Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

September 14, 2026
9:31 a.m. – 4:04 p.m. EDT
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attendance

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

Terry L. Mills Jr., MD, MMM, PTAC Co-Chair (Chief Medical Officer, Aetna Better Health of Oklahoma, and Owner, Strategic Health, LLC)
Soujanya R. Pulluru, MD, PTAC Co-Chair (President, CP Advisory Services, and Co-Founder, My Precious Genes)
Lindsay K. Botsford, MD, MBA (Regional Medical Director, One Medical)
Lauran Hardin, MSN, FAAN (Chief Integration Officer, HC^2 Strategies)
Walter Lin, MD, MBA (Chief Executive Officer, Generation Clinical Partners)
Krishna Ramachandran, MBA, MS (Chief Information Officer, UnitedHealth Group)

PTAC Members in Partial Attendance

Joshua M. Liao, MD, MSc (National Associate Vice President of Clinical Transformation, Ascension)*
David C. Tyson, MA (Senior Director, Policy & Regulatory Affairs, Public Affairs & Government Relations, Novant Health)*

PTAC Members Not in Attendance

Henish Bhansali, MD, FACP (Chief Medical Officer, Meridian Health Plan of Illinois, Centene Corporation)
Lawrence R. Kosinski, MD, MBA (Founder, VIOVOC)

Department of Health and Human Services (HHS) Guest Speaker

Abe Sutton, JD (Director, Center for Medicare and Medicaid Innovation [CMS Innovation Center], and Deputy Administrator, Centers for Medicare & Medicaid Services [CMS])

Office of the Assistant Secretary for Planning and Evaluation (ASPE) Staff

Steven Sheingold, PhD, Acting Designated Federal Officer

Via Zoom

List of Speakers and Handouts

1. **PTAC Presentation: PTAC Recommendations for Transforming Health Care Delivery Through Value-Based Care**

   Lee Mills, MD, MMM

   Handouts

   - Public Meeting Agenda
   - PTAC Presentation Slides
   - PTAC's Draft White Paper, *Transforming Health Care Delivery Through Value-Based Payment Models and Care: A Roadmap*

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

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

   John Whyte, MD, MPH, Chief Executive Officer and Executive Vice President, American Medical Association (AMA)*

   R. Shawn Martin, MHCDS, Executive Vice President and Chief Executive Officer, American Academy of Family Physicians (AAFP) (*Advanced Primary Care: A Foundational Alternative Payment Model [APC-APM] for Delivering Patient-Centered, Longitudinal, and Coordinated Care* proposal)

   Jennifer Podulka, MPAff, Senior Vice President, Federal Policy, America's Physician Groups (APG)

   Handouts

   - Expert Biographies
   - Session 1 Presentation Slides
   - Discussion Guide

3. **Session 2: Expert Input on PTAC's Recommendations on Value-Based Care: Part 2**

   Hoangmai (Mai) Pham, MD, MPH, President and Chief Executive Officer, Institute for Exceptional Care (IEC)*

   Paul Krakovitz, MD, FACS, Chief Executive Officer, Cone Health*

   Emily DuHamel Brower, MBA, President and Chief Executive Officer, National Association of ACOs (NAACOS)*

   Handouts

   - Expert Biographies
   - Session 2 Presentation Slides
   - Discussion Guide

4. **Session 3: Expert Input on PTAC's Recommendations on Value-Based Care: Part 3**

   Wyatt W. Decker, MD, MBA, Executive Vice President, Chief Physician, Value-Based Care & Innovation, and Executive Director, Health Care Transformation Hub, UnitedHealth Group

   Elizabeth Mitchell, President and Chief Executive Officer, Purchaser Business Group on Health (PBGH)*

Sarah Fogler, PhD, Senior Research Director, Healthcare Transformation, Duke-Margolis Institute for Health Policy*

Handouts

- Expert Biographies
- Session 3 Presentation Slides
- Discussion Guide

Via Zoom

[NOTE: A transcript of all statements made by PTAC members and public commenters at this meeting is available online: https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee].

Also see copies of the presentation slides, other handouts, and a video recording of the public meeting.

Welcome and Co-Chair Update

Soujanya Pulluru, PTAC Co-Chair, welcomed the Committee members and members of the public to the September 14-15 public meeting. She shared that 2026 marks 10 years of PTAC operations. The Committee members reflected on the evidence regarding Alternative Payment Models (APMs) and value-based care that has been presented to PTAC through stakeholder-submitted physician-focused payment models (PFPMs) and theme-based discussions. Based on the evidence, the Committee members believe that the efforts of the Centers for Medicare & Medicaid Services (CMS) Innovation Center, Center for Medicare, and other payers have made important progress in moving the nation towards value-based care.

Co-Chair Pulluru explained that the Committee members have drafted a white paper, titled *Transforming Health Care Delivery Through Value-Based Payment Models and Care: A Roadmap*. The white paper articulates a roadmap for building on current learning and successes to advance the development and implementation of APMs that support the transformation of the U.S. health care system toward high-value, patient-centered care. PTAC's white paper offers recommendations that focus on total cost of care (TCOC) models and strategies to accelerate the adoption of value-based care. The recommendations are based on information that has been discussed during PTAC's prior public meetings. For the public meeting, the Committee members have brought together experts to share their input and feedback on PTAC's draft white paper. Co-Chair Pulluru introduced Abe Sutton, JD, Director of the CMS Innovation Center and Deputy Administrator of CMS, who provided the opening remarks.

Mr. Sutton explained that PTAC and the CMS Innovation Center have different roles but a shared task: generate promising ideas, rigorously test the ideas, and move forward when the ideas improve care while protecting taxpayers. Mr. Sutton described broad areas of overlap in ideas between PTAC and the CMS Innovation Center, as well as several areas where ideas diverge.

PTAC and the CMS Innovation Center agree on the commitment to value-based care, which includes continuing to iterate, test, learn from, and revise payment models. There is also agreement on the importance of stable, predictable benchmarks. The CMS Innovation Center has collaborated with CMS' Office of the Actuary to produce stable benchmarks that avoid features such as retroactive trend adjustments and will not need to be updated year over year. Nested, episode-based models that build specialty-level accountability into a broader TCOC model show promise.

Mr. Sutton stated that transformation cannot focus only on organization-level TCOC. Complementary models can test outcome-aligned payments, support coordination with primary care, and increase the number of clinicians in accountable arrangements. For example, the Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model pays for measurable outcomes in technology-supported chronic care, creates a co-management pathway for referring clinicians, and complements Accountable Care Organizations (ACOs) and other risk-bearing arrangements.

Mr. Sutton indicated that PTAC and the CMS Innovation Center agree that accountable care must work for people with complex needs. The Long-term Enhanced ACO Design (LEAD) Model is designed to integrate high-needs patients, including patients who are dually eligible or homebound, across ACOs. Mr. Sutton explained that kidney care is an area where tailored accountability, early intervention, and coordination across settings are essential. The CMS Innovation Center supports PTAC's recommendation for entity-level approaches to measure performance with a clear link to payment.

The CMS Innovation Center recognizes that rural providers need a distinct path to value-based care. The Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model pairs state or regional accountability with prospective hospital global budgets and primary care investment. CMS' Rural Health Transformation Program (RHTP) supplies state-level investment in workforce, technology, and infrastructure. Capacity investment can create an on-ramp while payment reform makes that capacity sustainable.

Mr. Sutton reflected on the Committee members' recommendation to empower ACOs in a way that is similar to how Medicare Advantage (MA) plans are empowered. He explained that the Part D premium buy-down feature in the LEAD Model is intended to empower ACOs. There are opportunities to continue this work collaboratively.

The CMS Innovation Center has revised a Make America Healthy Again (MAHA)-specific Health Care Innovation Award-style program through the Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence (MAHA ELEVATE) Model. This model is designed to accomplish the goals referenced in PTAC's white paper and promote preventive health efforts.

Mr. Sutton explained that PTAC and the CMS Innovation Center agree that real-time, usable health data are essential to shared decision-making and improving a patient's health. The goals are to have information that helps clinicians act earlier, support patients with making informed choices, and allow payment to follow outcomes.

Mr. Sutton identified two areas where the CMS Innovation Center's approaches differ from PTAC's recommendations in the draft white paper. The first area of divergence is related to approaches for expanding participation and moving providers into meaningful downside risk. The second area of divergence is related to determining the accountable entity while preserving rigorous evaluation.

The CMS Innovation Center believes that it is addressing goals related to providing new on-ramps for upside-only risk and mandatory ACO participation. The LEAD Model is designed for organizations that historically have had difficulty with risk-based models without crowding ACOs with lower-risk that are served by the Medicare Shared Savings Program and Advanced Primary Care Management (APCM) service codes. In 2025, the CMS Innovation Center reviewed its model portfolio and concluded that its primary care portfolio was too crowded and potentially confused participants about which model to

join. The CMS Innovation Center aims to simplify entry into risk by operating fewer primary care models and designing models based on the needs of distinct populations and practices.

Mr. Sutton offered an alternative solution to mandating participation for ACOs. Geographic AHEAD (Geo AHEAD) is designed to increase the number of Medicare beneficiaries in accountable relationships without a mandate. By recognizing where many primary care physicians are, Geo AHEAD aims to provide a pathway to achieve accountable relationships without eliminating the fee-for-service (FFS) option. Other options should be tested before mandating participation.

Mr. Sutton discussed PTAC's recommendation to place accountability at the organizational level while allowing flexibility in how care is delivered. He explained that the CMS Innovation Center sometimes places accountability at an individual level while constraining flexibility in care delivery to allow rigorous model evaluation. This deliberate operational trade-off between participation versus model evaluation has been considered in the design of nearly all CMS Innovation Center models.

Mr. Sutton concluded that PTAC and the CMS Innovation Center have a high degree of alignment in the fundamentals of value-based care. Value-based care is essential in finding a better path to improve American health care. He explained the importance of stability and predictability and emphasized that patients deserve ownership over their data and their health care.

Following the opening remarks, Co-Chair Pulluru shared that the public meeting will include four sessions focused on obtaining expert input on PTAC's draft white paper. Experts from academia, organized medicine, provider and payer organizations, and other industry sectors will share their perspectives. PTAC's draft white paper and other materials related to the public meeting are posted on the Assistant Secretary for Planning and Evaluation (ASPE) PTAC website. Co-Chair Pulluru indicated that a public comment period will occur during the second day of the public meeting. Public comments are limited to three minutes each.

Following the public meeting, Committee members will prepare a final version of the white paper to submit in a report to the Secretary of Health and Human Services (HHS). As a Federal Advisory Committee, PTAC will base its final white paper on information that has been discussed at the public meetings. PTAC's final white paper will be posted on the ASPE PTAC website. Co-Chair Pulluru explained that PTAC is prepared to receive proposals on possible innovative approaches and solutions related to care delivery, payment, or other policy issues from the public. More information about submitting a proposal is posted on the ASPE PTAC website.

Co-Chair Pulluru invited Committee members to introduce themselves and share their thoughts regarding the two-day public meeting. Following Committee member introductions, Lee Mills, PTAC Co-Chair, delivered the PTAC presentation.

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

Co-Chair Mills delivered the PTAC presentation. For additional details, please see the presentation slides, transcript, and meeting recording (22:23-39:45).

- Co-Chair Mills provided an overview of PTAC, which was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to review stakeholder-submitted PFPMs against criteria established by the Secretary of HHS. PTAC also reflects on topics regarding payment

model innovation in PFPMs and APMs, holds public meetings to review PFPMs and associated topics, and submits comments and recommendations from theme-based discussions to the Secretary of HHS.

- PTAC consists of 11 active members who typically serve three-year terms. PTAC held its first quarterly public meeting in February 2016. Following public meetings, PTAC produces a report to the Secretary of HHS with recommendations. All reports to the Secretary are publicly posted on the ASPE PTAC website.
- To inform its review of PFPMs and theme-based discussion topics, Committee members conduct background research through environmental scans, perform supplemental analyses, request expert input, and request public feedback. All materials produced by PTAC are posted on the ASPE PTAC website.
- Over its 10 years of operations, PTAC has held 32 public meetings, received 37 PFPM proposals, deliberated and voted on 28 PFPM proposals, explored 16 theme-based discussion topics, and received input from 238 experts. One PFPM proposal is currently under review.
- Submitted PFPM proposals have varied by stakeholder (e.g., national provider associations or specialty societies, academic institutions), focus (e.g., health conditions, provider type or setting), and approach to payment for care delivery (e.g., per-beneficiary-per-month [PBPM] payments and shared risk, episode-based shared risk).
- Co-Chair Mills reviewed previous theme-based discussion topics, such as performance measures, pathways to maximize participation in population-based TCOC models, and multi-payer alignment.
- The Committee members have produced recommendations related to value-based care based on the quantitative and qualitative evidence presented to PTAC over the past 10 years. In addition to sharing recommendations pertaining to stakeholder-submitted PFPM proposals and theme-based discussion topics in reports to the Secretary of HHS, Committee members have summarized their recommendations in Issue Briefs that are posted on the ASPE PTAC website.
- Co-Chair Mills introduced PTAC's white paper, titled *Transforming Health Care Delivery Through Value-Based Payment Models and Care: A Roadmap*. The white paper provides a set of recommendations for policy to incentivize and support the transformation of the U.S. health care system to one that produces high-value, patient-centered care. The Committee members seek input on the draft white paper at the public meeting. The final white paper will be posted on the ASPE PTAC website later this year.
- The draft white paper includes 22 recommendations across nine topic areas. Co-Chair Mills described each recommendation in the draft white paper.
- Co-Chair Mills provided concluding comments.
    - Data on ACO outcomes have not quantified the impact of ACOs beyond cost savings.
    - There should be a shared vision of value-based care.
    - TCOC models should move beyond the current ACO model payment structure and serve as the primary vehicle for value-based care.
    - TCOC models should provide value to patients receiving care and incentivize and maximize participation for:
        - Organizations that are well-equipped to provide value-based care but view FFS as a more attractive option; and
        - Providers who need financial assistance and other assistance to invest in value-based care.
- Committee members have invited experts to the public meeting to share their thoughts on PTAC's draft white paper, including:

    - An overall assessment of the white paper and its value for policymakers;
    - The range of topics and recommendations covered in the draft white paper;
    - The wording and tone of the recommendations for a wide audience;
    - Whether any recommendations should be strengthened or made less prescriptive; and
    - Whether any other relevant recommendations or pertinent information should be included in the draft white paper.
- PTAC's recommendations in the draft white paper are based on topics that have been discussed at public meetings. Additional ideas shared during the public meeting could serve as topics for future public meetings.

Co-Chair Mills invited Committee members to ask questions about the PTAC presentation. The Committee members had no questions or comments about the PTAC presentation.

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

Subject Matter Experts (SMEs)

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

Previous Submitter

- R. Shawn Martin, MHCDS, Executive Vice President and Chief Executive Officer, American Academy of Family Physicians (AAFP) (*Advanced Primary Care: A Foundational Alternative Payment Model [APC-APM] for Delivering Patient-Centered, Longitudinal, and Coordinated Care* proposal)

Lindsay Botsford moderated the session with four SMEs regarding their input on PTAC's recommendations on value-based care. Full biographies and presentations are available.

Michael Chernew presented his response to PTAC's draft white paper.

- The FFS system creates barriers by putting problematic financial considerations into clinical decision-making and preventing the delivery system from being efficient and flexible. Although incentives matter, their impact on quality can be limited. Value-based payment helps create a system that gives providers the flexibility needed to find efficiencies while maintaining or improving the quality of care.
- There is waste in the American health care system. APMs create a system in which waste becomes an asset. Reducing waste can save money. In APMs, it is important to understand how waste is assigned and how incentives promote participation and savings.
- Dr. Chernew described his support for the Medicare Payment Advisory Commission's (MedPAC's) recommendation that APMs should be synergistic, default to population-based models, and add synergistic episodes (or other models) when they can support the entire system. A cleaner, more synergistic set of programs is needed.
- Dr. Chernew identified several key points on APMs.
    - APMs are a tool, not an end. Success is not having everyone in an APM; success is achieving lower cost and better quality.

    - APMs should minimize the degree of micromanagement. APMs give the delivery system flexibility to achieve spending and outcome goals without focusing on how the system achieves them. The context of delivery systems varies. It can be difficult to know how to structure a program and measure organizations' performance.
    - The APM system should be simple.
- Dr. Chernew shared his perspective on PTAC's recommendations.
    - Having a sense of urgency is reasonable but trying to achieve too much may not result in success. Working at a deliberate pace is preferred.
    - Dr. Chernew emphasized the importance of flexibility. Some of PTAC's recommendations align with Dr. Chernew's preference for broad flexibility, including Recommendations 3, 4, and 15. Recommendation 2 has a lot of specificity that he is uncertain about.
    - Models should be coordinated, as described in Recommendation 9.
    - The design of performance and benchmarks, including predictability and prospective payments, is important.
    - Data are important.
- Dr. Chernew described the importance of supporting policies.
    - MA reforms are needed. MA will overtake APMs in terms of scale and number of people enrolled.
    - How participation is incentivized is important. Rather than mandating participation, consider using carrots or sticks, which could include removing unrelated carrots. For example, CMS could explore changes such as not allowing the reclassification of wage categories for providers who are not participating in an APM. Other reforms are needed and can encourage APM participation.
    - Harmonize and simplify the models.

For additional details on Dr. Chernew's presentation, see the presentation slides (pages 2-9), transcript, and meeting recording (00:00-9:45).

John Whyte presented on leveraging physician expertise in the APM process to shape the future of value-based care.

- Dr. Whyte stated that AMA shares the Committee members' goal of making value-based care work better for physicians and patients and strongly supports the transition to value-based care. For the transition to value-based care to succeed, physicians need models that are sustainable, flexible, and designed around the realities of patient care. Dr. Whyte identified several themes regarding what is missing from PTAC's recommendations and shared ways to make the promise a reality.
- Many APMs have been designed around a short-term definition of success, including lowering spending that year. This short-term definition misses the point of value-based care because better care often requires up-front investment. Investments that help physicians manage chronic conditions earlier and prevent complications can improve outcomes and lower costs but take time to see results. Models need to be evaluated over longer timeframes, such as the new 10-year LEAD ACO Model. AMA supports the growing use of prospective payments, which can give physicians greater flexibility to invest in the care patients need.
- CMS APMs are built on an FFS foundation; benchmarks and target prices depend on Medicare physician payment. That foundation must be strengthened to allow more physicians to participate in APMs, especially independent practices that face barriers to investing in value-based care. Medicare payment has decreased by 33 percent since 2001 when adjusted for

inflation. AMA supports the bipartisan Patients First Act to strengthen Medicare physician payment, reform budget neutrality and the Merit-based Incentive Payment System (MIPS), and improve APMs.

- Dr. Whyte stated that AMA does not support mandatory models. Mandatory participation is often a mechanism to compel physicians to accept further Medicare reimbursement rates under the guise of financial risk. Designing models around patients and giving physicians the resources they need can create an opportunity to improve care and encourage physicians to participate.
- PTAC's draft white paper recognizes that small, independent, and rural practices face unique challenges and may need additional flexibility. AMA agrees with this notion and recommends considering different ways to define success in APMs. MACRA allows APMs to improve quality while holding spending steady; however, most models have primarily focused on reducing costs. Savings matter but should not be the only measure of success. It is worth exploring ways to expand access or improve quality of care while keeping spending steady. Small, independent practices, rural practices, and practices serving underserved communities often lack the resources, technology, and infrastructure to participate in APMs. AMA appreciated the attention given to rural practices and patients in the draft white paper. To achieve broader participation in value-based care, practices should be met where they are and given an opportunity to succeed.
- More opportunities for specialists to participate in APMs are needed. Most models have focused on primary care and population-based care. There are few models in which specialists can participate.
- It is important to consider which patients are being left out of APMs. Patients in low-income and underserved communities often have the most to gain from APMs because these models can address barriers that care under traditional FFS cannot address, such as arranging transportation or removing cost-sharing for important services.
- Technology should make APMs less burdensome in terms of time spent collecting and reporting performance data. Whenever possible, CMS should automatically pull quality and cost measures from existing sources, including claims and electronic health records (EHRs). AMA is encouraged by the increased use of claims-based measures. Technology at the point of care, such as real-time medication checks, better referral tools, and clinical decision support tools, can prevent complications, improve safety, expand access, and encourage patients to engage more directly in their own care. AMA supports models such as the ACCESS Model that promote greater use of technology to connect patients with care. Technology must be designed with physician feedback incorporated throughout development and implementation to ensure that physicians receive the right information at the right time. Information must be relevant, accurate, and up-to-date. Safeguards for technology are needed. Practices within the same ACO or APM may have different technology needs and abilities, including different EHR systems. This can make it difficult to collect quality data. Federal requirements should be flexible rather than prescriptive while efforts to promote interoperability are underway.
- The draft white paper did not address the need for better data feedback in APMs and MIPS. To participate in an APM, physicians need timely, useful information to understand what is working, improve patient care, and help build experience and confidence with information performance tracking.
- One promise of APMs is to focus more on outcomes and less on paperwork; however, APMs have not fully delivered on that promise. Physicians in APMs spend too much time on quality reporting. Reporting should be as simple and flexible as possible, including measuring at the ACO or accountable entity level, where appropriate, and aligning measures across programs and

payers, including traditional Medicare and MA. Regulatory waivers need greater clarity. Even when waivers are available, practices may not understand what is permitted.

- Prior authorizations are another source of burden. Prior authorizations can result in delays in patient care and contribute to serious adverse events. The adoption of electronic prior authorizations could help reduce this burden. Physicians should have freedom from prior authorizations if they are held accountable for cost, quality of care, and outcomes. Instead, physicians are expected to take responsibility for results without having the flexibility needed to deliver care.
- Physicians are often included in the model design process after major decisions have already been made. AMA encouraged CMS to consider engaging physicians early in the development of new models.
- AMA advocated for PTAC to recommend that CMS promote promising PFPMs that have yet to be tested. AMA will continue to support these models and encourage PTAC to do the same.

For additional details on Dr. Whyte's presentation, see the presentation slides (pages 10-16), transcript, and meeting recording (9:46-21:51).

R. Shawn Martin presented AAFP's assessment of PTAC's draft white paper.

- Mr. Martin reflected on his role in contributing to the language in MACRA that ultimately led to the formation of PTAC. He was the first person to present a model to PTAC on behalf of AAFP. Mr. Martin described PTAC's draft white paper as a roadmap with the right fundamentals.
- FFS is incongruent with the work primary care is asked to do in the practice setting. FFS creates barriers and silos and incentivizes the wrong things. AAFP believes that moving away from FFS is the most sustainable approach to improving primary care and agrees with the emphasis PTAC placed on a team-based approach to primary care.
- Mr. Martin summarized AAFP's points of agreement with the draft white paper.
    - High-quality primary care is foundational to a better health care system. AAFP encourages PTAC to consider continuity or usual source of care. Both global and U.S. data show that having a usual source of care is causally linked to better health outcomes and lower costs.
    - AAFP applauded PTAC for continuing to emphasize prospective payment. Prospective payment is important for advancing primary care and providing the flexibility and creativity that physicians and practices need.
    - Data and interoperability are critical to primary care, especially for APMs and advanced primary care functions. Data from across the health care system are needed, including other physician data, hospital data, pharmacy data, and consumer-driven or consumer-reported data. The ACCESS Model and patient-reported data are important components of primary care moving forward.
    - Mr. Martin believes that meaningful measurement is usual source of care and TCOC; however, he acknowledged that there will be other measures. It is important to make the measurement set as frictionless as possible for practices by asking practices to report data that can improve their work, contribute to the betterment of health, and reduce spending.
    - Rural and small independent practices face a unique set of challenges. Although these challenges are described well in the white paper, there are opportunities to go further. Rural physicians need additional resources to navigate the impacts of isolation.

    - There are opportunities for patients to be more engaged in their health care using tools such as artificial intelligence (AI) and digital health. These tools will put pressure on primary care to receive, harness, and interpret information in partnership with patients.
- Mr. Martin shared several areas in which AAFP encourages PTAC to strengthen its recommendations in the draft white paper.
    - There are opportunities to strengthen the discussion on prospective payment. The purpose of prospective payment is not solely about saving money. Although the overall construct is about saving money and improving health, this does not mean that every person or function within the system must save money. More investment in primary care could help save money more broadly in the system. There are opportunities to build population-based prospective payment in Medicare, APMs, and even the FFS system using codes such as APCM codes.
    - Real-time data sharing needs to be practical, usable, applicable, and able to inform implementation at the point of care.
    - AAFP encouraged PTAC to consider creating a multi-payer alignment roadmap in response to overlapping activity in APMs, the advanced primary care space within MA, and other innovators in the marketplace.
- Mr. Martin shared several areas in which AAFP urges caution before scaling.
    - Although AAFP generally aligns with the idea of encouraging the adoption of a non-FFS-based practice model, many practices are not ready to participate. From a workforce perspective, AAFP urged caution of mandating participation in models to avoid pushing out physicians who are nearing retirement and may not be interested in engaging in this type of transformation. In addition, PTAC should consider how mandatory and voluntary participation drives mergers, acquisitions, and market consolidation.
    - AAFP encouraged Committee members to consider additional opportunities to support rural and small practices, such as providing geography-based funds to help practices overcome isolation from resources that are available in urban and suburban areas.
- Mr. Martin described several additional areas for policymakers.
    - AAFP is heavily engaged in the concept of primary care investment. In collaboration with the National Association of Community Health Centers, AAFP has launched a campaign called the Triple Double. The campaign includes three elements: increasing investment in primary care, growing the primary care workforce, and increasing the number of Americans with a usual source of primary care.
    - AAFP encouraged PTAC to expand its discussion on technology by considering the role of technology within APMs. For example, the Committee members could consider whether technology is a tool, a partner, or both a tool and a partner in APMs and whether these services should be incorporated into population-based payments or kept separate.
    - Clear expectations are needed for alignment across payers.
- Mr. Martin concluded that PTAC's draft white paper emphasized the right fundamentals, including prospective payment, interoperability, and meaningful measures. He encouraged Committee members to consider ways to reduce friction for physicians, care teams, and patients in APMs.

For additional details on Mr. Martin's presentation, see the presentation slides (pages 17-25), transcript, and meeting recording (21:52-33:28).

Jennifer Podulka presented APG's comments on PTAC's draft white paper.

- APG is a national membership organization of more than 300 physician groups that are committed to value-based care. APG's members include roughly 260,000 physicians and other clinicians caring for nearly 90 million patients, representing one in four Americans or one in three individuals enrolled in MA. Its physician groups operate in nearly every APM, including the Medicare Shared Savings Program, CMS Innovation Center models, managed Medicaid, commercial accountable care arrangements, and two-sided risk contracts within MA.
- APG believes that PTAC's draft white paper is a valuable roadmap that should be sharpened rather than softened. The white paper's core conclusion—to evolve and expand value-based care rather than retreat from progress made to date—aligns with APG's position in its report, *Medicare Done Right: Prescriptions for Success*. APG agrees with PTAC's emphasis on using population-based total cost of care (PB-TCOC) models as the primary vehicle in the transition to value-based care. These models are cost-efficient and produce better outcomes for patients.
- The draft white paper is most persuasive where it offers clear, actionable recommendations, such as fixing ACO benchmarks and including prospective payments with defined glide paths. In areas with only high-level principles, the white paper risks reading as aspirational rather than providing a roadmap and would benefit from more specificity.
- Ms. Podulka observed that the white paper's focus areas give policymakers a complete picture of what it takes to scale accountable care within traditional Medicare. Although the white paper is framed as a roadmap for value-based payment models and care broadly, every recommendation addresses traditional Medicare ACOs and APMs. The white paper does not consider MA. The lack of discussion on MA is a significant gap in the white paper, as 55 percent of beneficiaries who are eligible for Medicare Parts A and B are now enrolled in MA.
    - APG commissioned a study released last year by Berkley Research Group called, *Sticker Shock: Personal Financial Factors Leading New Medicare Beneficiaries to Choose Medicare Advantage over Traditional Medicare*. The analysis modeled 15 real-world choices a new beneficiary may face when deciding whether to stay in traditional Medicare and add Medicare Supplement Insurance (Medigap) with a Part D drug plan or enroll in a zero-premium MA plan with drug coverage. The analysis found that MA was the better financial choice compared with traditional Medicare in 11 of the 15 scenarios. APG and its affiliated researchers published evidence in *JAMA Network Open* and the *American Journal of Managed Care* showing that physician groups in two-sided MA risk arrangements achieve superior outcomes compared with traditional Medicare, particularly for dually eligible and socially vulnerable populations. These results offer positive spillover into traditional Medicare.
    - PTAC's draft white paper lacks discussion on MA, the part of the Medicare program where most beneficiaries are and where physician-led accountable care is the most developed to date.
- Ms. Podulka stated that APG strongly supports six of PTAC's recommendations: providing flexibility for accountable entities; fixing the benchmark ratchet effect; providing prospective, up-front payment; creating a simple glide path to two-sided risk; encouraging specialist engagement by nesting accountability in TCOC models; and trimming and aligning performance measures.
- APG identified six recommendations that generally have the right direction but could benefit from sharpening the language: protecting physician-led accountability; expanding on "long-term predictability" with a defined benchmark methodology; calibrating any move to mandatory participation; linking enablers more clearly to a participation pathway; recognizing real-world

data limitations in certain EHR systems; and clarifying the patient safety earn-back model for ambulatory, physician-led entities.

- In addition to sharpening some of the language in the white paper, APG suggested three additional recommendations for PTAC to consider based on APG's report, *Medicare Done Right: Prescriptions for Success:*
    - MA risk arrangements should be explicitly addressed.
    - Risk adjustment and performance data should be aligned across MA, the Medicare Shared Savings Program, and other TCOC models.
    - The advanced APM bonus should be restructured as a flat dollar amount per attributed beneficiary rather than a percentage of fees.
- Ms. Podulka concluded by recommending that PTAC sharpen the white paper, not soften it. She recommended that Committee members retain the white paper's core direction of evolving and expanding PB-TCOC models rather than retreating from value-based care; pairing the white paper's strongest principles with specific, actionable recommendations and a defined methodology; protecting physician-led accountability that drives savings; and extending the roadmap to MA, where most beneficiaries are enrolled and where much of health care's risk-bearing innovation is taking place.

For additional details on Ms. Podulka's presentation, see the presentation slides (pages 26-39), transcript, and meeting recording (33:29-45:12).

Following the presentations, Committee members asked questions of the experts. For more details on this discussion, see the transcript and meeting recording (45:13-1:36:21).

Experts discussed how MA reforms could be structured.

- MA reforms could include lowering payment, removing the Stars Ratings program, changing risk adjustment, and standardizing benefits. MA plans may be more likely to transition to value-based models if they are paid better. It is difficult to reward MA plans for their use of different types of models because it is unclear whether the plans' actions are driven by administrative requirements or by finding better ways to achieve value. As MA plans increase engagement in the delivery system, they may choose to contract in ways that do not fit preconceived notions of how plans should contract with providers. It will be important to figure out how to handle the MA program to maintain a vibrant FFS system. Payment models should make the FFS system as efficient as possible.
- Little is known about payment mechanisms between MA plans and their contracted provider groups. The CMS Innovation Center is considering models that assess MA, which can help to better understand what payment mechanisms and incentives work when accountable care is tied to MA.
- What works well varies by context. It is difficult to ensure that regulation is appropriate in different areas while allowing MA plans and provider groups to have flexibility to behave in the most clinically and economically advantageous ways.

Experts discussed how to make waivers clearer given the potential of waivers to make changes without reforming the entire system.

- Waivers allow flexibility to test what is working and what is not working. Sometimes in clinical practice, aspects of models do not work as expected.

Experts discussed how to integrate specialists into value-based care, including which specialties should be included and how the model might be structured.

- Cardiology is a good fit for value-based care models when considering the continuum of care and a focus on prevention. Surgical areas including general surgery and orthopedics, as well as anesthesia, could also fit well with these models. There is a need to move away from the perception that value-based care is a primary care function and move toward including all specialists who are willing to participate and creating a structure that allows specialists to succeed.
- Primary care is well-positioned for value-based care because it is a community-based discipline, and most encounters and pathology take place in primary care. However, the burden of TCOC should not fall solely on the primary care workforce; participants from other disciplines should also be involved. Models should be designed to allow both procedural and non-procedural-based specialties to engage in value-based care.
- When designing episode-based models, one challenge is understanding how to attribute the portion of waste being eliminated to the specialist who is eliminating that waste, especially for patients with multiple conditions. For example, one expert inquired whether the savings should go to the cardiologist or the primary care doctor if a post-acute stay is avoided. Episode-based models that focus on specialty groups can result in too many models. It is important to be careful about how episode-based APMs interact with other types of providers and episodes. TCOC models should be built so that savings from reduced imaging or post-acute stays do not go only to specialists, which can make it difficult for primary care doctors to identify where the waste is. When specialists eliminate waste that primary care doctors could not eliminate, the savings should go to specialists. However, this can be difficult to operationalize when multiple groups claim that they can eliminate waste, particularly for complicated patients with multiple conditions.

Mr. Martin discussed what patient engagement might look like from a benefit design perspective (e.g., incentives). There has been a focus on payment models between physicians and payers, but it is also important to engage patients.

- For attributed population-based payment at the primary care level, the goal for patient engagement is to reduce barriers for patients to engage and to increase incentives for practices to engage.
    - To reduce barriers for patient engagement, AAFP has recommended the elimination of cost-sharing requirements for patients who are self-attributed or otherwise allocated to a designated primary care physician or team. This would create greater connectivity, incentivize usual source of care, and prevent leakage. The best attribution model is when the patient declares their primary care physician or team, and this should be rewarded by eliminating cost sharing. Eliminating cost sharing in primary care could begin with the usual source of care to incentivize longitudinal relationships. Elimination of this barrier prevents leakage to higher-cost care settings with moderate effectiveness, and leads to better health outcomes. The approach allows sick or high-needs patients to receive primary care services as much as needed to manage their health.
    - Using encounter data and performance measures can help create incentives for practice-level engagement by ensuring that practices are engaging with patients prospectively, especially related to primary prevention such as checkups, cancer screenings, and medication reconciliation.

- Incorporating technology into the comprehensiveness of the primary care team is important for patient engagement. Health care is at an inflection point regarding whether technology will be outside or inside the primary care team.
- To drive patient engagement, models should be agnostic to modality. Currently, there are payment, reporting, and documentation incentives that vary depending on visit modality (e.g., in-person, telehealth, digital, phone call, home visit). Modality should be determined by what is best for the patient, particularly in a longitudinal primary care model.

Experts discussed simple, predictable glide paths toward APMs. Accounting for differences, including urban versus rural and primary care versus specialty care, experts discussed glide paths that could give those making investments enough time to see what is coming and adapt accordingly.

- Policies should be created that help rural practices be the best versions of themselves and ultimately build skills that allow them to be incorporated into other models. The APCM codes in FFS should be expanded to serve as an on-ramp to population-based payment. Doing so would allow rural practices to shift from using an episode-based, FFS mindset to a population-based payment mindset.
- It will be important to clearly identify the skills that rural practices are asked to incorporate. Rural practices need to use technology to connect with other physicians and disciplines in a way that urban and suburban practices do not. Rural practices need funding that is solely geography-dependent to break down barriers of geographic isolation. Financial incentives should allow rural physicians to build support structures to join the glide path without forcing them out of practice.
- The term "ACO" stemmed from a research idea called "extended hospital medical staff" that was created as a proxy in the United States for the system-ness that other countries have in their health care. The extended hospital medical staff includes physicians with admitting privileges and other physicians and providers in the same catchment area whose treatment patterns and other characteristics could be measured by researchers, and among whom system-ness could perhaps be encouraged. Today, the crux of the issue remains a lack of system-ness, even with existence of ACOs. Obstacles for different groups should be addressed in the glide paths to ensure that there is more communication. For rural and other under-resourced providers, the first obstacle is investment. Rural and under-resourced providers cannot interact more broadly with their systems without investment. Other types of physicians, including certain procedure-based specialists, face the obstacle that the inherent carrots in prospective payment and FFS are too enticing to give up.
- Sometimes we conflate rural versus urban with independent versus system-based and with small versus large; however, there is a lot of heterogeneity within these categories that makes it difficult to develop regulations. The question of how to ensure access to care and technology in rural areas is extremely important and transcends decisions about payment models.
- There are operational reasons to not put APCM codes in FFS. However, investing in providers that have difficulty staying in business and providing care is important, regardless of whether this is done through an additional code in FFS, an APM tailored to the providers, or another mechanism. The overall integration of these providers with hospitals should be considered. Independent groups tend to do better than integrated delivery system groups. Models can be designed to give hospitals better incentives, and hospitals and hospital-based systems can provide value; however, models have generally not been designed this way. A version of TCOC accountability that places emphasis on primary care and leverages specialists where synergies

are possible is needed. From there, the technical details such as risk adjustment, attribution, benchmarks, quality, and distribution of savings can be figured out.

Experts discussed how to embed positive aspects of the direct primary care (DPC) model, including its success in establishing longitudinal patient relationships, into APMs such as ACOs while considering accountability and modeling prospective payment.

- The DPC model removes the noise and friction that comes between the physician or care team and the patient, including quality reporting and documentation. The payment model is a subscription that finances the relationship. When applying lessons learned from the DPC model to APMs, one consideration is how much can be taken from other models to ensure that population-based payment drives engagement between the physician and the patient in the exam room. DPC physicians report that the ultimate quality measure takes place on the first of every month when their subscription is paid and patients remain engaged with their practice. There is no such continuous affirmation in Medicare.
- There is a tendency to add more requirements, quality measures, and complexity that make it difficult for all physicians to practice. Many quality measurement programs, including those beyond APMs such as MIPS, should be removed or simplified to prevent substandard care. When designing APMs, provider burden should be considered. With subscription models of primary care, there is a tension about what the physician does for that fee, how to determine risk and risk adjust the fee when referring patients, and how to deal with people who are integrated with large groups. A model that works in one context may not work in other contexts.

Experts discussed types of quality or performance measurement that should be included in a more connected TCOC model, recognizing that how quality is measured in value-based care models is disconnected from TCOC.

- CMS and others have been working to reduce the primary care measure set to three to six impactful measures, such as continuity of care measures and measures that promote prevention (e.g., cancer screenings). Following the passage of the Affordable Care Act (ACA), there were hopes that quality measurement would solidify the value of primary care; however, it created an auditing system that allowed many payers to not pay family medicine physicians for provided services. Quality measurement pulled the wrong levers and led to burnout and quitting among family physicians while disease and spending continued to increase. Health care is now invested in identifying a manageable set of measures that drive better health. Many quality measures are extracted from notes or medical records. The measurement process is shifting toward real-time engagement at the point of care. This real-time engagement helps physicians and patients make the right choices to drive better health and should be incentivized at the point of care.
- Rather than asking how to create a quality measurement system to improve cancer screening or blood pressure control, the question should be how to improve and incentivize cancer screening or blood pressure control. There is strong evidence on the importance of screenings, but clinicians are penalized for providing poor care for reasons that may include patient-level barriers (e.g., out-of-pocket costs, transportation barriers, choosing to not be screened) or informational barriers (e.g., outdated medical records that do not reflect screening performed at another location). Quality measurement can also force doctors to follow checklists rather than focus on the most important problem for the patient.
- Quality guardrails for a TCOC model should focus on understanding and preventing substandard care, not determining who receives four or five stars. Clinicians should help answer what these

guardrails should be. Guardrails may not be needed for small practices but instead could happen at a broader, organizational level.

Experts discussed how to handle FFS during the transition to value-based care.

- Many physicians would dispute that FFS is comfortable; however, for some physicians, FFS is more comfortable than the alternative option. The CMS Innovation Center has been testing models for long enough that groups that would volunteer to participate have generally already done so. In many cases, participation mandates make sense. However, caution is needed for the groups that do not have the resources to participate. These groups do not necessarily find FFS comfortable, but they are unable to step away from it.
- Based on knowledge gained in 2014 and 2015, the MACRA construct of gradual discomfort in FFS was right. However, the COVID-19 pandemic was disruptive to that progression and to the roadmap that was executed. During that period, the only way to sustain most practices was to incentivize them through FFS. Following the COVID-19 pandemic, the progression of moving providers toward APMs did not continue. While it is important to move providers toward APMs, especially in family medicine and primary care, caution is needed. Mandatory models may push independent practices into consolidation or mergers and acquisitions or encourage providers to leave their practice altogether, especially providers in the later years of their careers. This could compound workforce problems in many communities.
- There is an important role for conveners and other organizations to help support small practices in managing information. Reforming APM bonuses to a per-person-type payment and solving design issues such as the benchmark ratchet effect should be considered for small organizations. Many organizations can provide value if models are designed to succeed.

Experts discussed training of medical residents.

- Residents, particularly family physicians and primary care physicians, are trained on an FFS model. These physicians do not leave their training programs with knowledge, skills, and experience in value-based models. This is an important gap that needs to be addressed.

Experts discussed the importance of simplicity and flexibility in value-based care.

- Models should be simplified wherever possible. Micromanaging models should be avoided. There are many unintended consequences with measurement. Administrative burden and complexity should be reduced, and flexibility should be built into models.
- AI will change how physicians practice in ways that are not yet understood. Flexibility for leveraging technology is needed.

Experts discussed beneficiary awareness and engagement in value-based care.

- Most beneficiaries enrolled in MA know the health care plan they are in; however, beneficiaries often do not know that they are aligned with ACOs or other TCOC models. It is important to build more patient awareness and engagement in ACOs and TCOC models.

Session 2: Expert Input on PTAC's Recommendations on Value-Based Care: Part 2

SMEs

- Hoangmai (Mai) Pham, MD, MPH, President and Chief Executive Officer, Institute for Exceptional Care (IEC)
- Paul Krakovitz, MD, FACS, Chief Executive Officer, Cone Health

- Emily DuHamel Brower, MBA, President and Chief Executive Officer, National Association of ACOs (NAACOS)

Lauran Hardin moderated the session with three SMEs regarding their input on PTAC's recommendations on value-based care. Full biographies and presentations are available.

Hoangmai Pham presented recommendations for strengthening value-based payment models and expanding participation in value-based care.

- Dr. Pham commended PTAC's draft white paper and recommendations and offered several considerations for strengthening the white paper. She emphasized that the impact of value-based payment extends beyond the performance of individual models, noting that value-based payment has influenced broader market behavior by counteracting traditional volume-based financial incentives. Policymakers should consider the counterfactual of a health care system without value-based payment, where volume incentives would remain largely unchecked.
- Referring to Recommendation 2, Dr. Pham emphasized that value-based payment models can promote patient empowerment and engagement, not only through voluntary alignment and attribution mechanisms, but also through greater beneficiary involvement in model design. Beneficiaries could help identify outcomes that matter most to patients, shape communication strategies, and improve voluntary alignment approaches. She stressed the importance of continuing efforts to address health disparities and social needs despite challenges with coordinating across health care and community-based sectors.
- Referring to Recommendation 8, Dr. Pham emphasized the importance of increasing participation among integrated health systems. Physician-led ACOs tend to perform well and should continue to be encouraged, but they are not the organizations currently causing the greatest harm from volume-based incentives. Policymakers should consider which provider organizations most need the "brake" that value-based payment places on volume-driven behavior.
- Referring to Recommendation 11, Dr. Pham encouraged PTAC and CMS to pursue a balanced set of measures that include technical clinical quality measures, population outcomes, and patient-reported outcomes. Current measure sets do not adequately capture outcomes that matter most to patients, including whether their concerns are addressed, whether they are treated with respect, and whether providers work together to coordinate their care.
- Dr. Pham argued that although value-based payment has become more common, participation remains limited, particularly among high-cost, high-growth "must-have" providers with substantial market leverage. The underrepresentation of these providers limits opportunities to reduce spending growth, constrains the financial incentives available to high-performing participants, and does little to counter the growing market power of large provider organizations. This dynamic can create political pressure to increase public-sector payment rates, potentially offsetting some of the gains achieved through value-based payment. To increase participation and strengthen value-based payment models, Dr. Pham expressed support for mandatory TCOC models and encouraged policymakers to reduce arbitrage opportunities within the current payment system, including pricing distortions, facility fees, and risk adjustment incentives.
- Dr. Pham argued that the Medicare Physician Fee Schedule (PFS) should be viewed as a value-based payment model because it provides the pricing foundation for many value-based payment arrangements. She highlighted a range of pricing and payment distortions within the fee schedule, including the overvaluation of some services and the undervaluation of other

services, as well as facility fee incentives, unbundled services, variation in payment across closely related procedures, and opportunities for upcoding. These distortions can create incentives that run counter to the goals of value-based care and often cannot be fully addressed by individual value-based payment models or organizations alone.

- Dr. Pham encouraged CMS and PTAC to consider fee schedule reform as an important area for value-based payment innovation, including exploring alternative pricing approaches, incorporating additional data sources into pricing decisions, reducing arbitrage opportunities, simplifying payment codes into broader payment families, and testing alternative fee schedule designs. She also emphasized that FFS should be viewed as one tool within a broader payment framework rather than as the opposite of value-based care.

For additional details on Dr. Pham's presentation, see the presentation slides (pages 2-11), transcript, and meeting recording (00:00-17:33).

Paul Krakovitz presented health system perspectives on implementing value-based care and reducing barriers to participation.

- Dr. Krakovitz described Cone Health's experience participating in value-based care arrangements and generally endorsed PTAC's recommendations. Starting with Recommendation 14, he emphasized the importance of multi-payer alignment, noting that health systems often participate in multiple value-based contracts simultaneously and must navigate different quality measures, reporting requirements, and administrative processes across payers. He suggested that greater alignment would reduce complexity and allow organizations to focus more resources on improving care delivery.
- Dr. Krakovitz highlighted primary care as the foundation of value-based care and population health management. Clinicians are motivated not only by financial incentives but also by a desire to provide the best possible care for their patients and communities. One challenge is providing clinicians and provider networks with real-time data that can support quality improvement and care management. Given ongoing workforce shortages, he stressed the importance of equipping clinicians with the information and tools needed to succeed in value-based arrangements while maintaining opportunities for practice independence. Risk-bearing entities should have access to waivers, incentives, and other tools that align accountability and performance expectations throughout provider networks and down to the individual clinician level.
- Dr. Krakovitz identified behavioral health integration as an area that deserved greater emphasis in PTAC's recommendations. Behavioral health conditions contribute significantly to TCOC and increase the complexity of care delivery. He encouraged stronger integration of behavioral health and primary care services and suggested elevating behavioral health integration from a conclusion in the white paper to a more formal recommendation. He also encouraged PTAC to move away from fragmented, piecemeal models and instead promote platform-based approaches that are easier for health systems, ACOs, and clinically integrated networks to administer and use to support care delivery.
- Dr. Krakovitz discussed the role of AI in health care and emphasized the importance of responsible implementation. AI could help reduce administrative burden and provide clinicians with more timely, actionable information, particularly for quality measurement and reporting activities. However, he cautioned against unnecessary regulatory requirements and emphasized that AI should make care delivery simpler rather than add complexity. Reducing administrative burden is important for addressing clinician burnout and supporting participation in value-based care.

- Dr. Krakovitz identified two additional areas that he believed warranted greater emphasis in PTAC's recommendations. First, he highlighted the importance of addressing social drivers of health through stronger partnerships with community organizations, noting that health systems cannot solve these issues alone and that incentives should support cross-sector collaboration. Second, he emphasized the need for greater alignment across Medicare, Medicaid, MA, and commercial value-based arrangements. More universal quality measures and reduced administrative variation across lines of business would lessen burden and improve care coordination for health systems responsible for entire communities.

For additional details on Dr. Krakovitz's presentation, see the presentation slides (pages 12-23), transcript, and meeting recording (17:34-28:27).

Emily Brower presented on ACO perspectives on sustaining and expanding value-based care models.

- Ms. Brower highlighted recent Medicare ACO results showing continued year-over-year improvements in quality and utilization, including emergency department (ED) visits and admissions, readmissions, overall quality scores, and chronic disease management. These results reflect the work of ACOs and their provider networks and the investments they make to improve the health of the populations they serve.
- Ms. Brower framed her comments on PTAC's recommendations around NAACOS' priorities for modernizing ACOs: sustainability, burden reduction, and innovation. Under sustainability, she emphasized the need to address the benchmark ratchet and supported a more robust add-back of savings earned by ACOs as they renew their participation. In discussing Recommendations 3, 4, and 7, she emphasized primary care as the center of accountability while supporting flexibility in how ACO networks are organized and their risk and cash flow arrangements. She also suggested adding partial or primary care capitation within TCOC to PTAC's table of payment methodologies.
- Regarding Recommendation 8, Ms. Brower encouraged CMS to improve existing accountable care pathways rather than create new models that take years to operationalize and evaluate. She emphasized preserving lower-risk options for small, independent, and rural providers until they can generate sufficient savings, protecting these providers from under-capture of illness burden and volatility associated with smaller populations, and using hybrid payment approaches that reflect different organizational structures. Models should recognize the higher historical costs of networks that include hospitals, specialists, and post-acute providers.
- Ms. Brower identified alignment between Medicare ACOs and MA as a near-term priority under Recommendation 14. More broadly, she supported investments and policies that make value-based payment more consistent across lines of business while preserving state-based innovation.
- Under the burden reduction pillar, Ms. Brower emphasized interoperability, patient choice, and simpler quality reporting. She recommended relying on existing patient safety organizations and accrediting bodies to support patient safety rather than adding duplicative requirements for ACOs.
- Under the innovation pillar, Ms. Brower emphasized that innovation grows out of opportunity and flexibility. Fair and sustainable benchmarks, reduced administrative burden, and flexible payment arrangements allow accountable entities to choose approaches that work for their networks, communities, cash flow needs, and care transformation strategies. Payment flexibility can help sustain and align provider networks, maintain primary care at the center of accountability, and create opportunities to reward preventive care.

- Ms. Brower encouraged PTAC to make ACO success more prominent in the draft white paper's introduction and conclusion sections. She also urged PTAC to move away from distinctions between physician-led and health system ACOs, noting that Medicare ACOs are physician-led but may make different choices about whether to include hospitals and other health system entities. She challenged the view that integrated delivery networks and hospital systems have little incentive to participate, explaining that ACOs can reduce preventable admissions that generate little or negative hospital margin while creating opportunities to earn shared savings. She recommended incorporating more real-world financial information into the white paper and preserving flexibility for accountable entities to choose the model, track, and downstream arrangements that support their clinical and financial goals.

For additional details on Ms. Brower's presentation, see the presentation slides (pages 24-33), transcript, and meeting recording (28:28-41:51).

Following the presentations, Committee members asked questions of the experts. For more details on this discussion, see the transcript and meeting recording (41:52-1:03:56).

Experts discussed opportunities to strengthen behavioral health integration and address health-related social needs (HRSNs) through value-based care models.

- Integrated behavioral health is an essential component of accountable care. Existing payment policies that allow providers to deliver and receive reimbursement for behavioral and physical health care in the same setting and on the same day can support care integration. Partnerships between ACOs and community care hubs can also connect beneficiaries with community-based organizations addressing HRSNs.
- In addition to supporting integrated behavioral health and community-based care, ACOs and other value-based payment organizations could be encouraged to partner with community-based providers that offer scalable services, such as peer support groups and group therapy programs. Greater revenue flexibility could help ACOs invest in these types of community-based supports.
- Behavioral health and social drivers of health are foundational needs that must be addressed before many other health outcomes can improve. While integrating behavioral health and primary care is important, smaller practices may face challenges implementing those models. Incentives that support collaboration with community-based and nonprofit organizations addressing social drivers of health could help reduce barriers and improve care, particularly because health care providers cannot address issues such as food and housing insecurity on their own.

Experts discussed opportunities to reduce barriers to embracing value-based care models.

- Designing value-based payment models often requires balancing fairness and simplicity. Providers have historically favored more precise and tailored approaches, but increased complexity can make models difficult to administer and may create only a false sense of precision. Future model development should consider where simplification is possible.
- An important source of friction comes from financial incentives and arbitrage opportunities outside of value-based payment models, which compete with organizational investments in population health and accountable care.
- Transitions of care remain a significant source of friction for value-based organizations, particularly when patients move from acute care settings to skilled nursing, post-acute, or other

care settings. Variability across payer policies can create barriers that delay or complicate these transitions. Reducing these administrative and operational barriers could improve care transitions, lower costs, and better support patients' goals of minimizing unnecessary hospital stays.

- ACOs have invested heavily in collecting and integrating data from multiple sources, including health information exchanges, admission-discharge-transfer notifications, claims, clinical records, and laboratory data, to improve quality and TCOC. However, the lack of interoperability and data standards makes quality reporting costly and burdensome because organizations must retrieve information from multiple unstandardized data sources. Continued progress on interoperability and data standardization could reduce burden.

Experts discussed opportunities and considerations for the use of AI in value-based care.

- AI could be used to provide more timely, actionable data and reduce administrative burden associated with quality measurement and reporting. Rather than adding new requirements, AI could help simplify existing processes and remove friction. AI may also help address workforce shortages.
- AI could help develop alternative approaches to risk adjustment by incorporating data beyond claims and potentially reducing incentives for gaming and upcoding associated with current risk adjustment methods. AI also offers opportunities to help providers identify efficiencies, but policymakers should avoid overly prescriptive approaches and allow flexibility in how AI is used. At the same time, guardrails are needed to ensure that AI supports rather than replaces the human-care relationship, particularly for patients with complex clinical and social needs.
- Accountable care models create incentives for clinicians and organizations to adopt innovations that support integrated care. As AI and other technologies continue to evolve, ACOs can serve as a setting for innovation that remains aligned with accountable primary care and coordinated care delivery, rather than relying on disconnected point solutions that operate outside of those relationships.
- Risk adjustment methodologies have evolved repeatedly and can be difficult for organizations participating in value-based care. While AI may offer opportunities to simplify some of these processes, stability and predictability remain critical for organizations assuming clinical, financial, and operational risk. New technologies should be implemented thoughtfully, noting that health care technologies have often increased complexity from the clinician perspective.
- Providers spend significant time and resources on Risk Adjustment Factor (RAF) scores and risk adjustment activities, even though many clinicians would prefer to focus their attention on patient care rather than maintaining risk scores.

Experts discussed the role of the Medicare PFS in shaping incentives within value-based care models.

- CMS has already begun addressing distortions within the Medicare PFS, including efforts to reevaluate overvalued and undervalued services. Broader fee schedule reform has often been limited by both operational resources and political resistance, despite growing recognition that current pricing distortions contribute to inefficiencies and poor outcomes. PTAC could consider encouraging further innovation through alternative pricing data sources, simplified payment code structures, and other reforms designed to prevent future distortions.
- FFS should not be viewed as the opposite of value-based care. Certain services, such as preventive care and house calls, may be appropriately supported through FFS payment. The broader goal should be to create a balanced mix of payment approaches that allow clinicians to

focus on patients' needs rather than financial incentives associated with particular payment structures.
- FFS and value-based payment arrangements can both play important roles in supporting high-quality care and should not necessarily be viewed as opposing approaches.

Session 3: Expert Input on PTAC's Recommendations on Value-Based Care: Part 3

SMEs

- Wyatt W. Decker, MD, MBA, Executive Vice President, Chief Physician, Value-Based Care & Innovation, and Executive Director, Health Care Transformation Hub, UnitedHealth Group
- Elizabeth Mitchell, President and Chief Executive Officer, Purchaser Business Group on Health (PBGH)
- Sarah Fogler, PhD, Senior Research Director, Healthcare Transformation, Duke-Margolis Institute for Health Policy

Krishna Ramachandran moderated the session with three SMEs regarding their input on PTAC's recommendations on value-based care. Full biographies and presentations are available.

Wyatt Decker presented recommendations on value-based care.

- Dr. Decker strongly supported continued expansion of value-based care and reflected on his experience as an emergency physician, noting that many patients presenting to emergency departments (EDs) could have avoided reaching a crisis with better access to primary care, specialty care, or other basic services. He described ED care as a costly response to needs that could often be addressed earlier and characterized value-based care as an opportunity to address these underlying gaps through more proactive and preventive care.
- Reflecting on the broader direction of value-based care, Dr. Decker characterized FFS as a root cause of dysfunction in the U.S. health care system because it rewards volume rather than keeping patients healthy. He cautioned that the term "value-based care" can have different meanings for policy stakeholders and patients. He suggested focusing communication on the intended care experience: a team that proactively engages patients, supports preventive care and screenings, and helps patients remain healthy. Dr. Decker emphasized that the health care system has only begun to realize the potential of fully accountable value-based care at the provider level and pointed to organizations where these approaches have produced meaningful results.
- Dr. Decker discussed patient churn as an ongoing challenge, particularly in MA, citing estimates of approximately 10 to 15 percent annually. Much of this churn reflects beneficiaries moving between plans. Greater continuity could strengthen incentives for plans to invest in long-term prevention rather than focusing on shorter-term outcomes. Similar challenges arise in employer-sponsored coverage.
- Regarding the transition to value-based payment, Dr. Decker emphasized that the appropriate pace and level of support should vary across providers. Organizations and health systems with substantial experience in value-based payment could move more quickly toward greater accountability and risk, while small, independent, and rural providers may require a more gradual transition. He strongly supported preserving a viable pathway for these providers and emphasized the need for grants, subsidies, infrastructure assistance, and access to experienced partners rather than expecting smaller practices to build these capabilities independently. He also highlighted roles for both public and private sector support.

- Dr. Decker reviewed research demonstrating improved outcomes under fully accountable value-based arrangements, highlighting substantial reductions in acute hospitalizations among MA patients. He also discussed evidence of spillover effects, noting that primary care providers focused on longitudinal value-based care may improve care for their FFS patients.
- Dr. Decker recommended keeping performance measures simple and focused. He described the number and complexity of Healthcare Effectiveness Data and Information Set (HEDIS) measures as a source of administrative burden and encouraged the use of a smaller set of high-level measures that could, where possible, be automated. He also supported start-up grants and access to vetted partners for smaller organizations entering value-based payment arrangements and emphasized that access to usable data is critical.
- Regarding specialty care, Dr. Decker highlighted opportunities to identify and preferentially refer patients to high-quality specialists based on evidence of quality, utilization, and appropriate care. These approaches can influence care even within FFS arrangements and do not necessarily require changes to the underlying incentive structure. He cautioned against conflating patient safety with value-based payment, emphasizing that safety is essential but requires its own appropriate oversight without creating an excessive measurement burden.
- Dr. Decker strongly supported next-generation primary care models that use data analytics and team-based approaches and suggested greater attention to transitions of care. He emphasized the importance of determining the most appropriate setting and supports needed following hospital discharge, including rehabilitation, skilled nursing, or home-based care. He also highlighted opportunities to move clinically appropriate patients to lower-cost sites of service and described home care as the next frontier for value-based care, while emphasizing that care at home must be supported appropriately to avoid adverse outcomes and readmissions.
- Regarding patient engagement and incentives, Dr. Decker cautioned that high out-of-pocket costs can create barriers to care. He noted that providing patients with financial incentives and information about high-quality, lower-cost care options can influence choices and generate both TCOC and out-of-pocket savings. He emphasized that higher prices are not necessarily associated with better quality or patient experience and suggested allowing patients to share in savings when they choose appropriate, high-quality, lower-cost care.

For additional details on Dr. Decker's presentation, see the presentation slides (pages 2-11), transcript, and meeting recording (00:00-19:52).

Elizabeth Mitchell presented her perspectives on health care transformation and opportunities to accelerate value-based care in the commercial market.

- Ms. Mitchell described the perspective of Purchaser Business Group on Health (PBGH), a nonprofit coalition representing many of the nation's largest private employers and public purchasers. She noted that the commercial market continues to experience increasing costs, flat or declining quality, and declining access despite longstanding efforts to improve quality, affordability, and equity. She emphasized the significant frustration among purchasers and patients with the current health care system and stressed the urgency for meaningful change.
- Reflecting on the pace of progress toward value-based payment, Ms. Mitchell noted that approximately 38.9 percent of commercial health care spending is outside of FFS arrangements, and less than 20 percent involves downside risk. She contrasted the slow adoption of APMs with the rapid implementation of Diagnosis-Related Groups (DRGs) and characterized the challenge as one of will rather than capability. Successful pilots demonstrate the health care industry's ability to change when sufficient commitment exists.

- Ms. Mitchell described PTAC's recommendations as thoughtful and reasonable but questioned whether they would produce meaningful improvements at the pace patients need. There is urgency among patients for greater affordability, better care experiences, and improved outcomes. Greater consideration of the commercial market is needed, including businesses, public purchasers, trusts, unions, and individual families that ultimately pay for care.
- As an example of ongoing payment reform, Ms. Mitchell highlighted PBGH's advanced primary care initiative in California, which includes more than 100 practices. She emphasized that payment approaches should be matched to desired outcomes and coupled with shared accountability, noting that the initiative allows for FFS, prospective population-based payments, and capitation. She also highlighted the importance of common standards, meaningful payment incentives, and a simple, concise set of high-priority quality measures.
- Ms. Mitchell discussed PBGH members' experience with preferred provider partnerships that incorporate upside and downside risk and financial, quality, and patient experience measures. These arrangements have resulted in improvements in employee health measures, including depression and cancer screening, along with lower out-of-pocket costs and TCOC savings. Employers are also applying value-based contracting approaches to other partners, including pharmacy benefit managers.
- Ms. Mitchell reported 7 to 14 percent reductions in TCOC, reduced ED utilization, and other savings from direct contracting for advanced primary care. These successes have primarily occurred in regions where employers have a sufficient number of employees; however, PBGH members are seeking to scale the approach nationally. These arrangements use prospective population-based payments and hold participating practices accountable for common measures.
- Ms. Mitchell pointed to growing provider interest in direct employer contracts as evidence of provider readiness for greater accountability. She highlighted PBGH's experience operating a directly contracted centers of excellence network for specialty care, noting that participating employers achieved savings alongside improved outcomes and high patient satisfaction. These experiences show that successful approaches can be scaled more rapidly.
- Ms. Mitchell emphasized that value-based payment alone does not adequately address the issue of health care pricing. She described substantial price variation across providers and sites of care and noted that price is not consistently correlated with quality or safety. Employers are prepared to steer employees toward higher-quality, higher-value providers when they have the information necessary to identify them.
- Additional policy priorities included addressing anticompetitive contracting practices, strengthening price transparency, and ensuring that purchasers have access to their claims data. Data access remains a significant barrier, even when purchasers are legally entitled to the information, and is critical to implementing effective value-based arrangements.
- Ms. Mitchell concluded by emphasizing the urgency of health system transformation from the patient perspective. Drawing on her experience serving in California's Office of Health Care Affordability, she described hearing directly from workers and other community members about the significant financial and personal consequences of high health care costs. She encouraged policymakers and health care leaders to respond to the urgency being expressed by the people the health care system is intended to serve.

For additional details on Ms. Mitchell's presentation, see the presentation slides (pages 12-32), transcript, and meeting recording (19:53-33:30).

Sarah Fogler presented her assessment of PTAC's white paper and identified priorities for accelerating accountable care and population-based payment models.

- Dr. Fogler characterized PTAC's white paper as timely and directionally appropriate but suggested that the health care system may be at a different stage of value-based care maturity than the white paper assumes. Expanding participation in accountable care models does not necessarily translate into better outcomes or lower spending. As an example, Dr. Fogler noted that ACOs have generated measurable savings and improved coordination, but their overall impact on Medicare spending has remained modest. This experience should prompt greater attention to the barriers preventing successful models from achieving broader impact and scale.
- Regarding the white paper's strengths, Dr. Fogler supported the emphasis on person-centered, coordinated, team-based care and the recognition that advanced primary care alone is insufficient to achieve whole-person care. She emphasized the importance of integrating specialty care into accountable care strategies and noted that payment approaches should reflect the different roles specialists play, including episodic, procedural, and longitudinal chronic disease management. Depending on the provider and type of care, she noted that FFS, accountable care arrangements, bundled payments, and other approaches may each have appropriate roles.
- Dr. Fogler questioned whether payment design remains the primary barrier to transformation, noting that a broad range of payment strategies and risk arrangements already exist. She observed that many of the recommendations reflect priorities the field has been discussing for years and emphasized the need for greater urgency and actionable strategies to drive the next wave of adoption and impact. Data interoperability, workforce capacity, transformation financing, and actionable implementation evidence are increasingly important barriers to scale. She encouraged greater attention to strategic participation, selection effects, and gaming within voluntary models. Dr. Fogler stressed that the central challenge is determining how successful pilots can move into permanent programs at scale.
- Dr. Fogler identified four priorities to move from model design toward broader system transformation: establishing a clearer strategy for broad-scale accountability; investing in data and technology infrastructure; better aligning incentives across payers; and strengthening implementation and scaling. She characterized multi-payer alignment as critical to system-wide transformation and reducing burden on providers. For opportunities for accelerating population-based care, Dr. Fogler recommended greater simplification by reducing the number of models operating in the market and refining reporting requirements. She encouraged a greater focus on outcomes rather than prescribing specific care delivery models. She also emphasized the continued need for a trusted data infrastructure, noting that providers still have difficulty accessing timely and actionable information despite progress in interoperability standards. The remaining challenge is moving beyond technical interoperability toward routine use of data to improve care and reduce administrative burden.
- Dr. Fogler supported providing organizations with greater flexibility in how they deliver care and design benefits while holding them accountable for more substantial improvements in outcomes. She emphasized the importance of sustainable participation pathways for rural providers, independent practices, and safety-net organizations, noting that system-wide transformation will be difficult to achieve if participation remains concentrated among well-resourced organizations.
- Looking ahead, Dr. Fogler identified several forces that could shape the next generation of accountable care beyond current payment reform discussions, including transformative therapies, precision diagnostics, advanced prevention strategies, digital infrastructure, and AI.

She noted that AI could reduce administrative burden, expand access, and support improved outcomes but cautioned that its potential will be limited without a functional, interoperable data infrastructure. She encouraged broader accountability for prevention, care coordination, and social drivers of health.

- Dr. Fogler concluded that PTAC's overall vision was largely appropriate but emphasized that the principal obstacles to transformation increasingly involve data infrastructure, implementation capabilities, aligned incentives, and creating conditions that allow accountable care to succeed at scale. She encouraged faster learning cycles and stronger alignment across CMS, states, and other payers to move successful pilots into permanent programs.

For additional details on Dr. Fogler's presentation, see the presentation slides (pages 33-55), transcript, and meeting recording (33:31-45:43).

Following the presentations, Committee members asked questions of the experts. For more details on this discussion, see the transcript and meeting recording (45:44-1:05:41).

Experts discussed potential approaches to support participation in value-based care across different provider types and settings.

- Large, sophisticated health systems generally have the capabilities to participate in value-based care but may require stronger financial incentives to transition from FFS. Small, rural, independent, and safety-net providers face different barriers and may require partners that can provide technology, contract management, and other infrastructure.
- State and federal governments could help small providers identify appropriate partners and provide temporary grants or other types of funding to support transformation. Such assistance could help practices build the capabilities needed to participate before becoming financially self-sustaining.
- Small rural practices can achieve outcomes comparable to large, better-resourced practices when they have access to data and targeted technical assistance. Relatively straightforward support, such as coaching on team structures and care delivery changes, could help small practices successfully participate in value-based care.
- Incentive structures should be considered alongside actuarial projections and the financial requirements for sustaining models over time. A combination of incentives and requirements may be necessary to encourage participation and support models that can become permanent components of Medicare, Medicaid, and other programs.

Dr. Decker discussed potential approaches to improve care and payment for patients with complex and high-cost needs.

- Fully accountable care models can support more intensive services for medically complex patients, including in-home primary care and team-based support, because reducing avoidable utilization creates a financial rationale for investing additional resources in these patients.
- Payment approaches could include a complexity multiplier that provides additional reimbursement for the time clinicians spend caring for medically complex patients. A bonus or portion of the enhanced payment could be tied to subsequent reductions in ED visits or other downstream utilization. This approach could combine elements of FFS payment, which recognizes the additional resources required to care for complex patients, with accountability for TCOC over time.

Experts discussed patient churn and opportunities to strengthen incentives for long-term investments in health.

- MA benefits could be structured to encourage beneficiaries to remain with a plan longer, strengthening incentives for plans to invest in long-term prevention and coordinated care. Benefits tied to health outcomes, such as enhanced care coordination and transportation support, may be preferable to benefits that encourage beneficiaries to move between plans.
- Churn in employer-sponsored insurance is more difficult to address because coverage is tied to employment. Potential approaches could involve employer groups or alternatives to employer-based coverage, but the structure of the employer market poses a fundamental challenge to long-term investment.
- Patient retention operates differently in traditional Medicare ACOs because beneficiaries maintain freedom of provider choice. Although beneficiary attribution and retention presented challenges during early ACO implementation, beneficiaries appear increasingly likely to remain within ACO arrangements over multiple years.
- Employers have incentives that are generally aligned with employees and their families for lower costs, better care, and improved health outcomes. Employers also have sufficient scale to influence health care delivery and payment.

Experts discussed the appropriate balance between flexibility, voluntary participation, mandatory approaches, and accountability in value-based care models.

- Meaningful improvements in affordability, health outcomes, and access are needed within a shorter time horizon. Organizations should have flexibility in how they achieve these goals, but accountability for outcomes and costs should not be flexible.
- Policymakers should reconsider reliance on voluntary approaches if they do not produce more rapid progress. Greater transparency into outcomes and costs is also necessary to determine whether value-based arrangements are achieving meaningful results.
- Voluntary CMS Innovation Center models can be affected by selection bias because organizations expecting to succeed may be more likely to participate and remain in the models. This can limit the generalizability of model findings and make it more difficult to move successful pilots into permanent programs.
- Relatively few CMS Innovation Center models have been expanded, and many of the models that have been scaled used mandatory testing. Greater use of mandatory testing could provide more generalizable evidence and facilitate movement of successful approaches into permanent programs.
- Mandatory models can create unintended consequences when they have not been sufficiently tested. MA demonstrated that voluntary arrangements could achieve broad participation when beneficiaries, payers, and providers perceive sufficient value in participating.
- Rather than focusing solely on whether participation should be voluntary or mandatory, policymakers should consider whether the benefits of participation are sufficient to justify the administrative burden and operational changes required of clinicians and health systems. Incentives should be meaningful enough for organizations to invest in transformation while allowing them to benefit when they improve care and control costs.
- The benefits of health care transformation should also extend to employers and families that finance and experience care, rather than focusing solely on creating sufficient incentives for participating providers and health systems.

Committee Discussion

Co-Chair Pulluru opened the floor to Committee members to reflect on the day's presentations and discussions. The Committee members discussed the topics noted below. For additional details, please see the transcript and meeting recording (00:00-29:46).

- One Committee member emphasized the importance of flexibility.
- Based on expert input, the draft white paper is on target but should be taken one step further. There is an urgent need to improve care delivery.
- There are opportunities for the white paper to better emphasize the integration of behavioral health, HRSNs, and the diversity of needs to achieve success in rural areas.
- Dedicated funding and a centralized infrastructure can help to account for the lack of system-ness. For example, experts highlighted the potential role of hubs and financial incentives to help build a more sustainable system. These considerations should be reflected in the white paper.
- The white paper should consider MA and models outside of traditional Medicare.
- Benefit design, such as member incentives and copay waivers, can advance value-based care and should be considered in the white paper.
- The white paper could place a greater emphasis on the importance of data interoperability.
- There may be opportunities to better describe the role of conveners in the white paper.
- The Committee members should consider the role of medical residents, graduate students, and training opportunities to promote workforce development.
- One Committee member emphasized the sense of urgency to promote change. Instead of building incentives or new payment models, policy can be used to reduce friction in participating in current payment models.
- Ninety percent or more of total payment should be prospective payments in rural areas. This percentage is approximately 60 percent in non-rural areas. In many cases, plans report that prospective payments account for less than 10 percent of the total payment. There is a disconnect between what providers report needing prospectively compared with what is reported by employers and health plans.
- Although transparency is generally viewed as important, transparency related to risk adjustment has not been useful or led to improved outcomes. Transparency in risk adjustment can lead providers to overemphasize risk adjustment or game the system.
- Independent and rural providers are unlikely to voluntarily join models because they do not have the time or resources to participate. There may be opportunities to consider a glide path toward mandatory participation for rural providers.
- One Committee member stressed the importance of removing friction and simplifying models.
- Longevity could be rewarded for both beneficiaries and providers.
- There may be opportunities to develop more incentives, particularly incentives at the consumer level (e.g., coinsurance, copay waivers), instead of solely relying on sticks.
- Primary care, preventive services, and high-performing specialists should be incentivized. One Committee member inquired how to make doing the right thing financially beneficial for patients.
- Existing models can be simplified, and the number of models can be reduced.
- One Committee member inquired whether current quality measures assess the correct outcomes. Quality measures could focus on ensuring that providers are not gaming the system rather than focus on ensuring a certain level of how effective providers are.
- Rural areas need more funding. Payment should be different for providers in isolation, regardless of the geographic practice setting.

- Requiring primary care models to demonstrate cost savings may prevent the ability to test the impact of investments, which can have benefits that extend beyond the model testing period.
- It is unclear whether data interoperability and sharing need to be in a payment model or if they need to be in the infrastructure that exists to promote value-based care.
- Outside of a payment model, flexibility in mode and modality of service (e.g., extension of telehealth flexibilities) could help to drive value.
- One Committee member noted that PTAC has received mixed input from experts on whether models should be mandated. One expert shared that well-designed models should not need to be mandatory. MA could serve as an example of this notion; however, MA has grown because it is paid more than traditional Medicare. Traditional Medicare could consider applying lessons learned from MA, including models that provide care for seriously ill and chronically complex patients. One expert cautioned that MA will overtake APMs and traditional Medicare in terms of performance.
- There may be alternative ways to assess quality compared with how quality is currently measured. TCOC may be able to obviate the need for quality metrics.
- The Medicare PFS is a value-based payment model. There may be an opportunity to reform the PFS because the fee schedule plays an important role in incentivizing volume of care and service mix, even in value-based care models.
- There is a need to simplify quality measures to ensure that patients do not receive poor care in a TCOC system. Rather than incentivizing average to great performance, the focus should be on incentivizing poor to average performance.
- One Committee member inquired whether technology is a tool, partner, and/or model that should be separately paid. The Committee members should consider including recommendations in the white paper based on expert input on technology presented over the years. There is an expectation that technology is linked to data and point-of-care systems to drive better outcomes. Technology is a partner or tool but not a model.
- One Committee member reflected on a comment made by an expert who stated that when designing value-based payment models, it often involves balancing fairness and simplicity but cannot be both fair and simple. Oftentimes, providers would like to see actuarial evidence; however, actuarial evidence is complex. It can be difficult to predict what will happen.
- Value-based care has a branding problem. In policy and legislation, there are different perspectives on value-based care. To the wider audience, value-based care is not necessarily viewed as quality care.
- Several experts noted that there are issues described in the white paper that are not new; however, it is worthwhile to bring these issues forward and use lessons learned to sharpen the conversation on those topics. Committee members, organizations, and stakeholder groups should consider the barriers to progress. The white paper could have a key role in facilitating this conversation.
- One Committee member made a distinction between a flaw in a fundamental strategy for how care is paid for versus a flaw in implementation of care. A payment model or incentive could achieve its intended goals but not if it is implemented poorly.
- One Committee member indicated that the expert discussions helped identify areas in which policy aspiration meets operational reality. The white paper can focus on these areas.
- Outcomes are measured. However, participation is necessary to achieve outcomes. Penetration challenges continue to exist. If payment models are sufficiently attractive, accessible, and workable, mandates would not be necessary. However, mandates are needed in some cases.

- There is burden in quality reporting and measurement. It is important to consider regulatory safeguards against, for example, favorable selection and measure distortion. Although doing so can strengthen a model's integrity, each safeguard adds reporting burden, compliance costs, and implementation friction. Simplicity can be beneficial, but moving too far in one direction may not be beneficial.
- Health care affordability challenges have created a sense of urgency. A 10-year horizon is intolerable. Generally, there seems to be agreement in the goals of value-based care. It is time to execute the lessons learned.
- There is agreement that value-based care is important. There is a dichotomy between deconstructing what exists versus constructing new ideas.
- There is a need to reinvest in primary care in a way that incentivizes global continuity as a mechanism for quality as opposed to separating different types of primary care. Quality should be deconstructed.
- There is a need to treat geographies differently. For example, in rural areas, there should be a significant amount of prospective payment without extensive quality gating and regulation. Incentives for large hospital systems—which primarily exist in urban areas—need to be sizeable. In a budget-neutral environment, this would include allocating a higher percentage of funds to certain value-based care initiatives while reallocating money away from procedural initiatives. This approach would involve a shift in how the American health care system pays for care.
- One Committee member proposed a quantitative analytic opportunity. Voluntary models are likely to underrepresent the highest-cost providers because these providers may be less likely to participate. An analysis could assess what the published savings would have been if 80 percent of the market, including higher-cost providers who did not participate, had been represented with an appropriate benchmark.

Closing Remarks

Co-Chair Pulluru adjourned the meeting.

The public meeting adjourned at 4:04 p.m. EDT.

Approved and certified by:

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Steven Sheingold, PhD
Acting Designated Federal Officer
Physician-Focused Payment Model Technical
Advisory Committee

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