Value-Based Care: Something For Everyone — Really

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TMA

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CME OBJECTIVES

Upon completion of this program, participants should be able to:

- Explain how VBC policy, regulation, and market trends affect health care costs, patient access, and physician practice sustainability.
- Differentiate MIPS/MVPs, Advanced APMs, and ACOs within Medicare and how they compare with other payer programs.
- Assess how quality metrics, attribution, and risk adjustment affect revenue and practice operations.
- Evaluate financial and contractual risks, including shared-risk structures and practice infrastructure needs, before entering value-based arrangements.

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Agenda

I. **Why VBC Is Here to Stay**
   Why this matters now — regardless of specialty or practice size

II. **What Actually Counts as VBC**
   What is and is not a VBC contract

III. **The ACO Model Across Payers**
   What stays the same; what changes

IV. **Questions?**

"You may still be paid fee-for-service, but value-based incentives are now built into every public payer program."

Health Spend Per Capita: 1970-2024

$14,000
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$0

1970
1980
1990
2000
2010
2020
2024

United States
Germany
Belgium
United Kingdom
Japan
Italy
South Korea
Chile
Mexico
China
India

Organization for Economic Cooperation and Development (OECD), 2025

Life Expectancy at Birth: 1980-2022

84
82
80
78
76
74
72

Comparable Country Average

United States

1980 1985 1990 1995 2000 2005 2010 2015 2020

Comparable countries include Australia, Austria, Belgium, Canada, France, Germany, Japan, the Netherlands, Sweden, Switzerland, and the U.K.

An Aging Nation

Projected percentage of population

22.8%

Adults 65+

23.4%

Children under 18

19.8%

15.2%

Projected number (millions)

	2016	2034	2060
Adults 65+	49.2	77.0	94.7
Children under 18	73.6	76.5	80.1

2016 '20 '25 '30 2034 '40 '45 '50 '55 2060

Per Capita Health Care Spend by Age

Total health care spending per capita, USD

50 000
40 000
30 000
20 000
10 000
0

Australia
Canada
Germany
Japan
Netherlands
Switzerland
United Kingdom
United States
Mean

0-4 5-9 10-14 15-19 20-24 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-64 65-69 70-74 75-79 80-84 ≥85

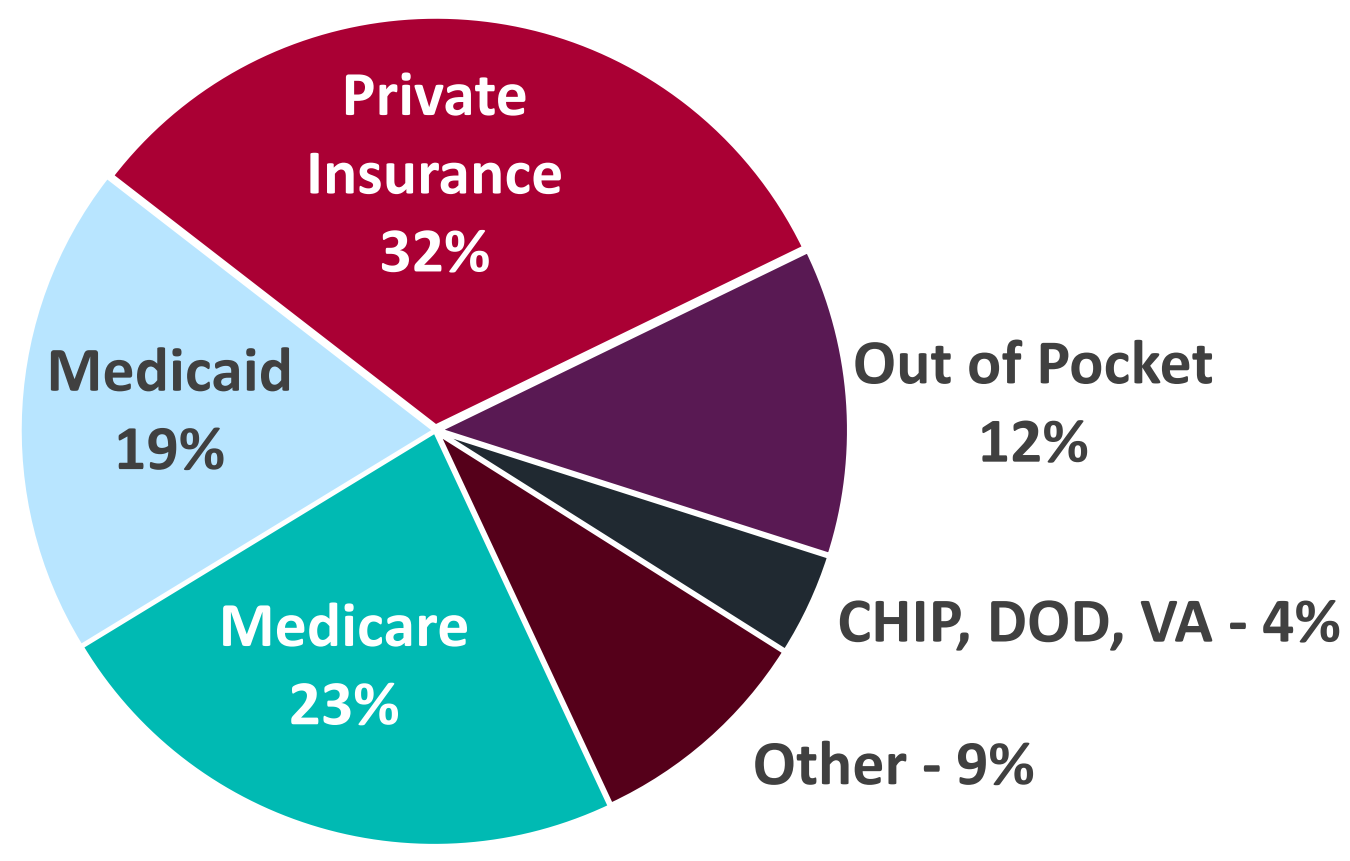
Age, y

JAMA Network Open, Vol. 3, No. 8, Aug. 2020

Health Care Purchasers: 2023

Total =
$4.1 trillion

The federal government is responsible for 50% of the spend



Health Care Spending and the Medicare Program, MedPAC, July 2025

Medicare Physician Fee Schedule

- 2025 was the 5th consecutive year of Medicare physician payment cuts with AMA calculating 33% decline in inflation-adjusted payments from 2001-2025.
- The Medical Economic Index (MEI), a cumulative measure of the individual costs of running a practice will increase by 3.5% in 2026

Conversion Factor Decrease from Previous Year

2025: 2.83% decrease
2024: 3.37% decrease/1.68%
2023: 2.08% decrease
2022: .082% decrease
2021: 3.32% decrease

2026 Temporary Relief

	2025 Conversion Factors	2026 Conversion Factors	Percentage Change
APM Qualifying Participant (QP)	*Non-existent in 2025*	$33.57	+3.77%
Non-APM QP	$32.35	$33.40	+3.26%
Anesthesia APM QP	*Non-existent in 2025*	$20.60	+1.39%
Anesthesia Non-APM QP	$20.32	$20.50	+0.88%

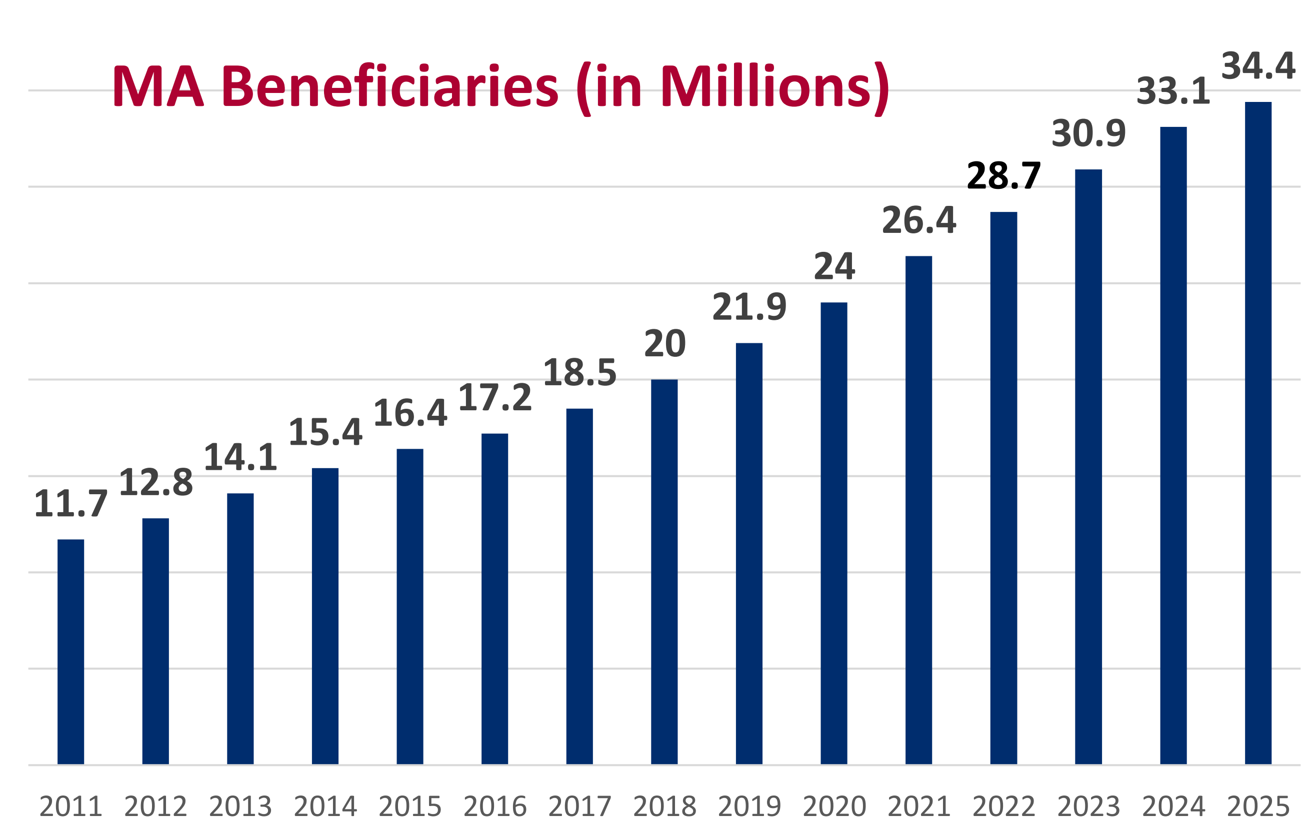
The 2026 federal funding law reinstated the 3.1% Advanced APM bonus, preventing a major disincentive for physician participation in accountable care organizations and other risk-based Medicare models."

Qualified Participant (QP)

- 50% of Medicare Part B payments or 35% Medicare patients via AAPM
- Exempt from MIPS reporting and receive an enhanced conversion factor

Medicare Advantage Enrollment

- **Roughly 51% of all eligible Medicare beneficiaries are enrolled in MA.**
- MA is growing at a faster pace than FFS (traditional) Medicare
- MedPAC estimates that MA plans are responsible for 20% more spending than similar beneficiaries in traditional Medicare.



MedPAC Data Book: Health Care Spending and the Medicare Program, July 2025

Texas MA Penetration (55%)

Potter
10,253 (50%)

Lubbock
28,338 (53%)

Collin
68,300 (43%)

Taylor
12,140 (43%)

Tarrant
180,058 *(56%)*

Dallas
197,810 (55%)

Smith
25,977 *(49%)*

El Paso
113,552 (74%)

Travis
74,006 (46%)

Nacogdoches
6,500 *(51%)*

Bexar
190,880 (58%)

Harris
400,235 (61%)

Maverick
8,697 (76%)

Jefferson
27,699 (60%)

Webb
24,730 (64%)

Nueces
43,711 (65%)

Cameron
53,903 (74%)

Hidalgo
96,015 (77%)

Starr
8,742 (84%)

Taylor County

1. Humana
2. United Healthcare

CMS.gov: MA State/County Penetration – Jan. 2026

Medicaid/CHIP Coverage in Texas (Oct. 2025)

Total Medicaid	Children's Medicaid	Aged Related	Disability Related	Pregnant Women	Parents	Women's Cancer	Regular CHIP
4,033,446	2,910,309	370,915	360,315	266,191	121,806	3,910	173,835

- Medicaid is jointly funded by states and the federal government through a federal match program known as the federal medical assistance percentage, or FMAP.
- Texas currently receives about 59.8% in matching funds.

Medicaid/CHIP Coverage In Texas

- **19% of Texans**
- **43% of Texas children**
- **53% of Texas births**
- **56% of Nursing home residents**

Commercial Plans

As the health care delivery system evolves, employers continue to search for ways to curb spending while ensuring their employees receive the care and services they need.

- Data is slow coming
- PPO very difficult to manage (leakage)
- Payouts much lower than other service lines

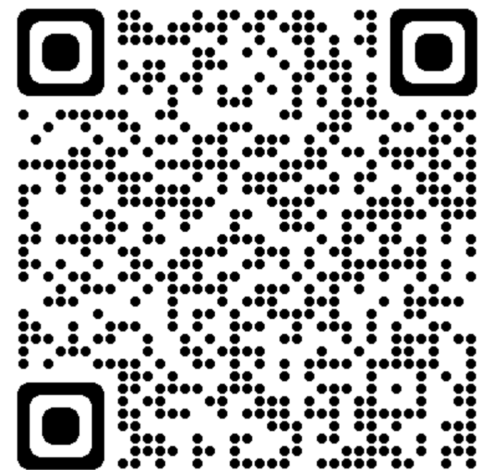
VBC Challenges: Why I Don't Participate

- 70% Practice lacks staff resources
- 68% No control over patient behaviors that other providers see
- 67% No control over patients' care seeking behaviors
- 66% Practice can be slow to change
- 56% Practice lacks financial resources
- 42% No payers with sufficient patient population for contracting
- 42% Fee-for-service works well for the practice
- 39% Practice lacks data and reporting

2022 MGMA and Humana Joint Research Study: Shifting to Value Amid Pandemic and Staffing Challenges

Health Care Payment Learning & Action Network (LAN)

https://hcp-lan.org/



CATEGORY 1

FEE FOR SERVICE – NO LINK TO QUALITY & VALUE

CATEGORY 2

FEE FOR SERVICE – LINK TO QUALITY & VALUE

A

Foundational Payments for Infrastructure & Operations

(e.g., care coordination fees and payments for HIT investments)

B

Pay for Reporting

(e.g., bonuses for reporting data or penalties for not reporting data)

C

Pay-for-Performance

(e.g., bonuses for quality performance)

CATEGORY 3

APMS BUILT ON FEE -FOR-SERVICE ARCHITECTURE

A

APMs with Shared Savings

(e.g., shared savings with upside risk only)

B

APMs with Shared Savings and Downside Risk

(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

CATEGORY 4

POPULATION – BASED PAYMENT

A

Condition-Specific Population-Based Payment

(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)

B

Comprehensive Population-Based Payment

(e.g., global budgets or full/percent of premium payments)

C

Integrated Finance & Delivery System

(e.g., global budgets or full/percent of premium payments in integrated systems)

Category 1: Fee For Service

Category	Working Harder to Get Paid
No link to quality or value	• Medicare fee schedule not tied to inflation • Medicare’s 2026 efficiency adjustment (-2.5%) for 7,000+ codes • Site of service differentials • Increased prior authorizations and retrospective denials • Downcoding • Medical records requests and audits • Payment recoupments • Tiered, preferred, and narrow networks

Payment is based on services provided, rather than measured results.

Category 2: FFS Linked to Quality

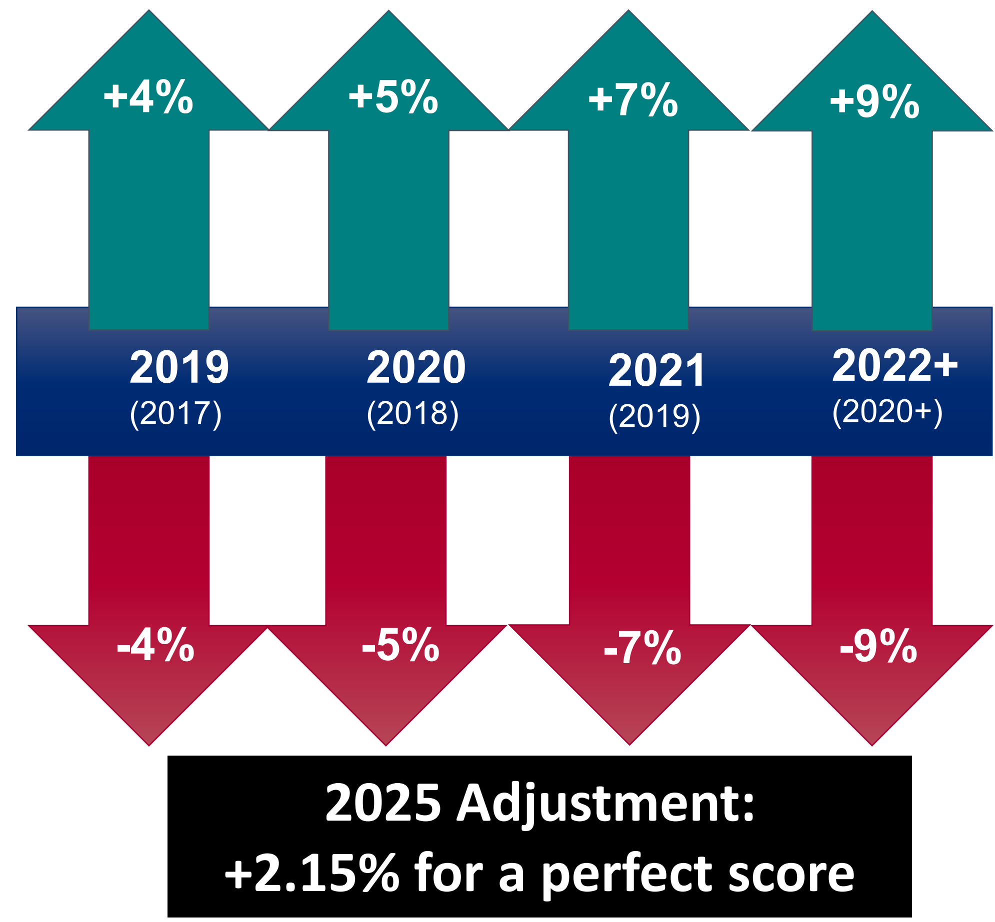
Category	Description	Examples
A. Foundational Payments	Care coordination fees/or practice support payments	Medicare: Advanced Payment Commercial: sophisticated groups
B. Pay For Reporting	Bonuses for submitting data (or penalties for no reporting)	MA: Star measures Medicaid HEDIS measures
C. Pay For Performance	Bonuses or penalties for achieving quality targets	Medicare: MIPS and MVPs MA: Star measures Medicaid: HEDIS measures Commercial: HEDIS/Utilization

You still bill CPT codes, but now they adjust your payment.

Cat. 2: CMS Quality Payment Program

Under the CMS Quality Payment Program (QPP), clinicians receive payment adjustments based on their performance in the Merit-based Incentive Payment System (MIPS) or as a qualifying participant in the advanced alternative payment model (APM) track.

AMA estimates cost of compliance at $12,800 per physician per year and 53 hours of work



CMS Quality Payment Program (QPP)

- MIPS Value Pathways (MVPs) were introduced in 2023 as an alternative to MIPS.
- MVPs are currently voluntary, but CMS has signaled that it will replace MIPS as early as 2029.
- Advance registration is required for MVP reporting (April 1-Dec 1), but clinicians can still choose to report traditional MIPS (instead of, or in addition to, an MVP).
- In 2023
  - 41,765 clinicians registered for an MVP
  - 20,484 reported MVPs
  - 6,790 clinicians received their final score from MVP reporting.

CMS: 2023 QPP Participation and Performance Results

MVPs: Performance Year 2026

Cardiology • Afib & Cardiac Arrhythmia • Coronary Artery Disease • Heart Failure Care	**Primary Care** • Chronic Condition Management • Prevention and Screening • Value in Primary Care
Dermatology	**Ophthalmology**
Emergency Medicine	**Orthopedics (Musculoskeletal Care)**
Gastroenterology	**Pain Management**
Infectious Disease (Prevention and Sepsis)	**Pathology**
Nephrology (Kidney Health)	**Podiatry**
Neurology	**Pulmonology (Respiratory Care)**
Neuropsychology	**Radiology (Diagnostic and Interventional)**
Obstetrics/Gynecology • Women's Health • Prenatal/Maternal Care	**Surgical** • General Surgery • **Vascular Surgery**
Oncology (Cancer Care)	**Urology**

Category 3: APMs Based on FFS

Category	Description	Examples
A. APMs with Shared Savings	If spending is lower, you shared in savings. If spending is higher, nothing happens.	Medicare Shared Savings Program Texas Medicaid MA and Commercial – glide path
B. APMs with Up and Downside Risk	If spending is lower, you win. If spending is higher, you pay back money.	Medicare: MSSP/CMMI Models Medicare Advantage Medicaid Commercial

You still bill CPT codes, but now you are accountable for cost

Cat. 3: Medicare Shared Savings Program

A group of physicians, hospitals and/or others who take responsibility for the total cost and quality of care for a specific group of patients. If they do it well and save money, they share in the savings.

Accountable Care Organization
Health System Entities
Large Group Practices
Payer

Indepenent Practice Association (IPA)
Clinically Integrated Networks (CIN)
Management Services Organizations

MSSP 2024 Performance Year Results

- ACO’s achieved the highest rates of shared savings since the inception of the program - $6.5 Billion
- Medicare saved $2.4 billion in net savings
- Out of 476 ACOs (75%), earned performance payments totaling $4.1 billion. These groups covered 10.3 million lives.
- Only 16 ACOs owed shared losses totaling $20.3 million.
- Low revenue ACOs continue to outperform high revenue ACOs, generating $316 vs $175 net per capita savings.

Category 4: Population-Based Payment

Category	Description	Examples
A. Condition-Specific Population-Based Payment		Some Medicare CMMI models
B. Comprehensive Population-Based Payment	More common for large groups and narrow networks	Capitation Global budgets Delegated Entities
C. Integrated Finance & Delivery Systems		Kaiser-style models Health system paid % of premiums

Here is your budget. Take Care of the Patient.

Cat. 3 & 4: Specialty/Condition APMs

- **Kidney Care Choices Model** – 2022
  Ends December 2026 (Voluntary)
- **ACO Realizing Equity, Access & Community Health (ACO REACH)** – 2023
  (Voluntary) Will be replaced Jan. 2027 by Long-term Enhanced ACO Design Model (LEAD)
- **Enhancing Oncology Model** – 2023
  Ends June 2028 (Voluntary)
- **Transforming Episode Accountability Models** – 2026
  Ends December 2030 (Mandatory in select areas – Texas sites are included)
- **The Ambulatory Specialty Model** – 2027
  Ends December 2030 (Mandatory in select areas to be determined)

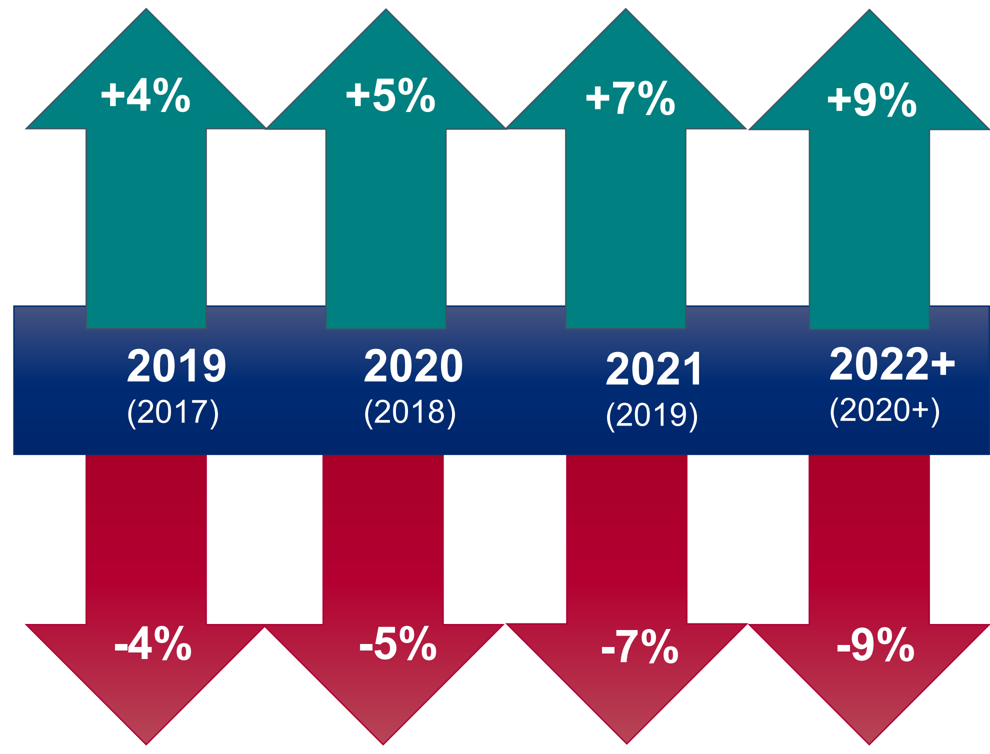
Cat 4: Ambulatory Specialty Model

- A mandatory model (for chosen locales) beginning Jan. 1, 2027, and running five years.
- The focus is on low back and heart failure with a 20-patient minimum threshold over a 12-month period.
- This applies at the individual (NPI) level; not group reporting (TIN).
- Your score will be compared only to physicians treating the same chronic conditions.
- A final participation list will be available July 2026.

Houston, Pasadena, The Woodlands
Amarillo
Austin-Round Rock-San Marcos
College Station-Bryan
Corpus Christi
Dallas-Plano-Irving
Fredericksburg
Kerrville
Lufkin
McAllen-Edinburg-Mission
Paris
San Antonio-New Braunfels
Sherman-Denison
Texarkana
Tyler
Wichita Falls

Cat 4: Ambulatory Specialty Model

- The model will follow the MIPS incentive/penalty payment structure of up to 9% in the first year and up to 12% by the end of the model.
- Adjustments will be made for small practices and "complex patients"
- Like MIPS, the payment adjustment is two years after the performance year.
- You will be exempt from MIPS reporting and participation.
- What specialties/conditions are next?



41,765 clinicians registered for an MVP with only 20,484 reporting – 6,790 clinicians received their final score from MVP reporting.

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I. **Why VBC Is Here to Stay**
   Why this matters now — regardless of specialty or practice size

II. **What Actually Counts as VBC**
   What is and is not a VBC contract

III. **The ACO Model Across Payers**
   What stays the same; what changes

IV. **Questions?**

"No matter the payer, every ACO boils down to the same thing: a patient list, a budget, quality rules, data, and money at risk."

All “ACOs” Have This in Common

1. **Legal/Contractual Structure**
2. Defined Patient Population (attribution)
3. Quality Expectations
4. Cost Benchmark
5. Financial Risk

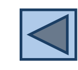
The “Provider” Agreement

1. Physician leadership, ACO management team, and performance history
2. Exclusivity, non-competes, and exit strategy
3. ACO members and attribution
4. Capital contributions required?
5. How will shared savings/losses and incentives be handled?

Don’t sign until you know who you are accountable for, how success is measured, how you get paid, and how you could lose money.

AMA Accountable Care Organizations Model Checklist, 2025

The “Provider” Agreement



6. In-kind benefits such as care coordination staff and administrative staff
7. Contracts available, open panels, and all-products requirements
8. Data sharing, analytics, and reporting
9. Clinical autonomy

Don’t sign until you know who you are accountable for, how success is measured, how you get paid, and how you could lose money.

AMA Accountable Care Organizations Model Checklist, 2025

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In value-based care, attribution determines which patients you’re held responsible for — whether you know it or not.”

Attribution Issues

Most contracts require a minimum number of attributed patients.

- Auto-assignment and misattribution when a patient-physician relationship has not been clearly documented;
- Inability to challenge and remove misattributed or non-compliant patients from patient panels;
- Lack of due process to dispute attribution errors that impact clinician performance and payment; and
- Inaccurate, insufficient, and/or delayed data from payers to support the care of attributed patients.
- Payers' lack of uniformity, transparency, consistency, and accountability regarding their attribution methods.

How ACOs Differ: Attribution

Medicare	Medicare Advantage	Medicaid	Commercial
CMS assigns patients based on primary-care claims history. ACOs may choose prospective or retrospective	Members are assigned based on enrollment, then attributed to an ACO through their selected PCP. **What happens when a large employer moves to another health plan?**	Members are assigned by enrollment in a Managed Care Organization (MCO) and then by PCP selection **Patient “churn” is a big issue in Medicaid**	The Plan attributes members based on enrollment or PCP selection **What happens when a large group practice leaves your ACO?**

All “ACOs” Have This in Common

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How ACOs Differ: Quality

Medicare	Medicare Advantage	Medicaid	Commercial
Standardized CMS measures Quality scores determine the percentage of savings an ACO can earn.	Mostly HEDIS measures, Star Ratings, and plan-specific metrics. Typically includes a pay-for-performance component to the contract	Determined by the state and imposed on MCOs, which then flow down to ACOs.	Mix of HEDIS, custom employer measures, and process metrics

The Universal Foundation

- CMS operates more than 20 quality programs, each with its own set of quality measures
- Several of the 2026 QPP proposals coincide with CMS' National Quality Strategy, an attempt to align quality initiatives across traditional Medicare, Medicare Advantage, Medicaid, CHIP, and Marketplace plans

[The Universal Foundation of Quality Measures]

MA Health Plan: P4P Quality Bonus

Measure	Eligible	Achieved	Rate	Tier	Tier	Tier
ACE/ARB Medication Adherence	359	305	85%	82%	84%	85%
Breast Cancer Screening	67	60	90%	78%	81%	84%
Colorectal Cancer Screening	320	217	68%	72%	77%	81%
Controlling High Blood Pressure	401	291	73%	75%	81%	86%
Diabetes: Blood Sugar Controlled	209	146	70%	76%	80%	84%
Diabetes: Eye Exam	209	161	77%	73%	77%	81%
Diabetes: Medication Adherence	180	146	81%	81%	84%	86%
Diabetes: Statin Use	172	147	85%	78%	80%	82%
Medication Reconciliation: Post Discharge	75	57	76%	64%	71%	77%
Chronic Visits: Both Visits Complete	350	324	93%	90%		
Inpatient (Acute) Admits per 1,000	9,522	95	119.72	170		
Office Visits	735	683	93%	90%		
Plan All-Cause Readmission	40	5	10%	10%		
Rx Generic Dispensing Rate	32,439	29,886	92%	90%		

Quality Bonus:
$74,272

Quality Impact on Shared Savings

Quality Measures Achieved	Year 1 Percent of Shared Savings	Year 2 Percent of Shared Savings	Year 3 Percent of Shared Savings
10	40%	50%	50%
9	35%	50%	50%
8	30%	50%	50%
7	25%	25%	25%
6	20%	25%	25%
5	15%	25%	0%
0-4	0%	0%	0%

All "ACOs" Have This in Common

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5. Financial Risk

How ACOs Differ: Cost Benchmarks

Medicare	Medicare Advantage	Medicaid	Commercial
CMS sets a risk- and region-adjusted spending benchmark based on historical costs and national growth.	CMS pays the Plan a capitated rate with bonuses for quality measures and patient risk. The Plan gives the ACO a sub-budget	Based on state-approved capitation rates and actuarial targets paid to MCOs	Negotiated target based on employer or payer spending

Cost Reduction Strategies

- Wellness visits / prevention drives attribution and catches risk early
- Chronic care management focuses on high cost and high utilization patients
- Deliver care in the most cost-effective setting without sacrificing outcomes
- Avoidable ED use/hospital admissions and readmissions

- 90% of health care dollars spent each year are for people with chronic health conditions.
- Most savings come from managing chronic disease and avoiding unnecessary acute care—not from seeing patients less.

Rand Corporation. Multiple Chronic Conditions in the United States. March 2019.

Ambulatory Care Sensitive Conditions

Admissions	Statewide Avg. Admission Charge
Angina W/O Procedure	$32.872
Bacterial Pneumonia	$42,863
COPD	$39,047
Dehydration	$30,129
Diabetes: Long Term Complications	$61,142
Diabetes: Short Term Complication	$31,713
Congestive Heart Failure	$44,474
Hypertension	$30,546
Urinary Tract Infection	$29,901

TDHS: Age adjusted rates per 100,000 population (all ages)

All “ACOs” Have This in Common

1. Legal/Contractual Structure
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4. Quality Expectations
5. **Financial Risk**

How ACOs Differ: Financial Risk

Medicare	Medicare Advantage	Medicaid	Commercial
ACOs can start up-side only but must gradually move into two-sided risk	Usually two-sided, often with real downside exposure Could offer care coordination fees – that are put at risk if benchmarks not met	Partial to full risk, depending on the contract with the MCO	Often upside only, sometimes two sided

ACO Payout

Details	Funds
ACO Performance Target PMPM	$745 PMPM
ACO Performance Actual PMPM	$611 PMPM
ACO Shared Savings	**$239,090**
Quality Measures: Passed 6 out of 10	20%
Total Payout to ACO	**$47,818**
Quality Measure Bonus	**$74,272**
Total ACO Payout	**$122,090**

Key Take Aways

1. Value based care is not coming – IT IS HERE!
2. Value-based care isn't one model — it's a spectrum of contracts
3. Don't sign a provider agreement until you understand accountability, data, and risk
4. Specialists – you can't afford to sit back and watch

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V. Questions?

"You may not always be able to opt out of value-based care — but you can decide how it impacts your patients and your practice."