Preliminary Comments Development Team (PCDT) Presentation:

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

James Walton, DO, MBA (Lead)
Henish Bhansali, MD, FACP
Lawrence Kosinski, MD, MBA
Walter Lin, MD, MBA

March 3, 2025

Objectives of This Theme-Based Meeting

- Understand the factors that affect different kinds of organizations' business decisions about participating in PB-TCOC models
- Discuss Pathways to reduce organization-level barriers and incentivize the participation of different kinds of organizations in PB-TCOC models
- Discuss specific incentives for improving clinical integration and supporting primary and specialty care transformation in different kinds of organizations participating in value-based care
- Discuss how to enhance the sustainability and competitiveness of PB-TCOC models

Context for This Theme-Based Meeting

- PTAC has received 35 proposals for physician-focused payment models (PFPMs)
- Nearly all of these proposals addressed the potential impact on scope (specifically opportunities for APM participation) and on quality and cost, to some degree
- Committee members found that 18 of these proposals met both Criterion 1 (Scope) and Criterion 2 (Quality and Cost), including several proposals that were directly related to promoting accountable care and/or reducing barriers related to participation in APMs

Agenda

Background

Provider Participation in APMs

Addressing Organization Level Characteristics that Affect Accountable Care Organization (ACO) Participation and Profitability

Developing Pathways for Maximum Participation in Accountable Care

Approaches for Supporting Primary and Specialty Care Transformation

Maximizing the Competitiveness and Sustainability of PB-TCOC Models

PTAC Working Definition of an Accountable Care Relationship

- PTAC is using the following working definition of an accountable care relationship:
  - *A relationship between a provider and a patient (or group of patients) that establishes that provider as accountable for quality and total cost of care (TCOC) including the possibility of financial loss/risk for an individual patient or group of patients for a defined period (e.g., 365 days).*
  - *Would typically include accountability for quality and TCOC for all of a patient's covered health care services.*
- This definition will likely continue to evolve as the Committee collects additional information from stakeholders.

PTAC Working Definition of PB-TCOC Models

- PTAC is using the following working definition of PB-TCOC models:
  - *Alternative Payment Model (APM) in which participating entities assume **accountability for quality and TCOC** and receive payments for **all covered health care costs*** for a broadly defined population with varying health care needs during the course of a year (365 days).*
  - *Within this context, a PB-TCOC model would not be an episode-based, condition-specific, or disease-specific specialty model. However, these types of models could potentially be "nested" within a PB-TCOC model.*
- This definition will likely continue to evolve as the Committee collects additional information from stakeholders.

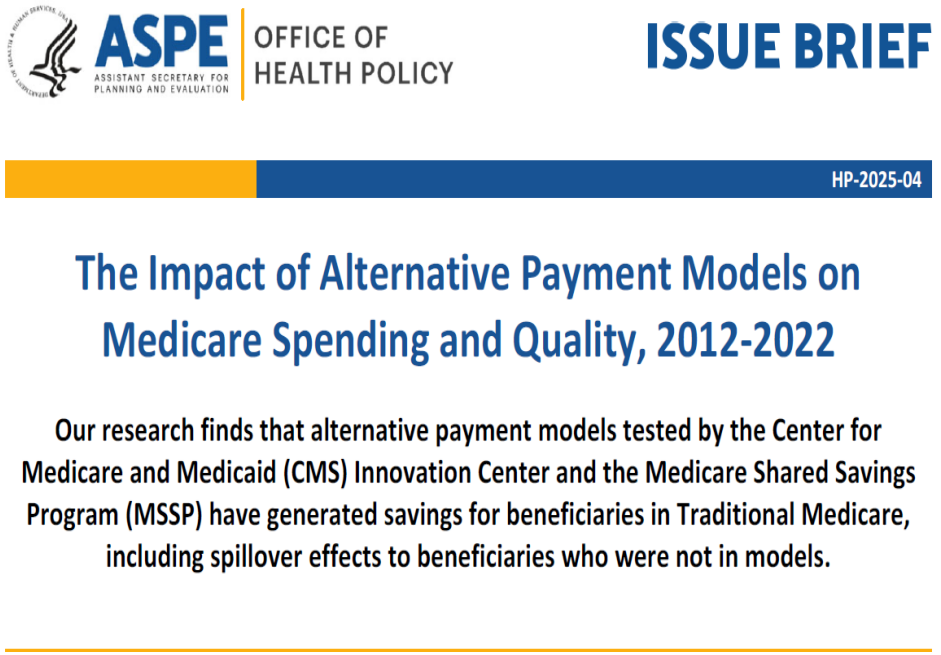
* For this purpose, all covered health care costs does not include pharmacy-related costs (Medicare Part D)

PTAC Working Definition of Health Care Business Models

- PTAC is using the following working definition of a "health care business model" for consideration of factors related to participation in PB-TCOC models:
  - *A viable health care business model is one that allows a health care entity to provide health care services that meet patient needs and deliver value while ensuring financial returns that make it worthwhile to continue operating over time.*
- This definition will likely continue to evolve as the Committee collects additional information from stakeholders.

APMs Have Created Value for Medicare

- Between 2012 and 2022 selected CMS Innovation Center models generated total gross savings of $7.7 – $11.0 billion.
- Between 2012 and 2022, MSSP generated total gross savings of $23 – $31 billion.
- Most of the estimated reductions in Medicare spending from Innovation Center models were attributed to counties that attained or maintained relatively high levels of model penetration over the study period.
  - Gross annual savings per capita from 2018-2022 were $65 for high penetration growth counties vs. $6 for low penetration growth counties
  - If the actual county-level 90th percentile penetration rate occurred nationwide, transitional care management (TCM) would increase by 7.4% in MSSP and 5.0% in Innovation Center models.
- There were also improvements in several claims-based quality measures (e.g., healthy days at home).



Source ASPE. The Impact of Alternative Payment Models on Medicare Spending and Quality, 2012-2022. Jan 15, 2025.

Agenda

Background

Provider Participation in APMs

Addressing Organization Level Characteristics that Affect Accountable Care Organization (ACO) Participation and Profitability

Developing Pathways for Maximum Participation in Accountable Care

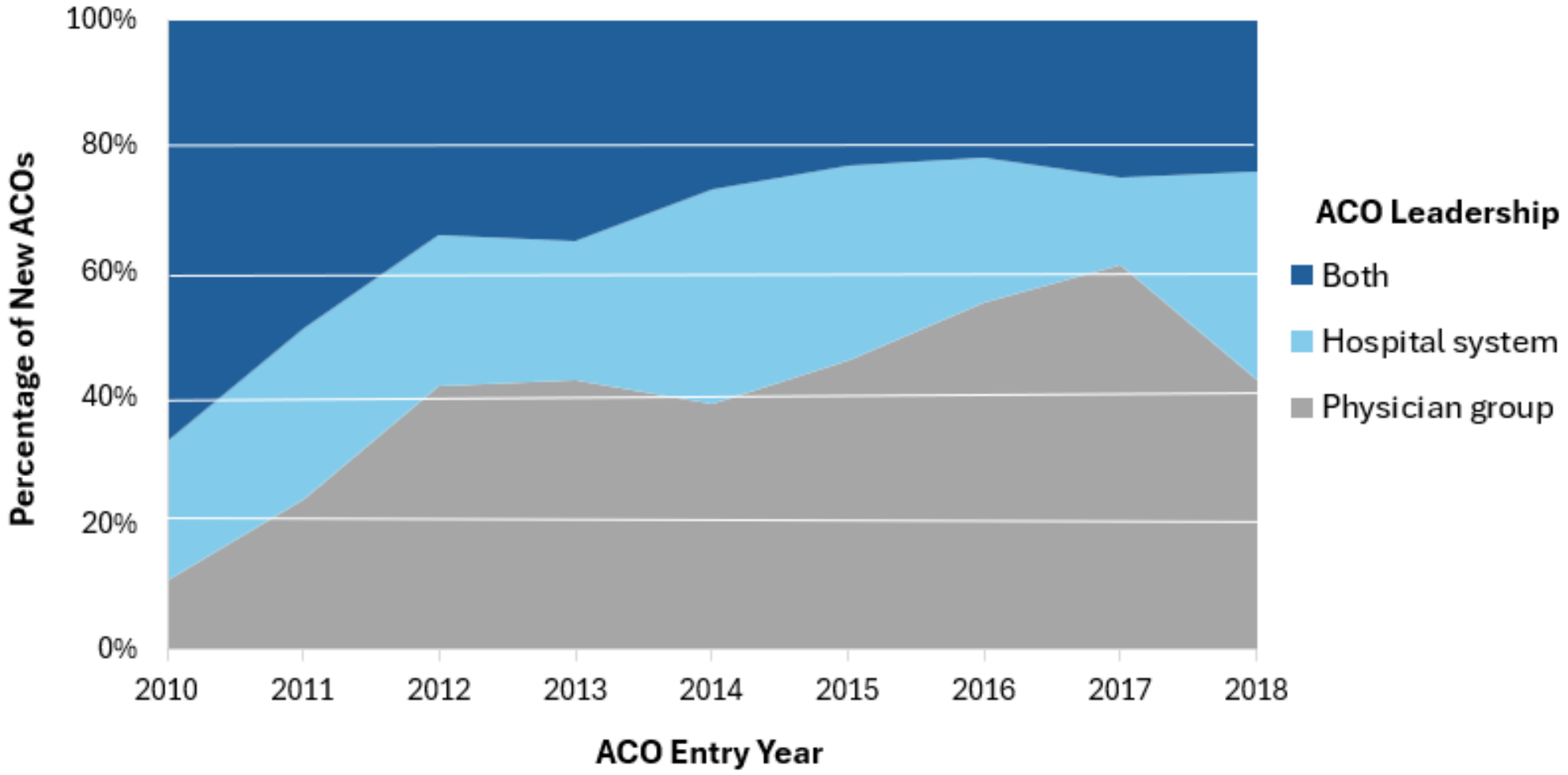
Approaches for Supporting Primary and Specialty Care Transformation

Maximizing the Competitiveness and Sustainability of PB-TCOC Models

Provider Participation in APMs: Key Trends

- Participation in Medicare APMs has plateaued in recent years
- A similar trend is occurring in APMs for all payers
- Hospital and integrated delivery system participation in ACOs has declined as the share of physician led ACOs has risen
- Physician led ACOs are growing more rapidly
- Specialists are less likely to participate in ACOs

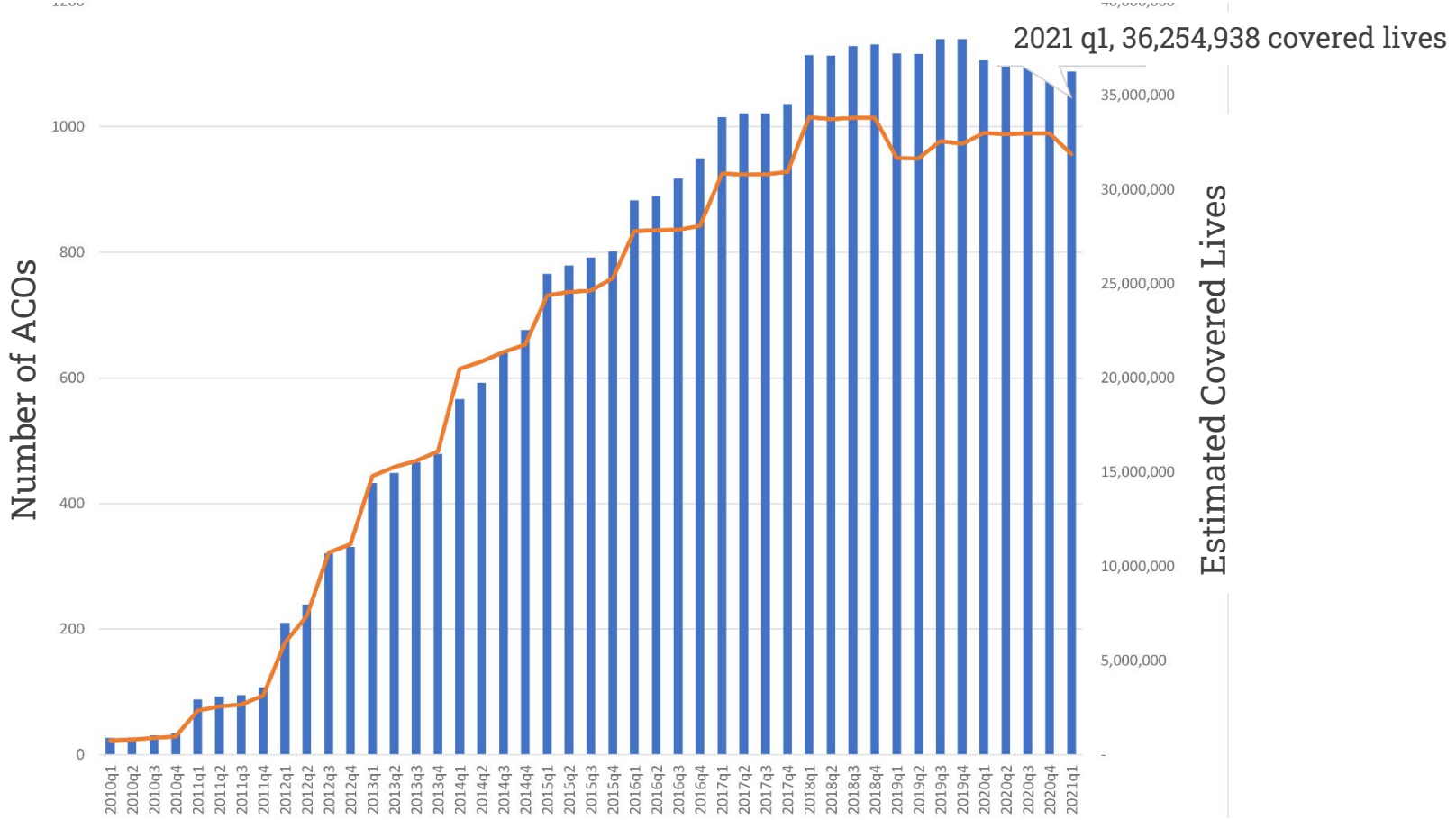
Physician-Led ACOs Have Grown the Most Rapidly and Account for the Largest Percentage of New ACOs



Source: Adapted from figure provided in Muhlestein et al, Accountable Care Organizations Are Increasingly Led by Physician Groups Rather than Hospital Systems. AJMC. 2020.

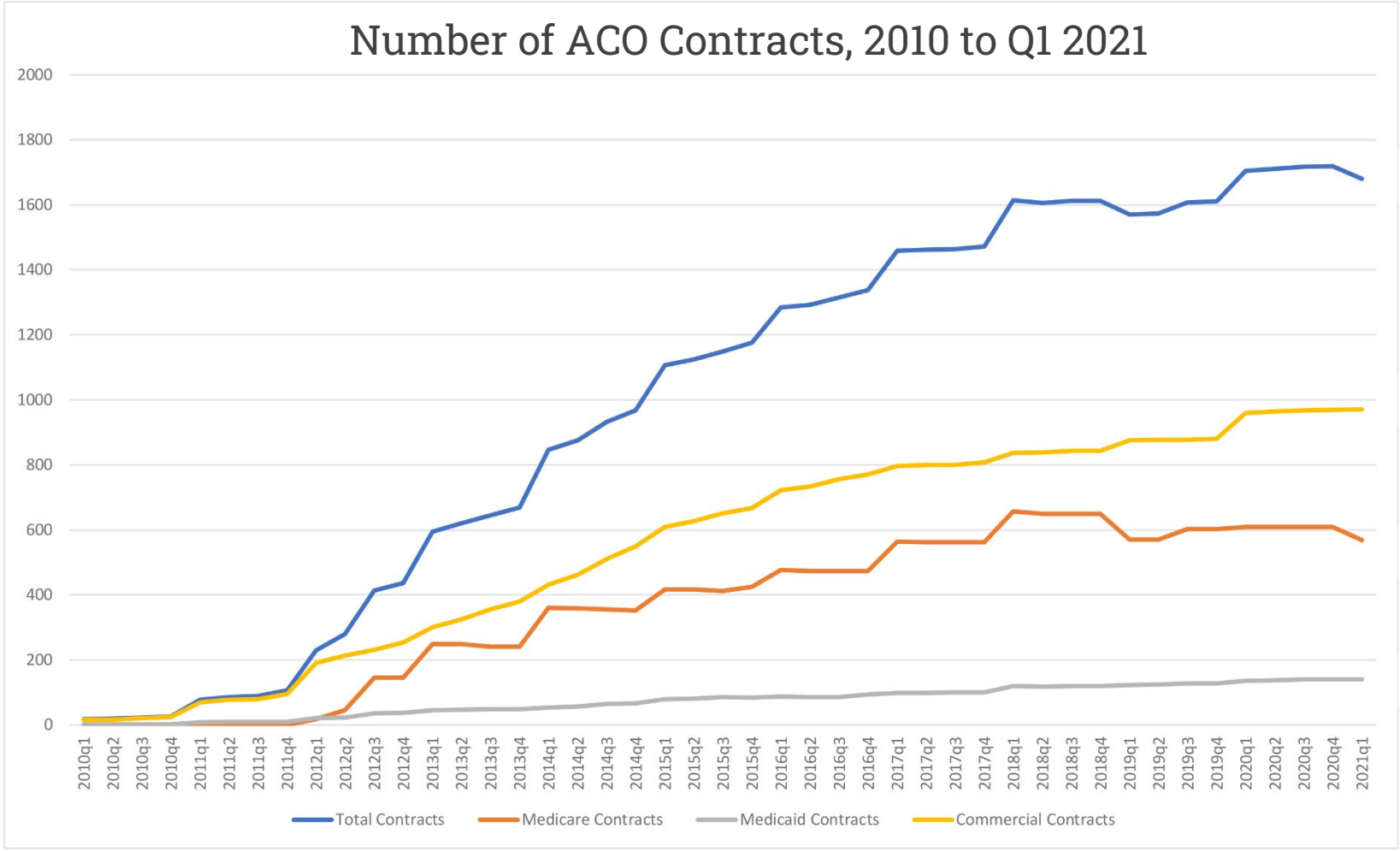
ACO Growth Has Plateaued

Total Number of ACOs and ACO-covered lives, All Payers, 2010 to Q1 2021



Note: *Blue bars are covered lives. Orange line is number of ACOs.*
Source: Muhlestein et al, All-Payer Spread of ACOs and Value-Based Payment Models in 2021: The Crossroads and Future of Value-Based Care. Health Affairs Forefront. 2021.

ACO Growth Has Plateaued Across All Payers



Total

Commercial

Medicare

Medicaid

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

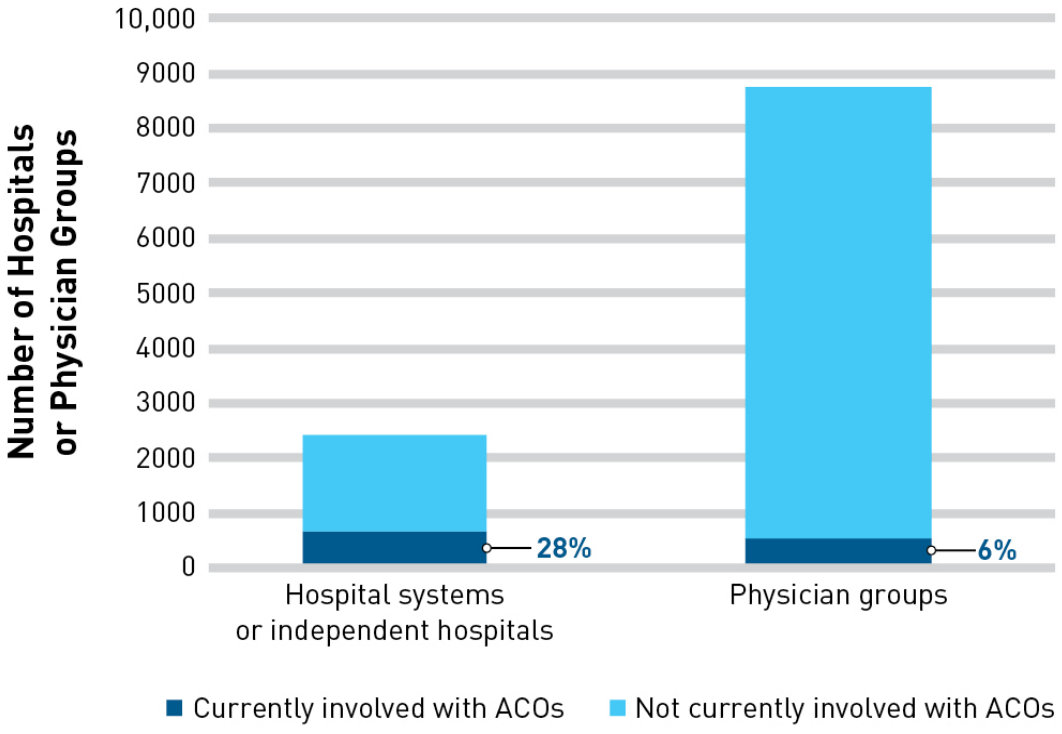
All Payer ACO Market Entrants and Exits

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

ACO Growth Potential for Physician Groups is Substantially Greater than for Hospital Systems

- Only a small percentage of hospitals/hospital systems and physician groups that could become an ACO participate in a Medicare ACO

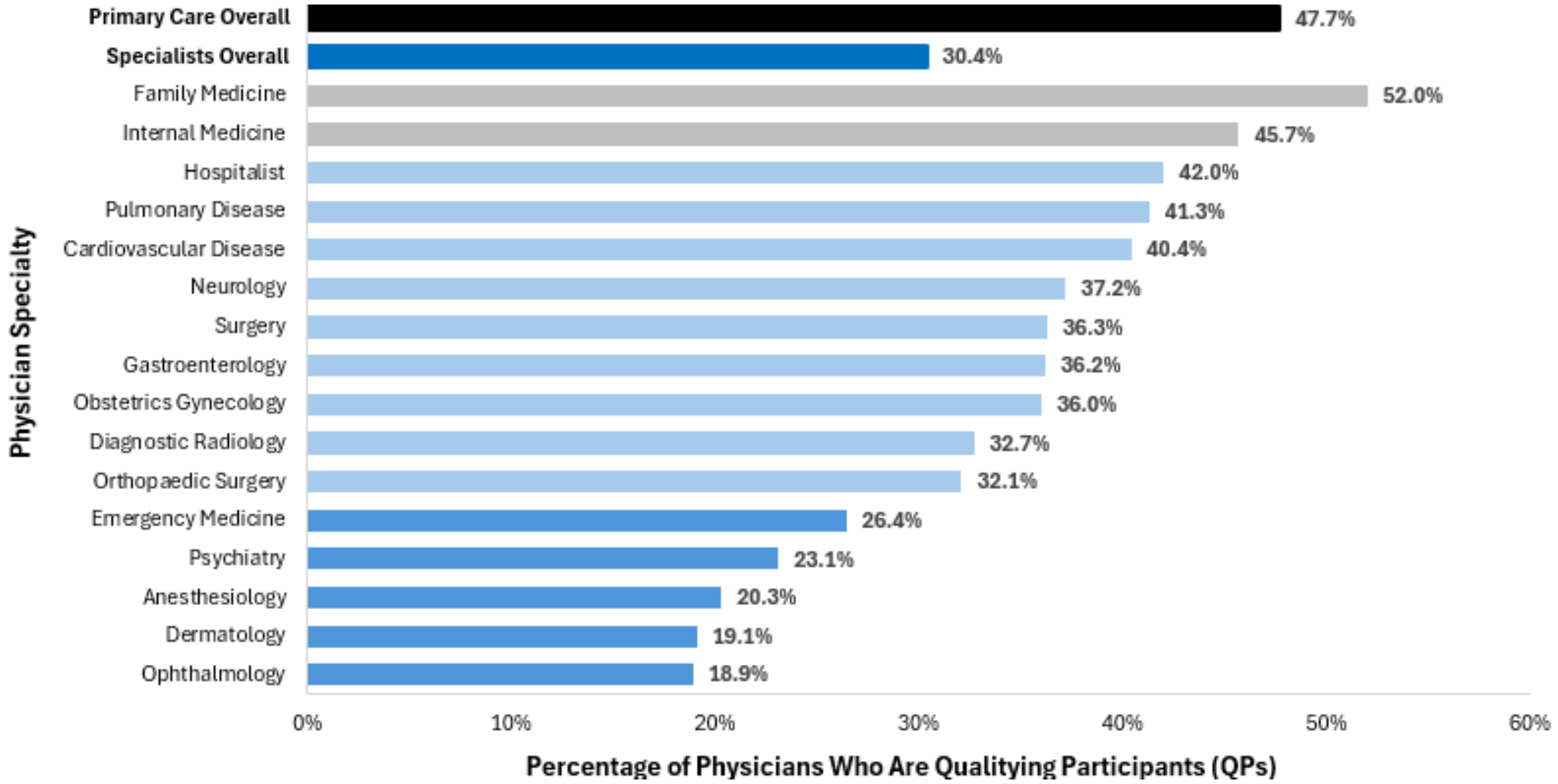
FIGURE 2. Market Potential for ACOs



ACO indicates accountable care organization.

Source: Muhlestein et al, Accountable Care Organizations Are Increasingly Led by Physician Groups Rather than Hospital Systems. AJMC. 2020.

Qualifying Participants (QPs) in CMS Advanced Alternative Payment Models (AAPMs), 2023 – Specialty Physicians are Less Likely to Participate



Source: Adapted from figures provided in Muhlestein, Assessing Provider Adoption of Medicare Advanced Alternative Payment Models. Health Affairs Forefront. December 16, 2024.

Integrated Delivery Systems (IDSs) and Accountable Care

- A key objective for this meeting is to consider Pathways that can bring all providers into accountable care models, including smaller and independent practices
- We also focus on integrated delivery systems because:
  - There has been significant consolidation in the health care market:
    - Physicians are increasingly employed by hospitals or corporate entities (from 62% in January 2019 to 78% in January 2024)
    - Hospitals are increasingly affiliated with larger health systems (from 53% in 2005 to 68% in 2022)
  - Participation of IDSs is critical to moving beneficiaries into relationships with providers accountable for TCOC and quality
    - These organizations dominate many markets
    - Have the resources and potential to provide high value, well coordinated care

Analysis to Examine Trends in Large IDS Participation in Medicare ACO Models

- Two research questions:
  - RQ1: Has there been a decrease in the number of IDS-led ACOs as accountable entities?
  - RQ2: Are physicians and hospitals able to participate in ACOs if the IDS they are affiliated with is not participating as the lead organization?

Trends in Large IDS Participation in Medicare ACO Models: Analysis Overview

- A descriptive analysis focused on tracking Medicare ACO participation among large integrated delivery systems (IDSs) in 2016, 2018, 2020, and 2022.
- The analysis includes the following Medicare ACOs:
  - Medicare Shared Savings Program (MSSP): 2012 – present
  - Pioneer ACO Model: 2012 – 2016
  - Next Generation ACO (NGACO) Model: 2016 – 2021
  - Global and Professional Direct Contracting (GPDC) Model, 2021 – 2022 / ACO Realizing Equity, Access, and Community Health (REACH), 2023 – 2026

The Percentage of ACOs Led by IDSs has Declined Over Time

Pioneer ACO Model

In 2016, 5 of the 8 (62.5%) participating ACOs were led by IDSs and had a proprietary relationship with a hospital.

SOURCE: Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Final Report

NGACO Model

The percentage of participating ACOs led by IDSs dropped over the course of the model:

- 56% in 2016
- 36% in 2018
- 39% in 2020

SOURCE: Next Generation Accountable Care Organization (NGACO) Model Evaluation, Fourth Annual Report

GPDC Model

In 2022, 18 of the 78 participating ACOs (23.1%) were IDSs led by a hospital system.

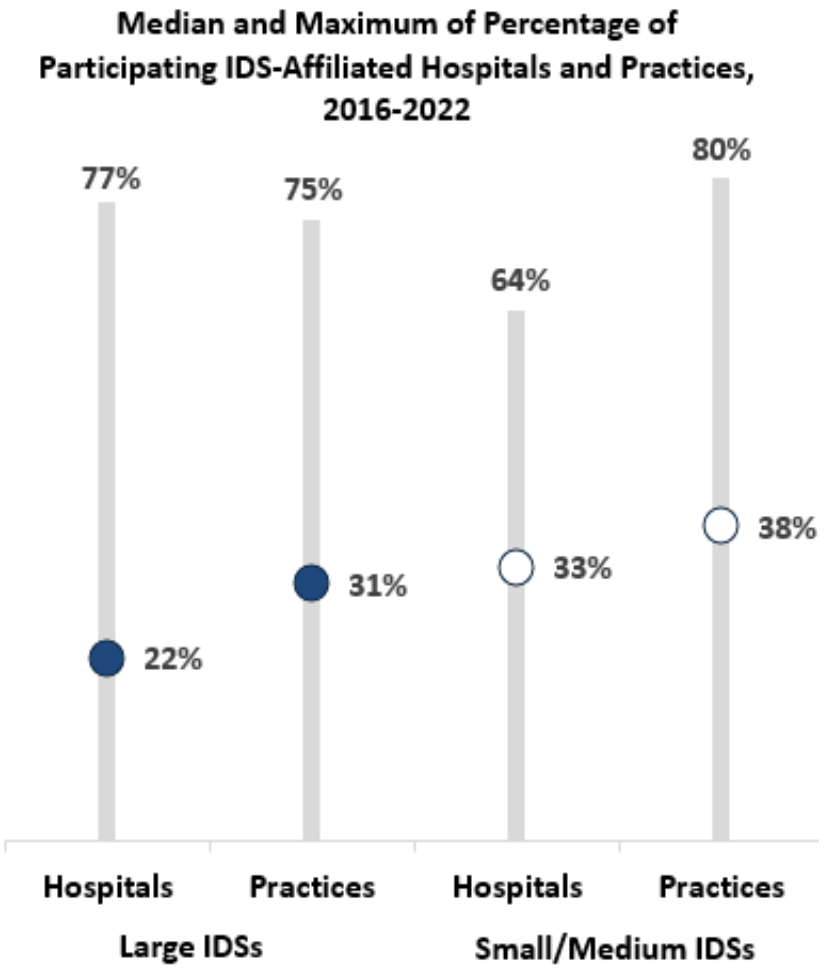
All 18 were Standard ACOs; no New Entrant or High Needs ACOs were IDSs.

SOURCE: Evaluation of the Global and Professional Direct Contracting Model, Annual Report 2

* IDS leadership role was determined by independent evaluators of these models. This determination was based on ACO application data, interviews, and/or survey data collected by evaluators. Thus, definitions of "IDS-led" may vary across the models.
Evaluation reports for the CMMI ACO models (Pioneer, NGACO, ACO REACH) indicate that IDS leadership of Medicare ACOs may have declined over time.

Extent of IDS Partial Participation - Affiliated Hospital and Practice Participation in Medicare ACOs

- **While IDS participation as lead organization for ACOs declined, 90% of IDSs engaged in partial participation –** e.g., with a small percentage of their affiliated hospitals and physician practices
- **Hospital and Practice Participation.** Large IDSs had a median of 22% of their affiliated hospitals and 31% of their affiliated practices participating in Medicare ACOs, which was lower than for small/medium IDSs (33% and 38%, respectively).
- **Participation in Multiple ACOs**. Over a quarter of large IDSs participated in more than one Medicare ACO model in each year. In 2022, large IDSs with affiliated hospitals or practices participating in Medicare ACOs participated with an average of 5.2 unique ACOs.
- **Multistate IDSs**. Slightly over half of large IDSs with both affiliated hospitals and practices participating in Medicare ACOs spanned multiple states.



Key Takeaways

- The percentage of CMMI ACO models led by IDSs has declined over time.
- In contrast, partial participation of large IDSs in Medicare ACO models was high, with about 90% of large IDSs having affiliated hospitals or practices participate in Medicare ACOs each year. This was higher than participation among small/medium IDSs (<70% in each year).
- Despite large IDSs' high rates of participation in Medicare ACO models, the percent of its providers participating was relatively low.
- The extent of large IDSs' participation was lower than for small/medium IDSs as measured by the percentage of an IDS's affiliated hospitals (22% vs. 33%) and practices (31% vs. 38%).

Agenda

Background

Provider Participation in APMs

Addressing Organization Level Characteristics that Affect Accountable Care Organization (ACO) Participation and Profitability

Developing Pathways for Maximum Participation in Accountable Care

Approaches for Supporting Primary and Specialty Care Transformation

Maximizing the Competitiveness and Sustainability of PB-TCOC Models

Types of Provider Organizations and Organizational and Market Factors That May Affect Value-Based Care Participation

Organization Types	
Physician-owned	Single specialty PCP or SCP
	Multi-specialty
	Independent practice association (IPA)
	Clinically integrated network (CIN)
Hospital-owned	Employed PCP or SCP
	Contracted providers
	Integrated delivery system (IDS)
	Physician hospital organization
	CINs
Payer-owned	Employed PCP or SCP
	Hospitals
	Ambulatory surgery centers (ASCs)

Organization Operational Characteristics
Degree of Centralized Management and Control
Clinical integration
Financial integration
Defined referral patterns
Common EHR
Joint governance
Centralized integration/ control
Shared fee schedules

Market Forces
Urban/rural location
Area Deprivation Index (ADI)
Proximity to patient population
Medicare Advantage penetration
Physician, hospital and insurer concentration in market

Important "Revenue" Concepts for Accountable Care Participation

- Size of total annual revenue for the accountable entity
- Mix of revenue sources
- Revenue of ACO participants compared to total spending for assigned beneficiaries
  - Low revenue ACOs defined by CMS as less than 35% of total spending
  - High revenue ACOs greater than 35%
- A large group primary care practice that leads an ACO and is accountable for TCOC may have relatively high annual revenues but a relatively small share of total spending for the assigned population – thus is a low revenue ACO

Relationship of Revenue Concepts to Incentives for Accountable Care Participation

Business Model Characteristic	Relationship to Accountable Care Participation
ACO revenues as a share of TCOC	• Improvements in patient health from value-based care may shift or reduce demand for certain health care services (e.g., inpatient), which can affect the revenue for businesses that provide those services • Low revenue ACOs have more opportunities to reduce other providers' demand but less formal relationships and control of other providers • High revenue ACOs have potentially more control and integration but fewer opportunities to shift revenue losses – **disincentive for participation**
Annual Revenue	• Affects ability to invest in value-based care infrastructure • May affect the organization's ability and willingness to assume downside risk in PB-TCOC models • Determines the relative contribution and impact that PB-TCOC financial incentives have on total revenue (i.e., incentives represent a smaller revenue impact for larger revenue organizations)

Organization Type	Revenue Source
Physician-owned	• Outpatient and office visits (CPT-code driven services)
Hospital-owned	• Inpatient care • Outpatient (varies by hospital) • Non-patient revenue (e.g., cafeteria, parking lot fees, investments, charitable contributions)
Payer-owned	• Outpatient and office visits • Inpatient care
IDS	• Full range of services

Agenda

Background

Provider Participation in APMs

Addressing Organization Level Characteristics that Affect Accountable Care Organization (ACO) Participation and Profitability

Developing Pathways for Maximum Participation in Accountable Care

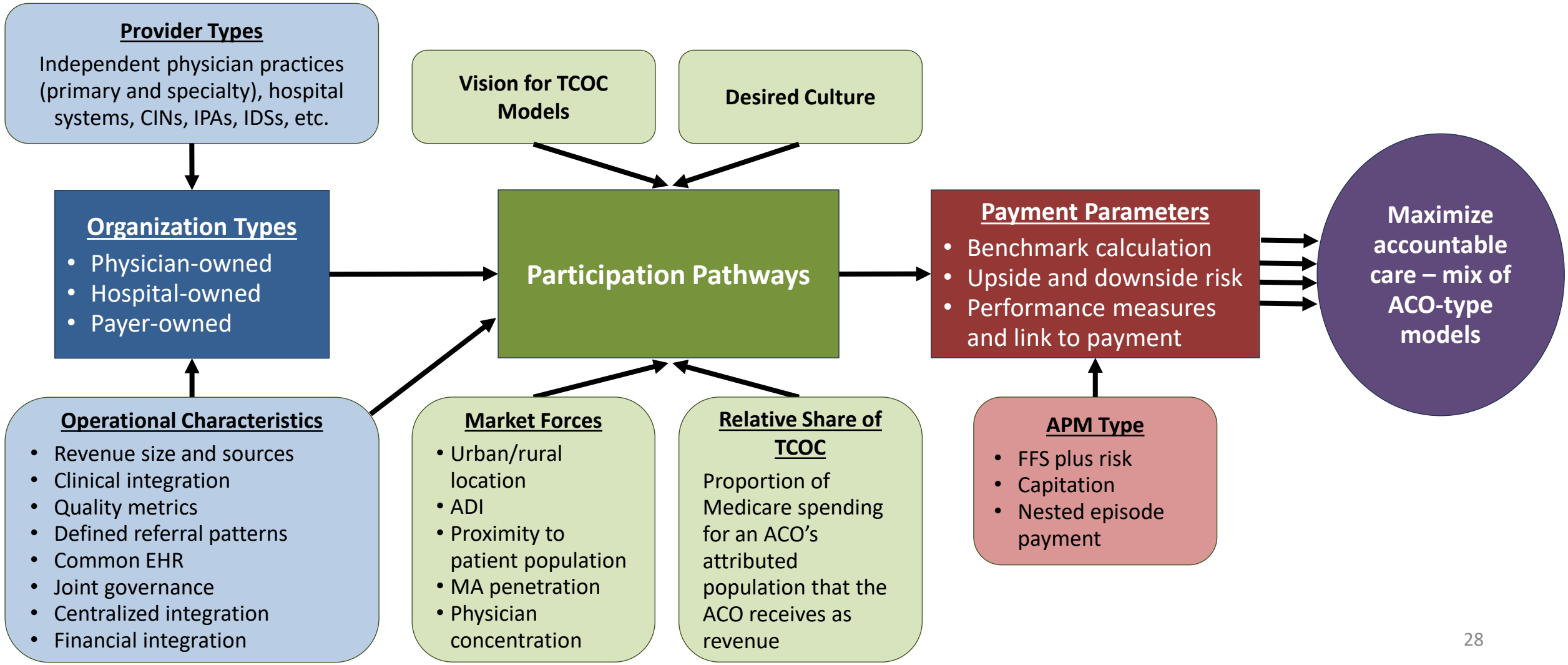
Approaches for Supporting Primary and Specialty Care Transformation

Maximizing the Competitiveness and Sustainability of PB-TCOC Models

PTAC Working Definition of Identifying Pathways for Increasing Participation in PB-TCOC Models

- Different factors affect different kinds of organizations' decisions about participating in PB-TCOC models.
- PTAC is using the following working definition of a "Pathway" for incentivizing increased participation in PB-TCOC models:
  - *A Pathway may be thought of as a grouping of health delivery organizations that might be treated similarly with regard to benchmarks, two-sided risk, and how performance measures affect payment within the context of other incentives. These parameters could be specified for the Pathway.*
- This definition will likely continue to evolve as the Committee collects additional information from stakeholders.

Developing TCOC Model Pathways to Maximize ACO Participation



From Organization Business Model to ACO Participation Pathways

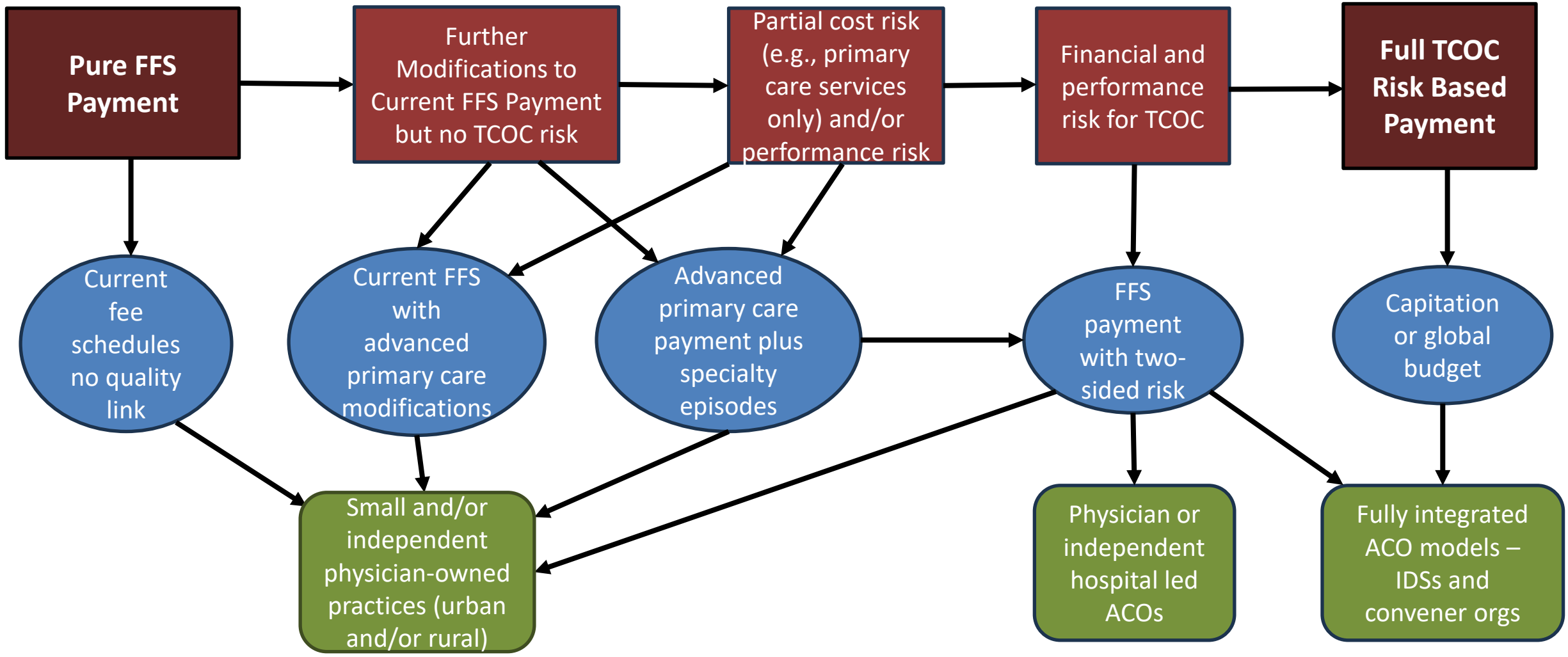
- These organizational business model classifications are useful for understanding reasons why organizations may or may not participate in ACOs.
- The business model classifications are also useful as concepts and building blocks for Pathways but not necessarily as the Pathways themselves.
- Pathways might use business model classifications – provider types and their key characteristics (e.g., revenue, revenue source, management control) as building blocks.
- The Pathways might represent groupings of provider organizations for which it is reasonable to apply similar payment approaches such as benchmarks, two-sided risk, and performance measures.

Pathway Considerations

- Pathways and adjustments might recognize factors that affect outcomes and are not easily modifiable by the organizations (e.g., ADI, geographic location).
- Pathways and adjustments might not recognize factors that may affect outcomes but are expected to be modifiable and consistent with accountable care vision (e.g., primary/specialty coordination).
- Balance incorporating important factors while avoiding complexity that would be difficult to administer and comprehend by stakeholders.
- Possibly consider a different Pathway acknowledging the role of VBC enablers/conveners* to manage Medicare beneficiaries in downside risk arrangements. The use of enablers/conveners is estimated to increase from approximately 5 to 19 million beneficiaries between 2023 and 2028.

* VBC enablers/conveners assist organizations with transitioning to VBC.

Pathways and Payment Policies to Enhance Value



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

Pathways and Payment Parameters

Types of Providers / Organizations in Pathway	PAYMENT CONSIDERATIONS							
	BENCHMARKS	**BENCHMARK ADJUSTMENTS**	**ANNUAL UPDATE/ CONVERSION FACTOR**	**DOWNSIDE RISK**	**UPSIDE RISK**	**SPECIALTY PAYMENT**	**PERFORMANCE RELATED RISK**	**INFRASTRUCTURE/Issue related to this pathway**
PATHWAY 1 Small/Rural PCP Practices?	Regional, National Provider specific blend?	Urban/Rural ADI/other	Inflation factor	% relative to benchmark	% relative to benchmark	Performance info provided, episode payment, nested models	Relationship of scores based on performance measures to upside and downside risk	Incentives, obstacles specific issues to consider
PATHWAY 2 Medium/Large PCP Practices?								
PATHWAY 3 Large Multi-Specialty Groups?								
PATHWAY 4 Large IDSs?								
Pathways X - ?								

Agenda

Background

Provider Participation in APMs

Addressing Organization Level Characteristics that Affect Accountable Care Organization (ACO) Participation and Profitability

Developing Pathways for Maximum Participation in Accountable Care

Approaches for Supporting Primary and Specialty Care Transformation

Maximizing the Competitiveness and Sustainability of PB-TCOC Models

Approaches for Supporting Primary and Specialty Care Transformation

- Share patient data between primary and specialty care providers
  - Standardize or democratize data (e.g., make data readily accessible and in a form that is usable for everyone who needs it)
  - Increase the usefulness of shareable data by organizing data by the relevancy of information to the provider
  - Establish data sharing protocols and responsibilities for data encryption and privacy
- Use nested episodes to encourage provider collaboration

Approaches to Using Nested Episodes to Integrate Specialty Care in PB-TCOC Models

Approaches	Examples
Assess the variation of costs in particular conditions	• Conditions with low-cost variation are best suited to using nested episodes (e.g., colon polyps, gastritis)
Create specialty condition-based payment models (SCMs)	• Cardiology, musculoskeletal, respiratory, and behavioral and mental health specialties are most favorable for creating longitudinal specialty care Pathways • SCMs could be nested in TCOC models, with acute episode payments nested within the SCM and paid separately, allowing the specialist to be accountable for the acute episode

Agenda

Background

Provider Participation in APMs

Addressing Organization Level Characteristics that Affect Accountable Care Organization (ACO) Participation and Profitability

Developing Pathways for Maximum Participation in Accountable Care

Approaches for Supporting Primary and Specialty Care Transformation

Maximizing the Competitiveness and Sustainability of PB-TCOC Models

Considerations for Increasing Competitiveness of PB-TCOC Models

- Regardless of the number of Pathways, there are other policies that can help to make APMs more flexible and competitive

Policy Area	Considerations
Factors that influence competitiveness	Physician concentration, Medicare Advantage penetration, socioeconomic conditions, market consolidation
Waivers to promote model adoption	Federal waivers (e.g., 3-day SNF, coinsurance) can encourage collaboration between entities, incentivize provider participation, and permit model performance evaluation
Beneficiary engagement	Financial incentives for beneficiaries, shared decision-making tools, support social determinants of health (e.g., nutrition, transportation services)
Specialty integration	Example: nested episodes

PTAC Public Meeting Focus Areas

- Reducing Organization-Level Barriers Affecting Participation in PB-TCOC Models
- Supporting Primary and Specialty Care Transformation
- Enhancing the Ability of PB-TCOC Models to Be Competitive
- How to Maximize Participation of Beneficiaries in Accountable Care and Improve the Sustainability of Effective PB-TCOC Models

Appendix A
Additional Information About the ASPE Analysis of the Impact of Alternative Payment Models on Medicare Spending and Quality

21 APM Models Used in the ASPE Analysis of the Impact of Alternative Payment Models on Medicare Spending and Quality

Model #	Model Name	Grouping	Year
7	Pioneer	CMMI - ACO	2012-2016
21	Next Generation	CMMI - ACO	2016-2021
63	Global and Professional Direct Contracting(GPDC) Model , ACO Reach, 2023)	CMMI - ACO	2021-2022
2	Physician Group Practice Transition Demonstration	CMMI - Adv PC	2012
3	Multi-payer Advanced Primary Care Demonstrations	CMMI - Adv PC	2012-2014
9	Medicare Health Care Quality Demonstration – 646 Demo for North Carolina	CMMI - Adv PC	2012
12	Comprehensive Primary Care Initiative (CPCI)	CMMI - Adv PC	2012-2016
22	Comprehensive Primary Care Plus (CPC+), non-SSP Participants	CMMI - Adv PC	2017-2022
57	Primary Care First	CMMI - Adv PC	2021-2022
56	Maryland Total Cost of Care (MDTCOC): Primary Care Program (CMMI)	MDTCOC	2019-2022
53	Vermont All-Payer Model (CMMI)	VT All Payer	2019-2022
11	Medicare Medicaid Coordination Office (MMCO) Financial Alignment Demonstration (Duals)	CMMI - Other	2013-2022
13	Community Based Care Transition	CMMI - Other	2012-2017
14	Medicare Health Care Quality Demonstration – 646 Demo for Indiana	CMMI - Other	2012
1	Independence at Home Practice Demonstration	CMMI - Other	2012-2017, 2019 -2022
18	Comprehensive ESRD Care (CEC)	CMMI - Chronic Condition	2015-2022
66	Kidney Care Choices	CMMI - Chronic Condition	2021-2022
71	Value in Opioid Use Disorder Treatment Dem	CMMI - Chronic Condition	2021-2022
64	ESRD Treatment Choices Model	CMMI - Chronic Condition	2021-2022
8	Medicare Shared Savings Program (MSSP)	MSSP - ACO	2012-2022
23	Comprehensive Primary Care Plus (CPC+), SSP Participants	MSSP - ACO	2017-2022

Note: APM models includes 21 CMMI/MSSP models used in the analysis. Does not include BPCI and CJR.
Source: https://aspe.hhs.gov/reports/impact-alternative-payment-models-medicare-spending-quality-2012-2022

Appendix B
Value-Based Care Components of Selected CMMI Models

Key Value-Based Care Components of Selected CMMI Models

Model	Clinical Focus	Value-Based Care and Technical Components
Pioneer Accountable Care Organization (Pioneer ACO) *Not Active* Years active: 2012 – 2016	Primary and specialty care	**Overall Model Design Features:** Pioneer ACO brought together ACOs with experience in care coordination across different settings to progress from a shared savings to a population-based payment model. **Use of Waivers:** Skilled Nursing Facility (SNF) Three-Day Rule Waiver: waived the requirement of a three-day stay in an inpatient, acute care, or critical access hospital before admission to a SNF. Participation Waiver: waived portions of the Federal anti-kickback statute and the physician self-referral law to enable participants to undertake certain activities that "promote accountability for the quality, cost, and overall care" for the model beneficiaries. Shared Savings Distribution Waiver: allowed for shared savings across providers. Compliance with the Physician Self-Referral Law Waiver: waived the physician self-referral law between the ACO and its participants Waiver for Patient Incentives: waived portions of the Federal anti-kickback statute to enable participants to provide patient incentives. **Financial Methodology:** For the first two years, ACOs had a shared savings payment arrangement; in the third year, ACOs who earned savings were eligible to shift to a population-based payment, which was a PBPM payment that would replace FFS payments. ACOs assume 60% risk and must take on downside risk. **How Payment is Adjusted for Performance:** ACOs must meet quality performance standards to earn shared savings (if achieved). **Approaches to Incorporate Multi-Payer Alignment:** Required to expand payment arrangements beyond Medicare to commercial and other payers.

Key Value-Based Care Components of Selected CMMI Models, Continued

Model	Clinical Focus	Value-Based Care and Technical Components
Next Generation Accountable Care Organization (NGACO) *Not Active* Years active: 2016 – 2021	Primary and specialty care	**Overall Model Design Features:** NGACO built on components implemented as part of the Pioneer ACO Model and MSSP. **Use of Waivers:** Telehealth Expansion Waiver: Waived the requirement that use of telehealth services be limited to rural geographic areas; also, allows for the use of asynchronous telehealth technology – where medical information can be provided through virtual telehealth methods (e.g., retinal scanning images) for dermatology and ophthalmology specialties. Skilled Nursing Facility (SNF) Three-Day Rule Waiver: Waived the requirement of a three-day stay in an inpatient, acute care, or critical access hospital before admission to a SNF. Post-Discharge and Care Management Home Visit Waivers: Gave flexibility for staff outside the direct physician to provide home visits to beneficiaries following discharge from an inpatient setting by waiving the requirement that these services must be provided by the physician. Participation Waiver: Waived portions of the Federal anti-kickback statute and the physician self-referral law to enable participants to undertake certain activities that "promote accountability for the quality, cost, and overall care" for beneficiaries. Shared Savings Distribution Waiver: Allowed for shared savings across providers. Compliance with the Physician Self-Referral Law Waiver: Waived the physician self-referral law between the ACO and its participants Waiver for Patient Incentives: Waived portions of the Federal anti-kickback statute to enable participants to provide patient incentives. All-Inclusive Population-Based Payments (AIPBP) Payment Arrangement Waiver: Allowed for certain payment arrangements. Cost Sharing: Reduced cost-sharing amounts for certain Medicare Part B services to minimize beneficiary financial barriers. Chronic Disease Management Reward: Permitted up to $75 worth of gift card(s) per year to encourage eligible beneficiaries to participate in chronic disease management programs. **Financial Methodology:** ACOs gradually shift from FFS to all-inclusive population-based payments, which are monthly payments to the ACO based on estimated total annual costs of care. ACOs assume either 80% or 100% risk and must take on downside risk. **How Payment is Adjusted for Performance:** ACOs may receive an earned quality bonus for meeting quality requirements. CMS uses a quality "withhold," in which a portion of an ACO's benchmark is held "at-risk" dependent on the ACO's quality score. An ACO that achieves a 100% quality score will have the full withhold credited to its benchmark. ACOs that receive less than a 100% quality score will have a proportionate amount withheld. **Approaches to Incorporate Multi-Payer Alignment:** N/A

Key Value-Based Care Components of Selected CMMI Models, Continued

Model	Clinical Focus	Value-Based Care and Technical Components
Global and Professional Direct Contracting (GPDC) *Not Active* Years active: 2021-2022	Primary and specialty care	**Overall Model Design Features:** GPDC brought together health care providers, including PCPs, specialty providers, and hospitals, to form a Direct Contracting Entity (DCE). GPDC was retitled the ACO REACH Model in 2023 to underscore the importance of addressing health disparities. **Use of Waivers:** Participation Waiver: waived portions of the Federal anti-kickback statute and the physician self-referral law to enable participants to undertake certain activities that "promote accountability for the quality, cost, and overall care" for the model beneficiaries. Telehealth Expansion Waiver: waives the requirement that use of telehealth services be limited to rural geographic areas; also, allows for the use of asynchronous telehealth technology – where medical information can be provided through virtual telehealth methods (e.g., retinal scanning images) for dermatology and ophthalmology specialties. Skilled Nursing Facility (SNF) Three-Day Rule Waiver: waives the requirement of a three-day stay in an inpatient, acute care, or critical access hospital before admission to a SNF. Care Management Home Visit Waiver: allows a home visit by a clinician before a potential hospitalization to reduce the risk of hospitalization. Home Health Homebound Requirement: expands the criteria for home health-bound services to beneficiaries with multiple chronic conditions at risk of an unplanned inpatient hospital admission. Post-Discharge Home Visit Waiver: allows for a limited number of home visits after discharge from an inpatient facility to reduce the risk of hospitalization and improve patient outcomes. Cost Sharing: reduces cost-sharing amounts for certain Medicare Part B services to minimize beneficiary financial barriers. Chronic Disease Management Reward: permits up to $75 worth of gift card(s) per year to encourage eligible beneficiaries to participate in chronic disease management programs. **Financial Methodology:** Two risk-sharing options: 1) Professional: 50% savings/losses; participants receive a primary care capitation payment (risk-adjusted monthly payment for primary care services; 2) Global: 100% savings/losses; participants can receive either a primary care capitation payment or a total care capitation payment (risk-adjusted monthly payment for all covered services, including specialty care). **How Payment is Adjusted for Performance:** 5% of benchmark is withheld each year for DCEs to earn back based on their performance on quality measures. Specifically, 1% can be earned back based on their score on 1 of 2 utilization measures; DCEs can earn back the remaining 4% based on reporting all other measures (pay-for-reporting). **Approaches to Incorporate Multi-Payer Alignment:** GPDC is not a multi-payer model; however, the model encourages participation of other payers beyond Medicare.

Key Value-Based Care Components of Selected CMMI Models, Continued

Model	Clinical Focus	Value-Based Care and Technical Components
Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) *Active* Years active: 2023-Present	Primary and specialty care	**Overall Model Design Features:** ACO REACH brings together health care providers, including PCPs, specialty providers, and hospitals, to form an ACO. ACO REACH was formerly named the Global and Professional Direct Contracting (GPDC) Model from prior to 2023. See table row on GPDC for more information. **Use of Waivers:** Same as GPDC; see GPDC table row for more information. **Financial Methodology:** Same as GPDC; see GPDC table row for more information. **How Payment is Adjusted for Performance:** ACOs earn a quality score (0-100%) based on performance across all measures compared to the benchmark; 2% of ACO benchmark is withheld to be earned back based on quality score. Additionally, there is a Continuous Improvement and Sustained Exceptional Performance (CI/SEP) component. ACOs that meet or exceed the CI/SEP criteria can receive up to the full (2%) based on quality score; ACOs that do not meet the CI/SEP criteria can receive only half (1%) based on quality score. **Approaches to Incorporate Multi-Payer Alignment:** Same as GPDC; see GPDC table row for more information.

Appendix C
Value-Based Care Components of Selected PTAC Proposals

Selected PTAC Proposals that Included Value-Based Care Components

Nearly all of the 35 proposals that have been submitted to PTAC addressed the potential impact on scope (specifically opportunities for APM participation) and quality and cost. Committee members found that 18 of these proposals met both Criterion 1 ("Scope") and Criterion 2 ("Quality and Cost"), including several proposals that were directly related to promoting accountable care, and/or proposed to use waivers to reduce barriers related to participation in APMs.

Proposal	Clinical Focus	Value-Based Care and Technical Components
American Academy of Family Physicians (AAFP) *(Provider association and specialty society)* **Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care** Recommended for limited-scale testing, 12/19/2017	Primary Care	**Overall Model Design Features**: APC-APM builds on concepts tested through CPC and CPC+ models. Primary care medical homes work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange. **Use of Waivers**: N/A **Financial Methodology**: Capitated PBPM with shared risk options for accountability. **How Payment is Adjusted for Performance**: Participants assume performance risk. APMs that meet or exceed agreed-upon benchmarks retain incentive payment. Failure to meet benchmarks would involve repaying all or part of the incentive payment. **Approaches to Incorporate Multi-Payer Alignment:** APC-APM aligns with the multi-payer CPC and CPC+ models, which promote longitudinal, comprehensive, and coordinated care with primary care teams.

Selected PTAC Proposals that Included Value-Based Care Components, Continued

Proposal	Clinical Focus	Value-Based Care and Technical Components
American College of Emergency Physicians (ACEP) (*Provider association/ specialty society*) **Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions** Recommended for implementation, 09/06/2018	Emergency medicine	**Overall Model Design Features**: Several elements are adapted from the CJR and the BPCI Advanced Models. **Use of Waivers**: Telehealth: Allows emergency physicians to provide telehealth services in the beneficiary's residence and to bill one of the in-home visits as telehealth. Post-discharge home visit: Licensed clinical staff may provide home visits under the general supervision of an emergency physician. Transitional care management: Authorizes emergency physicians to bill for a transitional care management code, utilizing Current Procedural Terminology (CPT) codes (99494 and 99496) or the ED-specific acute care transition codes. **Financial Methodology**: Bundled payment methodology with retrospective reconciliation. **How Payment is Adjusted for Performance**: A composite quality score, including post-ED event rates and patient safety measures, determines whether participants are eligible for a reconciliation payment or if repayment to Medicare is warranted. **Approaches to Incorporate Multi-Payer Alignment:** N/A
American College of Physicians-National Committee for Quality Assurance (ACP-NCQA) *(Provider association and specialty society/other*) **The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version)** Recommended for testing to inform payment model development, 09/15/2020	Improved coordination in primary and specialty care practices	**Overall Model Design Features**: The model builds on the CPC+, Patient-Centered Medical Homes (PCMHs), and Patient-Centered Specialty Practice (PCSP) concepts. **Use of Waivers**: Telehealth: Removes the requirements for Medicare site-of-service and geographic limitations for telehealth services. 3-day SNF: This policy exempts participants from requiring patients to have at least a 3-day hospital inpatient stay to be eligible for SNF coverage. Shared Savings: Allows for participants to share savings based on performance. Stark and Anti-kickback Fraud and Abuse: Permits health care providers to engage in specific value-based compensation agreements. Pre-participation: Protects groups when in the process of building an Advanced APM without a formal contract. **Financial Methodology**: Participants receive a monthly PBPM care coordination fee and a retrospective positive or negative payment adjustment. Track 1 includes fee-for-service payments, while Track 2 has a reduced fee-for-service payment and a comprehensive specialty care payment (CSCP). **How Payment is Adjusted for Performance**: Performance-based payment adjustment is based on spending relative to a financial benchmark, adjusted for performance on quality and utilization metrics. **Approaches to Incorporate Multi-Payer Alignment:** Intended to align payment criteria and incentives across payers.

Selected PTAC Proposals that Included Value-Based Care Components, Continued

Proposal	Clinical Focus	Value-Based Care and Technical Components
The American College of Surgeons (ACS) *(Provider association/specialty society)* **The ACS–Brandeis Advanced Alternative Payment Model** Recommended for limited-scale testing, 4/11/2017	Cross-clinical focus with sets of procedural episodes of care	**Overall Model Design Features**: Focused on procedural episodes, leveraging the Episode Grouper for Medicare (EGM) software developed by CMS and Brandeis University. The model is based on shared accountability, integration, and care coordination as fundamental building blocks. **Use of Waivers**: Waivers permitting financial incentives to encourage beneficiaries to accept referrals. **Financial Methodology**: Retrospective payment that compares episode target prices to the actual cost of the care provided. **How Payment is Adjusted for Performance**: Performance (e.g., unacceptable, acceptable, good, excellent) determines the shared savings retained by the APM entity or the amount to repay CMS for losses. **Approaches to Incorporate Multi-Payer Alignment:** The model creates a "bundle of bundles" and clusters episodes of care to facilitate business efficiencies in a multi-payer environment.
Avera Health (Avera Health) (*Regional/local multispecialty practice or health system*) **Intensive Care Management in Skilled Nursing Facility Alternative Payment Model (ICM SNF APM)** Recommended for implementation, 3/27/2018	Geriatric primary care for residents in long-term care	**Overall Model Design Features**: Provides access to a geriatrician-led care team through telemedicine, provides geriatric care management and management of care transitions, and mentors and trains long-term care staff. **Use of Waivers**: N/A **Financial Methodology**: One-time payment for new admission care and a PBPM payment for post-admission care. Two payment method options are proposed for the model: 1) a *performance-based payment* adjusted on quality performance; and 2) a *shared savings model* with an annual financial reconciliation. **How Payment is Adjusted for Performance**: In the *performance-based payment* option, payments are adjusted positively or negatively by the ability to meet performance criteria. **Approaches to Incorporate Multi-Payer Alignment**: N/A

Selected PTAC Proposals that Included Value-Based Care Components, Continued

Proposal	Clinical Focus	Value-Based Care and Technical Components
Coalition to Transform Advanced Care (C-TAC) (*Coalition*) **Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model** Recommended for limited-scale testing, 3/26/2018	Advanced illness, palliative care, end-of-life care	**Overall Model Design Features**: An interdisciplinary care team implements the ACM care delivery services. **Use of Waivers**: Consideration of waivers granted in the NGACO and OCM models (e.g., telehealth expansion waiver; SNF 3-day rule waiver; post-discharge and care management home visit waivers; participation waiver; shared savings distribution waiver; waiver for patient incentives). **Financial Methodology**: A non-tiered PMPM payment with downside risk for TCOC and an upside bonus for quality, subject to maximum payment and loss amounts. **How Payment is Adjusted for Performance**: pay-for-quality structure, where participants are eligible for a quality-based bonus funded by shared savings and determined by performance measure performance. **Approaches to Incorporate Multi-Payer Alignment**: N/A
Hackensack Meridian Health and Cota, Inc. (HMH/Cota) *(Regional/ local multispecialty practice or health system; Device/ technology company)* **Oncology Bundled Payment Program Using CNA-Guided Care** Recommended for limited-scale testing, 9/8/2017	Oncology	**Overall Model Design Features**: This is an oncology bundled payment model in which care choices are modulated by the prior outcomes of similar patients from real-world data. This process is called Cota Nodal Address (CNA) guided care. **Use of Waivers**: N/A **Financial Methodology**: Prospective payment is provided to HMH for patients participating in the model. HMH bears the risk of bundled payments and distributes payments to physicians. **How Payment is Adjusted for Performance**: Compensation is, in part, incentive-based and determined by the achievement of clinical quality and patient satisfaction outcomes. **Approaches to Incorporate Multi-Payer Alignment**: N/A

Selected PTAC Proposals that Included Value-Based Care Components, Continued

Proposal	Clinical Focus	Value-Based Care and Technical Components
Johns Hopkins School of Nursing and the Stanford Clinical Excellence Research Center (Hopkins/Stanford) *(Academic institution)* **CAPABLE Provider Focused Model** Recommended for testing as specified in PTAC comments, 9/6/19	Chronic conditions and functional limitations	**Overall Model Design Features**: A time-limited intervention performed by an interdisciplinary team to target specific functional goals, perform limited home repairs and modifications, and address common geriatric concerns. **Use of Waivers**: N/A **Financial Methodology:** Partial bundled payment with partial upside, moving toward a fully capitated model of care. **How Payment is Adjusted for Performance**: A bonus for meeting quality metrics would be awarded. **Approaches to Incorporate Multi-Payer Alignment**: N/A

Selected PTAC Proposals that Included Value-Based Care Components, Continued

Proposal	Clinical Focus	Value-Based Care and Technical Components
Illinois Gastroenterology Group and SonarMD, LLC (IGG/SonarMD) *(Regional/local single specialty practice; Device/technology company)* **Project Sonar** Recommended for limited-scale testing, 4/10/2017	Chronic disease (Crohn's disease)	**Overall Model Design Features**: The model integrates evidence-based medicine with proactive patient engagement. It allows physicians to participate in chronic disease management that is not triggered by a surgical procedure or on an inpatient or outpatient basis. **Use of Waivers**: N/A **Financial Methodology**: Add-on PBPM payment with two-sided risk, plus a payment to support remote monitoring. **How Payment is Adjusted for Performance**: Payments would be adjusted based on quality and financial performance. **Approaches to Incorporate Multi-Payer Alignment**: N/A
Innovative Oncology Business Solutions, Inc. (IOBS) *(For-profit corporation)* **Making Accountable Sustainable Oncology Networks (MASON)** Referred for further development and Implementation, 12/10/2018	Oncology	**Overall Model Design Features**: Builds off the Community Oncology Medical Home (COME HOME) CMMI project. **Use of Waivers**: N/A **Financial Methodology**: Determined by the oncology payment category (OPC), consisting of FFS payments for physician visits, imaging, lab, radiation therapy, surgery; infusion with a facility fee; ambulatory payment classifications (APC) for hospital outpatient care; diagnosis-related groups (DRGs) for inpatient care; and the patient-centered oncology payment (PCOP) for medical home infrastructure. **How Payment is Adjusted for Performance**: Two percent of the OPC, which includes all expenses related to cancer care except drugs, is reserved for a quality pool. If quality measures are not met, the two percent is not rewarded. **Approaches to Incorporate Multi-Payer Alignment**: N/A

Selected PTAC Proposals that Included Value-Based Care Components, Continued

Proposal	Clinical Focus	Value-Based Care and Technical Components
Large Urology Group Practice Association (LUGPA) *(Provider association and specialty society)* **LUGPA Advanced Payment Model for Initial Therapy of Newly Diagnosed Patients with Organ Confined Prostate Cancer** Not recommended, 2/28/18	Prostate cancer	**Overall Model Design Features**: This model creates episode-based payments for low-risk prostate cancer patients appropriate for active surveillance (AS) instead of active intervention (AI). **Use of Waivers**: Stark law waiver to permit compensation for increased utilization of AS or individual performance on quality measures. **Financial Methodology**: Add on PBPM payment with shared risk. **How Payment is Adjusted for Performance**: Participants are eligible for a performance-based payment if quality thresholds are met to enhance the utilization of AS. **Approaches to Incorporate Multi-Payer Alignment**: N/A
Icahn School of Medicine at Mount Sinai (Mount Sinai) (*Academic institution*) **"HaH-Plus" (Hospital at Home-Plus): Provider-Focused Payment Model** Recommended for implementation, 9/17/2017	Inpatient services in the home setting	**Overall Model Design Features**: Multidisciplinary care around an acute care event to reduce complications and readmissions. **Use of Waivers**: Homebound requirement for HaH participants during the acute phase of HaH care (but would remain for post-acute services) and a waiver of the OASIS assessment requirement at the start and the conclusion of the acute phase of HaH care. **Financial Methodology**: Bundle payment covering the acute episode and an additional 30 days of transition services. Two components are in the payment model: 1) a new DRG-like HaH-Plus payment to substitute for the acute inpatient payment to the hospital and attending physician, and 2) the potential for a performance-based payment linked to the total Medicare spend for the entire HaH-Plus episode and the APM performance on quality metrics. **How Payment is Adjusted for Performance**: The APM entity's performance on quality metrics influences payment. **Approaches to Incorporate Multi-Payer Alignment**: Submitters stated that MA and Medicaid managed care plans expressed interest in the HAH model. This model was also implemented at the VA.

Selected PTAC Proposals that Included Value-Based Care Components, Continued

Proposal	Clinical Focus	Value-Based Care and Technical Components
New York City Department of Health and Mental Hygiene (NYC DOHMH) *(Public health department)* **Multi-provider, bundled episode of care payment model for treatment of chronic hepatitis C virus (HCV) using care coordination by employed physicians in hospital outpatient clinics** Not recommended, 12/18/2018	Hepatitis C virus (HCV)	**Overall Model Design Features**: The Project INSPIRE Model proposes integrated medical, behavioral, and social services for patients with HCV. **Use of Waivers:** N/A **Financial Methodology**: Bundled payment with the opportunity for shared savings. **How Payment is Adjusted for Performance**: Additional shared savings are awarded for being a "high-performing facility" based on their sustained virological response (SVR) score. **Approaches to Incorporate Multi-Payer Alignment**: N/A
Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group (PMA) (*Regional/local single specialty practice*) **The COPD and Asthma Monitoring Project** Not Recommended, 4/11/2017	Pulmonology, COPD, and asthma	**Overall Model Design Features**: Remote, interactive monitoring mode targets high-risk patients with COPD and other chronic lung conditions. **Use of Waivers**: Stark law waiver for a safe harbor designation; pharmaceutical and devise manufacturer waivers would be permitted to allow beneficiaries COPD and asthma controller agents and devices without cost; no copayments would be required. **Financial Methodology**: Bundled episode-based payment replacing FFS with shared risk. **How Payment is Adjusted for Performance**: N/A **Approaches to Incorporate Multi-Payer Alignment**: N/A

Selected PTAC Proposals that Included Value-Based Care Components, Continued

Proposal	Clinical Focus	Value-Based Care and Technical Components
Personalized Recovery Care (PRC) (*Regional/local single specialty practice*) **Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home** Recommended for implementation, 3/26/2018	Inpatient services in the home setting or skilled nursing facility	**Overall Model Design Features**: This is a home hospitalization care model that proposes to provide inpatient hospitalization-level care and personalized recovery care (PRC) at home or a skilled nursing facility for patients with certain conditions through an episodic payment arrangement. **Use of Waivers**: 3-day SNF: This policy exempts participants from requiring patients to have at least a 3-day hospital inpatient stay to be eligible for SNF coverage. **Financial Methodology**: Bundled episode-based payment not tied to an anchor admission, replacing FFS with shared risk. Bundled payment has two components: 1) risk payment for delivering care compared to the targeted cost of care and 2) a per-episode payment made for care provided instead of an acute care hospitalization. **How Payment is Adjusted for Performance**: A portion of physician compensation is tied to quality metrics and outcomes. **Approaches to Incorporate Multi-Payer Alignment**: PRC is currently available in commercial and MA plans.
Renal Physicians Association (RPA) (*Provider association and specialty society*) **Incident ESRD Clinical Episode Payment Model** Recommended for implementation, 12/18/2017	End-stage renal disease (ESRD)	**Overall Model Design Features**: Condition-specific, episode-of-care payment model for ESRD patients during the first six months of dialysis therapy that promotes coordination, patient choice for treatment, CKD patient education, quality of life, and advanced care planning. **Use of Waivers**: A waiver to assist patients with transportation to dialysis and vascular access services. **Financial Methodology**: Episode of care payment model with shared savings achieved over the entire 6-month episode of care. There is also a one-time bonus payment for nephrologists to facilitate a patient receiving a kidney transplant preemptively or during the episode of care. **How Payment is Adjusted for Performance**: Physicians' quality scores based on performance on patient-centered quality measures determine the percentage of overall shared savings the physician receives. The higher the quality score, the higher amount of shared savings received. **Approaches to Incorporate Multi-Payer Alignment**: Designed for Medicare but could be adapted to other payers.

Selected PTAC Proposals that Included Value-Based Care Components, Continued

Proposal	Clinical Focus	Value-Based Care and Technical Components
University of Chicago Medicine (UChicago) *(Academic Institution)* **The Comprehensive Care Physician Payment Model (CCP-PM)** Recommended for limited-scale testing, 9/7/2018	Frequently hospitalized patients	**Overall Model Design Features**: The model seeks to defragment care for patients at risk for hospitalization by providing a physician to provide inpatient and outpatient care. **Use of Waivers**: N/A **Financial Methodology**: Add on PBPM payment with shared risk **How Payment is Adjusted for Performance**: Providers will continue to be incentivized or penalized for quality outcome measures based on their APM or MIPS participation. **Approaches to Incorporate Multi-Payer Alignment**: The model can be adapted across other payers, such as Medicaid and private payers.
The University of New Mexico Health Sciences Center (UNMHSC) (*Academic institution*) **ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Emergencies** Recommended for implementation, 9/16/2019	Cerebral emergency care; telemedicine	**Overall Model Design Features**: Rural EDs can consult neurologists via teleconsultation and assess patients' condition when they present at the hospital ED. The model aims to reduce costs in hospital transfers and ambulatory medicine. **Use of Waivers**: N/A **Financial Methodology**: Additional one-time payment without shared risk **How Payment is Adjusted for Performance**: Performance is monitored but does not impact payment. **Approaches to Incorporate Multi-Payer Alignment**: CMS and commercial payers can use the creation of a new bundled code for telemedicine consultations.

Appendix D
Analysis of Factors Affecting ACO Participation By Organization Revenue Size

Considerations for ACO Participation by Organization Revenue Size

Organization Revenue Size	Considerations
Low Revenue	• Insufficient revenue and infrastructure to support participation • Training • Participate via conveners • Limiting downside risk requirements encourages entry • High proportion of revenue part of ACO contract • Administrative costs and burden to participate • Ratchet effect where high-performing groups have to out-do their own performance
High Revenue	• Sufficient revenue and infrastructure to support participation • Low proportion of organization revenue part of ACO contract • Size of ACO rewards is insufficient to encourage participation • Incorporation of regional spending may make it more difficult for high-spending ACOs to meet benchmarks

Considerations for ACO Participation by Organization's Medicare Revenue Compared with Total Spending for Assigned Population

Proportion of TCOC Revenue	Considerations
Low Revenue	• More opportunities to reduce TCOC through reducing utilization of other provider's services • Encourages advanced primary care and care coordination • Fewer opportunities for team-based care and less ability to coordinate primary and specialty care • Greater flexibility for multiple types of provider organizations to participate in risk-based agreements • Insufficient data to make referral to preferred specialists • Vertical integration may reduce incentives/ability for physicians to reduce hospital use
High Revenue	• Greater opportunity to provide team-based, coordinated care • Opportunities to align incentives across the full range of care • Fewer opportunities to reduce utilization without revenue losses that would exceed shared savings • Develop incentives that would encourage participation from organizations that might be best able to provide high value, coordinated care • Size of ACO rewards is insufficient to encourage participation • Current FFS payments are likely to always be more attractive APMs to these organizations

Major Barriers to Participating in PB-TCOC Models by Organization Business Model Type (Revenue Size and Source)

Barrier to Participation	Low Revenue Organizations			High Revenue Organizations		
	Outpatient or Office	Mixed Revenue	Inpatient	Outpatient or Office	Mixed Revenue	Inpatient
Low motivation to participate in PB-TCOC models that attempt to minimize hospital inpatient stays and ED visits		✓	✓		✓	✓
Administrative burden / cost of participation (e.g., data analytics, health IT, infrastructure)	✓	✓	✓			
Reluctance to take on downside risk (financially infeasible)	✓	✓	✓			
PB-TCOC incentives represents a small proportion of revenue, not sufficient to motivate behavior change				✓	✓	✓
Difficulty integrating specialists and lack of payment incentive structure to encourage specialist transition to value-based relationships	✓			✓		

Appendix E
Additional Information About Analysis of IDS Participation in Medicare ACOs

Methodology for Identifying IDSs

Identifying IDSs

Defined IDSs using AHRQ's Compendium of U.S. Health Systems definition of system, which includes:

- At least **one non-Federal acute care hospital**
- At least **50 physicians**
- At least **10 primary care physicians**

791 unique IDSs

Average of 982 beds & 1,031 physicians in 2022

Large IDSs

Identified as systems in the top 20th percentile of beds and physicians in each year of Compendium data, plus ten systems identified in Hospitalogy's list of largest health systems by revenue as of 2023.

129 unique IDSs

Average of 3,565 beds & 3,857 physicians in 2022

Small/Medium IDSs

Identified as all IDSs in Compendium data **not** identified as large IDSs.

662 unique IDSs

Average of 528 beds & 429 physicians in 2022

List of 129 Large Integrated Delivery Systems Included in the Analysis

AdventHealth (FL)	Cedars Sinai Health System (CA)	Indiana University Health (IN)
Adventist Health (CA)	ChristianaCare (DE)	Inova Health System (VA)
Advocate Aurora Health (IL)	Christus Health (TX)	Integris Health (OK)
Advocate Health (NC)	Cleveland Clinic (OH)	Intermountain Healthcare (UT)
Advocate Health Care (IL)	CommonSpirit Health (IL)	Jackson Health System (FL)
Allegheny Health Network (PA)	Community Health Systems (TN)	Jefferson Health (PA)
Allina Health (MN)	Corewell Health (MI)	Johns Hopkins Health System (MD)
Ascension Health (MO)	Dignity Health (CA)	Kaiser Permanente (CA)
Atlantic Health System (NJ)	Duke University Health System (NC)	Lahey Health System (MA)
Atrium Health (NC)	Emory Healthcare (GA)	Lehigh Valley Health Network (PA)
Aurora Health Care, Inc (WI)	Essentia Health (MN)	Lifepoint Health (TN)
Banner Health (AZ)	Fairview Health Services (MN)	Los Angeles County Department of Health Services (CA)
Baptist Memorial Health Care Corporation (TN)	Franciscan Health (IN)	Mass General Brigham (MA)
Baylor Scott and White Health (TX)	Froedtert and the Medical College of Wisconsin (WI)	Mayo Clinic Health System (MN)
Beaumont Health Systems (MI)	Geisinger (PA)	McLaren Health Care Corporation (MI)
Beth Israel Deaconess Medical Center (MA)	Greenville Health System (SC)	Medical University of South Carolina Medical Center (SC)
Beth Israel Lahey Health (MA)	Hackensack Meridian Health (NJ)	MedStar Health (MD)
BJC Healthcare (MO)	Hartford Healthcare (CT)	Memorial Hermann Healthcare System (TX)
Bon Secours Health System (MD)	HCA Healthcare (TN)	MemorialCare Health System (CA)
Bon Secours Mercy Health (OH)	Henry Ford Health (MI)	Mercy (MO)
Catholic Health (NY)	HonorHealth (AZ)	Mercy Health (OH)
Catholic Health Initiatives (CO)	Houston Methodist (TX)	Montefiore Medical Center (NY)

List of 129 Large Integrated Delivery Systems Included in the Analysis, Continued

Mount Sinai Health System (NY)	Providence (WA)	UC Health (OH)
New York City Health and Hospitals Corporation (NY)	Quorum Health Corporation (TN)	UF Health (FL)
New York Presbyterian Healthcare System (NY)	Rush System for Health (IL)	UNC Health Care System (NC)
NorthShore Edward-Elmhurst Health (IL)	RWJBarnabas Health (NJ)	Unitypoint Health (IA)
Northwell Health (NY)	Saint Joseph Health System (CA)	Universal Health Services (PA)
Northwestern Medicine (IL)	Saint Lukes University Health Network (PA)	University Hospitals (OH)
Norton Healthcare (KY)	Sanford Health (SD)	University of California Health (CA)
Novant Health (NC)	Scripps Health (CA)	University of Colorado Health (CO)
NYU Langone Health (NY)	Sentara Healthcare (VA)	University of Maryland Medical System (MD)
Ochsner Health System (LA)	Sharp Healthcare (CA)	University of Michigan Health System (MI)
Ohiohealth (OH)	Sisters of Charity of Leavenworth Health System (CO)	University of Pennsylvania Health System (PA)
Orlando Health (FL)	SSM Health (MO)	University of Rochester Medical Center (NY)
OSF Healthcare System (IL)	Stanford Health Care (CA)	UPMC (PA)
Palmetto Health (SC)	Steward Health Care System (TX)	UW Medicine (WA)
Parkview Health System (IN)	Sutter Health (CA)	Vanderbilt Health (TN)
Peacehealth (WA)	Tenet Healthcare (TX)	Wake Forest University Baptist Medical Center (NC)
Piedmont Healthcare (GA)	Texas Health Resources (TX)	WellStar Health System (GA)
Presence Health (IL)	The Ohio State University Wexner Medical Center (OH)	West Virginia University Health System (WV)
Prime Healthcare Services (CA)	The University of Kansas Health System (KS)	Yale New Haven Health System (CT)
Prisma Health (SC)	The University of Texas System (TX)	
ProMedica (OH)	Trinity Health (MI)	
Prospect Medical Holdings (CA)	UAB Health System (AL)	

Number of Large and Small/Medium IDSs, 2016-2022

	Total IDSs*			Large IDSs			Small/Medium IDSs		
	Number of IDSs	Average Number of Beds	Average Number of Physicians	Number of IDSs	Average Number of Beds	Average Number of Physicians	Number of IDSs	Average Number of Beds	Average Number of Physicians
2016	626	965	742	122	3,151	2,539	504	433	307
2018	637	962	927	119	3,328	3,326	518	417	376
2020	629	1,000	945	115	3,525	3,382	514	432	399
2022	640	982	1,031	112	3,565	3,857	528	429	431

* Total IDSs includes all systems identified in the Compendium. Large IDSs are IDSs in the top 20th percentile of beds and physicians in each year. Small/medium IDSs are all other systems included in the Compendium each year that were **not** identified as large IDSs.

Nature of IDS Participation in Medicare ACO Models

- IDSs can participate in Medicare ACO models in a variety of ways, including as a lead organization (i.e., ownership of an ACO) or as a participant in one or more ACOs.
- Participation is not necessarily system-wide; hospitals and practices can participate in Medicare ACO without all hospitals/practices in the system participating.
- A single IDS can participate in multiple Medicare ACO models and ACOs within a single model.

Example:
One IDS' Participation in Medicare ACO Models, 2016-2022

2016
- 4 MSSP ACOs in 4 states

2018
- 9 MSSP ACOs in 8 states
- 1 NGACO in 1 state

2020
- 5 MSSP ACOs in 4 states
- 1 NGACO in 1 state

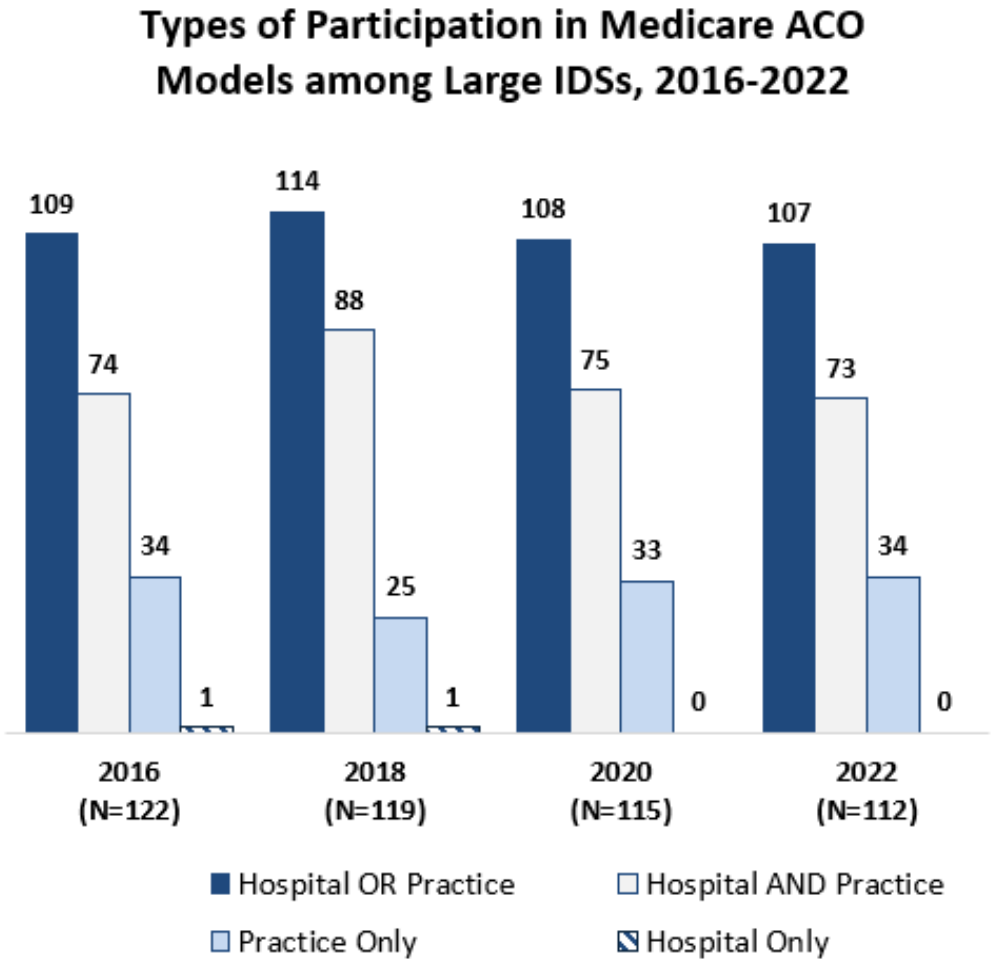
2022
- 8 MSSP ACOs in 12 states
- 3 GPDC ACOs in 16 states

Extent of Participation of IDSs in Medicare ACO Models

- Participation in Medicare ACO models among large IDSs was high, with about 90% of large IDSs having at least one affiliated hospital or practice participate in a Medicare ACO each year.

- Large IDS participation in Medicare ACO models typically involved both hospitals and practices:
  - About two-thirds of large IDSs participated with both **hospitals and practices.**
  - About a third of large IDSs participated with **practices only.**
  - Less than 1% of large IDSs participated with **hospitals only.**

- ACO participation was **lower** among small/medium IDSs:
  - Two-thirds of small/medium IDSs had affiliated hospitals or practices participating in Medicare ACO models in 2022.
  - In 2022 approximately 50% of small/medium IDSs participated with practices only and 50% participated with both hospitals and practices.



Appendix F
Examples of ACO Participation Pathways

ACO Participation Pathway Examples

Type of Organization	Participation Pathway	Payment Model	Potential Participation Issues

Low-Revenue Physician-Owned Practice (Small/Rural Practice)	• Lower levels of financial risk
	• Accountability for performance
	• Potential advanced payment
		• Partial capitation
		• Shared savings possibly either upside risk only or minimal downside
		• Possible upfront payment to support practice transformation
			• Business pressures impacting organization interest in ACO participation:
			  ○ Low proportion of TCOC received as revenue by the physician-owned practice; practice revenue not at risk (positive incentive)
			  ○ Significant administrative and infrastructure barriers/costs may exist (negative incentive); a convener/enabler organization may be needed to facilitate participation

High-Revenue Independent Practice-Led ACO	• Higher levels of financial risk
	• Full performance accountability
		• Shared savings with upside and downside risk
		• Higher upside potential
			• Business pressures impacting organization interest in ACO participation:
			  ○ Low proportion of TCOC received as revenue by the practice; practice revenue not at risk (positive incentive)
			  ○ Less formal relationships with specialists may increase downside risk and impede willingness to participate (negative incentive)

Hospital-Owned (Large IDS)	• Full financial and performance accountability	• Full capitation or FFS with higher levels of two-sided risk
		• Nested solutions
			• Business pressures impacting organization interest in ACO participation:
			  ○ High proportion of TCOC received as revenue by the hospital-owned IDS; IDS revenue at risk (negative incentive)
			  ○ Payment incentives may be too low relative to overall organization revenue to be motivating (negative incentive)

Appendix G
Maximizing the Competitiveness and Sustainability of PB-TCOC Models

Factors that Influence Competitiveness of PB-TCOC Models

Factors	Impact on Competitiveness of PB-TCOC Models
Physician concentration	• Low physician concentration in a given market is associated with greater ACO participation ○ Possibly due to markets with high physician concentration already having established partnerships with large health systems limiting the remaining market share for physician practices to develop/join an ACO

Medicare Advantage (MA) penetration	• Areas with MA penetration around 20-40% of the market share are associated with greater ACO participation
	  ○ MA rates around 20-40% may provide participants with risk contracting experience to support creating/joining ACOs
	• Areas with MA penetration less than 20% or greater than 40% are associated with less ACO participation
	  ○ Once MA rates exceed 40%, it may become difficult to compete with MA incentives

Socioeconomic conditions	• Participation in ACOs has been historically low in areas with socioeconomic issues (e.g., high rates of poverty, uninsured, and lack of education)
Market consolidation	• Consolidation has increased through vertical mergers, horizontal mergers, and clinically integrated networks ○ Consolidation may facilitate participation for integrated health systems • Areas with the most significant consolidation changes among small physician practices are seeing the highest county-level ACO penetration

Factors Influencing Competitiveness of PB-TCOC Models Compared with Fee-for-Service and Medicare Advantage Plans

System	Factors Influencing Competitiveness
APMs	• APMs require substantial financial resources to transform care delivery • Complexity and number of APM options may overlap, creating competition for shared savings within models • Value-based care is viewed as a small market share without a sense of urgency for transformation • APMs can utilize incentives not readily available under FFS to capture underserved populations and their providers, establish peer-to-peer learning, coordinate care, and incorporate social needs into patient care plans
FFS	• FFS is viewed as less administratively complex than APMs • Attempts to make FFS less desirable such as bundling FFS have been unsuccessful because the number of billable episodes of care is not limited • Academic medical centers continue to focus on higher acuity care in the FFS system because it is more profitable
MA	• MA plans offer more favorable benchmarks and flexibility for reimbursement compared to APMs

Use of Waivers in CMMI Models

- Federal waivers can encourage collaboration between entities, incentivize provider participation, and permit model performance evaluation
- Medicare program rule waivers and fraud and abuse waivers can be grouped into three main domains:

Type of Waiver	Domain	Waiver Example	Description	CMMI Models
Medicare Program Rule	**Care Delivery Design**	3-Day SNF	Allows for a patient to be admitted to a SNF without a prior 3-day hospital stay to promote coordinated care and improved patient transitions	BPCI-A (Active); BPCI (Not Active); CKCC (Active); DC (Not Active); NGACO (Not Active); Pioneer ACO (Not Active)
Fraud and Abuse	**Patient Engagement Incentives**	Cost Sharing	Reduces cost-sharing amounts for certain Medicare Part B services to minimize beneficiary financial barriers	CKCC (Active); DC (Not Active); NGACO (Not Active); PCF (Active)
	Participation Coordination	Participation Waivers	Waives portions of the Federal anti-kickback statute and the physician self-referral law to enable participants to undertake certain activities that "promote accountability for the quality, cost, and overall care" for the model beneficiaries	NGACO (Not Active); Pioneer ACO (Not Active); Vermont ACO

Use of Waivers in CMMI Models, Continued

- The use of Medicare program waivers in CMMI models has been modest
  - Only 21% of practices in the PCF Model reported using at least one waiver, and only 6% of practices reported using cost-sharing support waiver
  - Although half of the ACOs in the NGACO Model used the 3-day SNF rule waiver, only 3% of SNF stays were attributed to the waiver's use
  - Use of the transportation and nutrition patient engagement incentives declined throughout the CEC Model period
- Potential solutions to increase the use of waivers in CMMI models
  - Provide detailed guidance on the use of specific waivers
  - Streamline waiver options across models
  - Offer protections for unintentional waiver misuse
  - Expand the population eligible for waivers

Strategies Influencing Beneficiary Health Behaviors in Value-Based Care

Strategy	Example
Provide financial incentives to drive beneficiaries towards higher-value providers	• Provide benefits or rewards for healthy lifestyles • Reduce or eliminate co-pays for primary care
Use APM-financed clinical tools to enhance the beneficiary experience	• Shared decision-making tools
Implement enhanced strategies to support social determinants of health	• Nutrition services • Transportation services

Appendix H
References

References

Slide 7 – APMs Have Created Value for Medicare

- ASPE. The Impact of Alternative Payment Models on Medicare Spending and Quality, 2012-2022. Jan 15, 2025. https://aspe.hhs.gov/reports/impact-alternative-payment-models-medicare-spending-quality-2012-2022

Slide 10 – Physician-Led ACOs Have Grown the Most Rapidly and Account for the Largest Percentage of New ACOs

- Muhelstein D, Tu T, Colla C. Accountable Care Organizations Are Increasingly Led by Physician Groups Rather than Hospital Systems. AJMC. 2020. https://www.ajmc.com/view/accountable-care-organizations-are-increasingly-led-by-physician-groups-rather-than-hospital-systems

Slide 11 – ACO Growth Has Plateaued

- Muhlestein D, Bleser W, Saunders R, McClellan M. All-Payer Spread of ACOs and Value-Based Payment Models in 2021: The Crossroads and Future of Value-Based Care. Health Affairs Forefront. 2021. https://www.healthaffairs.org/content/forefront/all-payer-spread-acos-and-value-based-payment-models-2021-crossroads-and-future-value

References

Slide 12 – ACO Growth Has Plateaued Across All Payers

- Muhlestein D, Bleser W, Saunders R, McClellan M. All-Payer Spread of ACOs and Value-Based Payment Models in 2021: The Crossroads and Future of Value-Based Care. Health Affairs Forefront. 2021. https://www.healthaffairs.org/content/forefront/all-payer-spread-acos-and-value-based-payment-models-2021-crossroads-and-future-value

Slide 13 – All Payer ACO Market Entrants and Exits

- Muhlestein D, Bleser W, Saunders R, McClellan M. All-Payer Spread of ACOs and Value-Based Payment Models in 2021: The Crossroads and Future of Value-Based Care. Health Affairs Forefront. 2021. https://www.healthaffairs.org/content/forefront/all-payer-spread-acos-and-value-based-payment-models-2021-crossroads-and-future-value

Slide 14 – ACO Growth Potential for Physician Groups is Substantially Higher than for Hospital Systems

- Muhelstein D, Tu T, Colla C. Accountable Care Organizations Are Increasingly Led by Physician Groups Rather than Hospital Systems. AJMC. 2020. https://www.ajmc.com/view/accountable-care-organizations-are-increasingly-led-by-physician-groups-rather-than-hospital-systems

References

Slide 15 – Qualifying Participants (QPs) in CMS Advanced Alternative Payment Models (AAPMs), 2023 – Specialty Physicians are Less Likely to Participate

- Muhlestein, Assessing Provider Adoption of Medicare Advanced Alternative Payment Models. Health Affairs Forefront. December 16, 2024. https://www.healthaffairs.org/content/forefront/assessing-provider-adoption-medicare-advanced-alternative-payment-models

References

Slide 16 – Integrated Delivery Systems (IDSs) and Accountable Care

- Physicians Advocacy Institute. Avalere Health. Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019-2023. April 2024. https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI-Avalere%20Physician%20Employment%20Trends%20Study%202019-2023%20Final.pdf?ver=uGHF46u1GSeZgYXMKFyYvw%3d%3d
- Levinson Z, Godwin J, Hulver S, Neuman T. Ten Things to Know About Consolidation in Health Care Provider Markets. Kaiser Family Foundation. April 2024. https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/
- U.S. Integrated Delivery Network Market Size, Growth, Report 2024-2033. BioSpace. 2024. https://www.biospace.com/u-s-integrated-delivery-network-market-size-growth-report-2024-2033
- U.S. Integrated Delivery Network Market Size, Share & Trends Analysis Report By Integration Model (Vertical, Horizontal), By Service (Acute Care/Hospitals, Primary Care, Long-term Health, Specialty Clinics), By Facility, And Segment Forecasts, 2024 – 2030. Grand View Research. https://www.grandviewresearch.com/industry-analysis/us-integrated-delivery-network-market
- The Value-Based Care Enabler Landscape: 2024 Update. PitchBook Data, Inc. https://pitchbook.com/news/reports/q1-2024-pitchbook-analyst-note-the-value-based-care-enabler-landscape-2024-update

References

Slides 17-18, 20-21 – Large IDS Participation in Medicare ACO Models

- PTAC Commissioned Work – Analysis by NORC in support of PTAC

Slide 19 – The Percentage of ACOs Led by IDSs has Declined Over Time

- Evaluation of the Global and Professional Direct Contracting Model. Centers for Medicare and Medicaid Innovation (CMMI). 2024. https://www.cms.gov/priorities/innovation/data-and-reports/2024/gpdc-2nd-ann-report
- Fourth Evaluation Report: Next Generation Accountable Care Organization (NGACO) Model Evaluation. Centers for Medicare and Medicaid Innovation (CMMI). 2021. https://www.cms.gov/priorities/innovation/data-and-reports/2021/nextgenaco-fourthevalrpt
- Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Final Report. Centers for Medicare and Medicaid Services (CMS). 2016. https://www.cms.gov/priorities/innovation/files/reports/pioneeraco-finalevalrpt.pdf

Slides 23-25, 27-32

- Input from the PTAC Preliminary Comments Development Team (PCDT) and ASPE

Slide 30 – Pathway Considerations

- The Value-Based Care Enabler Landscape: 2024 Update. PitchBook Data, Inc. https://pitchbook.com/news/reports/q1-2024-pitchbook-analyst-note-the-value-based-care-enabler-landscape-2024-update

References

Slide 34 – Approaches for Supporting Primary and Specialty Care Transformation

- Health Care Payment Learning & Action Network (HCPLAN). Accelerating and aligning population-based payment models: patient attribution. Published May 13, 2016. Accessed December 2, 2024. https://www.multiplechronicconditions.org/wp-content/uploads/2022/12/2016-HCPLAN-Accelerating-and-Aligning-Population-Based-Payment-Models.pdf
- National Coordinator for Health Information Technology (ONC). Health IT Playbook. Accessed December 4, 2024. https://www.healthit.gov/playbook/health-information-exchange/
- American College of Physicians. Beyond the referral: principles of effective, ongoing primary and specialty care collaboration. Published 2022. Accessed December 4, 2024. https://www.acponline.org/sites/default/files/acp-policy-library/policies/beyond_the_referral_position_paper_2022.pdf
- Kosinski LR, Brill JV. The impact of cascading accountability on specialty practice: time for a nested solution. *Practice Management: The Road Ahead.* 2023. doi: 10.1016/j.cgh.2022.11.001

References

Slide 35 – Approaches to Using Nested Episodes to Integrate Specialty Care in PB-TCOC Models

- Kosinski LR, Brill JV. The impact of cascading accountability on specialty practice: time for a nested solution. *Practice Management: The Road Ahead.* 2023. doi: 10.1016/j.cgh.2022.11.001
- Japinga M, Jayakumar P, de Brantes F, et al. Strengthening specialist participation in comprehensive care through condition-based payment reforms. Duke Margolis Center for Health Policy. 2022. https://healthpolicy.duke.edu/sites/default/files/2022-11/Strengthening%20Specialist%20Participation%20in%20Comprehensive%20Care%20through%20Condition-Based%20Payment%20Reforms.pdf

Slide 40 – 21 APM Models Used in the ASPE Analysis if the Impact of Alternative Payment Models in Medicare Spending and Quality

- ASPE. The Impact of Alternative Payment Models on Medicare Spending and Quality, 2012-2022. Jan 15, 2025. https://aspe.hhs.gov/reports/impact-alternative-payment-models-medicare-spending-quality-2012-2022

Slides 58-59 – Considerations for ACO Participation

- Input from the PTAC Preliminary Comments Development Team (PCDT) and ASPE

References

Slide 60 – Major Barriers to Participating in PB-TCOC Models by Organization Business Model Type (Revenue Size and Source)

- Friedberg MW, Chen PG, Simmons M, et al. Effects of health care payment models on physician practice in the United States: follow-up study. *Rand Health Q*. 2020;9(1):1.
- Khullar D, Bond AM, O'Donnell EM, Qian Y, Gans DN, Casalino LP. Time and financial costs for physician practices to participate in the Medicare Merit-based Incentive Payment System: a qualitative study. *JAMA Health Forum*. 2021;2(5):e210527. doi:10.1001/jamahealthforum.2021.0527
- McWilliams JM, Hatfield LA, Chernew ME, Landon BE, Schwartz AL. Early performance of accountable care organizations in Medicare. *N Engl J Med*. 2016;374(24):2357-66. doi:10.1056/NEJMsa1600142
- Payment Reform for Better Value and Medical Innovation. National Academy of Medicine. Finkelman EM, McGinnis JM, McClellan MB, et al., editors. Vital Directions for Health & Health Care: An Initiative of the National Academy of Medicine. Washington (DC): National Academies Press (US); 2017. Available from: https://www.ncbi.nlm.nih.gov/books/NBK595162/
- Ouayogodé MH, Fraze T, Rich EC, Colla CH. Association of organizational factors and physician practices' participation in alternative payment models. *JAMA Netw Open*. 2020;3(4):e202019. doi: 10.1001/jamanetworkopen.2020.2019
- United States Government Accountability Office. Medicare: Information on the Transition to Alternative Payment Models by Providers in Rural, Health Professional Shortage, or Underserved Areas. 2021. https://www.gao.gov/assets/gao-22-104618.pdf
- Wiler JL, Kosinski LR, Mills TL, Walton J. Where are all the specialists? Current challenges of integrating specialty care into population-based total cost of care payment models. *Annals of Internal Medicine*. 2024;177:375-382. doi:10.7326/M23-2991

References

Slides 62-67 – Additional Information About Analysis of IDS Participation in Medicare ACOs

- PTAC Commissioned Work – Analysis by NORC in support of PTAC

Slide 69 – ACO Participation Pathway Examples

- Input from the PTAC Preliminary Comments Development Team (PCDT) and ASPE

Slide 71 – Factors that Influence the Competitiveness of PB-TCOC Models

- Yan BW, Samson LK, Ruhter J, Zuckerman RB, Sheingold SH. Understanding Medicare ACO adoption in the context of market factors. *Popul Health Manag*. 2021;24(3):360-368. doi:10.1089/pop.2020.0060
- Yasaitis LC, Pajerowski W, Polsky D, Wener RM. Physician participation in ACOs in lower in places with vulnerable populations than in more affluent communities. *Health Aff.* 2016. doi:10.1377/hlthaff.2015.1635
- Levinson Z, Godwin J, Hulver S, Neuman T. Ten things to know about consolidation in health care provider networks. KFF. Published April 19, 2024. Accessed November 26, 2024. https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/
- Timbie JW, Ridgely MS. What have we learned about health care consolidation? RAND Health Care. Accessed November 26, 2024. https://www.rand.org/health-care/centers/health-system-performance/what-have-we-learned/consolidation.html
- Kanter GP, Polsky D, Werner RM. Changes in physician consolidation with the spread of accountable care organizations. *Health Aff.* 2019. doi:10.1377/hlthaff.2018.05415

References

Slide 72 – Factors Influencing Competitiveness of PB-TCOC Models Compared with Fee-for-Service and Medicare Advantage Plans

- Kannarkat JT, Shah S, Parekh N, Crosson FJ. Strengthening the Center for Medicare and Medicaid Innovation's approach to constructing alternative payment models. *Milbank Q.* 2023;101(1):11-25. doi: 10.1111/1468-0009.12597
- Liao JM, Navathe AS, Werner RM. The impact of Medicare's alternative payment models on the value of care. Annu Rev Public Health. 2020; 41:551-565. doi: 10.1146/annurev-publhealth-040119-094327
- Kocher B, Wachter RM. Why is it so hard for academic medical centers to succeed in value-based care? *Health Affairs Scholar.* 2023:1(1):1-3. doi: 10.1093/haschl/qxad002
- Werner RM, Emanuel E, Pham HH, Navathe AS. The future of value-based payment: a roadmap to 2030. Penn Leonard Davis Institute of Health Economics. Published February 2021. Accessed November 26, 2024. https://ldi.upenn.edu/our-work/research-updates/the-future-of-value-based-payment-a-road-map-to-2030/
- Jacobs D, Rawal P, Fowler L, Seshamani M. Expanding accountable care's reach among Medicare beneficiaries. *N Engl J Med*. 2022;387(32):99-102. doi: 10.1056/NEJMp2202991
- Bleser WK, Tchuisseu YP, Shen H, et al. ACO REACH and advancing equity through value-based payment, part 1. *Health Aff*. 2022. doi: 10.1377/forefront.20220513.630666

References

Slide 73 – Use of Waivers in CMMI Models

- Centers for Medicare & Medicaid Services (CMS). Fraud and abuse waivers. Updated September 10, 2024. Accessed November 25, 2024. https://www.cms.gov/medicare/regulations-guidance/physician-self-referral/fraud-and-abuse-waivers
- Gonzalez-Smith J, Zhao A, Bleser W, Saunders R. Improving waivers and program flexibilities for advanced payment models. Duke Margolis Center for Health Policy. Published June 30, 2021. Accessed November 13, 2025. https://healthpolicy.duke.edu/sites/default/files/2021-06/Improving%20Waivers%20and%20Program%20Flexibilities.pdf

Slide 74 – Use of Waivers in CMMI Models, Continued

- The Lewin Group. CMS bundled payments for care improvement initiative models 2-4: year 5 evaluation & monitoring annual report. Published October 2018. Accessed November 20, 2024. https://downloads.cms.gov/files/cmmi/bpci-models2-4-yr5evalrpt.pdf
- Mathematica. Evaluation of the Primary Care First model: second annual report. Published February 2024. Accessed November 20, 2024. https://www.cms.gov/priorities/innovation/data-and-reports/2024/pcf-second-eval-rpt
- NORC at the University of Chicago. Next Generation Accountable Care Organization model evaluation: third evaluation report. Published September 2020. Accessed November 20, 2024. https://www.cms.gov/priorities/innovation/data-and-reports/2020/nextgenaco-thirdevalrpt-fullreport
- Gonzalez-Smith J, Zhao A, Bleser W, Saunders R. Improving waivers and program flexibilities for advanced payment models. Duke Margolis Center for Health Policy. Published June 30, 2021. Accessed November 13, 2025. https://healthpolicy.duke.edu/sites/default/files/2021-06/Improving%20Waivers%20and%20Program%20Flexibilities.pdf

References

Slide 75 – Strategies Influencing Beneficiary Health Behaviors in Value-Based Care

- Kannarkat JT, Shah S, Parekh N, Crosson FJ. Strengthening the Center for Medicare and Medicaid Innovation's approach to constructing alternative payment models. *Milbank Q.* 2023;101(1)11-25. doi: 10.1111/1468-0009.12597
- Werner RM, Emanuel E, Pham HH, Navathe AS. The future of value-based payment: a roadmap to 2030. Penn Leonard Davis Institute of Health Economics. Published February 2021. Accessed November 26, 2024. https://ldi.upenn.edu/our-work/research-updates/the-future-of-value-based-payment-a-road-map-to-2030/