Session 1: *Expert Input on PTAC's Recommendations on Value-Based Care: Part 1*

Presenters:

Subject Matter Experts

- **Michael Chernew, PhD** – Professor of Health Care Policy, Department of Health Care Policy, and Director, Healthcare Markets and Regulation Lab, Harvard Medical School
- **John Whyte, MD, MPH** – Chief Executive Officer and Executive Vice President, American Medical Association (AMA)
- **Shawn Martin, MHCDS** – Executive Vice President and Chief Executive Officer, American Academy of Family Physicians (AAFP)
- **Jennifer Podulka, MPAff** – Senior Vice President, Federal Policy, America's Physician Groups (APG)

Session 1: *Expert Input on PTAC's Recommendations on Value-Based Care: Part 1*

Michael Chernew, PhD

Professor of Health Care Policy, Department of Health Care Policy,
and Director, Healthcare Markets and Regulation Lab,
Harvard Medical School

Reactions to:

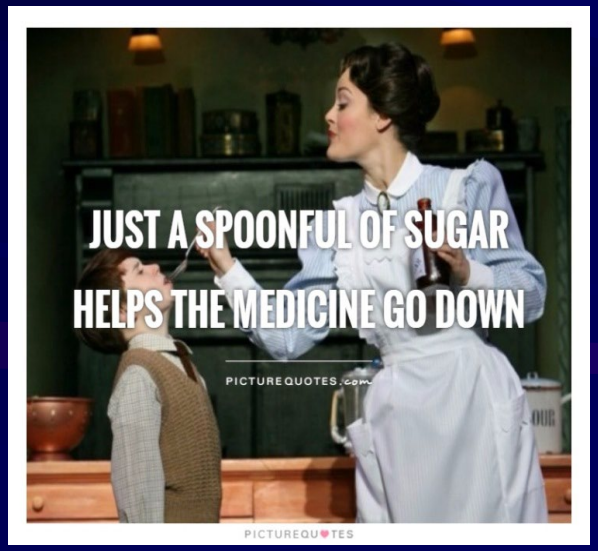
Transforming Health Care Delivery Through Value-Based Payment Models and Care: A Roadmap

Michael Chernew

Sept. 14 2026

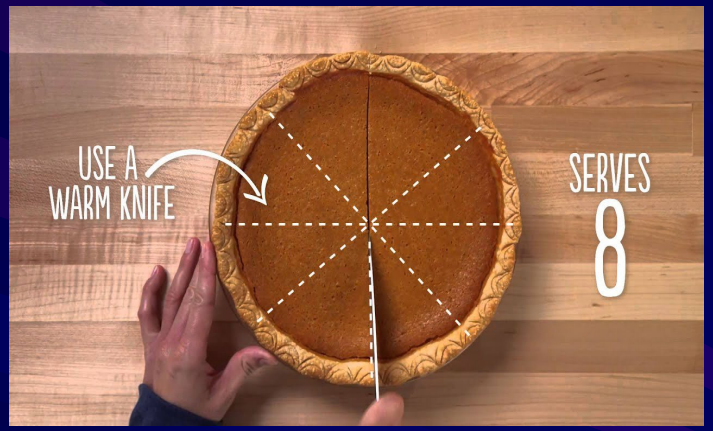
Disclaimer: The opinions presented represent my personal views and do not necessarily reflect the views of organizations I have been affiliated with

APMs are about risk transfer and flexibility in production



Waste is an asset: The ‘pie’ of savings is limited

- Different APMs assign gains from efficiencies to different stakeholders



- How waste is assigned affects incentives to save and participate

- APMS should be synergistic, default to pop-based, add synergistic episodes (or other models)

Policy Tension

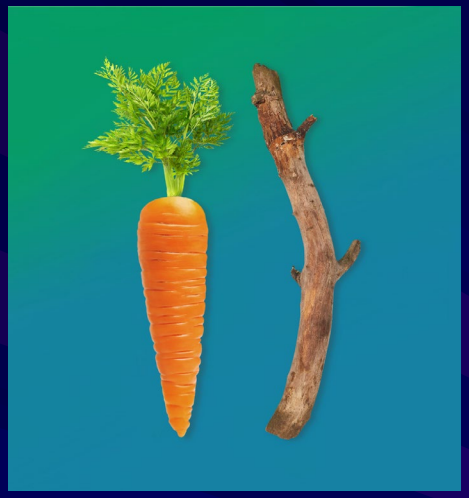
Main Thoughts RE APMs

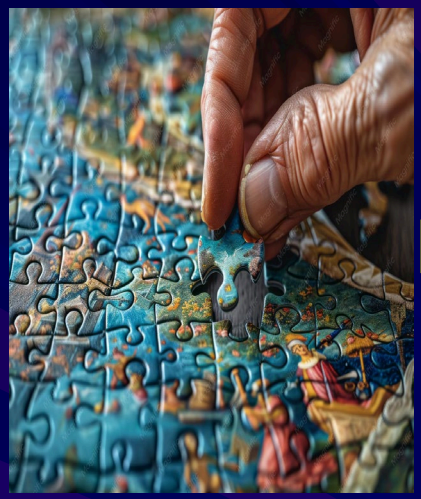
- APMs are a tool not an end
- APMs should minimize degree of micro management
  - We care about spending and outcomes not how we get there
- Avoid trying to do too much
  - Keep the APM landscape simple

Thoughts on Recs

- Urgency is fine, but doing too much may backfire (rec 1; rec 14; recs 16-17)
- Flexibility is key (🤷‍♂️ recs 2 & 19; 👍 recs 3 &4; rec 15)
- Models should be coordinated (👍 rec 9; 🤷‍♂️ recs 14& 21)
- Design is crucial
  - Benchmarks (👍 recs 5 -8;)
  - Performance (👍 recs 10-12; rec 20)
- Data is important (👍 rec 13; rec 18)

Supporting policies 👍





Reform MA

➔ else MA may swamp APMs

Incent participation

➔ Mandatory helps

➔ Remove unrelated carrots (GME or wage reclass)

Harmonize/ simplify models

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John Whyte, MD, MPH

Chief Executive Officer and Executive Vice President,
American Medical Association (AMA)

AMA
AMERICAN MEDICAL ASSOCIATION

Shaping our Value-Based Care Future

Leveraging Physician Expertise in the APM process

John Whyte, MD, MPH
CEO
American Medical Association

September 2026

American Medical Association
CEO

Internal Medicine physician

WebMD
Chief Medical Officer

Discovery Channel
VP of Health and Med Education

Officer at CMS, FDA

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Theme 1: Invest in patients

- Most APMs have focused on short term savings. The goal of APMs should be improving patient care, not short-sighted payment cuts.
- Investing in patient care improves management of underlying conditions for better outcomes. But transformation requires patience.
- APMs are built on an FFS infrastructure, but we need to strengthen.
- We need to fix these core issues *before* mandating participation.
- Re-evaluate the goals of each APM.

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Theme 2: Targeted model design

- Some practices types face disproportionate barriers to participating in existing APMs, such as:
  - Limited up-front resources
  - Infrastructure requirements
  - Outdated technology

- Many specialists don't have available models.

- **We need dedicated tracks or entire models designed with them in mind.**

- Also models for some patient populations (e.g. located in HPSAs or those with a certain diagnosis), which could stand to benefit from low-cost interventions.

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Theme 3: Make technology work for you

Technology has the potential to …

- **Reduce burden** through automated data extraction for quality reporting.
- **Improve care** through real-time medical checks, referrals and CDS
- **Engage patients** through RPM & wearable tech

But must be developed the <u>right way</u>.

- More data is *not* always better. Needs to be timely, relevant and accurate.
- Physician expertise is critical, especially when it comes to AI.
- Tech needs/abilities vary. Flexibility and interoperability are key
- Timely performance feedback not only in APMs, but MIPS too

Theme 4: Let physicians focus on patient care

- **Physicians must be freed to focus on patients, not paperwork, especially when they are held accountable for costs and outcomes.**
  - Quality reporting needs to be flexible & at “macro” level
  - Waivers from Stark Law, Anti-Kickback & other compliance requirements need to be clearer
  - PA need to be drastically cut back (or not at all)
- **As experts in patient care, physicians have ideas about what makes an APM successful.**
- AMA continues to press CMMI to engage physicians in model development and adopt physician-focused models.

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Shawn Martin, MHCDS

Executive Vice President and Chief Executive Officer,
American Academy of Family Physicians (AAFP)

AAFP

AAFP PERSPECTIVES

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

The AAFP's assessment of PTAC's draft white paper

Shawn Martin, Executive Vice-President and CEO

American Academy of Family Physicians

September 16, 2026

A roadmap worth building on

American Academy of Family Physician's assessment of 'Transforming Health Care Delivery Through Value-Based Payment Models and Care: A Roadmap'

The paper gets the fundamentals right.

Fee-for-service does not reward value. Sustainable transformation requires payment that supports longitudinal, relationship-based care.

It builds on the right foundation.

The answer isn't abandoning value-based care — it's improving and scaling the models that are working.

The care model is well grounded.

High-quality primary care, team-based care, coordination, prevention, and population health are foundational to family medicine.

The enabling conditions are appropriately identified.

Predictable payment, upfront investment, aligned incentives, and actionable data are what make transformation possible.

PTAC has provided a thoughtful roadmap that places primary care at the center of delivery system transformation — and offers practical recommendations for helping physicians succeed in value-based care.

Where AAFP strongly agrees

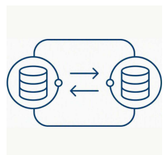
PTAC covers high-priority topics and real barriers family physicians face

High-quality primary care

High-touch, longitudinal, multidisciplinary care — the 4 Cs in practice.

Prospective payment

Payment structure that enables physicians to devote the necessary time to patient care, care management, behavioral health and other infrastructure when appropriately funded.



Data and interoperability

Real-time, patient-level clinical and claims data across care settings.

Meaningful measurement

Fewer, better measures focused on outcomes and patient experience.

Rural and small practices

Upfront investment and glide paths before practices assume risk.

Patient engagement

Safety and shared decision-making, central to relationship-based care.

Recommendations to strengthen

Three focus areas where PTAC's recommendations could go further

RECOMMENDATION

06

Prospective payment

Prospective payment isn't just about how physicians are paid — it's about what they're able to do. It funds the infrastructure behind prevention, coordination, behavioral health, and social needs – beyond historic FFS payment levels.

RECOMMENDATION

13

Real-time data sharing

Physicians need integrated clinical, claims, pharmacy, and social needs data in usable formats at the point of care — actionable data that reduces burden rather than adding to it.

RECOMMENDATION

14

Multi-payer alignment

Practices can't operate under dozens of different measures, attribution methods, and benchmarks. Alignment — including Medicare Advantage parity — is a prerequisite for transformation.

Where we'd urge caution

Areas that need additional considerations before they're scaled

Mandatory participation

We understand the rationale, but successful participation requires infrastructure, data access, technical assistance, risk adjustment, and financial support first.

Well-designed models shouldn't need to be mandatory.

Rural and Small Practice Support

As CMS centers value-based care on ACO participation, the advantages — data, infrastructure, care management, shared savings — compound over time.

Independent, small, and rural practices need glide paths – policymakers should make sure they're not left behind.

What we'd add for policymakers

Three priorities that would improve value-based care for family physicians

PRIORITY **1**

Primary care investment

Set clear goals for increasing the amount of healthcare spending devoted to primary care. Payment reform should enable greater investment in primary care capabilities and infrastructure, not simply recreate today's funding levels through different payment mechanisms.

PRIORITY **2**

Expand the technology discussion

Emphasize transparency, interoperability, responsible AI adoption, human oversight, and reduction of administrative workload. Technology and AI should support clinical decision-making while remaining under physician oversight.

PRIORITY **3**

Clear expectations for multi-payer alignment

Promote greater alignment in patient attribution, risk adjustment, quality measurement, and data-sharing requirements. Clear and consistent standards would reduce administrative burden, improve accountability, and enable physicians to focus on care transformation rather than navigating payer-specific requirements.

CLOSING STATEMENT

An important blueprint for the future

We strongly support the paper's emphasis on primary care, prospective payment, interoperability, meaningful measurement, and patient-centered care. As policymakers move forward, we encourage an even stronger focus on primary care investment, administrative simplification, data interoperability, and multi-payer alignment.

Transformation will succeed only if family physicians have the resources, flexibility, and support necessary to deliver the comprehensive, coordinated care patients deserve.

AAFP

Thank you

Session 1: *Expert Input on PTAC's Recommendations on Value-Based Care: Part 1*

Jennifer Podulka, MPAff

Senior Vice President of Federal Policy,
America's Physician Groups (APG)

APG's Comments on PTAC's Draft White Paper, "Transforming Health Care Delivery Through Value-Based Payment Models and Care: A Roadmap"

SEPTEMBER 14, 2026

Jennifer Podulka, MPAff
Senior Vice President of Federal Policy
America's Physician Groups

AMERICA'S PHYSICIAN GROUPS

AMERICA'S PHYSICIAN GROUPS

Jennifer Podulka, MPAff

Jennifer Podulka serves as the senior vice president of federal policy for America's Physician Groups (APG). In this role, she works with federal agencies to advance APG's policy perspectives on behalf of APG's members, focusing on the alternative payment models in which they participate.

Ms. Podulka has published numerous studies and presented to national audiences on such as physician payment policy, CMMI models, Medicare Advantage, value-based care, prescription drugs, and the federal budget and broader health care system.

Previously, she advised Congress on payment and policy options as a staff member for *MedPAC* and the *Government Accountability Office*. She also held positions with the *National Quality Forum*, *Truven Health Analytics*, *Acumen, LLC, and HMA*.

She earned her B.A. in government and MPAff in Public Affairs from the University of Texas, Austin.

America's Physician Groups

APG is a national membership organization that represents more than 300 physician groups nationwide committed to value-based care

APG groups comprise roughly 260,000 physicians and other clinicians providing care to nearly 90 million patients, including an estimated 1 in 4 Americans and 1 in 3 Medicare Advantage enrollees.

Member organizations participate in a wide range of alternative payment models, including the Medicare Shared Savings Program, multiple models created by CMMI, managed Medicaid, and commercial ACOs, among others.

APG's motto, 'Taking Responsibility for America's Health,' represents our members' commitment to clinically integrated, coordinated, value-based healthcare in which physician groups are accountable for the costs and quality of patient care.

Visit us at: www.apg.org

OVERALL ASSESSMENT

A Valuable Roadmap, Grounded In Evidence — But Sharpening Of Some Recommendations Is Needed

APG commends PTAC for a roadmap built on 10 years of proposal review, 250+ expert presentations, and real participation data.

OVERALL ASSESSMENT

AMERICA'S PHYSICIAN GROUPS

- The PTAC paper's core focus — evolve and refine value-based care rather than retreat from the progress made to date— matches APG's own position as set forth in multiple communications, including our March 2025 report, *Medicare Done Right: Prescriptions For Success.**

- The PTAC paper's emphasis on population-based total cost of care (PB-TCOC) models as the primary vehicle for transformation resonates fully with our physician-led member organizations, which have demonstrated that such models are cost-efficient and produce superior outcomes for patients.

- The PTAC paper will be most effective in persuading and motivating policymakers in its recommendations for clear, actionable policies, such as fixing ACO benchmarks and adopting prospective payment and glide paths for evolution. When it simply states high-level principles, it risks being read as aspirational only, rather than offering a clear and specific roadmap for change.

*See report at https://www.apg.org/wp-content/uploads/2025/04/Medicare-Done-Right-Final-4.1.25.pdf

The Paper Is Comprehensive In Its Recommendations For Traditional Medicare, But Is Largely Silent On Medicare Advantage

AMERICA'S PHYSICIAN GROUPS

APG recommends that the paper reflect the CMMI's anticipated MA models.

- The white paper's focus areas — payment, participation, measurement, enablers, rural access, technology, and patient safety — give policymakers a genuinely complete picture of what it takes to scale accountable care in traditional Medicare.

- However, the paper is framed as a roadmap for "value-based payment models and care" broadly, while its recommendations address only traditional Medicare's ACOs and APMs and not value-based arrangements in MA.

- Most Medicare beneficiaries — 55% of those eligible because they are enrolled in Parts A and B — are now in MA, and that share appears to be growing. APG members participating in two-sided risk arrangements between plans and physician groups have clearly demonstrated their ability to produce superior outcomes.* A roadmap that is silent on the role of such MA models in value-based care would omit the part of Medicare in which accountable care is already most advanced.

*See Appendix slide #13 for references.

AMERICA'S PHYSICIAN GROUPS

Six Recommendations That APG Strongly Supports

1) Flexibility for accountable entities (Rec. 4) — enabling TCOC to manage care is essential to solving fee-for-service downsides.

2) Fixing the benchmark "ratchet effect" (Rec. 5–6) — the issue that APG has raised most consistently with CMS, since long-term, predictable benchmarks are foundational to sustaining participation.

3) Prospective, upfront payment (Rec. 6) — matches our call for advance investment payments, especially for smaller and safety-net practices building risk-bearing infrastructure.

Six Recommendations That APG Strongly Supports

4) A simple glide path to two-sided risk (Rec. 7) — this is the realistic on-ramp that new entrants need, and one that APG has asked CMS to formalize.

5) Encourage specialist engagement by nesting accountability into TCOC models (Rec. 9) — this is the best option at this stage of model development.

6) Trimming and aligning performance measures (Rec. 10–11) — APG's members directly experience the burden of the existence of 618 measures across 24 Medicare programs, 61% of which are used nowhere else.

AMERICA'S PHYSICIAN GROUPS

Six Recommendations To Sharpen

1) Protect physician-led accountability (Rec. 3, 8). The paper notes that physician-led ACOs drive savings while integrated delivery systems often have little incentive to participate. New pathways to bring IDS's into ACOs should not come at the cost of the accountability standards that physician-led ACOs already meet.

2) Expand on "long-term predictability" with a defined benchmark methodology (Rec. 5). This recommendation is directionally correct, but policymakers need a specific, published approach — not a principle — on which to act.

3) Calibrate any move to mandatory participation. The Supporting Policies section raises mandates as a remedy for selection bias; APG agrees that incentives should scale with organizational size and readiness, but small and independent practices need funded on-ramps before any requirement, not after.

Six Recommendations To Sharpen

4) Link enablers to role in providing a pathway for greater participation (Rec. 8).

5) Recognize real-world data limitations in certain electronic health record systems (Rec. 11); because of them, not all groups are equipped to collect and report quality measures using EHRs.

6) Clarify the patient-safety earn-back model (Rec. 21) for ambulatory, physician-led entities; as written it reads as hospital-centric.

Additional Recommendations That PTAC Should Consider

AMERICA'S PHYSICIAN GROUPS

Drawing on APG's own Medicare Done Right *recommendations, three additions would make this roadmap more complete:*

1) Address MA risk arrangements explicitly; recommend that CMS actively encourage more two-sided risk relationships between MA plans and providers, not just traditional Medicare ACOs.

2) Align risk adjustment and performance data across MA, MSSP, and other TCOC models. Accountable entities operating in both arms of the program need one consistent, credible source of truth on patient risk and outcomes.

3) Redesign the Advanced APM bonus as a flat dollar amount per attributed beneficiary, rather than a percentage of fees. The current design skews away from primary care and even rewards specialists unevenly, skewing further toward the better-paid ones.

In Sum: Sharpen, Don't Soften

- Keep the paper's core direction — evolve and expand PB-TCOC models rather than retreat from value-based care.
- Pair its strongest principles — fair benchmarks, prospective payment, glide paths — with specific, actionable recommendations and methodology.
- Protect the physician-led accountability that the existing evidence, which the paper cites, is driving savings today.
- Extend the roadmap to MA, where most Medicare beneficiaries are enrolled and where much of the risk-bearing innovation is already taking place.

AMERICA'S PHYSICIAN GROUPS

THANK YOU

APG looks forward to continuing to work with PTAC to strengthen this roadmap for policymakers.

Jennifer Podulka, MPAff
Senior Vice President of Federal Policy
America's Physician Groups

APPENDIX

AMERICA'S PHYSICIAN GROUPS

APG physician groups demonstrated the superior outcomes achieved for Medicare Advantage enrollees in two-sided risk arrangements in the following papers:

- Cohen, K. R., B. Vabson, J. Podulka, N. J. Smith, E. Everhart, O. Ameli, K. Catlett, M. S. Jarvis, C. Goldzweig, J. H. Kuo, and S. Dentzer. 2025. Medicare risk arrangement and use and outcomes among physician groups. JAMA Network Open 8(1):e2456074. https://doi.org/10/1001/jamanetworkopen.2024.56074
- Vabson B, Cohen K, Ameli O, et al. Potential spillover effects on traditional Medicare when physicians bear Medicare Advantage risk. Am J Manag Care. Published online February 26, 2025. https://doi:10.37765/ajmc.2025.89686
- Cohen K, Vabson B, Podulka J, et al, Health Outcomes in Full Risk Medicare Advantage versus Traditional Medicare. Am J Manag Care. Published online May 9, 2025 (volume 31). https://doi:10.37765/ajmc.2025.89740
- Cohen K, Vabson B, Podulka J, et al, Health Outcomes of Dually Eligible Beneficiaries Under Different Medicare Payment Arrangements. Am J Manag Care. 2026; 23(5):26270. https://doi.org.10.37765/ajmc.2026.89827
- Cohen K, Catlett K, Podulka J, Health Outcomes of Socially Vulnerable Populations in Different Medicare Payment Arrangements. Am J Manag Care. 2026;32(5):262-270. https://doi.org/10.37765/ajmc.2026.89827