

# Maximizing Participation in Total Cost of Care (TCOC) Models: Issues and Strategies

## HIGHLIGHTS

- Maximum participation in population-based total cost of care (PB-TCOC) models is essential for effective delivery system transformation.
- There are obstacles to further significant growth in TCOC model participation. For example, participation in Accountable Care Organization (ACO) models is voluntary; integrated delivery and hospital-based systems have little to no incentive to participate in models; and rural practices do not have the financial resources to transition to value-based care and assume financial risk.
- The structures and business models of different types of provider organizations should be considered in developing multiple pathways for participation in accountable care.
- Several other actions might also be considered for maximizing participation, such as optimizing the number and types of models; simplifying and aligning performance measures across payers; democratizing and standardizing data; addressing competitive challenges to value-based care, including leveling the playing field with Medicare Advantage (MA); considering how financial incentives and cost savings can be shared with beneficiaries; and using conveners.

## INTRODUCTION

The most recent strategic objectives for the Centers for Medicare & Medicaid Services (CMS) Innovation Center are aligned with continuing the transformation of the health care system into one “in which people are empowered to achieve their health goals and providers are incentivized to compete to deliver high-quality, efficient care and improve the health outcomes of their patients.”<sup>1</sup> As a key part of that strategy, the CMS Innovation Center will continue to test Alternative Payment Models (APMs). Since 2022, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) has extensively studied one type of APM: the population-based total cost of care (PB-TCOC) model. Through public meetings, PTAC has compiled extensive input from a wide range of stakeholders and experts and provided information to the Secretary of Health and Human Services (HHS) on defining and implementing these models.

The PTAC public meetings in September 2024 and March 2025 focused on strategies to maximize participation in these models to substantially move the delivery system from fee-for-service (FFS) payment to value-based payment arrangements. This Issue Brief describes data presented at the public

<sup>1</sup> Centers for Medicare & Medicaid Services. CMS Innovation Center Strategy to Make America Healthy Again. May 13, 2025. <https://www.cms.gov/priorities/innovation/about/cms-innovation-center-strategy-make-america-healthy-again>

meetings on current participation trends and important policy directions to incentivize maximum participation in these arrangements. Specifically, the Committee analyzed the relationship between the structures and business models of different types of provider organizations and a range of TCOC payment mechanisms for incentivizing their participation. This Issue Brief then discusses other factors related to increasing participation in these models.

## MAXIMIZING PARTICIPATION IN APMs: ORGANIZATIONAL CHARACTERISTICS AND BUSINESS MODELS

Medicare has made significant progress in moving away from paying services on a purely FFS basis toward APMs. From 2012 to 2022, participation in APMs, either through CMS Innovation Center models or the Medicare Shared Savings Program, grew from 2.9 million to 17.2 million beneficiaries, or approximately one half of those enrolled in traditional Medicare.<sup>2</sup> The majority of beneficiaries were enrolled in Accountable Care Organizations (ACOs), which meet the PTAC definition of a PB-TCOC model.<sup>3</sup> By 2025, over 14 million traditional program beneficiaries (53 percent) were in ACOs.<sup>4</sup> Early evidence on the impact of ACOs has been mixed; however, recent evidence suggests that current ACOs are achieving success in terms of reducing spending while maintaining quality of care.<sup>5</sup> Recent estimates for the Medicare Shared Savings Program demonstrate gross savings of \$6.6 billion and net savings to the program of \$2.5 billion in 2024.<sup>6</sup>

Based on engagement and evidence gathered through public forums with a variety of stakeholders and experts, PTAC believes that maximum participation in TCOC models is essential for effective delivery system transformation. The recent growth in ACO participation, following a plateau from 2018 to 2022, is encouraging. Nonetheless, there are reasons for concern about obstacles to further significant increases in participation under current policies. Because ACO model participation is voluntary, providers and organizations that are less likely to succeed under shared savings arrangements are unlikely to participate. Physician-led organizations are now the predominant ACO type. They can achieve savings through effective care that results in reductions in hospital services such as admissions and emergency department visits. Integrated delivery systems (IDSs) and hospital-based systems have little or no incentive to participate, including fewer options for reducing utilization without reducing their own revenues to receive a lesser amount back in shared savings. At the other end of the provider spectrum, smaller and rural practices often do not have the resources to make investments needed for value-based care and to assume financial risk.

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<sup>2</sup> Preliminary Comments Development Team (PCDT), [Identifying a Pathway Toward Maximizing Participation in Population-Based TCOC Models](#), September 16, 2024.

<sup>3</sup> PTAC uses the following working definition of PB-TCOC models: “A population-based total cost of care (PB-TCOC) model is an 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 population-based 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 population-based TCOC model.”

<sup>4</sup> Centers for Medicare & Medicaid Services. CMS Moves Closer to Accountable Care Goals with 2025 ACO Initiatives. January 15, 2025. <https://www.cms.gov/newsroom/fact-sheets/cms-moves-closer-accountable-care-goals-2025-aco-initiatives>

<sup>5</sup> Nyweide DJ. The First Decade of ACO Model Evaluation in the Medicare Program: A Systematic Review. *Med Care Res Rev.* 2026;83(1):3–19. <https://doi.org/10.1177/10775587251325914>

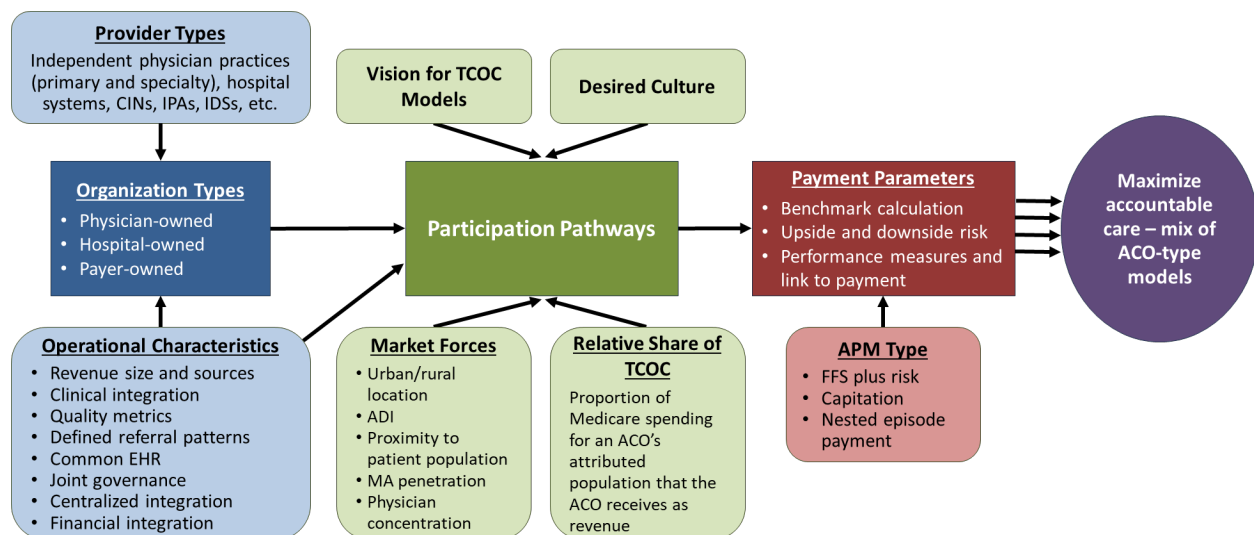
<sup>6</sup> Centers for Medicare & Medicaid Services. Medicare Shared Savings Program Accountable Care Organizations Updated Performance Year 2024 Financial and Quality Results. September 29, 2025. <https://www.cms.gov/files/document/fact-sheet-ssp-py24-financial-quality-results.pdf>

PTAC has sought research and public input for assessing how CMS might create multiple pathways that would incentivize the full range of provider organizations to enter value-based arrangements—especially TCOC models. The Committee has noted that the structure of payment arrangements is critical to maximizing participation in accountable care models. Payment models should promote financial stability for providers. Participation in value-based care must be financially viable for providers, and providers must be able to see a feasible path to savings to participate in APMs. For these reasons, the Committee has made the case that value-based payment arrangements should be consistent with the structure of provider organizations and their 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.”*

Figures 1 and 2 summarize the important issues and factors for considering pathways to accountable care for multiple types of provider organizations. Figure 1 describes organizational and market factors that affect organizations’ abilities to assume risk under different payment approaches. For example, large IDSs would have the resources, financial and clinical integration, and management controls to potentially accept financial and performance risk and distribute payments throughout their system. Relative to IDSs, physician-led ACOs have less ability to distribute payments and exert management control over other providers who care for their patients. In addition, market factors, such as demographics, provider and insurer concentration, and Medicare Advantage (MA) penetration might be considered in developing pathways to accountable care.

**Figure 1. Organizational Characteristics and Pathways to Maximize ACO Participation**



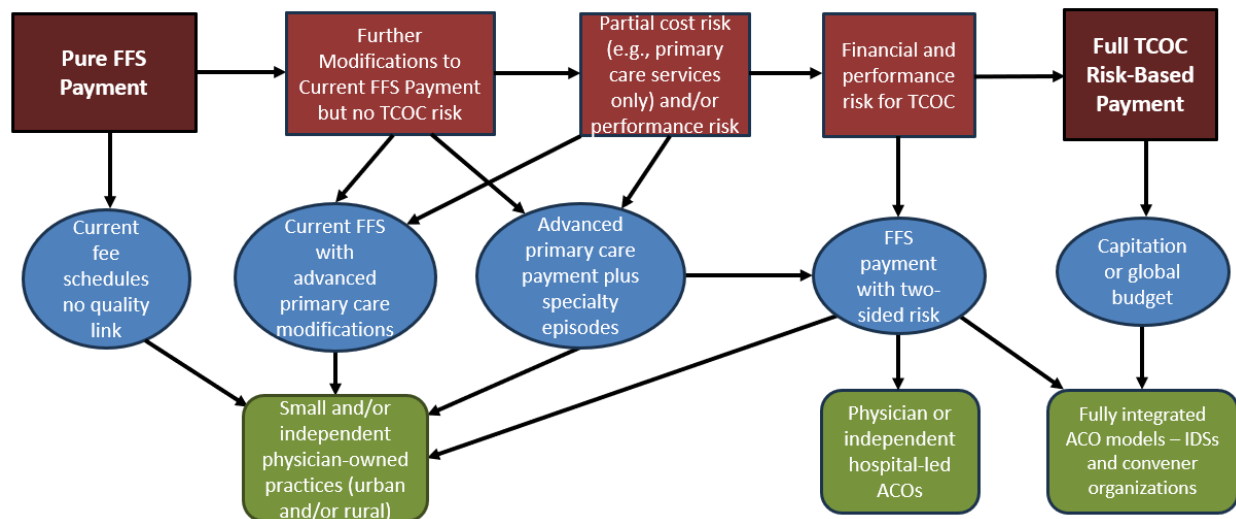
Abbreviations: ACO, Accountable Care Organization; ADI, Area Deprivation Index; CIN, clinically integrated network; EHR, electronic health record; FFS, fee-for-service; IDS, integrated delivery system; IPA, independent physician association; MA, Medicare Advantage; TCOC, total cost of care

Source: Physician-Focused Payment Model Technical Advisory Committee (PTAC). Preliminary Comments Development Team (PCDT), Reducing Barriers to Participation in Population-Based TCOC Models and Supporting Primary and Specialty Care Transformation. March 3, 2025.

Figure 2 describes the types of payment and risk arrangements (the red boxes) and specific types of payment (the blue ovals) that might be consistent with each type of organization that would potentially

participate as an ACO. For example, capitation or global payments might be appropriate for IDs and convener organizations; however, most physician-led ACOs would likely rely on an FFS chassis for their payments. Small and independent practices might start with modified fee schedules and some performance risk with a potential transition to two-sided risk arrangements.

**Figure 2. Payment Pathways and Organizational Characteristics to Enhance Value**



*Abbreviations: ACO, Accountable Care Organization; FFS, fee-for-service; IDS, integrated delivery system; TCOC, total cost of care*  
*Note: The payment models in the first row of the diagram are aligned with the payment model categories in the Health Care Payment Learning & Action Network APM Framework.*  
*Source: Physician-Focused Payment Model Technical Advisory Committee (PTAC). Preliminary Comments Development Team (PCDT), Reducing Barriers to Participation in Population-Based TCOC Models and Supporting Primary and Specialty Care Transformation. March 3, 2025.*

Table 1 provides a framework for considering how different types of organizations might be placed in different pathways to accountable care. The exact number of pathways might be determined based on identifying key provider organization types and monitoring their participation trends. The columns in Table 1 reflect the different payment parameters that might be appropriate for each pathway. While the table contains some examples of payment parameters, the individual cell contents would be determined by analyzing current evidence, as well as evidence produced by further model testing.

**Table 1. Framework for Considering Pathways and Payment Parameters**

Types of Providers/Organizations in Pathway	PAYMENT PARAMETERS							
	BENCHMARKS Enhanced FFS, Regional, National Provider Specific Blend?	BENCHMARK ADJUSTMENTS Urban/Rural/ADI/Other	ANNUAL UPDATE/CONVERSION FACTOR Benchmark Trend	DOWNSIDE RISK Percent Relative to Benchmark	UPSIDE RISK Percent Relative to Benchmark	SPECIALTY PAYMENT Performance Informaton Provided, Episode Payment, Nested Models	PERFORMANCE RELATED RISK Relationship of Scores Based on Performance Measures to Upside and Downside Risk	OTHER PAYMENT ISSUES Upfront Payments for Infrastructure Prospective and Retrospective Payment
PATHWAY 1 Small/Rural/Independent Practices?	Modified fee schedules, potentially as glide path	Existing fee schedule adjustments		None	None	Key information provided on quality and efficiency of specialists	Some bonuses and penalties based on TCOC performance measures	Consider some upfront payments for investments, particularly if this pathway is a glide path
PATHWAY 2 Medium/Large PCP Practices?								
PATHWAY 3 Large Multi-Specialty Groups?								
PATHWAY 4 Large IDSs?	PMPM payment		Trend factor (e.g., ACPT)	Full	Full	Shadow bundles or nested payment	Bonuses of penalties adjustments for performance scores	
PATHWAY 5 – ?								

Abbreviations: ACPT, Accountable Care Prospective Trend; ADI, Area Deprivation Index; FFS, fee-for-service; IDS, integrated delivery system; PMPM, per-member-per-month; PCP, primary care provider; TCOC, total cost of care

Source: Adapted from the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Preliminary Comments Development Team (PCDT), Reducing Barriers to Participation in Population-Based TCOC Models and Supporting Primary and Specialty Care Transformation. March 3, 2025.

## OTHER FACTORS TO CONSIDER FOR MAXIMIZING PARTICIPATION

In addition to structuring the parameters of payment models according to organizational characteristics and business models, several other factors may be necessary for maximizing participation in TCOC models.

### Optimize the Number and Types of Models

There is a need to simplify APMs, including reducing the number of models and increasing their duration. Providers often are confused about which models to join. Participating in multiple, disparate models can involve significant administrative complexities, such as different provider identification methods or performance benchmarks. Model performance also may be impacted by the presence of other models in the marketplace. For example, savings associated with population-based models may be diluted if portions of the overall savings are attributed to concurrent episode-based models. Model simplification is paramount, and collaboration with frontline physicians on model development may be useful. Models should be harmonized, and a synergistic portfolio of APMs should be offered that provides a clear, long-term vision of value-based payment reform.

There is a need to move away from continuously introducing new models and instead focus on updating and maintaining existing models that extend for a longer time. This shift may require conducting rapid evaluations and then refining existing models that are already in place. It will be important to find a balance between model consolidation and model customization that supports participation across a range of provider types.

### Simplify and Align Performance Measures Across Payers

In addition to the simplification of APMs, performance measures should be simplified. Measures should be developed to align with the vision for care in TCOC models. Measures of patient-provider continuity (e.g., whether the patient sees the same provider over time), access to care, and health outcomes

should be included. Additionally, it is important to prioritize measures that promote innovation, such as patient experience and care coordination metrics. Patient-reported outcome measures (PROMs) are a critical measure type. Measuring what matters most to patients and their families is important, and PROMs enable delivery of person-centered care. PROMs can serve to align patient expectations with outcomes, facilitate patient-physician communication, build trust, and empower patients during recovery.

Multi-payer alignment is a key factor in optimizing performance measurement. Providers may be required to report dozens or even hundreds of measures in multiple value-based care programs across public and private payers. Many measures capture similar concepts, but few measures utilize identical definitions. This lack of measure alignment creates significant administrative burden for providers who participate in multiple programs. Multi-payer alignment also can be extended to methods of data collection and reporting of performance measures. Some states, such as California, are engaging in multi-payer alignment efforts. A pathway to multi-payer alignment at the national level is also needed.

### **Democratize and Standardize Data**

Democratizing and standardizing health care data can promote value-based care and increase participation. That is, data should be made readily accessible and in a form that is easily usable for everyone who needs them. Furthermore, data should be available at a reasonable cost to ensure that small and rural practices can participate in APMs. Data are critical for managing patient care, administering APMs, understanding and improving provider performance in APMs, and ultimately driving value-based outcomes.

CMS plays a central role in standardizing and providing access to health care data. CMS has identified ongoing efforts to standardize and align the collection of social risk data. Sharing raw data with providers is inadequate; rather, providers need actionable information to promote APM participation. Processing and interpreting raw data are burdensome and expensive activities for practices, typically requiring investment to develop a data infrastructure and hire analysts or financial intermediaries with specialized data, software, and analytics expertise. Practices weigh these administrative costs with the potential financial gains (upside and downside risk) associated with participating in APMs. Practices should be provided with actionable information while payers or sponsors of value-based care take the lead on conducting the necessary analytics.

### **Address Competitive Challenges to Value-Based Care**

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

The playing field between MA, traditional Medicare, and APMs needs to be leveled to allow APMs to compete with other options. For example, developing approaches for ACOs to share savings directly with patients in a similar manner as MA plans could help level the playing field.

### **Consider How Financial Incentives and Cost Savings Can be Shared with Beneficiaries**

Similar to providers, beneficiaries should have incentives to participate in value-based care. Specifically, copays for high-value services such as mental health care, chronic care management (CCM), and services

covered through Advanced Primary Care Management (APCM) codes, should be eliminated. Waivers for cost sharing may create incentives for beneficiaries to seek these services and, in doing so, take greater ownership of their health. Beneficiary involvement in their own care is critical. Copays for coordination of care codes should be removed. Coordination of care saves lives, and many patients cannot afford the copay. Further, CCM, principal care management, and transitional care management services should have no deductible or copay. Savings achieved by the APM due to lowering health care costs can be shared with patients as a means to increase their participation in APMs.

### Use Conveners

Conveners aggregate risk across multiple practices, geographies, lines of business, and payers so that independent and disparate providers can participate in APMs. Many providers lack the actuarial expertise needed to understand different risk models. Conveners can identify cost variation, look for savings opportunities, and project future expenditures to validate the viability of the risk models for specific provider groups. Further, conveners may provide organizations or practices with cash reserves and financial capital to fund care transformation investments, protect providers from downside risk, and enable providers to maintain adequate cash reserves. One study indicated that the Medicare ACO landscape has evolved from mostly provider-sponsored organizations to a growing contingent of entrepreneurial “convenor groups” that manage multiple ACOs and now account for 30 to 40 percent of the Medicare ACO program.<sup>7</sup>

## CONCLUSION

Maximizing participation in PB-TCOC models is essential for delivery system transformation. There are challenges to increasing TCOC model participation. Providers and organizations that are less likely to succeed under shared savings arrangements are unlikely to participate in voluntary ACO models. IDs and hospital-based systems have little to no incentive to participate in models, while many smaller and rural practices do not have the financial resources to transition to value-based care and assume financial risk. The structures and business models of different types of provider organizations should be considered when developing multiple pathways for participation in accountable care. Other actions to maximize participation include optimizing the number and types of models, simplifying and aligning performance measures across payers, democratizing and standardizing data, addressing competitive challenges to value-based care (including leveling the playing field with MA), considering how financial incentives and cost savings can be shared with beneficiaries, and using conveners.

## RESOURCES

The following resources are publicly available on the ASPE PTAC website:

- [Report to the Secretary: Reducing Barriers to Participation in PB-TCOC Models and Supporting Primary and Specialty Care Transformation](#)
- [Reports to the Secretary: Performance Measures, Chronic Conditions, & Maximizing Participation in PB-TCOC Models](#)
- [Environmental Scan: Reducing Barriers to Participation in PB-TCOC Models and Supporting Primary and Specialty Care Transformation](#)
- [Environmental Scan: Identifying a Pathway Toward Maximizing Participation in PB-TCOC Models](#)

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<sup>7</sup> Mechanic RE, Shortell S. Accountable Care Organizations and Specialists: Opportunities for Neurologists. *Neurol Clin Pract.* 2024;14(1):e200251. <https://pmc.ncbi.nlm.nih.gov/articles/PMC10781562/pdf/CPJ-2023-000424.pdf>

- [Preliminary Comments Development Team \(PCDT\), Reducing Barriers to Participation in Population-Based TCOC Models and Supporting Primary and Specialty Care Transformation, March 3, 2025](#)
- [Preliminary Comments Development Team \(PCDT\), Identifying a Pathway Toward Maximizing Participation in Population-Based TCOC Models, September 16, 2024](#)
- [Trends in Traditional Medicare Spending and Outcomes in Urban and Rural Areas](#)
- [IDS Participation in Medicare ACOs](#)

## ABOUT PTAC

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to make comments and recommendations to the Secretary of Health and Human Services on proposals for physician-focused payment models (PFPMs) submitted to PTAC by individuals and stakeholder entities. Within this context, PTAC also reflects on proposed PFPMs that have been submitted to the Committee to provide further advisement on pertinent issues regarding effective payment model innovation in Alternative Payment Models (APMs) and PFPMs. Accordingly, PTAC has held an ongoing series of theme-based discussions on developing and implementing value-based care. The content in this PTAC Issue Brief is based on publicly available information from PTAC's theme-based discussions, including PTAC presentations and recommendations, presentations by stakeholders and experts, environmental scans, original research, and PTAC reports to the Secretary.

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