Physician-Focused Payment Model Technical Advisory Committee

October 16, 2025

Robert F. Kennedy Jr., Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Kennedy:

On behalf of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), we are pleased to submit PTAC's report on Reducing Barriers to Participation in Population-Based Total Cost of Care (PB-TCOC) Models and Supporting Primary and Specialty Care Transformation. Section 1868(c) of the Social Security Act directs PTAC to: 1) review physician-focused payment models (PFPMs) submitted to PTAC by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary.

PTAC's March 2025 public meeting focused on reducing barriers to participation in PB-TCOC models and supporting primary and specialty care transformation. The information that PTAC has gleaned from a review of previous PFPM proposals, other literature that addressed this important topic, as well as input received from the subject matter experts who participated in the public meeting has informed the Committee's comments, which are summarized in the following broad topic areas in this report:

- Topic 1: Addressing Provider Economics and Uncertainty;
- Topic 2: Incentivizing High-Value Care;
- Topic 3: Designing Value-based Care Models to Encourage Provider Participation; and
- Topic 4: Promoting Competitiveness in Value-based Care.

Key highlights include:

- Participation in APMs must be financially viable for providers to be able and willing to participate.
    - It is essential that value-based care models allow for long-term financial stability and predictability.
    - Timely incentive payments and a steady cash flow to providers are needed.
    - Upfront payments are necessary for providers to invest in the infrastructure, technology, and resources required to support the transition to value-based care.
- Payment model design should promote high-value care through an emphasis on holistic, coordinated, team-focused, and patient-centered care.
    - Artificial intelligence (AI), such as ambient listening and transcription tools, may promote provider efficiency and high-value care.
    - Provider performance measures should focus on patient outcomes that reflect positive results, such as attainment of a patient's goals of care.
- APMs should be simple, standardized, and easy to implement; have sufficient lead time for providers to prepare; and run for a reasonably long period.
    - Flexibility in model design, including payment approaches such as use of global budgets, is needed to promote participation among some types of providers (e.g., small and rural practices).
    - Technical assistance can facilitate providers' adoption of and implementation of APMs.
    - Conveners—intermediaries that bring together and assist providers with implementing value-based care models—can reduce barriers to APM participation, particularly for providers with limited resources and lower risk tolerance.
- Multi-payer alignment in value-based care may be needed to shift providers away from fee-for-service and Medicare Advantage.
    - APM design—including the incentive structure and risk adjustment method—should be modified to be more consistent and competitive with Medicare Advantage plans.
    - Models that involve multiple payers (e.g., Medicare, Medicaid, and commercial) may be necessary to deliver the patient volume that practices need to generate sufficient financial rewards from APMs.
    - A streamlined cross-payer model can minimize value-based care participation costs.

- Benchmarks—providers' financial and performance targets under value-based care— must be carefully structured to promote APM participation and retention among providers.
    - Having stable and predictable benchmarks is important for providers to effectively manage their businesses.
    - Benchmarking design should address challenges by avoiding the "ratchet effect" whereby resetting benchmarks makes them increasingly difficult to attain over time, ensuring that predicted cost trends that are used to establish benchmarks are valid and accurate, and utilizing comprehensive and robust patient risk- adjustment methods.
- Specialist integration in value-based care is critical.
    - Models should prioritize opportunities to integrate specialists, such as attributing patients to specialists when appropriate and nesting payments for episodes of specialty care within total cost of care (TCOC) models.
    - APMs could incentivize a more holistic and proactive approach to specialty care.
    - Tools could be developed to better support primary care provider (PCP) referrals to specialists and to provide greater opportunity for PCPs and patients to compare specialists.

In addition to summarizing the Committee's findings and comments related to these topics, the report also identifies areas where additional research is needed, issues for policy makers, and some potential next steps.

The members of PTAC appreciate your support of our shared goal of improving the Medicare program for both beneficiaries and the physicians who care for them. PTAC members would be happy to discuss any of these observations with you. However, the Committee appreciates that there is no statutory requirement for the Secretary to respond to these comments.

Sincerely,

// Terry Mills//

Terry L. Mills Jr., MD, MMM
Co-Chair

//Soujanya Pulluru//

Soujanya R. Pulluru, MD
Co-Chair

Attachment

Physician-Focused Payment Model Technical Advisory Committee

REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

Reducing Barriers to Participation in Population-Based Total Cost of Care (PB-TCOC) Models and Supporting Primary and Specialty Care Transformation

OCTOBER 16, 2025

About This Report

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to: 1) review physician-focused payment models (PFPMs) submitted by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary. PTAC reviews submitted proposals using criteria established by the Secretary in regulations at 42 CFR §414.1465.

Within this context, from time to time, it may be beneficial for PTAC to reflect on proposed PFPMs that have been submitted to the Committee to provide further advisement on pertinent issues regarding effective payment model innovation in Alternative Payment Models (APMs) and PFPMs. Given that, in the past, at least 18 of the proposals that have been submitted to PTAC met both Criterion 1 (Scope) and Criterion 2 (Quality and Cost), including several proposals that were directly related to promoting accountable care and/or proposed to use waivers to reduce barriers related to participation in APMs, PTAC now sees value in reviewing these elements in previously submitted proposals related to this topic, along with current information on reducing barriers to participation in APMs. To ensure that the Committee was fully informed, PTAC's March 2025 public meeting included a theme-based discussion on reducing barriers to participation in APMs and supporting primary and specialty care transformation.

This report summarizes PTAC's findings and comments regarding reducing barriers to participation in APMs. This report also includes: 1) areas where additional research is needed and some potential next steps; 2) a summary of the characteristics related to reducing barriers to participation in APMs from proposals that have previously been submitted to PTAC; 3) an overview of key issues relating to reducing barriers to participation in APMs and value-based care transformation; and 4) a list of additional resources related to this theme-based discussion that are available on the Assistant Secretary for Planning and Evaluation (ASPE) PTAC website.

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SUMMARY STATEMENT

From 2016 to 2020, PTAC received 35 proposals for PFPMs and voted on the extent to which 28 of these proposals meet the Secretary's 10 regulatory criteria. Nearly all of the 35 proposals that were submitted to PTAC addressed the proposed model's impact on quality and costs to some degree. Since 2022, PTAC has been conducting a series of theme-based discussions to explore care delivery and payment issues related to developing and implementing population-based total cost of care (PB-TCOC) models, including issues related to identifying a pathway toward maximizing participation in PB-TCOC models and addressing the needs of high-cost patients with complex chronic conditions or serious illnesses. Key themes that emerged from these meetings related to approaches to reduce barriers to participation in APMs and approaches to support primary and specialty care transformation. Additionally, at least 18 of the proposals that have been submitted to PTAC met both Criterion 1 (Scope) and Criterion 2 (Quality and Cost), including several proposals that were directly related to promoting accountable care and/or proposed to use waivers to reduce barriers related to participation in APMs.

For this reason, PTAC now sees value in further exploring elements in previously submitted proposals related to this topic, along with current information on reducing barriers to participation in APMs. To ensure that the Committee was fully informed, the Committee conducted a theme-based discussion on this topic during PTAC's two-day March 2025 public meeting. The theme-based discussion included an overview presentation by PTAC members, listening session presentations by previous submitters and other subject matter experts (SMEs), as well as panel discussions with other SMEs related to reducing barriers to participation in APMs and supporting primary and specialty care transformation. PTAC also requested public input during the meeting and through a Request for Input (RFI).

This report provides PTAC's findings and valuable information on best practices for reducing barriers to participation in APMs and supporting primary and specialty care transformation. The information that PTAC has gleaned from a review of previous PFPM proposals and other literature that addressed this important topic, as well as input received during the theme-based discussion, will help to inform PTAC in its review of future proposals. This material has informed the Committee's comments, which are summarized in the following broad topic areas in this report:

- Topic 1: Addressing Provider Economics and Uncertainty;
- Topic 2: Incentivizing High-Value Care;
- Topic 3: Designing Value-based Care Models to Encourage Provider Participation; and
- Topic 4: Promoting Competitiveness in Value-based Care.

Key highlights include:

- Participation in APMs must be financially viable for providers to be able and willing to participate.
    - It is essential that value-based care models allow for long-term financial stability and predictability.
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- APMs should be simple, standardized, and easy to implement; have sufficient lead time for providers to prepare; and run for a reasonably long period.
    - Flexibility in model design, including payment approaches such as use of global budgets, is needed to promote participation among some types of providers (e.g., small and rural practices).
    - Technical assistance can facilitate providers' adoption of and implementation of APMs.
    - Conveners—intermediaries that bring together and assist providers with implementing value-based care models—can reduce barriers to APM participation, particularly for providers with limited resources and lower risk tolerance.
- Multi-payer alignment in value-based care may be needed to shift providers away from fee-for-service and Medicare Advantage.
    - APM design—including the incentive structure and risk adjustment method—should be modified to be more consistent and competitive with Medicare Advantage plans.
    - Models that involve multiple payers (e.g., Medicare, Medicaid, and commercial) may be necessary to deliver the patient volume that practices need to generate sufficient financial rewards from APMs.
    - A streamlined cross-payer model can minimize value-based care participation costs.
- Benchmarks—providers' financial and performance targets under value-based care—must be carefully structured to promote APM participation and retention among providers.
    - Having stable and predictable benchmarks is important for providers to effectively manage their businesses.

    - Benchmarking design should address challenges by avoiding the "ratchet effect" whereby resetting benchmarks makes them increasingly difficult to attain over time, ensuring that predicted cost trends that are used to establish benchmarks are valid and accurate, and utilizing comprehensive and robust patient risk-adjustment methods.
- Specialist integration in value-based care is critical.
    - Models should prioritize opportunities to integrate specialists, such as attributing patients to specialists when appropriate and nesting payments for episodes of specialty care within total cost of care (TCOC) models.
    - APMs could incentivize a more holistic and proactive approach to specialty care.
    - Tools could be developed to better support primary care provider (PCP) referrals to specialists and to provide greater opportunity for PCPs and patients to compare specialists.

In addition to summarizing the Committee's findings and comments related to these topics, the report also identifies areas where additional research is needed, issues for policy makers, and some potential next steps.

I. PTAC REVIEW OF REDUCING BARRIERS TO PARTICIPATION IN APMS AND SUPPORTING PRIMARY AND SPECIALTY CARE TRANSFORMATION

In developing the comments in this report, PTAC considered information from the theme-based discussion during the March 2025 public meeting and an environmental scan developed to provide information on reducing barriers to participation in APMs and supporting primary and specialty care transformation. PTAC also considered an analysis that was conducted to examine trends in large integrated delivery system (IDS) participation in Medicare Accountable Care Organizations (ACOs).

PTAC formed a Preliminary Comments Development Team (PCDT) for the March 2025 theme-based discussion, which was comprised of James Walton, DO, MBA (Lead); Henish Bhansali, MD, FACP; Lawrence Kosinski, MD, MBA; and Walter Lin, MD, MBA (see Appendix 1 for a list of the Committee members). The PCDT reviewed the environmental scan and delivered a summary presentation to the full Committee during the theme-based discussion. The theme-based discussion included panel discussions with stakeholders from organizations that previously submitted PFPM proposals which related to promoting accountable care and/or reducing barriers to participation in APMs. The theme-based discussion also featured perspectives from a diverse group of SMEs, and an opportunity for public comments. At the end of the theme-based discussion, Committee members identified comments to be included in this Report to the Secretary (RTS).

The Committee synthesized information from PTAC proposals, the environmental scan, the Medicare ACO analysis, and panel discussions with a previous submitter and other SMEs during the March 2025 public meeting on reducing barriers to participation in APMs and supporting primary and specialty care transformation. This RTS summarizes PTAC's comments from its findings, which are organized in four topics:

- Topic 1: Addressing Provider Economics and Uncertainty;
- Topic 2: Incentivizing High-Value Care;
- Topic 3: Designing Value-based Care Models to Encourage Provider Participation; and
- Topic 4: Promoting Competitiveness in Value-based Care.

For each topic, relevant issues are highlighted, followed by a summary of PTAC's comments. Appendix 2 includes information about proposals that were previously submitted to PTAC which addressed issues related to reducing barriers to participation in APMs and supporting primary and specialty care transformation. Appendix 3 provides a list of additional resources related to PTAC's reducing barriers to participation in APMs theme-based discussion that are available on the Assistant Secretary for Planning and Evaluation (ASPE) PTAC website. Appendix 4 includes a complete list of the Committee's comments.

II. BACKGROUND: DEFINITIONS AND CONTEXT RELATED TO REDUCING BARRIERS TO PARTICPATION IN APMS AND SUPPORTING PRIMARY AND SPECIALTY CARE TRANSFORMATION

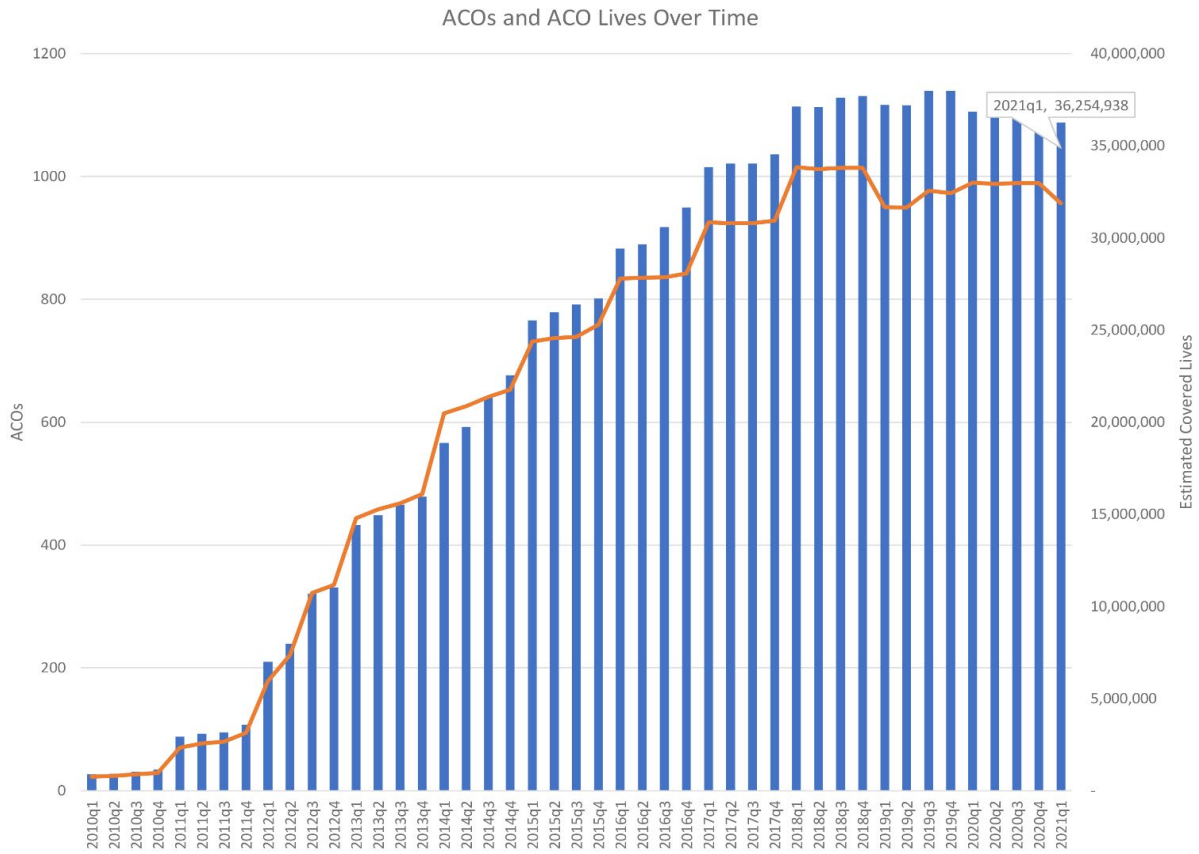
PTAC has developed the following working definition of an accountable care relationship:

- A relationship between a provider and a patient (or group of patients) that establishes that provider as accountable for quality and total cost of care (TCOC), including the possibility of financial loss/risk for an individual patient or group of patients for a defined period (e.g., 365 days).
- Would typically include accountability for quality and TCOC for all of a patient's covered health care services.

APMs have created value for Medicare. Between 2012 and 2022, selected Centers for Medicare & Medicaid Services (CMS) Innovation Center models generated total gross savings of $7.7–$11 billion. Additionally, the Medicare Shared Savings Program generated total gross savings of $23–$31 billion.[1]

Participation in Medicare APMs has plateaued in recent years (see Exhibit 1). A similar trend is occurring in APMs across all payers.[2]

Exhibit 1. Total Number of ACOs and ACO-Covered Lives, All Payers, 2010 to 2021 Q1



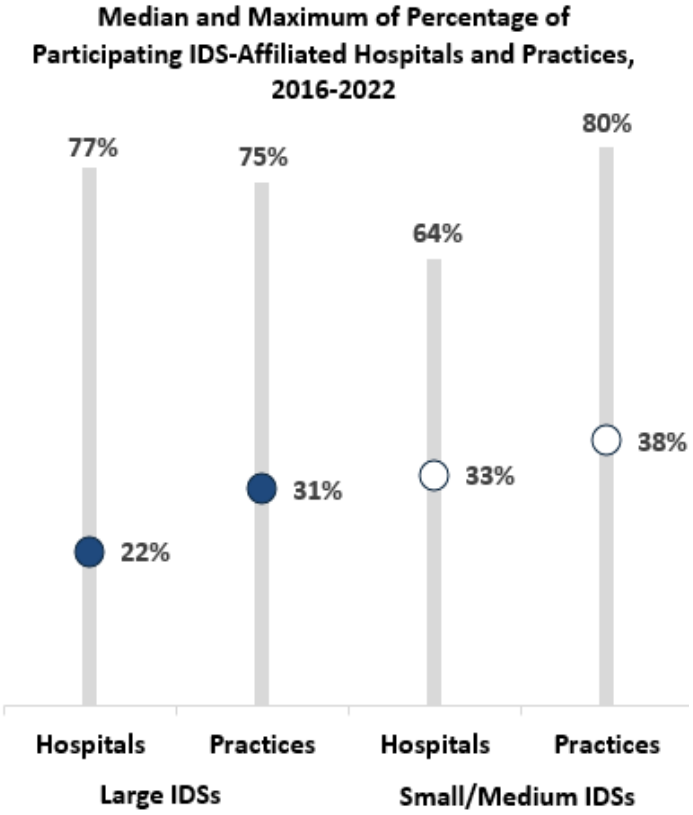
Source: Muhlestein et al., All-Payer Spread of ACOs and Value-Based Payment Models in 2021: The Crossroads and Future of Value-Based Care. Health Affairs Forefront. 2021.

Further, hospital and integrated delivery system (IDS) participation in ACOs has declined as the share of physician-led ACOs has risen. Hospitals and health systems led early ACO development from 2010-2015.[3] However, since 2016, physician groups have grown more rapidly compared with hospitals and health systems and account for the largest percentage of new ACOs.[4]

Increasing IDS participation in Medicare APMs is essential for achieving full provider participation in accountable care models. IDSs account for a significant proportion of the health care entities in many health care markets and possess the resources to provide high value, patient-centered care.[5] Further, physicians and hospitals are increasingly consolidating into larger health systems such as IDSs.[6,7]

A recent analysis by NORC at the University of Chicago, commissioned and presented by PTAC during the March 2025 public meeting, found that a high percentage of IDSs participated in Medicare ACOs by engaging at least some of their affiliated hospitals and group practices. However, the extent of IDS's engagement of their hospitals and practices in ACOs was low. As shown in Exhibit 2, approximately only one-third of IDS-affiliated hospitals and group practices were engaged in Medicare ACOs.

Exhibit 2. Median and Range of the Proportion of IDS-Affiliated Hospitals and Group Practices Engaged in Medicare ACOs, 2016-2022



Source: PTAC Preliminary Comments Development Team (PCDT) Findings Presentation, March 2025

III. CHARACTERISTICS OF PTAC PROPOSALS RELEVANT TO PROMOTING ACCOUNTABLE CARE AND/OR REDUCING BARRIERS TO PARTICIPATION IN APMS

From 2016 to 2020, PTAC received 35 proposals for PFPMs and voted on the extent to which 28 of these proposals meet the Secretary's 10 regulatory criteria, including "Scope" and "Quality and Cost."[i] The goal of the criterion on "Scope" is to "directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited" and the goal of the criterion on "Quality and Cost" is to "(1) improve heath care quality at no additional cost, (2) maintain health care quality while decreasing cost, or (3) both improve health care quality and decrease cost."

[i] The remaining seven proposals were withdrawn prior to the Committee's deliberation.

At least 18 of the proposals that have been submitted to PTAC met both Criterion 1 (Scope) and Criterion 2 (Quality and Cost), including several proposals that were directly related to promoting accountable care and/or reducing barriers related to participation in APMs. The 18 proposals were selected for an analysis of model features and characteristics that may promote accountable care and/or aid in reducing barriers to participation in APMs, including financial methodologies, use of waivers, approaches to incorporate multi-payer alignment, and approaches to specialty integration.

Of the 18 selected proposals, the target type of care or condition varied: five proposals focused on oncology, advanced illness, and/or end-of-life care across multiple settings of care; four proposals focused on delivering care in home and/or community-based settings; two proposals addressed primary care; two proposals addressed emergency department (ED) services in ED settings; two proposals focused on episodes of care within specialty care practices; one proposal addressed pulmonary services in outpatient or home settings; one proposal focused on end-stage renal disease (ESRD) in dialysis centers; and one proposal focused on improving coordination in primary care and specialty care practices.

In terms of the financial methodologies of the 18 proposals, ten proposals involved shared risk; seven proposals introduced bundled payments and/or episode of care payments; and one proposal included an additional one-time payment without shared risk.

Finally, of the 18 proposals selected:

- Nine proposals introduced the use of waivers (e.g., telehealth, 3-day skilled nursing facility [SNF], post-discharge home visit);
- Eight proposals described potential approaches to incorporate multi-payer alignment;
- Twelve proposals discussed various specialty integration approaches, such as providing interdisciplinary care teams and encouraging participation of specialists.

See Appendix 2 for additional information on the 18 selected proposals.

IV. COMMENTS FOR CONSIDERATION BY THE SECRETARY

Based on findings from the Committee's analysis of PTAC proposals, information in the literature, and information from listening session presentations and panel discussions involving a previous submitter and additional SMEs during the March 2025 public meeting, this section summarizes PTAC's comments regarding reducing barriers to participation in APMs and supporting primary and specialty transformation. PTAC's comments are organized in four topics:

- Topic 1: Addressing Provider Economics and Uncertainty;
- Topic 2: Incentivizing High-Value Care;

- Topic 3: Designing Value-based Care Models to Encourage Provider Participation; and
- Topic 4: Promoting Competitiveness in Value-based Care.

For each topic, relevant issues are highlighted, followed by a summary of PTAC's comments. Additionally, the Committee has identified areas where additional research is needed, as well as some potential next steps related to each topic. Appendix 4 includes a complete list of the Committee's comments.

IV.A. Topic 1: Addressing Provider Economics and Uncertainty

PTAC discussed the importance of addressing provider economics and uncertainty to increase participation in APMs:

- Participation in value-based care must be financially viable for providers; and
- Payment models should promote financial stability for providers.

PTAC's comments on addressing provider economics and uncertainty are listed in Exhibit IV.1.

Participation in value-based care must be financially viable for providers. PTAC indicated that providers must see a feasible path to savings to participate in APMs. Financial incentives for transitioning to value-based care need to be emphasized. One Committee member stressed that having about 40 to 60 percent of patients in at-risk arrangements is necessary to make participation in APMs profitable. Additionally, one SME explained that many health systems and providers practice in a hybrid financial environment (e.g., fee-for-service [FFS] and capitation payments) which can make it difficult to transform care until about half of a practice's patients are in APMs.

Several experts suggested moving toward a multi-payer model that includes patients in other types of risk arrangements (e.g., Medicare Advantage [MA], Medicaid, commercial) to help transform care away from a FFS structure. Committee members also stressed the importance of multi-payer alignment to make value-based care financially viable and increase participation in APMs. One expert noted that managing multiple quality measures and contracts across different payers is inefficient. Implementing a multi-payer model with standardized methodologies, risk adjustments, and quality measures could streamline the process and improve care. By consolidating efforts into a single model, budget and resources currently spent on managing various individual contracts could be better used to focus on patient care and improvement efforts. The expert suggested starting with implementation of a multi-payer database or multi-payer methodologies. Another expert noted the need to align care across value-based care and commercial patients and shared that their organization is exploring a standardized approach across both models using subscription-based services (e.g., a monthly/annual fee for specific health care services).

It is essential to explore options to make participation in APMs and value-based care financially viable, such as emphasizing financial incentives and implementing a multi-payer model.

Payment models should promote financial stability for providers. PTAC emphasized the importance of providing financial stability in payment models to increase participation in value-based care. It is important for value-based care models to offer practices financial stability and predictability that allow them to plan for future growth, including workforce investments and expansion of services. Successful value-based providers invest in clinical operations, including care coordination, emergency room diversion plans, and post-hospital discharge follow-ups, to avoid unnecessary costs and improve patient outcomes. Providers need stability and predictability in payment models (e.g., Medicare Shared Savings Program and ACO Realizing Equity, Access, and Community Health [REACH]), including stability in benchmarks, quality measures, and financial returns to drive participation in value-based care. One Committee member noted that providers need financial stability and are most likely more concerned with how payment models would mitigate downside risk than with the amount of money/savings providers could earn.

One expert indicated that reducing the risk associated with first-year patients—patients presenting to their PCP for the first time with undiagnosed or newly diagnosed conditions—could be helpful. This cohort tends to be more expensive and has a larger financial strain. Adjusting risk for this group could encourage more organizations to join APMs. As patients progress through care management, profitability improves. Reducing the high financial risk associated with first-year patients could provide significant benefits to organizations looking to transition to value-based care.

Experts indicated that physicians are often hesitant to adopt new payment structures, making the transition from FFS to value-based care models challenging. Uncertainty in the broader health care system impacts organizations' willingness to assume risk in value-based care models. For example, concerns about physician payment can reduce desire for risk. In particular, smaller organizations, especially independent physician groups, face significant uncertainty about the financial impact of participating in APMs. They experience concerns about potential reductions in FFS profitability and delays in payments.

Committee members stressed that upfront payments must be part of the payment model. One expert noted that providing health systems or practices with infrastructure investments will enable physicians to implement data technology, such as artificial intelligence (AI) scribes, and hire additional support staff, such as social workers and pharmacists. These investments may ease physicians' daily workloads, improve patient care, and contribute to the success of value-based care contracts. Additionally, experts highlighted the need for cash reserves and financial capital to fund investments in value-based care. One expert suggested increasing up-front funding for infrastructure development through access to advanced payments.

There are also often delays in payment contributing to the lack of financial stability for providers. Independent physician groups can struggle with cash flow and rely on timely payments, especially in some payment models where providers receive capitation payments in place of guaranteed FFS revenue (e.g., ACO REACH). PTAC stressed the importance of receiving timely payments and suggested reducing the time between performance and payment. Implementing a timelier reconciliation process is necessary for providers to receive money they need to successfully transition to value-based care payment models.

Exhibit IV.1: PTAC Comments

Topic 1: Addressing Provider Economics and Uncertainty

Comment 1A. The early innovators and the early adopters are participating. Now, consider changing the messaging and incentives to entice the mainstream market of providers.

Comment 1B. These models are complex, and the inertia is entrenched. Financially, participants must be far beyond the tipping point (e.g., 75 percent) to change how they practice.

Comment 1C. There is a high degree of burden of first-year patients where solutions will be needed to overcome this challenge.

Comment 1D. There must be a feasible, visualizable path to savings.

Comment 1E. The people transforming the health care system are focused on portfolio management of payer sources in order to stay in business.

Comment 1F. Multi-payer alignment is critical for success. There is a need to consider what the critical mass is for patients. Having between 40 percent to 60 percent of patients in at-risk arrangements is needed to make participation more profitable in these types of arrangements.

Comment 1G. In multi-payer alignment, a margin of 40 percent or 50 percent of a practice's entire panel is needed before considering changing the practice's operations.

Comment 1H. Consider aligning performance measures across multiple payers.

Comment 1I. In multi-payer frameworks, considering how multi-payer Electronic Clinical Quality Measures (eCQMs) can help streamline the administrative burden in participation in value-based arrangements is critical.

Comment 1J. Risk-reward analysis should be realistic and consistent with the business model of the practice.

Comment 1K. One Committee member questioned who should bear financial risk: providers (e.g., the Medicare Shared Savings Program), insurance companies (e.g., MA), or both.

Comment 1L. The 40 percent rule regarding risk may promote participation. Enough revenue should be at risk.

Comment 1M. How downside risk is mitigated or controlled is considered more important than how much gain is possible.

Comment 1N. Upfront payments must be part of the model.

Comment 1O. Tactical suggestions include reducing the time between performance and payment.

Comment 1P. The time between performance and payment must be reduced.

Comment 1Q. Consider "the last mile" to ensure that incentives make it to the doctors in a way that keeps providers engaged in the process, especially because reconciliation is delayed.

Comment 1R. Actuarial stability in benchmarking is important. There is a need to consider a reconciliation process that is quick so that providers can access money when they fall short.

IV.B. Topic 2: Incentivizing High-Value Care

PTAC expressed the importance of ensuring that APMs incentivize high-value care:

- Develop payment models to promote the highest-value care; and
- Ensure that measures align with value-based care goals.

PTAC's comments on incentivizing high-value care are listed in Exhibit IV.2.

Develop payment models to promote the highest-value care. Committee members emphasized that payment models should be designed to promote high-value care. Experts expressed the importance of a whole-person, coordinated, patient-centered approach to care. One SME recommended that value-based care be defined based on the care team having a clear understanding of the patient's preferences and wishes, and then working to ensure that the patient's specific goals of care are achieved. This requires a coordinated and transparent effort across the care team, including primary care providers and specialists, that emphasizes collaboration and focus to achieve the patient's desired goals.

Experts expressed that, compared with traditional FFS, value-based care can promote a better primary care model through its holistic patient focus and emphasis on team-based care. Through the performance measurement integral to value-based care, primary care physicians can be encouraged to better track and manage patients over time, such as following up on missed preventive care screenings. Value-based care also can encourage specialists to adopt an approach that is more focused on whole patient care rather than simply performing procedures.

Committee members and experts discussed the importance of integrating home health providers, behavioral health specialists, social workers, and pharmacists as part of the care team to ensure better patient outcomes. High-value care can be fostered through an advanced primary care (APC) model, which emphasizes the use of interdisciplinary care teams, coordinated service referrals, the provider/patient relationship to promote long-term positive outcomes, and the role of technology to improve patient care (such as the use of virtual health visits and asynchronous communications). APM incentives should be sufficient to support an APC model, and rewards should be shared with advanced practice providers, such as physician assistants and nurse practitioners, who support the primary care physician, as well as other members of the care team.

SMEs discussed the importance of clinical integration, connected care modalities, and proactive care models in promoting high-value care. First, value-based care directly aligns with clinical integration, which involves coordination of care across providers and settings, and a focus on quality, efficiency, and patient-centered care. Drivers of clinical integration include strong leadership and physician engagement, a coordinated care model, aligned financial incentives, and shared technology and data infrastructures. Second, connected care modalities—technology-driven ways to connect patient with their providers (e.g., personal patient health portals)—are an important way to help drive high-value care. Telehealth, in particular, is an essential care modality, especially for patients living in rural or remote areas. Third, care models that promote preventive care are crucial to keeping people healthy as they age. Proactive care models that focus on preventive health care and patient self-care may be particularly important among the younger population.

One Committee member identified the potential role of AI to promote efficiency and high-value care. Experts described areas where physicians are testing and using AI tools to help improve their delivery of care and reduce administrative burden. Examples include ambient listening tools that transcribe conversations between physicians and patients, tools that draft clinical notes, and tools that provide physicians with clinical guidelines and real-time advice. AI also can be useful for stratifying and identifying cohorts of patients who are at high risk or rising risk for specific conditions, and for predicting risk for individual patients. However, one SME cautioned that when using AI, users should be aware of the potential biases based on asymmetries in the underlying data, such as underrepresentation of some types of patients

Finally, PTAC suggested that payment changes may be needed to disincentive use of low-value care, which is estimated to cost the health system hundreds of billions of dollars each year.[8] Examples of low-value care—tests and treatments that provide little or no clinical benefit and may cause harm—include PSA testing for prostate cancer in men over 70 years of age, imaging for uncomplicated headaches, injections for low back pain, and antibiotics for adenoviral conjunctivitis (viral pink eye).[9] APMs can be designed to incentivize providers to utilize high-value care and eliminate use of low-value care.

Ensure that measures align with value-based care goals. PTAC commented that quality measures should be aligned with value-based care goals and emphasize outcomes over process. Experts observed that provider incentive payments should focus on outcomes such as total cost of care, emergency department (ED) admissions, hospital readmissions, and other meaningful health outcome measures more than process-oriented metrics such as post-acute office visits and medication adherence.

Committee members also identified the importance of quality measures that focus on positive outcomes, including measures of advance care planning. A key quality measure should center on patient goal attainment and can include a patient's assessment of achievement of their goals of care (administered, for example, before and after a surgical procedure). One expert recommended the Advanced Primary Care (APC) measure set developed by the Purchaser Business Group on Health's (PBGH's) California Quality Collaborative (CQC). The APC measure set includes measures of health outcomes and prevention (e.g., screenings and immunizations), patient-reported outcomes and patient experience, patient safety, and high-value care (e.g., total cost of care, ED and hospital utilization).[10] One Committee member noted that high-value care also can be ascertained using patient access measures, such as length of time to obtain a provider appointment.

Supporting Polices Raised by Experts

Investment in primary care. SMEs raised the importance of investment in primary care to ensure high-value care, noting the key role of primary care in better patient outcomes and lower costs. A small fraction of total health care spending in the United States is for primary care—6.2 percent in 2013 and 4.6 percent in 2020.[11]

Promote value-based care in graduate medical education (GME). SMEs also identified the role of GME in promoting value-based care among the next generation of health care professionals. GME programs should train medical students in value-based care, including the importance of coordinated care, primary/specialty collaboration, patient goals of care, and advance care planning. This training early in their careers may encourage new practitioners to adopt a value-based care mindset and approach to their practice of medicine.

Exhibit IV.2: PTAC Comments

Topic 2: Incentivizing High-Value Care

Comment 2A. Humana's care model developed through CenterWell supports the payment model. It is important to have a strong, underlying care model to succeed in PB-TCOC models. High-access clinics, home health services, and the pharmacy provide the type of care needed to succeed in PB-TCOC payment models.

Comment 2B. Policy recommendations for the Secretary must consider integrating behavioral health.

Comment 2C. There is a geographic disparity in participation and penetration of ACOs. Regarding cost and quality and the value proposition, consider the geographic disparities in penetration of participation, which may lead to low- versus high-value care.

Comment 2D. For rural providers to achieve success in PB-TCOC models, key themes from the March 2025 public meeting included community hospitals serving as community centers and the need to share resources across sectors to build integrated teams; and creativity for how care is delivered, which is particularly important for all-payer models.

Comment 2E. Additional key themes that emerged from the March 2025 public meeting included the integration of AI for broader, predictive work; the need for proactive, anticipatory disease and symptom management; and identifying needs, pathways, and roadmaps for rising risk populations. AI may be able to promote efficiency as the number of older adults increases and the workforce declines.

Comment 2F. Low-value care has a high cost, possibly $100 to $300 billion. Although there are efforts to find pennies in the margins for high-acuity patients, there is still a lot of money spent on low-value care.

Comment 2G. Consider not paying for low-value care.

Comment 2H. Quality measures should continue to move away from process measures, even in the Medicare Shared Savings Program, as there is more downside risk. This will reduce burden and decrease barriers for later adopters who want to participate.

Comment 2I. There is a National Consortium of Health Outcomes Management that states the positive outcomes for different interventions. Measurable, quality metrics should be focused on positive outcomes.

Comment 2J. Advance care planning (ACP) should be a fundamental part of all value-based care models and considered a core quality metric.

Comment 2K. Patient goal attainment should be a quality measure that is shared between all payers.

Comment 2L. There should be a financial value in the delivery system that is assigned to access, such as time to first appointment, same day appointment, time of return appointment, and time to specialty appointment.

IV.C. Topic 3: Designing Value-based Care Models to Encourage Provider Participation

PTAC discussed several important considerations in the design of value-based care models to encourage and maximize provider participation:

- Balance model simplicity with flexibility to encourage broad participation;

- Design models to increase specialist integration; and
- Ensure that model features address participation barriers.

PTAC's comments on designing value-based care models to encourage provider participation are listed in Exhibit IV.3.

Balance model simplicity with flexibility to encourage broad participation. PTAC identified the importance of ensuring that value-based care models are simple and standardized to lower barriers for entry and encourage ongoing provider participation. Having myriad models with varying design elements—such as different methodologies for calculating rewards, different risk-adjustment approaches, and different performance measures—is inefficient for providers and deters participation in APMs. Committee members and experts also observed that, to expand value-based care penetration beyond initial innovators to the broader range of mainstream providers, simple, stable, long-term, and easy-to-implement model designs are needed.

One important factor to promote model adoption is to allow sufficient lead time for providers to prepare to implement and participate in models. Providers, particularly those who are new to value-based care, require a ramp-up time to address any gaps in their organizations and to secure resources that may be needed to meet the participation requirements for APMs. One expert cited CMS' Transforming Episode Accountability Model (TEAM) as a good approach, noting that CMS allowed a full year lead time for provider participants to prepare prior to starting the model. Experts also emphasized that having models run for a significant period of time is important to make it attractive for providers to participate, to promote stability, and to realize and observe the benefits of the model. One SME pointed to the 11-year planned duration for the CMS States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model as a good example.

Committee members also identified the need to allow flexibility in model design—different approaches or pathways to implementation—to promote participation in value-based care in specific market areas for certain types of providers, particularly smaller and rural practices. PTAC noted that geography is a critical consideration in designing payment models to deliver high-value care. Participation in value-based care models varies widely across the United States, with lower participation in Medicare APMs in rural and micropolitan areas compared with metropolitan areas.[12] Rural providers may face unique challenges in participating in value-based care models due to their limited financial and personnel resources that inhibits their ability to invest in and manage complex APMs. Experts suggested that global budgets—fixed, prospective payments—can be particularly useful for rural providers that typically have low patient volumes and greater fiscal uncertainty and capacity to manage financial risk.

Other approaches that may help support small and rural provider participation in APMs include offering upfront funds to allow investment in technology, staff, and other resources needed to

support the conversion to value-based care, and using clinically integrated networks—formal collaborations of providers to support coordinated patient care—or urban-rural partnerships to bolster resources and capabilities.

Design models to increase specialist integration. Committee members expressed the importance of ensuring that value-based care models are designed to promote and support participation among specialists. Of the more than one million U.S. physicians in 2023, approximately one-third were in primary care specialties (e.g., family medicine, general practice, internal medicine, pediatrics), and the remaining two-thirds were in non-primary care specialty areas such as emergency medicine, anesthesiology, general surgery, and orthopedic surgery.[13] Specialists are less likely than primary care physicians (PCPs) to participate in value-based care models.[14]

Experts discussed opportunities to promote specialist integration in value-based care, citing the need for greater care coordination between PCPs and specialists. Similar to the challenges that exist for any type of small practice, many specialists need support to participate in APMs by:

- addressing data interoperability issues to promote data sharing across providers,
- standardizing data collection across specialists;
- ensuring that quality measurement and standard measurement reports are available to specialists; and
- providing up-front funding to allow small specialist practices to invest in the infrastructure and resources needed to support participation in value-based care.

One SME also suggested the use of e-consultations to help integrate specialists, whereby PCPs—ideally when actively meeting with a patient—can obtain a real-time consultation from a specialist.

Specialist integration and care coordination can be promoted via bundled payments—a fixed payment amount to cover all provider services and treatments associated with an episode of care (acute or chronic) over a fixed period of time—or gainsharing—sharing in the net savings or losses associated with cost improvements from value-based care. APMs also can be designed to incentivize specialists to adopt a more holistic, TCOC approach. For example, specialists (as well as PCPs) could be engaged to monitor a patient electronic health record (EHR) dashboard to help track the patient's condition and progress, and to proactively review the EHR for opportunities to detect conditions early and target prevention.

Committee members identified two areas of APM design that can be improved to better support specialist integration: attribution of beneficiaries to specialists and nesting of specialists within larger TCOC models. The patient attribution method is a critical design component of value-based care models because it determines which provider(s) is considered to be responsible for which patients' care, thereby determining eligibility for financial incentives

or gainsharing. Determining the appropriate attribution, which is commonly based on the plurality of a patient's visits, is particularly challenging when patients see multiple physicians for multiple conditions, such as co-occurring chronic health conditions. PTAC and experts identified one area for improving attribution is to ensure that attribution approaches extend beyond use of the Taxpayer Identification Number (TIN), which may be at an aggregated level of a practice or ACO and thus not allow proper attribution to the individual physician responsible for a patient. As such, a combination of TIN and the individual provider's National Provider Identifier (NPI) may be best for attributing patients to providers in APMs.

Specialists typically manage a patient for the condition aligned with the provider's specialty and not for the entire patient's spectrum of health care (e.g., an endocrinologist would be responsible for the patient's diabetes but not the patient's chronic kidney disease, which would be managed by a nephrologist). PTAC and experts identified nested models—bundled payment models for specialists nested within larger TCOC models for primary care physicians—as an approach to integrate specialists into value-based care. TCOC models focus on managing overall patient health to minimize the TCOC across time for a patient population. Bundled or episodic payment models (i.e., condition-based models) focus on managing the cost of care for a specific episode, which can be either an acute episode (e.g., a specific treatment or procedure such as hip replacement surgery) or a chronic episode (e.g., ongoing diabetes), over a fixed period of time (e.g., 30 days, one year). Experts noted challenges with condition-specific models related to accurately benchmarking payment for episode types that have low volume and high variation and risk adjusting for episode types that may have low predictive power.

PTAC identified the need for data and tools to help PCPs provide patients with referrals to specialists who deliver high-value care. One expert recommended creating a digital tool that provides transparent specialist metrics, including cost of care, quality of care based on STEEEP (safe, timely, effective, efficient, equitable, patient-centered), clinical outcomes, and patient-oriented goal outcomes. Another digital tool could be developed that provides information to PCPs and patients searching for a particular procedure, such as a cholecystectomy, to help them make informed decisions. Such an "episode compare" tool would allow comparison of specialists on items such as average episode cost, patient risk score, hospital readmission rate, patient rating, and other factors.

Finally, PTAC and experts noted that regional differences should be taken into account when considering approaches to integrating specialists into value-based care models. Competition and local culture may impact the relationship between PCPs, specialists, and patients. For example, some areas have limited availability of specialists, which limits a PCP's choice of referrals. Flexibility in model design, such as the financial arrangements for including specialists, may be needed.

Ensure that model features address participation barriers. PTAC expressed the importance of ensuring that APMs are designed to minimize barriers to provider participation. Although direct

financial incentives are important, operational factors such as the patient attribution methodology, risk-adjustment approach, and practice administrative burden also can affect the fiscal viability of value-based care and provider decisions to participate and remain in APMs.

Committee members and experts identified benchmarking as a critical participation barrier. Benchmarks are the standards or targets that providers are expected to meet in terms of quality and cost; benchmarks are used as the basis for determining financial incentives in value-based care models. Benchmarks are essential to ensure that providers are delivering and being rewarded for value-based care. However, benchmarks also can deter provider participation when they are improperly set (for example, set at unattainably high levels, especially for some types of providers), are not adequately risk-adjusted to account for different mixes of patients, or are frequently reset or rebased. Benchmark stability and predictability are important for providers to effectively manage the fiscal components of their businesses. The financial viability of participation in APMs is discussed in more detail under Topic 1 (Addressing Provider Economics and Uncertainty) in this report.

One common approach to financial benchmark setting is to create empirically-derived benchmarks based on a provider's or ACO's own historical spending for the applicable patient population, adjusting the target to account for national or regional cost growth trends, and risk-adjusting the target to account for the provider's unique patient population (e.g., patient demographics and health status). Benchmarks are commonly rebased over time to reflect updated information and to encourage providers to continue to make improvements. One SME cited several challenges of this benchmarking approach that must be addressed. First, the use of historical spending and rebasing can create a "ratchet effect" whereby a provider is effectively penalized for success in meeting a benchmark by the creation of a new more challenging goal that is increasingly unattainable. Second, prediction of cost growth trends can be inaccurate, which can significantly affect outcomes and rewards for providers that are measured based on these projections. Third, patient risk adjustment—commonly based on the CMS Hierarchical Condition Categories (HCCs) that utilizes clinical diagnosis codes and basic patient demographic factors (age, sex) to produce patient risk scores—may not fully reflect the risk of a provider's population (e.g., not accounting for health-related social needs) and may be differentially applied (e.g., through caps) in different programs.

Committee members also identified that modifications to the regulatory environment, through waivers and flexibilities in value-based care incentive structures, can reduce participation barriers and encourage uptake of APMs. Certain federal laws ban providers that receive CMS FFS payments from certain behaviors. For example, the Anti-Kickback Statue prohibits providers from receiving money or other items of value for making a physician referral; the Physician Self-Referral Law (or Stark Law) prohibits providers from referring patients to health care entities with which the provider is financially affiliated.[15] These laws would prevent providers from participating in some types or components of value-based care models, such as those designed

to reward physicians for making referrals to higher-quality providers and providing better coordinated care across physicians and their affiliated facilities. The Department of Health and Human Services (HHS) issues waivers to these laws to allow flexibility to providers to participate in certain APMs, as well as for other reasons (e.g., a public health emergency such as COVID-19). However, provider use of waivers has been low. One area for further exploration cited by experts is how to promote and streamline the use of waivers to increase value-based care model adoption.

PTAC and experts also noted that flexibility in value-based care incentives and rewards can promote APM participation. Infrastructure investments are key to help providers shift to providing higher-value care. Areas of investment may include AI (e.g., AI scribes to ease the burden of physician notetaking), other technology, and support staff to facilitate improvements in patient care. Experts cited the necessity of financial incentives that ensure a steady cash flow for practices. One challenge is the extended gap in time that may exist between when providers implement value-based behaviors that generate cost savings and when providers actually receive payment incentives for that value-based care. As such, upfront payment can be useful.

Finally, PTAC identified the importance of providing technical assistance to support providers with participation in APMs. Experts noted that technical assistance is particularly important to prepare providers to be able to implement models, such as going through the model application process. Technical assistance also may be crucial to help small, independent, and rural practices with the necessary changes and administrative requirements needed to participate in value-based care models.

Exhibit IV.3: PTAC Comments

Topic 3: Designing Value-based Care Models to Encourage Provider Participation

Comment 3A. One general theme that emerged was simplicity; keeping measures simple, lowering the barrier for entry, and aligning models.

Comment 3B. If everyone is going to participate in models, models cannot be complex.

Comment 3C. Models need lead time to prepare for participation.

Comment 3D. Tactical suggestions include increasing implementation timelines regarding payment demonstration projects in the future.

Comment 3E. Rural providers typically have a low volume of patients and will need their own set of standards as risk is higher in these settings.

Comment 3F. Innovation is difficult when the ship has holes in it. The U.S. has trouble with expanding and creating pathways to increase participation in value-based care so that the benefits of value-based care accrue to vulnerable populations. There is momentum growing in large environments; however, there is a group of people that will be left behind. Critical

Access Hospitals (CAHs) and rural providers are at a disadvantage regarding market forces, organizational structures, and business models that could affect participation decisions. There is a need to consider pathways for rural communities.

Comment 3G. Consider lowering the financial hurdle for smaller ACOs.

Comment 3H. Using global budgets for rural hospitals could help to rescue some of the hospitals that are needed in those specific areas.

Comment 3I. For rural providers to achieve success in PB-TCOC models, key themes from the March 2025 public meeting included a networks approach.

Comment 3J. There is not enough participation from specialists.

Comment 3K. FFS should be less desirable for specialists and more desirable for PCPs.

Comment 3L. To scale and integrate specialty care, consider simplicity and avoid complexity. Alternatively, consider embracing complexity as a requisite to engage specialists. These trade-offs should remain front and center in future conversations about specialty integration, multi-payer alignment, and scaling up either within or across payers and purchasers.

Comment 3M. Attribution can be improved by considering the level of the TIN and NPI instead of solely the level of the TIN to avoid attribution by specialty care alone.

Comment 3N. More work is needed to nest specialists into TCOC models, as well as to implement evaluation and management (E/M) services for chronic disease performed by specialists in TCOC models.

Comment 3O. Consider nesting a specialty, condition-based model within a TCOC model.

Comment 3P. Nested Patient-Centered Medical Homes (PCMHs) could create cascading accountability for chronic medical care.

Comment 3Q. An episode compare, or bundles compare, could engage specialists in value-based care. Referring physicians could see the value of care that the specialists in their areas provide.

Comment 3R. Consider regional flexibility when integrating specialists using the chassis that exists. Specialty care is regionally mediated in competition.

Comment 3S. The National Association of ACOs (NAACOS) has generated solutions to benchmarking, risk adjustment, and trend adjustment that are worth consideration.

Comment 3T. Actuarial stability in benchmarking is important. There is a need to consider ways providers can achieve actuarial stability in benchmarking.

Comment 3U. Consider new ways to adjust for the ratcheting effect.

Comment 3V. The 2020 Office of Inspector General (OIG) rules regarding flexibility and waivers need more attention. Consider why people were not using this program and how to make this part of the connective tissue in how care is delivered.

Comment 3W. Consider making the primary care payment tax deductible for the patient because the return on investment (ROI) on primary care is 13 to 1. Additionally, also consider a carve-out payment as a mechanism for a prospective payment to support PCPs.

Comment 3X. There is a need for technical assistance to participate in models.

Comment 3Y. Technical assistance to implement programs is important. Consider avoiding inadvertently incentivizing consolidation of organizations due to people not able to access data or technical assistance.

IV.D. Topic 4: Promoting Competitiveness in Value-based Care

PTAC discussed the importance of ensuring that value-based care and APMs are competitive with other products in the market:

- Address competitive challenges to value-based care;
- Use the Medicare Shared Savings Program to expand value-based care; and
- Promote patient choice.

PTAC's comments on promoting competitiveness in value-based care are listed in Exhibit IV.4.

Address competitive challenges to value-based care. PTAC discussed how participation in ACOs has plateaued and that an unfair playing field exists between traditional Medicare and MA. MA holds several advantages over traditional Medicare and APMs, making it difficult for these options to compete with MA. First, MA is heavily subsidized, allowing for better beneficiary coverage. Second, risk scoring in MA generally leads to higher provider payments than in traditional Medicare or value-based care. Third, MA plans and providers are allowed to advertise and discuss plan options with patients. Because of these advantages, MA is typically a more financially predictable and stable option for providers compared with traditional Medicare and value-based care options.

The playing field between MA, traditional Medicare, and ACOs/APMs needs to be leveled in order for ACOs/APMs to compete with other options. Experts offered several suggestions, including developing approaches for ACOs to share savings directly with patients in a similar manner as MA plans, strengthening incentives in ACO models, adopting an improved risk-adjustment model, rewarding quality, allowing ACOs to advertise or compare plan options with patients, and permitting providers to discuss trade-offs between ACOs and MA plans with their patients.

Additionally, PTAC discussed the importance of conveners (or enablers) in supporting financial stability for providers and increasing participation in APMs. Conveners are organizations that assist providers with implementing value-based care models. Conveners are typically the risk-bearing contract holder with the payer (e.g., APM, Center for Medicare and Medicaid Innovation [CMMI] model, MA plan) in value-based care agreements. Conveners aggregate risk across multiple practices, geographies, lines of business, and payers so that many independent and disparate providers can participate in APMs. Many providers lack the actuarial expertise needed to understand different risk models. Conveners can identify cost variation, look for savings opportunities, and project future expenditures to validate the viability of the risk models for specific provider groups. Further, conveners may provide organizations or practices with cash reserves and financial capital to fund care transformation investments, protect providers from downside risk, and enable providers to maintain adequate cash reserves. One Committee member shared that participation in accountable care grew from about 2 percent to 30 percent through the use of conveners, highlighting the important role conveners can play in increasing participation in value-based care.

Use the Medicare Shared Savings Program to expand value-based care. PTAC recommended focusing on building and testing models within the Medicare Shared Savings Program, versus developing stand-alone value-based care models, to provide organizations with financial stability and certainty in planning for the future. Developing models within the Shared Savings Program would also address provider concerns about the large volume and complexity of stand-alone value-based care models. Experts added that the Shared Savings Program should be the main value-based care program because it is a statutorily mandated program and has shown successful results. Efforts should focus on transitioning providers to value-based care using the Shared Savings Program.

Committee members suggested addressing issues with the Medicare Shared Savings Program through policy changes to strengthen and increase participation in the program. For example, the Shared Savings Program does not effectively control utilization, leading to waste and unnecessary costs. Further, the Shared Savings Program needs to address the “ratchet effect” (continually adjusting the benchmark based on meeting or exceeding current benchmarks); accurately measure population-level risk and address the tendency to regress to the mean (patients tend to get better [or die] regardless of treatment); and address the financial uncertainty and instability that accompanies the 4 percent “clawback” (providers are required to return a percentage, typically 4 percent, of their earned payments when not meeting quality or cost targets).

One expert asserted that most organizations and providers do not want to be innovators and instead want a stable and predictable model with minimal technical implementation burden. The Medicare Shared Savings Program can be this model for value-based care if it can work on addressing the noted issues.

Promote patient choice. PTAC indicated that making data readily accessible and in a form that is easily usable for everyone who needs this information enables patients to make active choices in their health plan and care delivery needs. To make active choices, patients need more readily available information, such as data on patient satisfaction with different health plans. SMEs shared that outcomes tend to be better when patients make active choices. However, patients typically do not make active choices. For example, patients usually choose a health plan and remain in the plan without considering or knowing other potentially more suitable options available to them. Increasing patient use of data will empower patients to make active choices in their health care needs to better meet their health goals.

Exhibit IV.4: PTAC Comments

Topic 4: Promoting Competitiveness in Value-based Care

Comment 4A. Participation among ACOs in PB-TCOC models has plateaued. The viable business models that thrive under FFS are a challenge to increasing participation in value-based care.

Comment 4B. Consider refining how competition is defined (e.g., competition between traditional Medicare and MA, competition between physicians and hospitals).

Comment 4C. There is an unfair playing field between MA and traditional Medicare. Because of its achieved savings and subsidies, MA can do more than traditional Medicare can, even under PB-TCOC models.

Comment 4D. MA has an advantage. Evidence suggests that business is moving from FFS to MA. However, evidence also suggests that FFS value-based care saves money and increases quality in the Medicare Shared Savings Program model. Consider policy-related recommendations related to minimizing MA's advantage regarding risk scoring and ratcheting effects that are adversely affecting FFS value-based care.

Comment 4E. ACOs are held to a stricter performance expectation without approaches such as networks or utilization management. TCOC models do not have the tools that MA plans have to help the models succeed. There should be additional considerations over time to add tools to the PB-TCOC model toolbox to help the models be more successful.

Comment 4F. The Medicare Shared Savings Program and traditional Medicare are not competitive with MA. The goal is to create patient choice. Consider what is paid for and what it is spent on, reflected in a financial model and an operational model. MA wins in both the financial and operational models because it allows creativity, such as reinventing care design. Traditional Medicare does not allow this type of creativity.

Comment 4G. Consider addressing barriers to make APMs a viable option as a choice for Medicare, Medicaid, and commercial beneficiaries. The goal is success.

Comment 4H. PB-TCOC models can and should be improved in a technical way to be one key offering in the market; however, there are other important models in the market.

Comment 4I. PB-TCOC models have different functions, and some models may be better for certain needs compared with other models. There is a trade-off between access, quality, and cost. This is apparent in the FFS versus MA markets. Competitiveness can be considered in a broader sense, not within a certain segment. PB-TCOC models represent an intermediate point between FFS and MA. Traditional Medicare is an open network with a uniform benefit structure, whereas MA supplemental benefits have restrictions. There is a continuum, and PB-TCOC models serve as the bridge. Consider the usefulness of an intermediate offering. The intermediate offering would need to have the right goal, the right value, and it would need to be competitive without ratcheting down and rebasing.

Comment 4J. Hybrid FFS capitation models should be investigated.

Comment 4K. There is a desire for a middle model between FFS to MA that is viable and strong to enable better outcomes. Consider changing the fee structure on the FFS chassis to increase the amount of money that goes to primary care for middle models (e.g., ACO REACH, Medicare Shared Savings Program). This approach could increase participation.

Comment 4L. One Committee member emphasized that businesses will step forward to make changes if existing structures cannot achieve the desired changes.

Comment 4M. Conveners have a role in participation for the middle market (i.e., the next addressable market). There was 2 percent to 3 percent participation in accountable care early on, and participation grew to 30 percent through the use of conveners. If conveners work with both MA and the middle products, they will have flexibility to repurpose the money they receive. This could improve the fee schedule, increase engagement with PCPs, and allow metrics to be more structured around outcomes (e.g., utilization outcomes). Increasing adoption through conveners could allow structuring payments to incentivize the right behaviors and create competitiveness while achieving desirable outcomes and increasing primary care investment and uptake.

Comment 4N. For rural providers to achieve success in PB-TCOC models, key themes from the March 2025 public meeting included the importance of conveners.

Comment 4O. The Medicare Shared Savings Program is the chassis on which value-based care should be driven.

Comment 4P. Instead of developing stand-alone models outside of the Medicare Shared Savings Program, focus on building within the Medicare Shared Savings Program to allow the continuation of programs. There may be a decreasing number of people who are interested in separate payment models outside of the Medicare Shared Savings Program. Accountable care models can be tested in the Shared Savings Program. This approach could provide stability and certainty regarding planning for the future. This approach could also help attract

providers who are not looking for innovation but rather the new normal. Additionally, this approach could address concerns about complexity by narrowing rather than expanding.

Comment 4Q. Consider simplifying the Medicare Shared Savings Program. However, the Shared Savings Program is blurred with the Merit-based Incentive Payment System (MIPS). Additionally, consider making MIPS less palatable and the Shared Savings Program more palatable.

Comment 4R. MIPS is used for too many functions (e.g., rate adjustments for everyone in the fee schedule, non-advanced APMs), and the technical pieces of MIPS could be adjusted. However, consider a health care system with FFS, MIPS FFS, and APMs built on the chassis of the Medicare Shared Savings Program; complex but narrowly focused specialty integration models; and MA. This approach should avoid overfitting PB-TCOC models for some segments (e.g., rural), which is not a defect in the system but a feature.

Comment 4S. The Medicare Shared Savings Program is considered a successful Medicare model, but it lacks the ability to demand utilization control upstream or utilization control in the organization as a way to reduce waste and unnecessary cost.

Comment 4T. The Medicare Shared Savings Program was compared with MA. Both programs have flaws that could be addressed with policy changes. For MA, consider addressing issues with Stars bonuses and risk adjustment. For the MSSP, consider addressing issues with the ratchet effect, regression to the mean, the 4 percent "clawback," and allow practices in a Medicare Shared Savings Program ACO to drive savings to make themselves more competitive with MA (e.g., reduced deductibles, added benefits).

Comment 4U. Patients need choices. The Medicare Shared Savings Program is the ACO for the FFS population, and MA is the ACO for the non-FFS population. The products for accountable care, value-based care, and PB-TCOC will be both the Medicare Shared Savings Program and MA because that enables choice.

Comment 4V. Data democratization and transparency enable more active choices to allow a functioning free-market health system.

APPENDIX 1. COMMITTEE MEMBERS AND TERMS

Terry L. Mills Jr., MD, MMM, *Co-Chair*
Soujanya R. Pulluru, MD, *Co-Chair*

Term Expires October 2025

Lindsay K. Botsford, MD, MBA
One Medical
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James Walton, DO, MBA
JWalton, LLC
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Term Expires October 2026

Jay S. Feldstein, DO
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Walter Lin, MD, MBA
Generation Clinical Partners
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Terry L. Mills Jr., MD, MMM
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Term Expires October 2027

Henish Bhansali, MD, FACP
Medical Home Network
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Lawrence R. Kosinski, MD, MBA
Independent Consultant
Scottsdale, AZ

Soujanya R. Pulluru, MD
CP Advisory Services, My Precious Genes
Sarasota, FL

Krishna Ramachandran, MBA, MS
Independent Consultant
Piedmont, CA

APPENDIX 2. CHARACTERISTICS OF SELECTED PTAC PFPM PROPOSALS IDENTIFIED AS BEING RELEVANT TO PROMOTING ACCOUNTABLE CARE AND/OR REDUCING BARRIERS RELATED TO PARTICIPATION IN APMS

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-based Care Components	Technical Components
American Academy of Family Physicians (AAFP) *(Provider association and specialty society)* Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care Recommended for limited-scale testing, 12/19/2017	**Clinical Focus**: Primary Care **Providers**: Physicians with a primary specialty in family medicine, general practice, geriatric medicine, pediatric medicine, or internal medicine **Setting**: Primary care practices **Patient Population**: Medicare FFS beneficiaries	**Overall Model Design Features**: APC-APM builds on concepts tested through Comprehensive Primary Care (CPC) and CPC+ models. Primary care medical homes work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange. **Organization Types**: Primary care practices **Specialty Integration Approaches**: N/A **Use of Waivers**: N/A	**Financial Methodology**: Capitated per-beneficiary-per-month (PBPM) with shared risk options for accountability. **How Payment is Adjusted for Performance**: Participants assume performance risk. APMs that meet or exceed agreed-upon benchmarks retain incentive payment. Failure to meet benchmarks would involve repaying all or part of the incentive payment. **Attribution**: Voluntary; prospective, claims-based **Risk Adjustment**: The two tracks for prospective, primary care global payment would be risk-stratified based on patient complexity (e.g., comorbidities). **Benchmarking**: Based on historical performance and reassessed after two or more years. Success is measured by assessments of quality and cost-effective care relative to agreed-upon benchmarks. **Approaches to Incorporate Multi-Payer Alignment**: APC-APM aligns with the multi-payer CPC and CPC+ models, which promote longitudinal, comprehensive, and coordinated care with primary care teams.

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-based Care Components	Technical Components
American College of Emergency Physicians (ACEP) (*Provider association/ specialty society*) Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions Recommended for implementation, 09/06/2018	**Clinical Focus**: Emergency medicine **Providers**: Emergency medicine physicians and advanced practice professionals **Setting**: Hospital emergency departments (EDs) **Patient Population**: Medicare FFS beneficiaries presenting in the ED	**Overall Model Design Features**: Several elements are adapted from the Comprehensive Care for Joint Replacement (CJR) and the Bundled Payments for Care Improvement (BPCI) Advanced Models. **Organization Types**: Hospital emergency departments **Specialty Integration Approaches**: N/A **Use of Waivers**: Telehealth: Allows emergency physicians to provide telehealth services in the beneficiary's residence and to bill one of the in-home visits as telehealth. Post-discharge home visit: Licensed clinical staff may provide home visits under the general supervision of an emergency physician. Transitional care management: Authorizes emergency physicians to bill for a transitional care management code, utilizing Current Procedural Terminology (CPT) codes (99494 and 99496) or the ED-specific acute care transition codes.	**Financial Methodology**: Bundled payment methodology with retrospective reconciliation. **How Payment is Adjusted for Performance**: A composite quality score, including post-ED event rates and patient safety measures, determines whether participants are eligible for a reconciliation payment or if repayment to Medicare is warranted. **Attribution**: Attribution is assigned to an ED professional after 1) a qualifying visit results in a discharge home; and 2) observational services were provided in the ED. **Risk Adjustment**: Two models, the CMS HCC methodology and custom-risk models built by MPA Healthcare Solutions, would be utilized in predicting admission rates. **Benchmarking**: Participants are benchmarked against their historical performance. **Approaches to Incorporate Multi-Payer Alignment**: N/A

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-based Care Components	Technical Components
American College of Physicians-National Committee for Quality Assurance (ACP-NCQA) *(Provider association and specialty society/other)* The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version) Recommended for testing to inform payment model development, 09/15/2020	**Clinical Focus**: Improved coordination in primary and specialty care practices **Providers**: Primary and specialty care practitioners **Setting**: Primary and specialty care practices **Patient Population**: Medicare FFS beneficiaries with multiple chronic conditions	**Overall Model Design Features**: The model builds on the CPC+, Patient-Centered Medical Homes (PCMHs), and Patient-Centered Specialty Practice (PCSP) concepts. **Organization Types**: Not specified **Specialty Integration Approaches**: Pre-consultations to ensure that the specialist has all the necessary supporting documentation and that scheduling an appointment is appropriate in a patient's treatment plan. **Use of Waivers**: Telehealth: Removes the requirements for Medicare site-of-service and geographic limitations for telehealth services. 3-day SNF: This policy exempts participants from requiring patients to have at least a 3-day hospital inpatient stay to be eligible for SNF coverage. Shared Savings: Allows for participants to share savings based on performance. Stark and Anti-kickback Fraud and Abuse: Permits health care providers to engage in specific value-based compensation agreements. Pre-participation: Protects groups when in the process of building an Advanced APM without a formal contract.	**Financial Methodology**: Participants receive a monthly PBPM care coordination fee and a retrospective positive or negative payment adjustment. Track 1 includes fee-for-service payments, while Track 2 has a reduced fee-for-service payment and a comprehensive specialty care payment (CSCP). **How Payment is Adjusted for Performance**: Performance-based payment adjustment is based on spending relative to a financial benchmark, adjusted for performance on quality and utilization metrics. **Attribution**: Voluntary; claims-based **Risk Adjustment**: Based on HCC scoring, adjusting for additional factors that influence outcomes (e.g., social determinants of health). **Benchmarking**: Retrospectively reconciled based on the practice's historical and regional spending in equal parts. **Approaches to Incorporate Multi-Payer Alignment**: Intended to align payment criteria and incentives across payers.

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-based Care Components	Technical Components
The American College of Surgeons (ACS) *(Provider association/specialty society)* The ACS–Brandeis Advanced Alternative Payment Model Recommended for limited-scale testing, 4/11/2017	**Clinical Focus**: Cross-clinical focus with sets of procedural episodes of care **Providers**: Single or multispecialty practices and groups of small provider practices **Setting**: Inpatient, outpatient, ambulatory **Patient Population**: Medicare FFS beneficiaries from over 100+ conditions or procedures	**Overall Model Design Features**: Focused on procedural episodes, leveraging the Episode Grouper for Medicare (EGM) software developed by CMS and Brandeis University. The model is based on shared accountability, integration, and care coordination as fundamental building blocks. **Organization Types**: Advanced APM entities **Specialty Integration Approaches**: The EGM automatically identifies clinicians participating in patient care during a defined episode of care. **Use of Waivers**: Waivers permitting financial incentives to encourage beneficiaries to accept referrals.	**Financial Methodology**: Retrospective payment that compares episode target prices to the actual cost of the care provided. **How Payment is Adjusted for Performance**: Performance (e.g., unacceptable, acceptable, good, excellent) determines the shared savings retained by the APM entity or the amount to repay CMS for losses. **Attribution**: The EGM logic assigns a level of fiscal risk to all clinicians who participate in the care of each patient for each type of episode. **Risk Adjustment**: Adjusted for each patient based on the patient's historical claims data. **Benchmarking**: Episode benchmarks are patient-specific and risk-adjusted from Medicare Parts A and B claims data. **Approaches to Incorporate Multi-Payer Alignment**: The model creates a "bundle of bundles" and clusters episodes of care to facilitate business efficiencies in a multi-payer environment.
Avera Health (Avera Health) (*Regional/local multispecialty practice or health system*) Intensive Care Management in Skilled Nursing Facility Alternative Payment Model (ICM SNF APM) Recommended for implementation, 3/27/2018	**Clinical Focus**: Geriatric primary care for residents in long-term care **Providers**: Geriatric care teams that include geriatricians, PCPs, nurses, social workers, pharmacists **Setting:** Skilled nursing homes and long-term care facilities **Patient Population**: Medicare FFS beneficiaries in skilled nursing homes or long-term care facilities	**Overall Model Design Features**: Provides access to a geriatrician-led care team through telemedicine, provides geriatric care management and management of care transitions, and mentors and trains long-term care staff. **Organization Types:** Not specified **Specialty Integration Approaches**: N/A **Use of Waivers**: N/A	**Financial Methodology**: One-time payment for new admission care and a PBPM payment for post-admission care. Two payment method options are proposed for the model: 1) a *performance-based payment* adjusted on quality performance; and 2) a *shared savings model* with an annual financial reconciliation. **How Payment is Adjusted for Performance**: In the *performance-based payment* option, payments are adjusted positively or negatively by the ability to meet performance criteria. **Attribution**: N/A **Risk Adjustment**: The *performance-based payment* option does not require payments to be risk-adjusted. The *shared savings model* would use CMS HCC risk score to adjust the target bundle price. **Benchmarking**: Programs can benchmark themselves against the long-term care population. **Approaches to Incorporate Multi-Payer Alignment**: N/A

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-based Care Components	Technical Components
Coalition to Transform Advanced Care (C-TAC) (*Coalition*) Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model Recommended for limited-scale testing, 3/26/2018	**Clinical Focus**: Advanced illness, palliative care, end-of-life care **Providers**: PCPs, specialists **Setting**: Hospitals, health systems, hospices, home health **Patient Population**: Medicare FFS beneficiaries with advanced illness in the last year of life	**Overall Model Design Features**: An interdisciplinary care team implements the ACM care delivery services. **Organization Types**: Advanced APM entities **Specialty Integration Approaches**: Comprehensive care coordination is achieved through interdisciplinary care teams. **Use of Waivers**: Consideration of waivers granted in the Next Generation ACO (NGACO) and Oncology Care Model (OCM) models (e.g., telehealth expansion waiver; SNF 3-day rule waiver; post-discharge and care management home visit waivers; participation waiver; shared savings distribution waiver; waiver for patient incentives).	**Financial Methodology**: A non-tiered per-member-per-month (PMPM) payment with downside risk for TCOC and an upside bonus for quality, subject to maximum payment and loss amounts. **How Payment is Adjusted for Performance**: Pay-for-quality structure, where participants are eligible for a quality-based bonus funded by shared savings and determined by performance measure performance. **Attribution**: N/A **Risk Adjustment**: Determined through episode-based regression analysis. **Benchmarking**: Based on risk-adjusted historical trends, adjusted at the regional level, and weighted toward more recent episodes. **Approaches to Incorporate Multi-Payer Alignment**: N/A
Hackensack Meridian Health and Cota, Inc. (HMH/Cota) *(Regional/ local multispecialty practice or health system; Device/ technology company)* Oncology Bundled Payment Program Using CNA-Guided Care Recommended for limited-scale testing, 9/8/2017	**Clinical Focus:** Oncology **Providers:** Clinicians with admitting privileges in the Hackensack Meridian Health (HMH) health system **Setting**: HMH health system that includes hospitals, home health, rehabilitation clinics, skilled nursing facilities, and mental health facilities **Patient Population**: Medicare patients with breast, colon, rectal, or lung cancer attributed to clinicians in the HMH health system	**Overall Model Design Features**: This is an oncology bundled payment model in which care choices are modulated by the prior outcomes of similar patients from real-world data. This process is called Cota Nodal Address (CNA) guided care. **Organization Types**: Hospitals **Specialty Integration Approaches**: N/A **Use of Waivers**: N/A	**Financial Methodology**: Prospective payment is provided to HMH for patients participating in the model. HMH bears the risk of bundled payments and distributes payments to physicians. **How Payment is Adjusted for Performance**: Compensation is, in part, incentive-based and determined by the achievement of clinical quality and patient satisfaction outcomes. **Attribution**: N/A **Risk Adjustment**: CNA will adjust for relative patient risk. **Benchmarking**: Based on data-driven classification system for cancer patient risk and treatment pathways **Approaches to Incorporate Multi-Payer Alignment**: N/A

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-based Care Components	Technical Components
Johns Hopkins School of Nursing and the Stanford Clinical Excellence Research Center (Hopkins/Stanford) *(Academic institution)* CAPABLE Provider Focused Payment Model Recommended for testing as specified in PTAC comments, 9/6/19	**Clinical Focus**: Chronic conditions and functional limitations **Providers**: Interdisciplinary team of an occupational therapist, registered nurses, and a handy worker **Setting**: Home and community-based settings **Patient Population**: Medicare FFS beneficiaries with at least two chronic conditions and difficulty with at least one activity of daily living	**Overall Model Design Features**: A time-limited intervention performed by an interdisciplinary team to target specific functional goals, perform limited home repairs and modifications, and address common geriatric concerns. **Organization Types**: Value-incentivized organizations **Specialty Integration Approaches**: The intervention uses an integrated team of providers. **Use of Waivers**: N/A	**Financial Methodology:** Partial bundled payment with partial upside, moving toward a fully capitated model of care. **How Payment is Adjusted for Performance**: A bonus for meeting quality metrics would be awarded. **Attribution**: N/A **Risk Adjustment**: N/A **Benchmarking**: N/A **Approaches to Incorporate Multi-Payer Alignment**: N/A
Illinois Gastroenterology Group and SonarMD, LLC (IGG/SonarMD) *(Regional/local single specialty practice; Device/technology company)* Project Sonar Recommended for limited-scale testing, 4/10/2017	**Clinical Focus**: Chronic disease (Crohn's disease) **Providers**: Specialty physicians **Setting**: Outpatient settings and specialty care practices **Patient Population**: Medicare FFS beneficiaries	**Overall Model Design Features**: The model integrates evidence-based medicine with proactive patient engagement. It allows physicians to participate in chronic disease management that is not triggered by a surgical procedure or on an inpatient or outpatient basis. **Organization Types**: APM entities **Specialty Integration Approaches**: The model targets specialists in managing chronic disease. **Use of Waivers**: N/A	**Financial Methodology**: Add-on PBPM payment with two-sided risk, plus a payment to support remote monitoring. **How Payment is Adjusted for Performance**: Payments would be adjusted based on quality and financial performance. **Attribution**: N/A **Risk Adjustment**: Patient risk assessment is calculated with the American Gastroenterology Associations' risk assessment tool, and patients are placed in risk categories. **Benchmarking**: N/A **Approaches to Incorporate Multi-Payer Alignment**: N/A

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-based Care Components	Technical Components
Innovative Oncology Business Solutions, Inc. (IOBS) *(For-profit corporation)* Making Accountable Sustainable Oncology Networks (MASON) Referred for further development and Implementation, 12/10/2018	**Clinical Focus**: Oncology **Providers**: Oncologists, surgeons, PCPs, pathologists, radiologists **Setting**: Oncology practices **Patient Population**: Medicare FFS beneficiaries	**Overall Model Design Features**: Builds off the Community Oncology Medical Home (COME HOME) CMMI project. **Organization Types:** Not specified **Specialty Integration Approaches**: N/A **Use of Waivers**: N/A	**Financial Methodology**: Determined by the oncology payment category (OPC), consisting of FFS payments for physician visits, imaging, lab, radiation therapy, surgery; infusion with a facility fee; ambulatory payment classifications (APCs) for hospital outpatient care; diagnosis-related groups (DRGs) for inpatient care; and the patient-centered oncology payment (PCOP) for medical home infrastructure. **How Payment is Adjusted for Performance**: Two percent of the OPC, which includes all expenses related to cancer care except drugs, is reserved for a quality pool. If quality measures are not met, the 2% is not rewarded. **Attribution**: N/A **Risk Adjustment**: Adjusted for comorbidities and the clinical situation of each patient. **Benchmarking**: Based on the distribution of expenditures. **Approaches to Incorporate Multi-Payer Alignment**: N/A
Large Urology Group Practice Association (LUGPA) *(Provider association and specialty society)* LUGPA Advanced Payment Model for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer Not recommended, 2/28/18	**Clinical Focus**: Prostate cancer **Providers**: Urologists and other coordinating physicians **Setting**: Urology practices **Patient Population**: Patients with low-risk, localized prostate cancer	**Overall Model Design Features**: This model creates episode-based payments for low-risk prostate cancer patients appropriate for active surveillance (AS) instead of active intervention (AI). **Organization Types**: APM entities **Specialty Integration Approaches**: Urologists and other coordinating physicians at risk for a beneficiary's TCOC over 12 months are incentivized to collaborate with physicians across the continuum of care, including specialists, therapists, and facility-based providers. **Use of Waivers**: Stark Law waiver to permit compensation for increased utilization of AS or individual performance on quality measures.	**Financial Methodology**: Add-on PBPM payment with shared risk. **How Payment is Adjusted for Performance**: Participants are eligible for a performance-based payment if quality thresholds are met to enhance the utilization of AS. **Attribution**: After a beneficiary's initial episode of care is attributed to a practice, any Medicare claim in the subsequent 12 months would be assigned to that episode. **Risk Adjustment**: Initial episodes incorporate the CMS-HCC scores of beneficiaries. **Benchmarking**: Defined based on a practice's historical clinical decision-making. **Approaches to Incorporate Multi-Payer Alignment**: N/A

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-based Care Components	Technical Components
Icahn School of Medicine at Mount Sinai (Mount Sinai) (*Academic institution*) "HaH-Plus" (Hospital at Home-Plus): Provider-Focused Payment Model Recommended for implementation, 9/17/2017	**Clinical Focus**: Inpatient services in the home setting **Providers**: Physicians and HaH-Plus providers; including nurse practitioners; registered nurses; social workers; physical, occupational, and speech therapists **Setting**: Patient homes **Patient Population**: Medicare FFS beneficiaries who have one of the 44 acute conditions	**Overall Model Design Features**: Multidisciplinary care around an acute care event to reduce complications and readmissions. **Organization Types**: Advanced APM PFPM **Specialty Integration Approaches**: N/A **Use of Waivers**: Homebound requirement for HaH participants during the acute phase of HaH care (but would remain for post-acute services) and a waiver of the Outcome and Assessment Information Set (OASIS) assessment requirement at the start and the conclusion of the acute phase of HaH care.	**Financial Methodology**: Bundle payment covering the acute episode and an additional 30 days of transition services. Two components are in the payment model: 1) a new DRG-like HaH-Plus payment to substitute for the acute inpatient payment to the hospital and attending physician, and 2) the potential for a performance-based payment linked to the total Medicare spend for the entire HaH-Plus episode and the APM performance on quality metrics. **How Payment is Adjusted for Performance**: The APM entity's performance on quality metrics influences payment. **Attribution**: N/A **Risk Adjustment**: A comparison group admitted to non-participating hospitals in the same region during the same calendar quarter will be used to obtain a spending target. **Benchmarking**: Calculated using CMS claims data for nationwide episodes that are candidates for HAH-Plus. **Approaches to Incorporate Multi-Payer Alignment**: Submitters stated that MA and Medicaid managed care plans expressed interest in the HAH model. This model was also implemented at the VA.
New York City Department of Health and Mental Hygiene (NYC DOHMH) *(Public health department)* Multi-provider, bundled episode of care payment model for treatment of chronic hepatitis C virus (HCV) using care coordination by employed physicians in hospital outpatient clinics Not recommended, 12/18/2018	**Clinical Focus**: Hepatitis C virus (HCV) **Providers**: Primary care and internal medicine physicians (infectious disease specialists, gastroenterologists) **Setting**: Hospital-based outpatient clinics **Patient Population**: Patients with HCV	**Overall Model Design Features**: The Project INSPIRE Model proposes integrated medical, behavioral, and social services for patients with HCV. **Organization Types**: APM entities **Specialty Integration Approaches**: The model supports a wide range of physicians through tele-mentoring. **Use of Waivers:** N/A	**Financial Methodology**: Bundled payment with the opportunity for shared savings. **How Payment is Adjusted for Performance**: Additional shared savings are awarded for being a "high-performing facility" based on their sustained virological response (SVR) score. **Attribution**: N/A **Risk Adjustment**: A facility-specific sustained SVR will be calculated, adjusting for case-mix and patient-level influences (e.g., disease stage, age). **Benchmarking**: Representative of all payment model participants, such as the average SVR for all participating facilities. **Approaches to Incorporate Multi-Payer Alignment**: N/A

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-based Care Components	Technical Components
Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group (PMA) (*Regional/local single specialty practice*) The COPD and Asthma Monitoring Project (CAMP) Not Recommended, 4/11/2017	**Clinical Focus**: Pulmonology, COPD, and asthma **Providers**: Pulmonary physicians **Setting**: Patient home, outpatient **Patient Population**: Medicare patients with COPD and asthma	**Overall Model Design Features**: Remote, interactive monitoring mode targets high-risk patients with COPD and other chronic lung conditions. **Organization Types**: Not specified **Specialty Integration Approaches**: The CAMP program allows remote specialists to initiate therapies and document their actions. **Use of Waivers**: Stark Law waiver for a safe harbor designation; pharmaceutical and device manufacturer waivers would be permitted to allow beneficiaries COPD and asthma controller agents and devices without cost; no copayments would be required.	**Financial Methodology**: Bundled episode-based payment replacing FFS with shared risk. **How Payment is Adjusted for Performance**: N/A **Attribution**: Assigned by a CAMP-based system that matches a patient to a common ID through the master patient index or creates a new patient ID and captures the attribution relationship. **Risk Adjustment**: Patients are grouped into three risk categories (low, medium, high) based on their disease control. **Benchmarking**: A risk-adjusted, national chronic condition-based benchmark. **Approaches to Incorporate Multi-Payer Alignment**: N/A
Personalized Recovery Care (PRC) (*Regional/local single specialty practice*) Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home Recommended for implementation, 3/26/2018	**Clinical Focus**: Inpatient services in the home setting or skilled nursing facility **Providers**: Admitting physicians at facilities receiving PRC payments; on-call physicians; recovery care coordinators **Setting**: Patient home or skilled nursing facility **Patient Population**: Commercial and Medicare Advantage patients with one of 150 acute conditions	**Overall Model Design Features**: This is a home hospitalization care model that proposes to provide inpatient hospitalization-level care and personalized recovery care (PRC) at home or a skilled nursing facility for patients with certain conditions through an episodic payment arrangement. **Organization Types**: APM entities **Specialty Integration Approaches**: The PRC model is intended for multi-specialty practices. **Use of Waivers**: 3-day SNF: This policy exempts participants from requiring patients to have at least a 3-day hospital inpatient stay to be eligible for SNF coverage.	**Financial Methodology**: Bundled episode-based payment not tied to an anchor admission, replacing FFS with shared risk. Bundled payment has two components: 1) risk payment for delivering care compared to the targeted cost of care, and 2) a per-episode payment made for care provided instead of an acute care hospitalization. **How Payment is Adjusted for Performance**: A portion of physician compensation is tied to quality metrics and outcomes. **Attribution**: Patient is identified upon admission to home hospitalization using claims data. **Risk Adjustment**: Based on clinical characteristics. **Benchmarking**: Derived from the historical 30-day episodic cost of related care with a 3% discount applied. **Approaches to Incorporate Multi-Payer Alignment**: PRC is currently available in commercial and MA plans.

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-based Care Components	Technical Components
Renal Physicians Association (RPA) (*Provider association and specialty society*) Incident ESRD Clinical Episode Payment Model Recommended for implementation, 12/18/2017	**Clinical Focus**: End-stage renal disease (ESRD) **Providers**: Nephrologists, PCPs **Setting**: Dialysis centers **Patient Population**: Medicare patients with ESRD	**Overall Model Design Features**: Condition-specific, episode-of-care payment model for ESRD patients during the first six months of dialysis therapy that promotes coordination, patient choice for treatment, chronic kidney disease (CKD) patient education, quality of life, and advanced care planning. **Organization Types**: Not specified **Specialty Integration Approaches**: Targets nephrologists, internal medicine, or other physicians treating ESRD patients. **Use of Waivers**: A waiver to assist patients with transportation to dialysis and vascular access services.	**Financial Methodology**: Episode of care payment model with shared savings achieved over the entire six-month episode of care. There is also a one-time bonus payment for nephrologists to facilitate a patient receiving a kidney transplant preemptively or during the episode of care. **How Payment is Adjusted for Performance**: Physicians' quality scores based on performance on patient-centered quality measures determine the percentage of overall shared savings the physician receives. The higher the quality score, the higher amount of shared savings received. **Attribution**: The date of the first dialysis treatment entered by a nephrologist will determine the attribution of the incident dialysis patient. **Risk Adjustment**: An individual Medicare beneficiary's most recent HCC risk score is normalized such that an average-risk patient would have a score of 1.0. A value >1.0 would indicate co-morbidities associated with higher care costs, whereas a value <1.0 indicates the converse. **Benchmarking**: Regional cost benchmarks will be set for the first six months of dialysis care for patients with ESRD. **Approaches to Incorporate Multi-Payer Alignment**: Designed for Medicare but could be adapted to other payers.
University of Chicago Medicine (UChicago) *(Academic Institution)* The Comprehensive Care Physician Payment Model (CCP-PM) Recommended for limited-scale testing, 9/7/2018	**Clinical Focus**: Frequently hospitalized patients **Providers**: Inpatient and outpatient providers **Setting**: Home care and rehabilitation **Patient Population**: Medicare beneficiaries who are at high risk for hospitalization	**Overall Model Design Features**: The model seeks to defragment care for patients at risk for hospitalization by providing a physician to provide inpatient and outpatient care. **Organization Types**: Not specified **Specialty Integration Approaches**: Encourages participation of specialists who provide primary care (e.g., gynecology). **Use of Waivers**: N/A	**Financial Methodology**: Add-on PBPM payment with shared risk **How Payment is Adjusted for Performance**: Providers will continue to be incentivized or penalized for quality outcome measures based on their APM or MIPS participation. **Attribution**: N/A **Risk Adjustment**: N/A; the submitter noted that the high-risk population the CCP-PM targets poses significant challenges to risk adjustment. **Benchmarking**: Benchmarks will be used in the model, but the method to establish them was not discussed. **Approaches to Incorporate Multi-Payer Alignment**: The model can be adapted across other payers, such as Medicaid and private payers.

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-based Care Components	Technical Components
The University of New Mexico Health Sciences Center (UNMHSC) (*Academic institution*) ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Emergencies Recommended for implementation, 9/16/2019	**Clinical Focus**: Cerebral emergency care; telemedicine **Providers**: Neurologists, neurosurgeons, and providers in rural and community systems **Setting**: Inpatient, outpatient, or emergency department **Patient Population**: Patients with neurological emergencies	**Overall Model Design Features**: Rural EDs can consult neurologists via teleconsultation and assess patients' condition when they present at the hospital ED. The model aims to reduce costs in hospital transfers and ambulatory medicine. **Organization Types**: APM entities **Specialty Integration Approaches**: Neurological and neurosurgical consultations from specialists via telehealth. **Use of Waivers**: N/A	**Financial Methodology**: Additional one-time payment without shared risk **How Payment is Adjusted for Performance**: Performance is monitored but does not impact payment. **Attribution**: N/A **Risk Adjustment**: N/A **Benchmarking**: N/A **Approaches to Incorporate Multi-Payer Alignment**: CMS and commercial payers can use the creation of a new bundled code for telemedicine consultations.

APPENDIX 3. ADDITIONAL RESOURCES RELATED TO PTAC'S THEME-BASED DISCUSSION ON REDUCING BARRIERS TO PARTICIPATION IN APMS AND SUPPORTING PRIMARY AND SPECIALTY CARE TRANSFORMATION

The following is a summary of additional resources related to PTAC's theme-based discussion on reducing barriers to participation in APMs and supporting primary and specialty care transformation. These resources are publicly available on the ASPE PTAC website:

Environmental Scan and Additional Analyses

Environmental Scan on Reducing Barriers to Participation in Population-Based Total Cost of Care (PB-TCOC) Models and Supporting Primary and Specialty Care Transformation

Integrated Delivery System (IDS) Participation in Medicare Accountable Care Organizations (ACOs)

Request for Input (RFI)

Reducing Barriers to Participation in Population-Based Total Cost of Care (PB-TCOC) Models and Supporting Primary and Specialty Care Transformation — Request for Input (RFI)

Materials from the Public Meetings

Materials from the Public Meeting on March 3, 2025

Presentation: Reducing Barriers to Participation in Population-Based Total Cost of Care (PB-TCOC) Models and Supporting Primary and Specialty Care Transformation — Preliminary Comments Development Team Findings

Presentation: Panelist Introduction Slides — Roundtable Panel Discussion

Presentation: Subject Matter Expert Listening Session 1

Presentation: Subject Matter Expert Listening Session 2

Panelist Biographies

Roundtable Panel Discussion Guide

Listening Session 1 Facilitation Questions

Listening Session 2 Facilitation Questions

Materials from the Public Meeting on March 4, 2025

Presentation: Panelist Introduction Slides – Panel Discussion

Presentation: Subject Matter Expert Listening Session 3

Panelist Biographies

Panel Discussion Guide

Listening Session 3 Facilitation Questions

Background Materials

ASPE Issue Brief: The Impact of Alternative Payment Models on Medicare Spending and Quality, 2012-2022

Trends in Traditional Medicare Spending and Outcomes in Urban and Rural Areas

Rural Health Disparities and Differences in Definitions of Rurality

Other Materials Related to the Public Meeting

Public Meeting Minutes

Public Meeting Transcripts

APPENDIX 4. SUMMARY OF PTAC COMMENTS ON REDUCING BARRIERS TO PARTICIPATION IN APMS AND SUPPORTING PRIMARY AND SPECIALTY CARE TRANSFORMATION

The Committee's comments have been summarized in the following broad topic areas:

- Topic 1: Addressing Provider Economics and Uncertainty;
- Topic 2: Incentivizing High-Value Care;
- Topic 3: Designing Value-based Care Models to Encourage Provider Participation; and
- Topic 4: Promoting Competitiveness in Value-based Care.

Topic 1: Addressing Provider Economics and Uncertainty	
1A	The early innovators and the early adopters are participating. Now, consider changing the messaging and incentives to entice the mainstream market of providers.
1B	These models are complex, and the inertia is entrenched. Financially, participants must be far beyond the tipping point (e.g., 75 percent) to change how they practice.
1C	There is a high degree of burden of first-year patients where solutions will be needed to overcome this challenge.
1D	There must be a feasible, visualizable path to savings.
1E	The people transforming the health care system are focused on portfolio management of payer sources in order to stay in business.
1F	Multi-payer alignment is critical for success. There is a need to consider what the critical mass is for patients. Having between 40 percent to 60 percent of patients in at-risk arrangements is needed to make participation more profitable in these types of arrangements.
1G	In multi-payer alignment, a margin of 40 percent or 50 percent of a practice's entire panel is needed before considering changing the practice's operations.
1H	Consider aligning performance measures across multiple payers.
1I	In multi-payer frameworks, considering how multi-payer Electronic Clinical Quality Measures (eCQMs) can help streamline the administrative burden in participation in value-based arrangements is critical.
1J	Risk-reward analysis should be realistic and consistent with the business model of the practice.
1K	One Committee member questioned who should bear financial risk: providers (e.g., the Medicare Shared Savings Program), insurance companies (e.g., MA), or both.
1L	The 40 percent rule regarding risk may promote participation. Enough revenue should be at risk.
1M	How downside risk is mitigated or controlled is considered more important than how much gain is possible.
1N	Upfront payments must be part of the model.
1O	Tactical suggestions include reducing the time between performance and payment.
1P	The time between performance and payment must be reduced.
1Q	Consider "the last mile" to ensure that incentives make it to the doctors in a way that keeps providers engaged in the process, especially because reconciliation is delayed.
1R	Actuarial stability in benchmarking is important. There is a need to consider a reconciliation process that is quick so that providers can access money when they fall short.

Topic 2: Incentivizing High-Value Care	
2A	Humana's care model developed through CenterWell supports the payment model. It is important to have a strong, underlying care model to succeed in PB-TCOC models. High-access clinics, home health services, and the pharmacy provide the type of care needed to succeed in PB-TCOC payment models.
2B	Policy recommendations for the Secretary must consider integrating behavioral health.
2C	There is a geographic disparity in participation and penetration of ACOs. Regarding cost and quality and the value proposition, consider the geographic disparities in penetration of participation, which may lead to low- versus high-value care.
2D	For rural providers to achieve success in PB-TCOC models, key themes from the March 2025 public meeting included community hospitals serving as community centers and the need to share resources across sectors to build integrated teams; and creativity for how care is delivered, which is particularly important for all-payer models.
2E	Additional key themes that emerged from the March 2025 public meeting included the integration of AI for broader, predictive work; the need for proactive, anticipatory disease and symptom management; and identifying needs, pathways, and roadmaps for rising risk populations. AI may be able to promote efficiency as the number of older adults increases and the workforce declines.
2F	Low-value care has a high cost, possibly $100 to $300 billion. Although there are efforts to find pennies in the margins for high-acuity patients, there is still a lot of money spent on low-value care.
2G	Consider not paying for low-value care.
2H	Quality measures should continue to move away from process measures, even in the Medicare Shared Savings Program, as there is more downside risk. This will reduce burden and decrease barriers for later adopters who want to participate.
2I	There is a National Consortium of Health Outcomes Management that states the positive outcomes for different interventions. Measurable, quality metrics should be focused on positive outcomes.
2J	ACP should be a fundamental part of all value-based care models and considered a core quality metric.
2K	Patient goal attainment should be a quality measure that is shared between all payers.
2L	There should be a financial value in the delivery system that is assigned to access, such as time to first appointment, same day appointment, time of return appointment, and time to specialty appointment.

Topic 3: Designing Value-based Care Models to Promote Provider Participation	
3A	One general theme that emerged was simplicity; keeping measures simple, lowering the barrier for entry, and aligning models.
3B	If everyone is going to participate in models, models cannot be complex.
3C	Models need lead time to prepare for participation.
3D	Tactical suggestions include increasing implementation timelines regarding payment demonstration projects in the future.
3E	Rural providers typically have a low volume of patients and will need their own set of standards as risk is higher in these settings.
3F	Innovation is difficult when the ship has holes in it. The U.S. has trouble with expanding and creating pathways to increase participation in value-based care so that the benefits of value-based care accrue to vulnerable populations. There is momentum growing in large environments; however, there is a group of people that will be left behind. Critical Access Hospitals (CAHs) and rural providers are at a disadvantage regarding market forces, organizational structures, and business models that could affect participation decisions. There is a need to consider pathways for rural communities.
3G	Consider lowering the financial hurdle for smaller ACOs.
3H	Using global budgets for rural hospitals could help to rescue some of the hospitals that are needed in those specific areas.

Topic 3: Designing Value-based Care Models to Promote Provider Participation	
3I	For rural providers to achieve success in PB-TCOC models, key themes from the March 2025 public meeting included a networks approach.
3J	There is not enough participation from specialists.
3K	FFS should be less desirable for specialists and more desirable for PCPs.
3L	To scale and integrate specialty care, consider simplicity and avoid complexity. Alternatively, consider embracing complexity as a requisite to engage specialists. These trade-offs should remain front and center in future conversations about specialty integration, multi-payer alignment, and scaling up either within or across payers and purchasers.
3M	Attribution can be improved by considering the level of the TIN and NPI instead of solely the level of the TIN to avoid attribution by specialty care alone.
3N	More work is needed to nest specialists into TCOC models, as well as to implement evaluation and management (E/M) services for chronic disease performed by specialists in TCOC models.
3O	Consider nesting a specialty, condition-based model within a TCOC model.
3P	Nested Patient-Centered Medical Homes (PCMHs) could create cascading accountability for chronic medical care.
3Q	An episode compare, or bundles compare, could engage specialists in value-based care. Referring physicians could see the value of care that the specialists in their areas provide.
3R	Consider regional flexibility when integrating specialists using the chassis that exists. Specialty care is regionally mediated in competition.
3S	The National Association of ACOs (NAACOS) has generated solutions to benchmarking, risk adjustment, and trend adjustment that are worth consideration.
3T	Actuarial stability in benchmarking is important. There is a need to consider ways providers can achieve actuarial stability in benchmarking
3U	Consider new ways to adjust for the ratcheting effect.
3V	The 2020 Office of Inspector General (OIG) rules regarding flexibility and waivers need more attention. Consider why people were not using this program and how to make this part of the connective tissue in how care is delivered.
3W	Consider making the primary care payment tax deductible for the patient because the return on investment (ROI) on primary care is 13 to 1. Additionally, also consider a carve-out payment as a mechanism for a prospective payment to support PCPs.
3X	There is a need for technical assistance to participate in models.
3Y	Technical assistance to implement programs is important. Consider avoiding inadvertently incentivizing consolidation of organizations due to people not able to access data or technical assistance.

Topic 4: Promoting Competitiveness in Value-based Care	
4A	Participation among ACOs in PB-TCOC models has plateaued. The viable business models that thrive under FFS are a challenge to increasing participation in value-based care.
4B	Consider refining how competition is defined (e.g., competition between traditional Medicare and MA, competition between physicians and hospitals).
4C	There is an unfair playing field between MA and traditional Medicare. Because of its achieved savings and subsidies, MA can do more than traditional Medicare can, even under PB-TCOC models.
4D	MA has an advantage. Evidence suggests that business is moving from FFS to MA. However, evidence also suggests that FFS value-based care saves money and increases quality in the Medicare Shared Savings Program model. Consider policy-related recommendations related to minimizing MA's advantage regarding risk scoring and ratcheting effects that are adversely affecting FFS value-based care.

Topic 4: Promoting Competitiveness in Value-based Care	
4E	ACOs are held to a stricter performance expectation without approaches such as networks or utilization management. TCOC models do not have the tools that MA plans have to help the models succeed. There should be additional considerations over time to add tools to the PB-TCOC model toolbox to help the models be more successful.
4F	The Medicare Shared Savings Program and traditional Medicare are not competitive with MA. The goal is to create patient choice. Consider what is paid for and what it is spent on, reflected in a financial model and an operational model. MA wins in both the financial and operational models because it allows creativity, such as reinventing care design. Traditional Medicare does not allow this type of creativity.
4G	Consider addressing barriers to make APMs a viable option as a choice for Medicare, Medicaid, and commercial beneficiaries. The goal is success.
4H	PB-TCOC models can and should be improved in a technical way to be one key offering in the market; however, there are other important models in the market.
4I	PB-TCOC models have different functions, and some models may be better for certain needs compared with other models. There is a trade-off between access, quality, and cost. This is apparent in the FFS versus MA markets. Competitiveness can be considered in a broader sense, not within a certain segment. PB-TCOC models represent an intermediate point between FFS and MA. Traditional Medicare is an open network with a uniform benefit structure, whereas MA supplemental benefits have restrictions. There is a continuum, and PB-TCOC models serve as the bridge. Consider the usefulness of an intermediate offering. The intermediate offering would need to have the right goal, the right value, and it would need to be competitive without ratcheting down and rebasing.
4J	Hybrid FFS capitation models should be investigated.
4K	There is a desire for a middle model between FFS to MA that is viable and strong to enable better outcomes. Consider changing the fee structure on the FFS chassis to increase the amount of money that goes to primary care for middle models (e.g., ACO REACH, Medicare Shared Savings Program). This approach could increase participation.
4L	One Committee member emphasized that businesses will step forward to make changes if existing structures cannot achieve the desired changes.
4M	Conveners have a role in participation for the middle market (i.e., the next addressable market). There was 2 percent to 3 percent participation in accountable care early on, and participation grew to 30 percent through the use of conveners. If conveners work with both MA and the middle products, they will have flexibility to repurpose the money they receive. This could improve the fee schedule, increase engagement with PCPs, and allow metrics to be more structured around outcomes (e.g., utilization outcomes). Increasing adoption through conveners could allow structuring payments to incentivize the right behaviors and create competitiveness while achieving desirable outcomes and increasing primary care investment and uptake.
4N	For rural providers to achieve success in PB-TCOC models, key themes from the March 2025 public meeting included the importance of conveners.
4O	The Medicare Shared Savings Program is the chassis on which value-based care should be driven.
4P	Instead of developing stand-alone models outside of the Medicare Shared Savings Program, focus on building within the Medicare Shared Savings Program to allow the continuation of programs. There may be a decreasing number of people who are interested in separate payment models outside of the Medicare Shared Savings Program. Accountable care models can be tested in the Medicare Shared Savings Program. This approach could provide stability and certainty regarding planning for the future. This approach could also help attract providers who are not looking for innovation but rather the new normal. Additionally, this approach could address concerns about complexity by narrowing rather than expanding.
4Q	Consider simplifying the Medicare Shared Savings Program. However, the Medicare Shared Savings Program is blurred with MIPS. Additionally, consider making MIPS less palatable and the Medicare Shared Savings Program more palatable.

Topic 4: Promoting Competitiveness in Value-based Care	
4R	MIPS is used for too many functions (e.g., rate adjustments for everyone in the fee schedule, non-advanced APMs), and the technical pieces of MIPS could be adjusted. However, consider a health care system with FFS, MIPS FFS, and APMs built on the chassis of the Medicare Shared Savings Program; complex but narrowly focused specialty integration models; and MA. This approach should avoid overfitting PB-TCOC models for some segments (e.g., rural), which is not a defect in the system but a feature.
4S	The Medicare Shared Savings Program is considered a successful Medicare model, but it lacks the ability to demand utilization control upstream or utilization control in the organization as a way to reduce waste and unnecessary cost.
4T	The Medicare Shared Savings Program was compared with MA. Both programs have flaws that could be addressed with policy changes. For MA, consider addressing issues with Stars bonuses and risk adjustment. For the Medicare Shared Savings Program, consider addressing issues with the ratchet effect, regression to the mean, the 4 percent "clawback," and allow practices in an Medicare Shared Savings Program ACO to drive savings to make themselves more competitive with MA (e.g., reduced deductibles, added benefits).
4U	Patients need choices. The Medicare Shared Savings Program is the ACO for the FFS population, and MA is the ACO for the non-FFS population. The products for accountable care, value-based care, and PB-TCOC will be both Medicare Shared Savings Program and MA because it enables choice.
4V	Data democratization and transparency enable more active choices to allow a functioning free-market health system.

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