots and sticks" may be needed, that is, making FFS payment less attractive while continuing to refine value-based payments to be more attractive to a wider variety of provider organizations. Again, the Committee emphasizes that while remaining out of value-based arrangements should be made less attractive, there are many fee schedule improvements that might be made to serve as pathways and foundations for value-based contracts.

Original Medicare and MA: Creating a more level playing field—In addition to Original Medicare, stakeholders discussed the need to reform MA payment to be financially beneficial to Medicare and level the playing field with accountable care in Original Medicare. They noted that overpayments result in supplemental benefits that are attractive to beneficiaries and lead some MA organizations to recruit patients and providers away from Original Medicare. Indeed, in geographic areas with very high MA penetration, it may be more difficult to recruit providers and beneficiaries in sufficient numbers to support accountable care models. Leveling the playing field could enhance choices for beneficiaries and stimulate competition between the two sectors.

PTAC's expert presenters have also pointed out that MA represents TCOC plans in which more than half of beneficiaries are enrolled. There may be payment and care innovation taking place in MA plans, but little is known publicly about this. Thus, CMS might consider fielding models for MA so that such innovation could be evaluated and made more transparent. Models could also test how to unify risk adjustment and performance measurement between MA plans and TCOC models in Original Medicare.

Shifting from voluntary to mandatory models—There is a range of incentives that can affect providers' choices regarding participating in a PB-TCOC model. The recommendations in this paper for maximizing participation include payment strategies for encouraging various providers to adopt value-based care. PTAC's expert presenters also described a continuum of strategies for moving away from the current payment environment, ranging from strongly incentivizing participation to making participation mandatory. Several presenters discussed the potential desirability of a gradual shift to mandatory participation for some providers.

There are several potential advantages related to mandatory participation. First, mandatory participation would require providers who have not engaged with value-based payment to join PB-TCOC models, thereby helping to increase the proportion of providers' revenues that are in value-based arrangements and the incentives for engaging in broader value-based transformation. TCOC models cannot succeed at providing North Star care without including enough of the right kinds of provider participants. Mandatory participation may be needed if TCOC models cannot create sufficient incentives to engage specialists, particularly in underserved and rural markets. Second, accountable entities facing losses in voluntary models are likely to exit, limiting the impact of the models. Mandatory participation would bring in and retain lower performing organizations and providers who are in most need of improving care delivery and spending.

There are also potential challenges associated with mandating participation in PB-TCOC models. Most notably, not all providers are positioned to succeed in PB-TCOC models. Stakeholders suggested approaches to navigating these challenges. One presenter supported an approach to encouraging participation in which incentives are considered on a spectrum, with different levels of incentives or

requirements depending on the type of provider. For instance, large organizations can be heavily incentivized or required to incorporate two-sided risk, and small organizations can participate in less heavily incentivized programs similar to the original MSSP. Stakeholders also noted that the move to mandatory participation can happen incrementally, starting with voluntary models, then introducing more downsides of nonparticipation in these models, and eventually moving toward mandatory models over time. A more gradual transition from voluntary to mandatory participation would allow more time for testing and evaluating new methods relevant to TCOC policy.

Limiting the CMS Innovation Center portfolio—Stakeholders cited several advantages to offering a limited range of harmonized PB-TCOC models. PTAC's expert presenters noted the importance of being able to test models, and how multiple models in the same market complicate evaluation. As APMs are becoming ubiquitous in many markets, it is difficult to select a comparative group that is not exposed to some form of a PB-TCOC model. Additionally, a select set of PB-TCOC models will make it easier to encourage multi-payer and multistate participation. Stakeholders discussed the advantage of having a limited number of PB-TCOC models and how it would reduce complexity for providers and patients. For providers, it would be easier to track patients across different payers and models, and to engage specialists. Only having to focus on requirements for one model would also reduce providers' administrative burden.

CONCLUDING COMMENTS

The recommendations presented in this roadmap white paper reflect PTAC's deliberations based on public testimony from multiple stakeholders and a growing body of research. The Committee has been impressed with the understanding, acceptance, and readiness to embrace value-based care among a wide variety of stakeholders from across the health care system. PTAC is also impressed by the innovation being implemented by providers and organizations in response to value-based care and payment. It is for these reasons that PTAC believes that savings estimates from the models to date greatly understate the impact CMS and other payers are having in pursuit of transforming into a patient-centered, high-value health care system. Indeed, the Committee members believe that it is time to use what they have learned to aggressively pursue maximum participation in value-based care across the entire system.

The Committee also believes that the focus for policymakers, purchasers, insurers, and patients should be on a shared vision of value-based care. Payment, performance measurement, and other policy tools described in this white paper should create support and strong incentives for making the desired care model a reality. PTAC also believes that TCOC models, such as the current ACO models, should be the primary vehicle for value-based care. With the appropriate mix of payment methods and performance measures, these models can offer the best opportunity for patient-centered, high-value care. Indeed, based on all the information considered, the Committee believes that optimizing key parts of the desired care model—such as advanced primary care, seamless care coordination, team-based care, patient safety, patient engagement, and technology-enabled care—is best achieved through TCOC models, as opposed to a more piecemeal approach to APM implementation.

Over the next few years, the CMS Innovation Center should modify its portfolio to reflect the focus on TCOC. 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. The focus on TCOC should be directed toward incentivizing and mandating, as

needed, the participation of: 1) organizations that are well-equipped to provide the value-based care model envisioned but that currently find FFS payment more attractive; and 2) providers who still need financial and other assistance to make the investment necessary for value-based care.

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Previous PTAC Members	
Jeffrey Bailet, MD, Interim Chief Medical Officer, Lee Health	**Elizabeth Mitchell,** President and Chief Executive Officer, Purchaser Business Group on Health
Robert Berenson, MD, Institute Fellow, Urban Institute	**Len M. Nichols, PhD, MA,** Non-Resident Fellow, Health Policy Center, Urban Institute
Paul Casale, MD, MPH, Founder and Principal, Casale Consulting, LLC	**Kavita K. Patel, MD, MSHS,** Teaching Professor; Stanford University; Venture Partner, New Enterprise Associates
Carrie Colla, PhD, Professor, The Dartmouth Institute for Health Policy and Clinical Practice in the Geisel School of Medicine, Dartmouth College	**Angelo Sinopoli, MD,** Former Executive Vice President, Value-Based Care, Cone Health
Charles DeShazer, MD, Co-Founder and Managing Partner, Nuvanta Consulting Group	**Bruce Steinwald, MBA,** President, Bruce Steinwald Consulting
Jay Feldstein, DO, President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine	**Grace Terrell, MD, MMM,** Chief Medical Officer, IKS Health; Senior Advisor, Oliver Wyman; General Internist, Wake Forest Baptist Health
Timothy Ferris, MD, MPH, Vice President, Healthcare Practice, InterSystems; Healthcare Practice President, Red Cell Partners	**James Walton, DO, MBA,** President, JWalton, LLC
Rhonda Medows, MD, Chief Executive Officer, Health Insights, LLC; Chairperson of the Board, Ayin Health Solutions	**Jennifer Wiler, MD, MBA,** Professor, Department of Emergency Medicine, University of Colorado School of Medicine; Co-Founder, UCHealth CARE Innovation Center; Chief Executive Officer, Minerva Partners
Harold D. Miller, MS, President and Chief Executive Officer, Center for Healthcare Quality and Payment Reform; Adjunct Professor of Public Policy and Management, Carnegie Mellon University	