Session 4: *Expert Input on PTAC's Recommendations on Value-Based Care: Part 4*

Presenters:

Subject Matter Experts

- **Marc M. Boutin, JD** – President and Chief Executive Officer, IVI
- **Reena Duseja, MD, MS** – Physician Executive, Oracle
- **Sean Cavanaugh, MPH** – Chief Policy Officer, Aledade
- **Robert M. Wachter, MD** – Professor and Chair, Department of Medicine, University of California, San Francisco

Session 4: *Expert Input on PTAC's Recommendations on Value-Based Care: Part 4*

Marc M. Boutin, JD

President and Chief Executive Officer, IVI

From Value-Based Care to Patient + Whole Family Health

Strengthening PTAC's Roadmap by Defining what Healthcare Should Ultimately Deliver

Testimony for the PTAC Public Hearing

Marc M. Boutin | President & CEO, IVI

PTAC Public Meeting • September 15, 2026

IVI

PTAC Gets the Foundation Right

IVI Shares PTAC's Vision

Whenever I run into a problem I can't solve, I always make it bigger.

- Dwight Eisenhower

Our system is simply not organized around a shared commitment to the fundamental principle of patient- and family-centered value.

Reimagine the System

Patient + Whole Family Centered

- Physical Health
- Mental Health
- Financial Health
- Family Stability & Caregiver Well-Being

Policy Reform Domains to Achieve Patient + Whole Family Health

1. Outcomes Definition and Measurement
2. Patient Engagement and Decision Support
3. Healthcare Systems Incentives and Oversight

IVI

IVI Recommendation

Whenever you are in doubt... recall the face of the poorest and the weakest person you have seen, and ask yourself whether the step you contemplate is going to be of any use to them. Will they gain anything by it? Will it restore them to control over their own life and destiny?

Mahatma Gandhi

Thank You

Marc Boutin
President & CEO
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Session 4: *Expert Input on PTAC's Recommendations on Value-Based Care: Part 4*

Reena Duseja, MD, MS

Physician Executive, Oracle

Value-Based Care Cannot Run on a Fragmented System

A longitudinal operating architecture for PB-TCOC

Reena Duseja, MD, MS

Physician Executive, Oracle
PTAC Public Meeting | September 15, 2026

My lens: the translation layer from policy to workflow

Is the right information visible, is responsibility clear, and is there a feasible next action?

Clinical care

- Emergency physician and former academic
- Care coordination and value research

Federal health policy

- Former Chief Medical Officer and Acting Group Director, CMS Quality Measurement and Value-Based Incentives Group
- Former senior executive, VA Office of Quality & Patient Safety

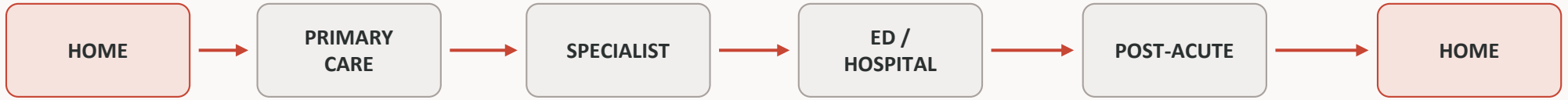
Technology & Implementation

- Connected provider, payer and patient workflows
- Longitudinal data, responsible AI, and implementation governance

PTAC Has the Right Destination- but the Operating System is Episodic

PTAC has correctly established longitudinal, organization-level accountability. The remaining gap is accountable operations.

ILLUSTRATIVE PATIENT JOURNEY



PAYMENT & ATTRIBUTION	Different incentives, rosters, and rules
INFORMATION	Claims, clinical, pharmacy, referrals, and care plans
WORKFLOW RESPONSIBILITY	Ownership resets at each transition
PATIENT SUPPORT	Multiple portals, instructions, and outreach

The patient-year is the unit of accountability. The encounter is still the unit of workflow.

Make transformation investable

Broad, equitable, sustained participation—not participation at any cost.

1 Predictable economics

- Durable benchmarks
- Ability to benefit from achieved value

2 Accountable-entity operating capability

- Care management, navigation. Data, safety, and workflow redesign
- Training, governance, monitoring and shared services

3 Graduated accountability

- Readiness-sensitive movement into risk
- Differentiated pathways for rural, independent, and integrated organizations

ENABLERS: targeted waivers | regional scale and risk pooling | patient protections

From Financial Accountability to Accountable Operations

1 SEE IT

- Timely events and usable longitudinal record
- Medications, referrals, care plans and patient-reported signals

2 OWN IT

- Named longitudinal accountability anchor
- Explicit primary–specialty and cross-model roles
- Human review and escalation responsibility

3 CLOSE IT

- Results, referrals, transitions, and follow-up completed
- Patient understands the next step
- Unresolved work routed and escalated

One patient. One reconciled longitudinal plan. Clear ownership of the next action.

Primary care anchors the plan. Care teams own the work.

The accountable entity owns whether the system works.

.

Technology Can Enable Connected Care—If Models Require It

Data exchange lets teams see. Coordinated workflows create ownership and closure. Governed AI can accelerate both.

Required capability	What PB-TCOC should expect
1 Connect the information Enables SEE IT	Timely clinical, claims, pharmacy, utilization, care-plan, referral, and patient-reported data across settings.
2 Coordinate the work Enables OWN IT + CLOSE IT	Information reaches the person who can act; referrals, results, transitions, outreach, and follow-up are routed, tracked, and closed.
3 Govern intelligent tools Accelerate responsibly	AI may summarize, prioritize, predict, and route—with human accountability, validation, monitoring, privacy, security, and correction.

Core capabilities are available today.
Model design must require and resource connected operations.

Measure What Longitudinal Care Should Change

Lower spending is not value if access, safety, function, experience, or equity worsen.

Measurement tier	What it should answer
1 External accountability	**Is whole-population value improving?** Outcomes, experience, function, safety, equity, and avoidable TCOC
2 Model evaluation	**Is longitudinal coordination working?** Transitions, medication reliability, primary–specialty coordination, patient goals, and care-team responsiveness
3 Internal improvement	**Where should teams improve?** Episode measures, workflow closure, time to action, and local diagnostics

Reviewer proposal — Adopt a measure budget: every new external requirement should replace, retire, or consolidate an existing one.

TRANSPARENT PAYMENT LINKAGE **Link core outcomes and safety at the accountable-entity level; return results while action is still possible.**

Safety is the stress test of longitudinal accountability

Harm frequently occurs where information and responsibility change hands.

DETECT

- Use longitudinal and patient/family information to identify unresolved risk

ASSIGN

- Name the owner of results, medication changes, referrals, transitions, and escalation

LEARN

- Reward transparent detection, correction, prevention, and learning across settings

Safety should be a floor across every PB-TCOC model—not a score that savings can offset

Three changes would make the roadmap more executable

When multiple CMS models touch one patient: one reconciled plan, explicit roles, and closed-loop action

1

Make transformation investable

Predictable economics, accountable prospective support, graduated accountability, and targeted flexibility

2

Make responsibility longitudinal

See–Own–Close across primary care, specialty care, payers, and overlapping CMS models

3

Make outcomes and safety longitudinal

A small core portfolio, timely feedback, transparent payment linkage, and patient, equity, and safety protections.

Value-based care cannot run on a fragmented system

Appendix

Discussion reserve: detail behind the recommendations

Not intended for oral presentation unless raised during discussion.

Direct response to PTAC’s guiding questions

My review in six sentences

Assessment, range, and tone

- Strong and directionally right; a useful synthesis that needs a clearer operating architecture
- The range is appropriately broad; the challenge is connecting the domains, not adding more categories
- The tone is generally appropriate; use “central organizing strategy” and “broad, equitable, sustained participation” where helpful

Changes, additions, and missing information

- Strengthen data and workflow ownership, multi-payer alignment, measure–payment linkage, and safety
- Test or temper mandatory participation, patient financial incentives, and hospital earn-back designs
- Add a cross-model longitudinal accountability standard and an implementation matrix: actor, authority, sequence, metric, safeguard

Reinforce the economics, operationalize alignment, and protect patients and providers

My assessment of PTAC's 22 recommendations

Broadly supportive; most changes are implementation precision and safeguards

1 Support and emphasize

Recs 2–4, 6, 9–13, 18, and 20

Care vision, organizational accountability, prospective support, specialty integration, measurement, data, and safety

2 Strengthen or operationalize

Recs 5, 7–8, 14–17, 19, and 22

Benchmark durability, participation pathways, payer alignment, rural scale, workflow action, and safety learning

3 Test or make less prescriptive

Rec 1 wording; mandatory participation; patient cost-sharing incentives; hospital earn-back design

4 Add or clarify

Cross-model accountability; closed-loop workflow standard; measure budget; implementation matrix

The destination remains the same; the roadmap needs more explicit transition and operating architecture

Make participation investable—and alignment operational

The economics and the workflow must reinforce each other

Transition architecture

- Predictable benchmarks and ability to benefit from achieved value
- Prospective payments tied to capability milestones
- Graduated risk and differentiated participation pathways
- Waivers, regional aggregation, and shared services

Operational multi-payer compact

- Common attribution and patient identity
- Core longitudinal data package and latency expectations
- Aligned measure specifications and reporting periods
- Consistent feedback, patient communication, and accountability expectations

Rural and low-volume success may mean stable spending with materially better access and quality—not immediate large savings.

Alignment that is not visible in daily work is not alignment

Specialty care is the first test of See–Own–Close

Primary care cannot manage total cost while specialty care remains a separate economic operating system.

PB-TCOC accountability

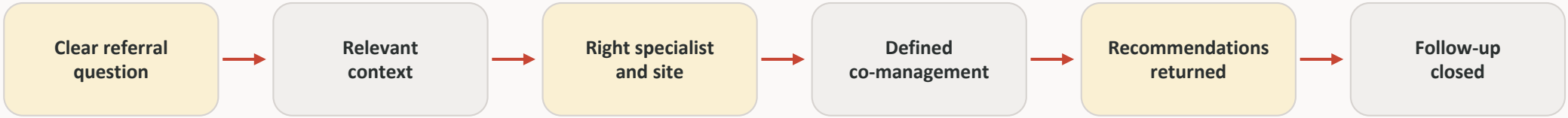
Is whole-person value improving across the full patient journey?

+

Selected episode insight

Where is clinically meaningful variation in cost, quality, access, complications, or site of care?

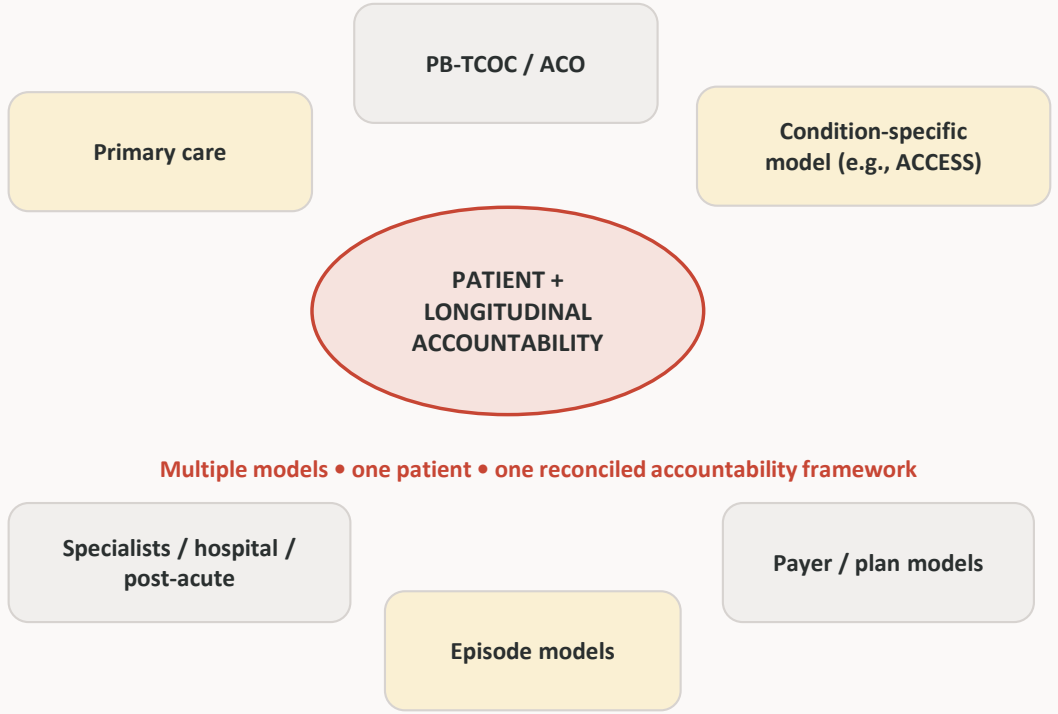
A SHARED CARE PATHWAY



The patient understands the plan and who owns the next step.

Prevent model innovation from creating new coordination silos

Reviewer proposal: cross-model longitudinal accountability



CMS/CMMI model terms should clarify

- Who owns which elements of care
- How care plans are reconciled
- How data move and which team responds
- How referrals and transitions close
- What the patient is told
- How payments and measures interact

ACCESS is a building block—not a PB-TCOC substitute.

Technology-enabled care can reduce fragmentation—or digitize and scale it

Meaningful longitudinal outcomes—and a measure budget

Use measures with a credible theory of change

Longitudinal function → meaningful outcome → TCOC pathway

Function	Meaningful outcomes	Plausible TCOC pathway
Care transitions	Follow-up, medication safety, patient understanding	Prevent harm and avoidable acute use
Primary–specialty integration	Referral completion, site of care, coordination	Reduce delay, duplication, and inefficient care
Chronic and medication management	Symptoms, function, adverse events, treatment burden	Prevent deterioration and escalation
Patient navigation and equity	Access, comprehension, experience, digital inclusion	Prevent underuse, abandonment, and exclusion

Proposed measure budget

- Small core set for external accountability
- Each new external measure replaces, retires, or consolidates an existing requirement
- Episode and workflow measures primarily support internal improvement
- Each measure has validity, patient relevance, actionability, reasonable burden, and an intended user

If value-based care requires more measurement than fee-for-service, it has failed as a transformation strategy

AI should earn its place in PB-TCOC

Evaluate net value—not adoption alone

Evaluation domain	Question for PB-TCOC
Care coordination	Did it improve transition follow-up, referral closure, care-team routing, or patient outreach?
Patient outcomes and experience	Did it improve access, understanding, timely care, function, or relevant clinical outcomes?
Safety	Did it reduce—or introduce—medication, diagnostic, communication, or transition risk?
Equity	Did performance or access vary by patient group or contribute to digital exclusion?
Workflow impact	Did it eliminate repetitive work—or create alerts, inboxes, documentation, or monitoring burden?
TCOC relevance	Is there a plausible pathway to preventing avoidable utilization or cost shifting?

Guardrails for patient access, equity, safety, and AI net value

The patient is the only person who experiences the full model across settings and payers

Patient agency

- Understandable care plans and shared decisions
- Human and non-digital navigation
- Language access and clear next steps

Equity

- Stratified access, outcomes, experience, and safety
- Monitor risk avoidance and network narrowing
- Prevent digital exclusion and burden shifting

Safety

- Medication, diagnostic, transition, and referral reliability
- Patient and family signals
- Near-miss learning and transparent correction

AI net value

- Coordination and workflow impact
- Outcomes, experience, safety, and equity
- Plausible relevance to avoidable TCOC

AI should earn its place: evaluate net value—not adoption alone.

Risk adjustment is necessary for fair payment; equity accountability is necessary for fair care

Suggested addition: cross-model interoperability and longitudinal outcomes

Reviewer-proposed language—not current PTAC text

CMS should ensure that technology-enabled, condition-specific models complement rather than fragment PB-TCOC accountability by establishing cross-model expectations for data exchange, care-plan sharing, care-team ownership, patient navigation, outcome measurement, and payment interaction.

Longer alternative

CMS and the CMS Innovation Center should develop and evaluate PB-TCOC model pathways that make longitudinal care coordination actionable across settings, clinicians, and payment models. These pathways should support timely, interoperable data exchange; clear care-team ownership; closed-loop transitions and referrals; patient navigation and accessible care plans; and meaningful outcome measures linked to the longitudinal care functions the model is designed to improve. CMS should assess whether these capabilities improve patient outcomes, experience, safety, equity, care-team workflow, and avoidable total cost of care.

Session 4: *Expert Input on PTAC's Recommendations on Value-Based Care: Part 4*

Sean Cavanaugh, MPH

Chief Policy Officer, Aledade

PTAC Recommendations for Transforming Health Care Delivery Through Value-Based Care

Sean Cavanaugh

September 15. 2026

Aledade

Policy Institute

Today's speaker

Sean Cavanaugh
Chief Policy Officer

Sean has been at Aledade since 2017. In 2025, Sean spearheaded the launch of the Aledade Policy Institute.

Prior to Aledade, Sean was at the Centers for Medicare and Medicaid Services (CMS) where he served as Deputy Administrator & Director of the Center for Medicare and Deputy Director for the Center for Medicare & Medicaid Innovation.

Aledade Policy Institute

Aledade at a glance

Physician-led, national leader in value-based care.

3K+
Primary care partners*

3M+
Patients*

$1B+
Shared Savings**

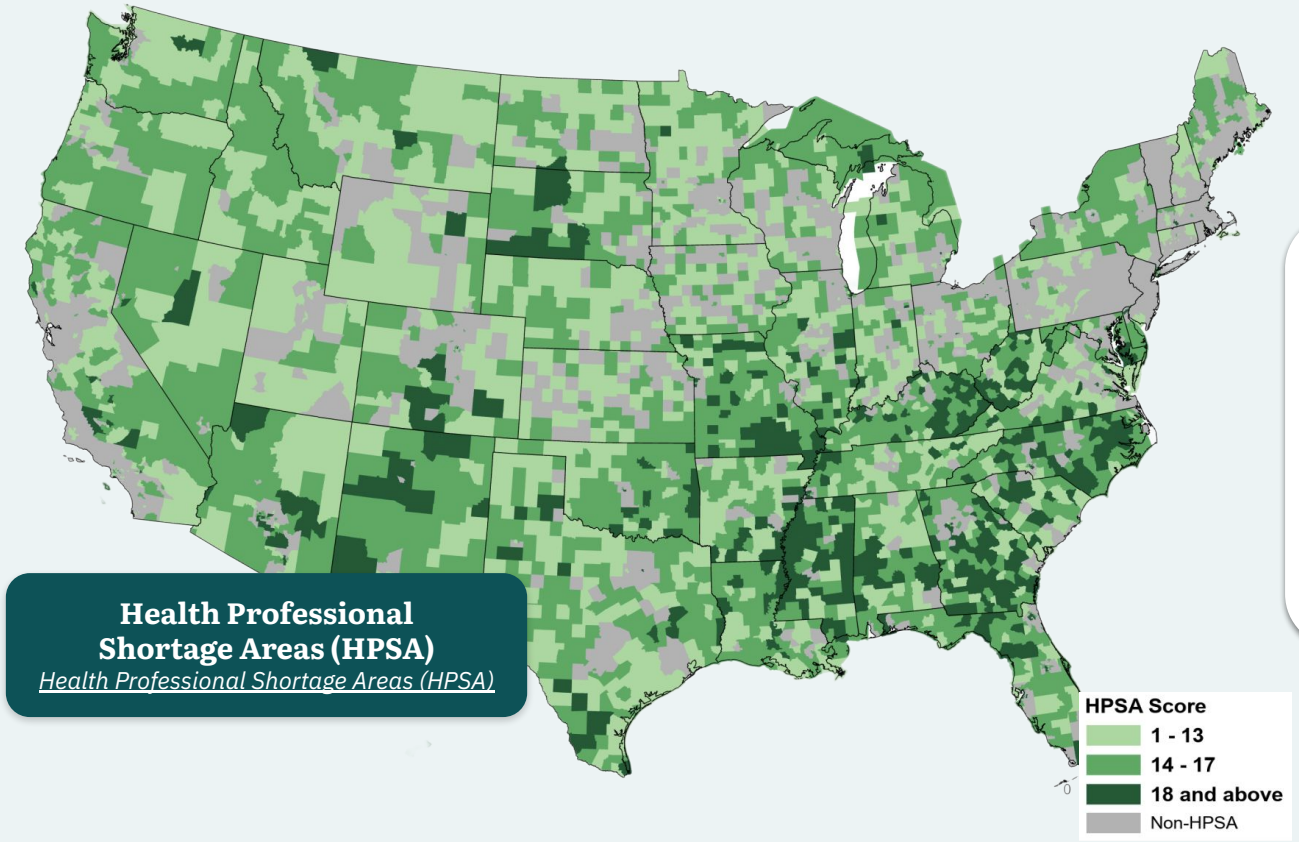
270+
Contracts***

68
MSSP ACOs*

46
States + D.C.*

*Scale as of 3/31/ 2026. The map shows primary locations for 2026 partner practices.
**Financials as of 12/31/ 2025
***As of 6/1/2026
Shared savings data based on internal analysis of data from 2024 CMS ACO Public Use File. Past performance is not indicative or future performance. Shared savings not guaranteed.

Aledade supports all communities through value-based care



Health Professional Shortage Areas (HPSA)
Health Professional Shortage Areas (HPSA)

of Aledade partners are in Primary Care Health Professional Shortage Areas

As of May 2025 internal analysis of data; HPSA

Delivering quality health outcomes

In 2024, Aledade's ACOs enabled primary care organizations to deliver more preventive care, resulting in better health outcomes and more satisfied patients.

92%

approval rating from patients of Aledade member practices

~171K

unnecessary hospitalizations and emergency department visits avoided

780K+

wellness visits between seniors and their primary care clinicians

84%

of patients agreed Aledade practices allowed them to get timely care and information

92%

also rated the office staff as helpful and courteous

83%

MSSP quality score

CAHPS Survey; 2024 CMS ACO Public Use File.

Recommendations on *Transforming Health Care Delivery Through Value-Based Care*

Aledade
Policy Institute

Focus on core principles, followed by precise recommendations

- Currently the paper outlines 22 specific recommendations that feel targeted to the “middle ground”

- A more compelling structure would be to start with a smaller set (3-5) of high level principles that ground the work, then follow with precise recommendations

Aledade
Policy Institute

Medicare Shared Savings Program (MSSP) should be the anchor

In the 2027 Proposed Physician Fee Schedule, CMS says:

"We have observed that when participation in (MSSP) increases, we see increases in both quality improvements for beneficiaries and increased savings to the Trust Funds.

(MSSP) has demonstrated improved quality performance over time and higher quality performance relative to other physician groups, suggesting that (MSSP) is achieving savings while improving quality of care."

The paper speaks to total cost of care models, but should give more attention to the flagship ACO program that has demonstrated success and that CMS continues to invest in, strengthen, and grow.

Aledade Policy Institute

Other considerations for the committee to focus on

Risk adjustment

All of the payment models rely on the same risk adjustment paradigm that is fundamentally broken

The committee should consider recommendations to improve risk adjustment and address some of the hindrances of the current model

Market forces

The lack of meaningful specialty engagement in models, for example, is more a market failure than a policy one

The committee should consider recommendations beyond incentives for specialists, as FFS remains too compelling

Patient safety

The committee should consider the CMS program, Partnership for Patients, to build on patient safety work, looking beyond the health care innovation awards to advance this work

Questions?

Aledade
Policy Institute

Session 4: *Expert Input on PTAC's Recommendations on Value-Based Care: Part 4*

Robert M. Wachter, MD

Professor and Chair, Department of Medicine,
University of California, San Francisco

AI and Value-Based Payment: A Presentation to PTAC

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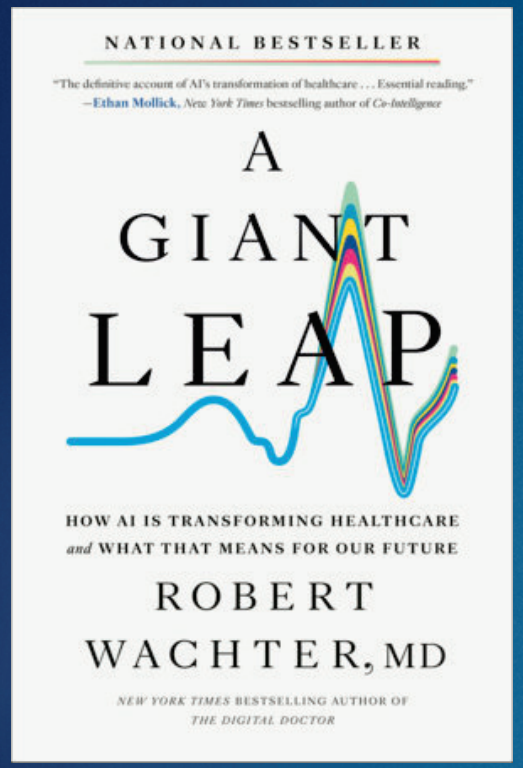
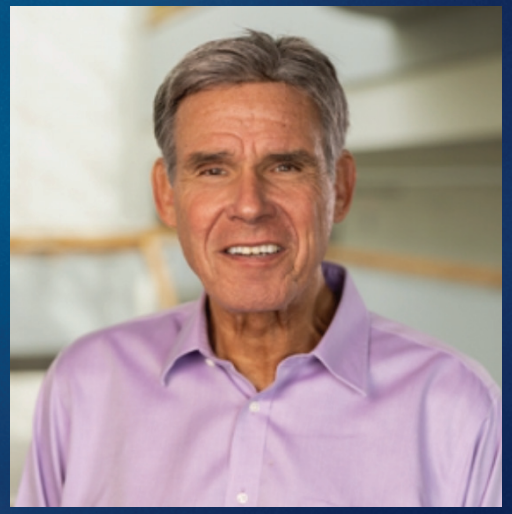
Author, *A Giant Leap: How AI is Transforming Healthcare – and What That Means for Our Future*



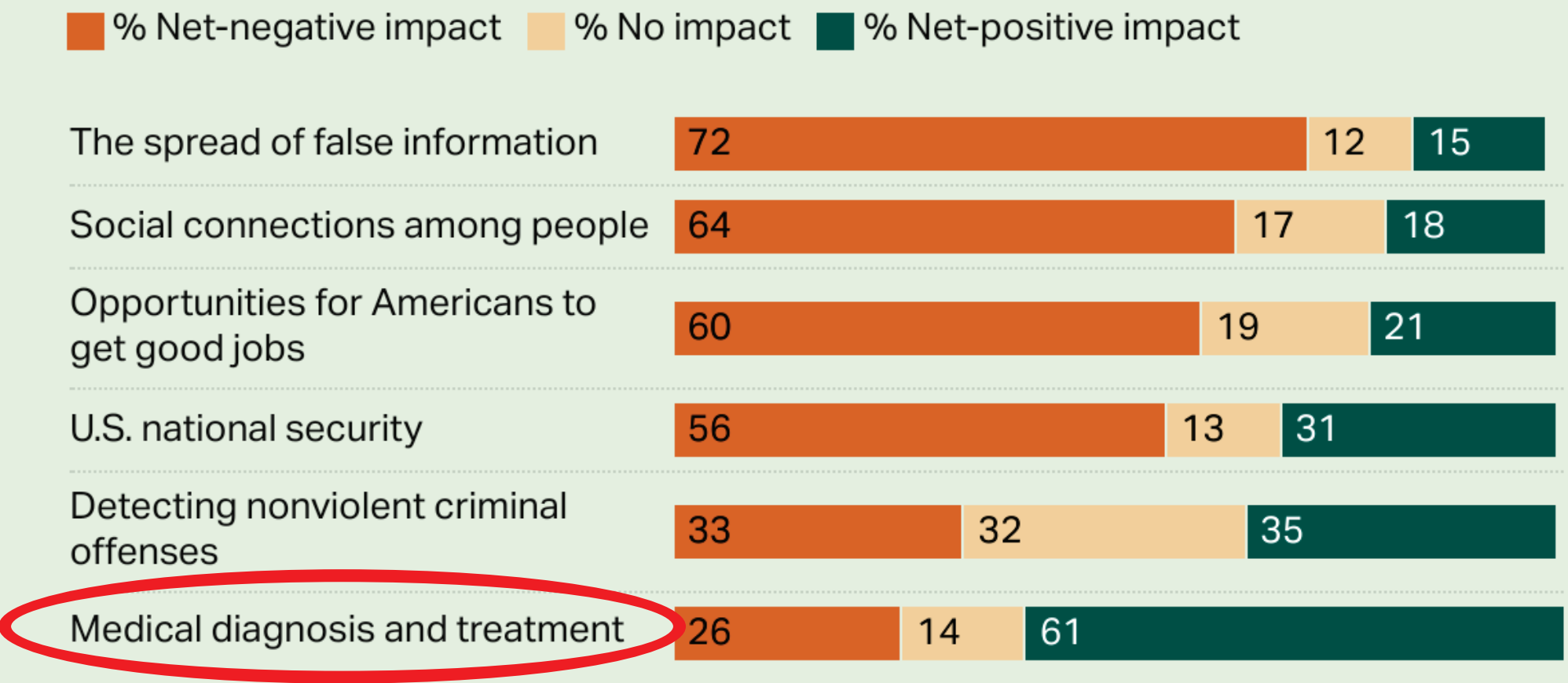
"An engaging hype-free case for **informed optimism**"

Eric Topol, MD
Bestselling author of *Super Agers* and *Deep Medicine*



Americans Have More Negative Than Positive Views About AI's Potential Impact on U.S. Society

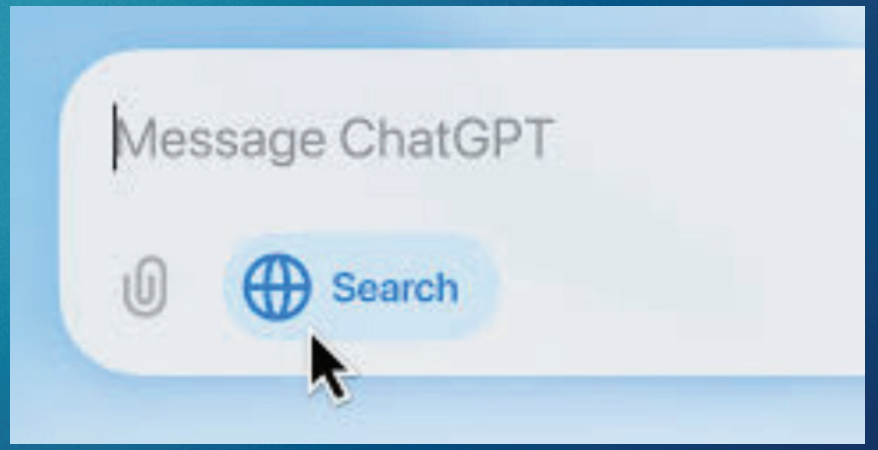
In the next five years, do you believe that AI will have a positive or negative impact on … ?



Gallup 2025

Other Industries Didn't *Need* AI to Rescue Them…

- No one *needed* a better search tool than Google



…But Healthcare *Needs* AI: 1) Clinical Documentation

…But Healthcare *Needs* AI: 2) The Medical Record

JAMIA Open, 2024, **7(2)**, ooae039
https://doi.org/10.1093/jamiaopen/ooae039
Research and Applications

AMIA INFORMATICS PROFESSIONALS. LEADING THE WAY.

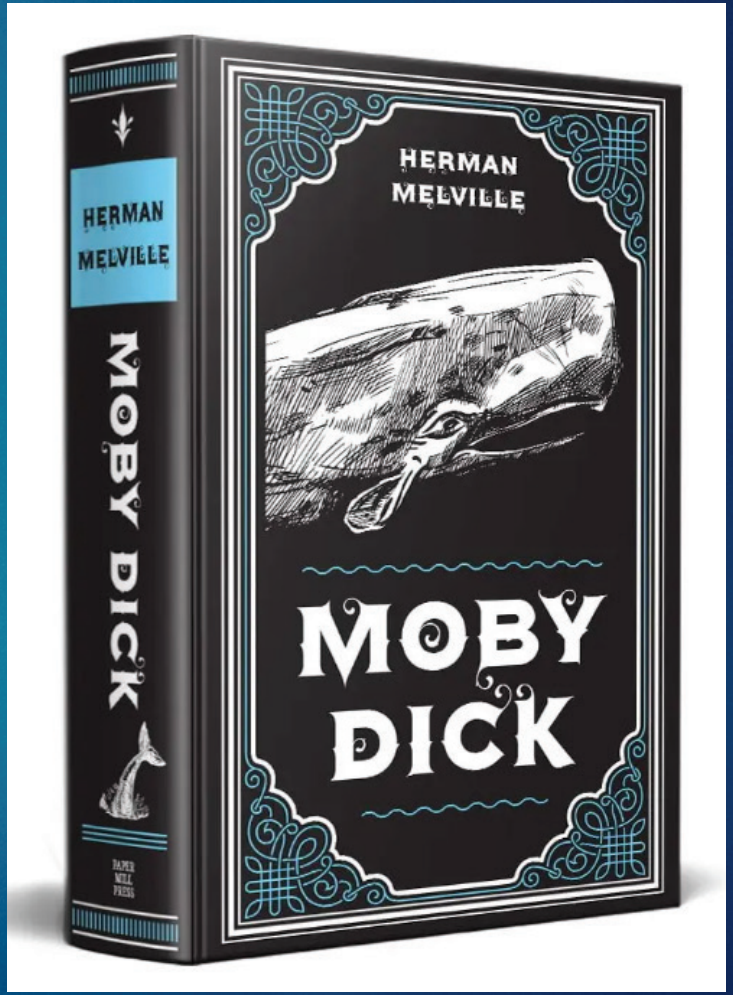
OXFORD

Research and Applications

Call me Dr Ishmael: trends in electronic health record notes available at emergency department visits and admissions

Brian W. Patterson, MD, MPH[1,2,3,*], Daniel J. Hekman, MS[1], Frank J. Liao, PhD[1,2], Azita G. Hamedani, MD, MBA[1], Manish N. Shah, MD, MPH[1,4,5], Majid Afshar, MD, MS[4]

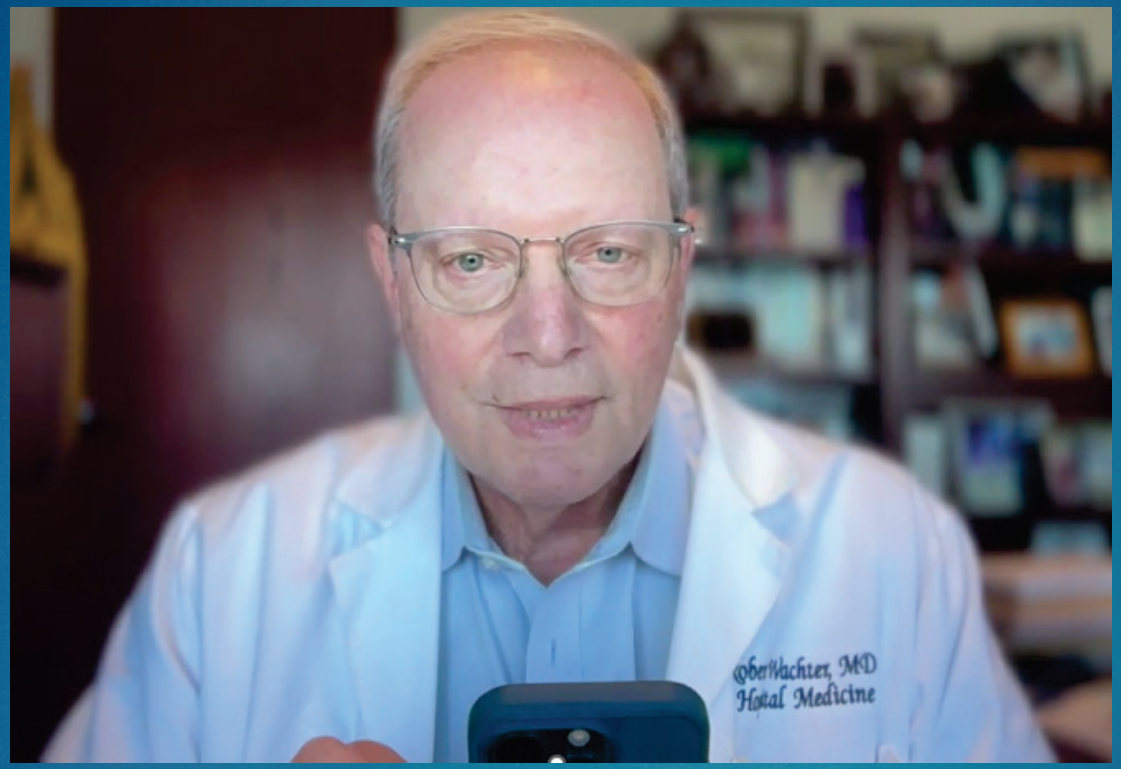
[1]BerbeeWalsh Department of Emergency Medicine, School of Medicine and Public Health, University of Wisconsin-Madison, Madison, WI



…But Healthcare *Needs* AI:
3) The Medical Literature

~8,000 medical articles per day

Today's AI is Pretty Darn Good



Transcript

Doctor:
Hi, I'm taking care of a 35-year-old woman who presents with two days of shortness of breath, pleuritic chest pain, and a swollen left leg. She smokes, takes oral contraceptives, and had a tibial fracture that was traumatic 2 months ago that left her immobilized until last week.

What do you think is going on?

AI:
Searching the medical databases. Checking the clinical guidelines.

Acute pulmonary embolism with a left leg DVT is by far the most likely diagnosis. She has essentially every major provoking factor stacked together recent tibial fracture, prolonged immobilization, estrogen contraceptives, and smoking. Plus, the classic triad of dyspnea, pleuritic pain, and unilateral leg swelling. Her pretest probability is high, so skip the D-dimer and go straight to CT pulmonary angiography with a leg compression ultrasound to confirm the DVT.

Get an ECG and troponin to assess right heart strain and to keep acute coronary syndrome, aortic dissection, pneumonia, and pneumothorax on the radar, though those are much less likely here. If she's stable, start anticoagulation with a direct oral anticoagulant. If she's hypotensive, treat as high-risk PE and activate your PE response team for possible thrombolysis.

Doctor:
What's the point of getting the leg ultrasound if I'm getting a CT of the chest anyway, if I find she has PE? Won't I assume that she has a DVT? And if her DVT ultrasound is negative, does that really lower the probability of pulmonary embolism?

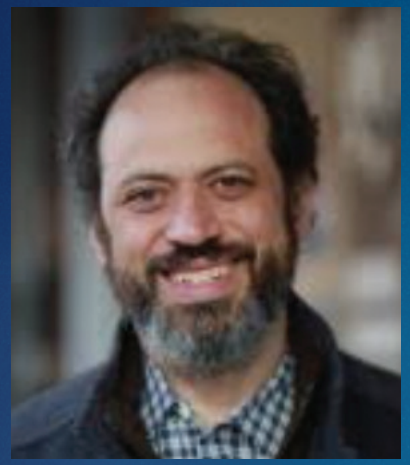
AI:
Looking into the clinical data. Good instinct.

If CT pulmonary angiography confirms PE, you don't need the leg ultrasound to make treatment decisions since the anticoagulation is the same regardless of whether you image the clot in the leg. Its real value is when CT is non-diagnostic, contraindicated, or negative, but suspicion stays high. A positive leg ultrasound then lets you treat without further chest imaging.

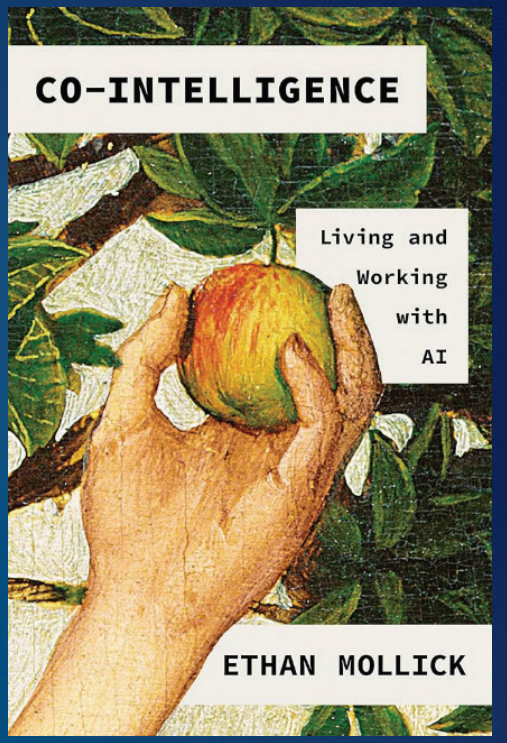
And you're right that a negative leg ultrasound does not rule out PE because many emboli have already left the leg or came from pelvic veins, so it can't lower your probability meaningfully in this high pretest patient. So if you're getting the CT anyway, the ultrasound is optional up front.

Doctor:
Great, thanks very much.

Ethan Mollick's Rule



Assume that the AI you're using today is the worst AI you'll ever use



Three Topics to Cover Briefly

- 1) The Cost Paradox
  - AI can raise or lower costs, depending on what payment game is being played
- 2) The business case for AI
  - There may not be much of one under FFS
- 3) AI to the rescue for VBP
  - Improvements in quality measurement
  - Improvements in risk adjustment, critical for VBP plans
  - Improvements in attribution and care coordination

The Cost Paradox

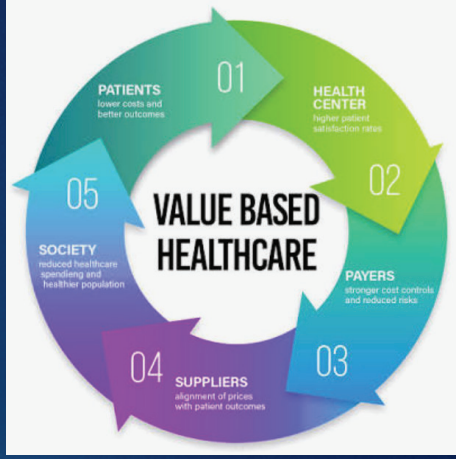
PETERSON HEALTH TECHNOLOGY INSTITUTE

Administrative AI: Current Use and Potential Impact

INDUSTRY INSIGHT | APRIL 2026

- One of AI's promises has been to lower total cost of care
  - Through fewer tests, less administrative waste, better prevention, labor substitution, clinical decision support guiding providers to cost-effective options
- Evidence to date: AI is ***raising*** the cost of care
  - "Better" billing, arming providers for the prior auth war, more findings leads to more work-ups, plus the cost of AI itself

How AI Could Help in a VBP Environment



- By scribing the current note and "reading" the chart, gen AI creates opportunity for improved quality and safety measurement
  - Far better than the Garbage In-Garbage Out when using administrative claims data
- Risk adjustment can also be improved by "reading" the chart (including notes, labs, x-rays)
  - Will still require strong auditing, since gaming will now focus on the notes in the chart rather than the documented diagnoses and complications
- AI could also help in operationalizing value-based care
  - Facilitating panel management, closing care gaps, real time risk assessment, changing patient behavior

Pricing AI Under FFS: Problematic

- Under FFS, healthcare organizations and AI companies want separate reimbursement for AI tools
  - While this may make sense at times, ideally, the overarching incentives would drive HCOs to wisely purchase and implement AI
  - Over time, AI-enabled tools and agentic AI will be so ubiquitous that the concept of separate payments will be silly
    - Like buying a car and paying separately for AI-enabled brakes, wipers, and cruise control. At some point, it needs to be embedded in a bundle

The Bottom Line

- AI is here to stay in healthcare
  - Though there are obstacles: regulatory, stakeholder concerns, liability, and the general AI backlash
  - Plus, we'll inevitably have our Kit Kat moment
- AI creates our best opportunity to rethink payment system
  - By offering tools that can help facilitate VBP, as well as challenging the FFS system's way of paying for helpful adjunctive technologies
- Whether AI bends the cost curve may be the most important healthcare AI question of all
  - It's likely to do so only if we change how we pay for care