Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

June 16, 2026
9:02 a.m. – 11:33 a.m. EDT
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attendance

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

Terry L. Mills Jr., MD, MMM, PTAC Co-Chair (Chief Medical Officer, Aetna Better Health of Oklahoma, and Owner, Strategic Health, LLC)
Soujanya R. Pulluru, MD, PTAC Co-Chair (President, CP Advisory Services, and Co-Founder, My Precious Genes)
Lindsay K. Botsford, MD, MBA (Market Medical Director, One Medical)
Lauran Hardin, MSN, FAAN (Chief Integration Officer, HC^2 Strategies)*
Lawrence R. Kosinski, MD, MBA (Founder and Chief Medical Officer, VOCnomics, LLC)*
Krishna Ramachandran, MBA, MS (Chief Information Officer, UnitedHealth Group)
David C. Tyson, MA (Senior Director, Policy & Regulatory Affairs, Public Affairs & Government Relations, Novant Health)

PTAC Members Not in Attendance

Henish Bhansali, MD, FACP (Independent Consultant)
Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)
Joshua M. Liao, MD, MSc (National Associate Vice President of Clinical Transformation, Ascension)
Walter Lin, MD, MBA (Chief Executive Officer, Generation Clinical Partners)

Department of Health and Human Services (HHS)

Samuel Watters (Counselor, Immediate Office of the Secretary, U.S. Department of Health and Human Services [HHS])

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

Marsha Clarke, PhD, MBA, COR III, PTAC Designated Federal Officer
Steven Sheingold, PhD

Via Zoom

List of Speakers and Handouts

1. **Session 4: Payment Mechanisms and Financial Incentives to Encourage Patient Safety in Alternative Payment Models**

   John M. Hollingsworth, MD, MSc, Urologist and Professor, University of Florida College of Medicine, and Chief Quality Officer, UF Health*

   Jennifer L. Wiler, MD, MBA, FACEP, Professor, Department of Emergency Medicine, University of Colorado School of Medicine, Co-Founder, UCHealth CARE Innovation Center, and Chief Executive Officer, Minerva Partners*

   Jimmy Blanton, MPAff, Deputy Director, Quality and Program Improvement, Medicaid and CHIP Services, Texas Health and Human Services*

   Susan E. Sheridan, MIM, MBA, DHL, President and Chief Executive Officer, Patients for Patient Safety US (PFPS US)

   Handouts

   - Expert Biographies
   - Session 4 Presentation Slides
   - Session 4 Discussion Guide

2. **Public Commenters**

   Divvy Upadhyay (Self)
   Linda Hayes Bennett (George Mason University)
   Gina Hoxie (American Society of Clinical Oncology [ASCO])
   Patrick Romano (University of California, Davis)

***Via Zoom**

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

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

Welcome and Co-Chair Overview

Lee Mills, PTAC Co-Chair, welcomed the Committee and members of the public to the second day of the June 15-16 public meeting. He explained that the first day of the public meeting included perspectives on targeting improvements in patient safety through Alternative Payment Models (APMs). Co-Chair Mills then reviewed the agenda for the day, noting that guest speakers would share their perspectives on payment mechanisms and financial incentives to encourage patient safety in APMs. Co-Chair Mills indicated that a public comment period would be held later in the morning. Participants must register to provide an oral public comment, and public comments are limited to three minutes. Following the public comment period, the Committee members will discuss comments and recommendations for the report to the Secretary of Health and Human Services (HHS).

Co-Chair Mills then invited Committee members to introduce themselves and share their experience with patient safety. Following Committee member introductions, Co-Chair Mills acknowledged four Committee members who were not in attendance but contributed to the preparation of the public meeting: Henish Bhansali, Jay Feldstein, Joshua Liao, and Walter Lin.

Co-Chair Mills shared that background materials for the public meeting, including an environmental scan, can be found on the public meeting registration site and will be posted online on the ASPE PTAC website. The Committee is prepared to receive proposals on possible innovative approaches and solutions related to care delivery, payment, or other policy issues from the public. More information about submitting a proposal is posted on the ASPE PTAC website.

Session 4: Payment Mechanisms and Financial Incentives to Encourage Patient Safety in Alternative Payment Models

Subject Matter Experts (SMEs)

- John M. Hollingsworth, MD, MSc, Urologist and Professor, University of Florida College of Medicine, and Chief Quality Officer, UF Health
- Jennifer L. Wiler, MD, MBA, FACEP, Professor, Department of Emergency Medicine, University of Colorado School of Medicine, Co-Founder, UCHealth CARE Innovation Center, and Chief Executive Officer, Minerva Partners
- Jimmy Blanton, MPAff, Deputy Director, Quality and Program Improvement, Medicaid and CHIP Services, Texas Health and Human Services
- Susan E. Sheridan, MIM, MBA, DHL, President and Chief Executive Officer, Patients for Patient Safety US (PFPS US)

Lindsay Botsford moderated the session with four SMEs on payment mechanisms and financial incentives to encourage patient safety in APMs. Full biographies and presentations are available.

John Hollingsworth presented an academic health system perspective on targeting improvements in patient safety through APMs.

- Dr. Hollingsworth noted that 25 years ago, *To Err Is Human: Building a Safer Health System* changed the way people think about patient safety. Instead of attributing errors to individual negligence, the report recognized that errors stem from issues with health care system design. He explained that this shift accelerated transparency, reporting, and accountability; widespread adoption of checklists and standardized workflows; greater organizational focus on safety culture; and development of national measurement and reporting infrastructures. Dr. Hollingsworth emphasized that the next challenge in patient safety is to transform system capability.
- Dr. Hollingsworth described the health care industry's "safety drift" or "fatigue," noting that health care organizations face competing priorities that impact the industry's focus on patient safety. Work in patient safety has increasingly become fragmented into compliance programs, dashboards, regulatory reporting, and isolated performance metrics that are observable, codable, and extractable from administrative data (e.g., infections, falls, pressure injuries). Although he acknowledged that these tools create accountability and operationalize improvement, he warned that there is a risk that safety will be defined by what is easiest to observe and report, rather than by the full spectrum of patient harm and system vulnerability.
- Modern safety threats are longitudinal and contextual, emerging through a series of small failures rather than a single catastrophic event. These threats cross organizational and care-setting boundaries and are poorly captured through claims data, surveillance systems, and traditional quality reporting infrastructures. The absence of measurable harm does not equate to the presence of safety.
- Advances in technology have created new opportunities to identify previously invisible risks, such as diagnostic delays, communication failures, unsafe operational conditions, and hand-off

failures. These technologies allow health care to move from retrospective defect counting toward continuous system risk sensing. Artificial intelligence (AI) may provide the infrastructure necessary to identify risks earlier and intervene before harm occurs.

- Dr. Hollingsworth discussed financial incentives. The current payment mechanisms in safety-focused payment programs and initiatives share common retrospective and punitive architecture: detect harm, assign accountability, and impose a financial consequence. These approaches have structured finance around the failure of safety instead of safety capabilities.
- Dr. Hollingsworth listed factors that reward organizations for proactive measures, including the capability to identify risk early, strengthen reliability in communication, reduce operational fragility, improve care transitions, build learning systems, and continuously adapt. He highlighted an opportunity to complement traditional lagging indicators with leading indicators of safety and resilience (e.g., diagnostic safety infrastructure, closed-looped communication systems). This approach shifts the focus from measuring whether harm occurred to measuring whether an organization possesses the capability to prevent it.
- The Centers for Medicare & Medicaid Services (CMS) Patient Safety Structural Measure is an important shift away from safety policies focused on adverse events toward a focus on organizational capabilities to reliably prevent harm.
- Many federal APMs remain voluntary, which introduces important limitations. Well-resourced organizations that are already aligned with models are more likely to participate in APMs, while lower-performing organizations tend to opt out. As a result, improvement observed within APMs can reflect participation bias rather than delivery system transformation. For example, Dr. Hollingsworth's team evaluated the Medicare Shared Savings Program and found that estimated savings were attenuated when accounting for nonrandom clinician exit. The observed improvement from these models may reflect both delivery system transformation and compositional change.
- Mandatory APMs can reduce selection bias, generate more generalizable evidence, force operational redesign, expose implementation barriers, and create broader accountability.
- Dr. Hollingsworth recommended that safety-oriented payment reform be a required aspect of participation in APMs to make patient safety a foundational expectation of health care delivery.
- Dr. Hollingsworth explained that the initial architecture for patient safety delivered important gains but also has limitations. Next, the patient safety architecture should include diagnostic safety, longitudinal care coordination, operational resilience, continuous learning systems, and capabilities in advanced analytics to identify risk before harm occurs.

For additional details on Dr. Hollingsworth's presentation, see the presentation slides (pages 2-15), transcript, and meeting recording (6:30-18:44).

Jennifer Wiler presented a provider's perspective on payment mechanisms and financial incentives to encourage patient safety in APMs.

- Dr. Wiler discussed considerations for financial incentives to encourage safety improvements, including focusing on areas with the highest harm rates, that touch the most patients, that have the highest impact on morbidity or mortality, and with the highest cost to health care organizations.
- Dr. Wiler described national variability in patient safety performance. She inquired whether payment models should incent decreasing the variability among the top- and bottom-performing organizations, targeting improvements among the worst-performing organizations, or maintaining high performance among the high-performing organizations. Additionally, she

recommended considering whether payment models should be the same for high- and low-performing organizations.
- Dr. Wiler recommended that patient safety metrics focus on avoidable harm or adverse events. Medical errors are often categorized as never events and preventable sentinel events. She proposed that payment models focus on avoidable areas with the highest harm.
- Dr. Wiler described data capture and its impact on developing patient safety metrics. Currently, most publicly reported data come from structured data sources. She highlighted that there is variability and disagreement regarding definitions for patient safety metrics.
- Dr. Wiler discussed whether the selection of patient safety metrics should focus on one model or on the holistic improvement of the system and inquired what the impact would be on drivers of harm. She noted that holistic improvement in the system is ideal but acknowledged that executing a holistic approach would be a challenge.
- Dr. Wiler indicated that many strategies to improve patient safety had been discussed during the public meeting, including standardization and training, use of technology, and use of checklists. A challenge emerges when trying to crosswalk these safety improvement strategies to a financial reward or disincentive. Dr. Wiler discussed the different types of payment incentives that have been used to change provider behaviors related to patient safety, which have had minimal impact.
- The goal of patient safety measures is to eliminate avoidable harm, especially never events and high-harm events, and reduce hospital-acquired conditions (HACs) that occur within inpatient facilities due to high case volumes. She noted that there are opportunities to align patient safety performance and payment, such as timeliness of care (diagnosis to implementation of treatment plan), reliability (adherence to treatment plan), access to care, learning systems that make safety improvements, and the cost of harm to patients.
- Dr. Wiler identified several potential domains for financial incentives, including paying for access to data and data sharing; process (e.g., event review); action (e.g., addressing errors identified in event reviews); or outcomes (e.g., closing a gap).
- Dr. Wiler highlighted different ways to categorize payment for performance in patient safety. She cited examples, including the site of service, the patient population or disease condition, and provider specialty.
- Unintended consequences are created from financial incentives, such as overtreatment or undertreatment; a disproportionate focus on short-term outcomes; and risk avoidance. Dr. Wiler shared that perverse incentives exist within payment systems, including patient selection and data manipulation.
- Dr. Wiler emphasized that overreliance on performance metrics may impact a low-performing organization's focus on implementing whole system changes.

For additional details on Dr. Wiler's presentation, see the presentation slides (pages 16-34), transcript, and meeting recording (18:45-33:06).

Jimmy Blanton presented on patient safety in Texas Medicaid Managed Care.
- Mr. Blanton currently oversees Texas Medicaid and has been involved in the state's efforts to transition the program to a value-based model for over 15 years. He noted that patient safety has been a critical priority for the state.
- Mr. Blanton outlined the state's Managed Care Programs, which serve 4.5 million people across 13 regions. Sixteen Managed Care Organizations (MCOs) administer the program, and the state oversees contractual policy and oversight levers and uses incentive payment programs. Texas has

a diverse patient mix and a diverse provider community with rural hospitals and small and independent practices.

- Keeping patients free from harm is one of Texas Medicaid's quality strategy goals. It operationalizes this strategy using objectives that focus on reducing avoidable complications and adverse events across all care settings and by reducing severe maternal morbidity and unnecessary cesarean sections. Mr. Blanton provided an overview of the measures and statewide patient safety initiatives that have been implemented in Texas Medicaid.
- Mr. Blanton highlighted software used to assess potentially preventable complications. The state is encouraging certain cultures of practice for quality improvement. For example, the state promoted the adoption of maternal morbidity safety bundles through Texas Alliance for Innovation on Maternal Health.
- Mr. Blanton described the state's Comprehensive Hospital Increase Reimbursement Program (CHIRP). In this program, hospitals can earn bonuses for improvement, reporting, and activities that promote quality goals. The state tracks different metrics in its direct payment programs and uses dashboards with interactive capabilities to assess roughly 100 quality measures. Dashboards also include incentive program performance metrics and five-star ratings for MCOs, among others. These quality and performance measures impact capitation payments distributed to providers.
- Mr. Blanton explained that MCOs participate in APMs. Since 2018, the state has tracked uptake of provider reimbursements through APMs. Use of these models among Managed Care Programs has nearly doubled since 2018. He noted that challenges still exist to extend the programs due to dollars being nominally linked to an APM.
- Mr. Blanton described the Hospital Quality-Based Payment Program, which is the state's primary patient safety APM within the Medicaid program. The program assesses rates of potentially preventable complications and potentially preventable readmissions in Medicaid at the hospital level using proprietary software. The program calculates an actual-to-expected ratio of complications for MCOs and hospitals. Results are shared with the organizations for improvement efforts.
- Even with well-defined programs, progress to reduce readmissions and complications is challenging.
- Texas MCOs adopted additional APMs that at least partially include patient safety.
- Mr. Blanton summarized that the state's approach to patient safety improvements involves setting goals and objectives, providing technical assistance, and standardizing reporting and metrics. Health care payers provide oversight to implement programs across Texas, which are then tailored to the market implemented.

For additional details on Mr. Blanton's presentation, see the presentation slides (pages 35-49), transcript, and meeting recording (33:07-49:42).

Susan Sheridan presented on payment mechanisms and financial incentives to encourage patient safety in APMs.

- Ms. Sheridan shared her reflections on topics covered during the first day of the public meeting:
    - Participation in models should be mandatory, not voluntary.
    - Models should not be punitive.
    - It is important to collect and learn from Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs). PROMs and PREMs assess what matters most to patients, promote transparency and accountability for patient safety,

and contribute to a real-time learning network to identify safety risks and prevent patient harm.

- Ms. Sheridan described the aims of the Patients Involved in deVeloping Outcomes Together (PIVOT) Earn-Back Model. The model uses PROMs and PREMs to measure what matters most to patients, such as failures in diagnostic and safety delays, communication breakdowns, and preventable harm. The model promotes safety and diagnostic improvements by allowing organizations to reinvest and recover performance losses through demonstrated safety improvement; rewarding measurable improvement rather than using a one-time penalty cycle; encouraging transparency and learning rather than fear and hiding harms; using technology; and achieving better outcomes and lower costs.
- Ms. Sheridan acknowledged the potential to include the CMS Patient Safety Structural Measure in future versions of the model.
- Ms. Sheridan shared that the PIVOT Earn-Back Model is a two-sided risk model where organizations can share in savings and are accountable for their performance. When organizations do not meet their benchmarks, payment is withheld in a performance reserve that the organization can then earn back in the future. PROMs, PREMs, and a digital AI component are used in the model.
- The model includes three domains of outcomes: clinical, patient-reported, and cost efficiency. A structural domain may need to be added. PROMs and PREMs assess patients' unexpected physical, emotional, and financial harms, and unmet concerns.
- Ms. Sheridan described opportunities for technology-enabled learning and reductions in burden associated with the model. PROMs will be measured automatically through an application (app) or patient portal, and AI can then directly embed the measure into the revenue cycle. This approach can reduce burden.
- Ms. Sheridan described the model's earn-back cycle. First, if an organization does not meet a benchmark, a portion of the payment is withheld and placed in a reserve. If the organization shows improvements, then the organization has the opportunity to earn back the withheld payment.
- Ms. Sheridan introduced the concept of an economic flywheel. The more an organization invests in patient safety, the more the organization can reduce harm and associated costs. This will result in earning back returns, in which those returns create capacity to continue to invest in patient safety. Ultimately, these changes drive a continuous cycle of improvement and value. The model incentivizes continuous learning and investment in areas of greatest interest to patients.
- Ms. Sheridan quoted Sir Liam Donaldson, former Chief Medical Officer (CMO) for England and an international leader in patient safety with the World Health Organization (WHO), stating, "To err is human, to cover up is unforgivable, and to fail to learn is inexcusable." She shared that one of the greatest risks to patient safety in current payment models is the status quo, emphasizing that courage is required to change practice in patient safety. She added that the patient community is relying on PTAC to help improve patient safety and payment models.

For additional details on Ms. Sheridan's presentation, see the presentation slides (pages 50-60), transcript, and meeting recording (49:43-1:05:44).

Following the presentations, Committee members asked questions of the experts. For more details on this discussion, see the transcript and meeting recording (1:05:45-1:40:35).

Experts discussed whether patient safety should be embedded into existing payment models or the focus of a model.

- The best approach is the one that makes patients safe.
- One expert indicated that patient safety should be both embedded into existing models and the focus of a model. There is an opportunity to include patient safety and potential harm measures in existing models, such as primary care or cancer care models. Patient safety should also be considered a core infrastructure, which requires capital. This capital may be paid through a standalone model.
- Better data infrastructure through electronic health records (EHRs) and Health Information Exchanges (HIEs) is key to patient safety and quality improvement. Better data infrastructure will enable improved patient tracking, issue identification, and the identification of evidence-based patient safety and quality practices to embed within existing models.
- There are opportunities to take advantage of existing models while working toward the development of a standalone model. This work would include moving away from focusing on what is easy to measure and building a learning system that will identify how to protect patients from harm.

Experts discussed whether providers choose to opt out of participation in models due to increasing amounts of withheld payments.

- Providers did not opt out in Texas Medicaid at a large scale, potentially because the percentage of risk was not large, and hospitals needed the Medicaid payments for operational stability.
- One option to mitigate concerns about participation is to implement an all-payer model. This approach would ensure that all patient populations are included, not solely those who are covered by certain insurers or geographic regions.

Experts discussed metrics, practices, and incentives for mental health and substance use disorders, which are confounders to patient safety, cost, and complexity of care.

- Access to care is a simple metric that is already collected in data systems. Timeliness in receiving care and connection is important to the patient population.
- There is a strong relationship between preventable events and mental health and substance use disorders. One expert's organization tries to account for the relationship between preventable events and mental health and substance use disorders by using risk adjustment. Behavioral health needs have been prioritized across their state to increase MCO participation.
- A gap in access to care for behavioral health exists across the country, which could be mitigated through AI. Behavioral health should be considered for any recommendations as a confounder to patient safety measurement.

Experts discussed strategies to improve safety culture.

- Patient perspectives and advocacy can meaningfully change outcomes and policies.
- Samuel Watters stated that there are four reasons to implement a standalone model for patient safety. First, pay-for-reporting increases reporting of patient harm. Second, failing to invest directly in patient safety will hinder improvement, as hospitals already face cost constraints. Third, patient safety has been discussed for over 20 years with minimal impact; it is time to recognize that a dedicated effort is needed to improve patient safety. Fourth, with the emergence of new technologies, commitment is needed to identify best practices and better integrate patient safety into health care.
- There is currently an opportunity to make real change to patient safety.

Experts discussed the types of investments that may be needed (e.g., payment, technology, programs) to achieve meaningful change in patient safety.

- Incentives should be designed strategically to use a proactive approach to patient safety.
- Barriers to infrastructure need to be addressed. Care coordination and communication can mitigate infrastructure barriers in patient safety. In addition, there may be opportunities to pay for timeliness of data and information to identify patient care gaps at scale.
- A program such as Meaningful Use is needed to improve the latency of patient data.

Experts shared final thoughts.

- The PIVOT Earn-Back Model is a mechanism that can help the industry proactively approach patient safety and invest meaningfully in needed infrastructure.
- The future of patient safety APMs should be structured as investments in organizational capability to better identify risk rather than avoiding penalties.
- Smaller hospitals should be considered in the structure of future APMs.

Public Comment Period

Co-Chair Pulluru opened the floor for public comments. The following individuals made comments:

- Divvy Upadhyay (Self)
- Linda Hayes Bennett (George Mason University)
- Gina Hoxie (American Society of Clinical Oncology [ASCO])
- Patrick Romano (University of California, Davis)

Committee Discussion

Co-Chair Pulluru opened the floor to Committee members to reflect on the day's presentations and discussions. The Committee members discussed the topics noted below. For additional details, please see the transcript and meeting recording (17:24-38:13).

- Improving patient safety will require attention, payment, and innovation. AI can materially change patient safety, specifically by supporting early detection and warning systems.
- There may be ways to emphasize patient safety in existing models, potentially by using existing quality measures that assess safety. For example, some medication reconciliation measures promote the avoidance of errors.
- Overall, a mandatory approach may be needed to improve patient safety; however, the source of the payment remains unclear. Rather than penalties for unsafe environments, payments to invest in infrastructure—including data, technology, and safety capabilities,—may help improve patient safety.
- The use of prospective payments and a regulatory intervention may be two strategies to improve patient safety. One Committee member noted that a concrete payment model focused on patient safety had not been described, potentially indicating that more work is needed before developing a model.
- It is important to consider administrative burden, cognitive overload, and operational fragility of the system when considering adding new expectations.
- When considering approaches beyond penalties, it is important to understand that delays in payment or withholds can be a penalty for many systems.
- There are opportunities to align APMs with existing certification programs as opposed to designing entirely new models or programs. This could be a place to start the process of improving patient safety.

- Payment models align incentives to shape different areas of focus in the health care delivery system. It is time to reinvigorate a focus on patient safety. One Committee member recommended first introducing patient safety parsimoniously into existing models. If this approach does not work well or does not reach the intended scale, then efforts should focus on creating a dedicated patient safety model with high intensity, such as using mandates or withholds.
- While there is risk in trying something new to improve patient safety, there is equal or greater risk in not trying something new.
- The policy tools and the legal framework needed to improve patient safety already exist.
- A mandatory approach may be needed to improve patient safety. One Committee member inquired whether a mandatory approach could be used as a policy tool. Providers will opt out if a model is too challenging or if their journey to improve will be too long. As an example, a new APM could be mandatory for hospitals in the bottom quartile of patient safety mechanisms, and then a bonus incentive could be provided for those already performing at or above the median. These levers could be used independently; mandatory participation does not have to be implemented for all providers.
- One Committee member expressed interest in a two-tailed model where there is an upside bonus for providers already performing at or above the median, while there is a downside risk loss prevention mechanism for providers performing at the bottom.
- A patient safety model would need to ensure that the magnitude of the fee or penalty for poor performance is worse than not trying to improve patient safety.
- Care coordination and transitions of care are not typically built in as required or mandatory metrics in CMS and CMS Innovation Center models, despite a large body of evidence supporting care coordination and transitions of care. These measures could be prominently featured in models.
- One Committee member expressed interest in the six actionable steps described by Dr. Patrick Romano during the public comment period (safety should be part of all APMs, there should be a balanced approach across multiple measures, there should be a graded approach to the money at stake, innovation in infrastructure and measurement should be promoted, providers should be engaged from the bottom up with alignment in actionability and accountability, and unintended consequences should always be considered).
- Improving patient safety is about changing culture. Culture change is slow, measured in years, and incremental. This multiyear, incremental process should be considered when incorporating patient safety into existing models, as well as developing a specific model. Incentives, either upside or downside, will need to gradually increase in bonus or severity over the multiyear period.
- Patient safety is not a standalone issue; harm often results from system failures.
- Health care is in a technological revolution. Advances in AI may provide an inflection point in the implementation of care redesign.
- To improve patient safety, culture needs to change on an individual- and team-level basis.
- Payment models must be structured correctly. Patient safety needs to be part of every value-based care model, in addition to EHR integration, patient engagement, and care coordination.
- One Committee member recommended that PTAC consider developing a structure of a value-based care model that includes all lessons learned from past public meetings. This structure, which would encompass all components of value-based care instead of focusing on a single component, could be presented to the Secretary of HHS.

- One Committee member reflected on an idea presented by one of the SMEs, where safety is a nonrevenue-generated cost center. Changing culture across multiple services, including hospitals, primary care, and ambulatory settings, is needed to improve patient safety.
- It is important to address challenges in the workforce, such as administrative burden, stress, and having the right information at the point of care to inform decisions.
- The core components of improving patient safety include longitudinal care coordination, interdisciplinary team engagement, and integration of behavioral health. The core components of design that result in change are learning systems and a focus on safe system design.
- Real-time patient reporting provides an opportunity to improve patient safety. The integration of AI and the expansion of technology provide an opportunity to use prospective systems and continuous risk assessment.
- Rewards rather than penalties may motivate systems change. Evidence shows that investments in Meaningful Use resulted in a large-scale transformation and integration of EHRs. There are opportunities to assess the types of investments that will motivate change.
- One Committee member reflected on an idea presented by one of the SMEs, indicating that absence of measurable harm is not necessarily the presence of safety.
- Improving patient safety nationally may require both a bottom-up and top-down approach.
    - Working from the bottom up, it is important to ensure that the right measurement is used. Interoperable, real-time, predictive, and prospective data should be used. Additionally, patient-report data should be used. The power of AI should be leveraged to synthesize and syndicate data to make data actionable. Current certification mechanisms can be used to train providers and physicians in various specialties. Patient safety can be embedded into current APMs to some degree.
    - Working from the top down, it is important to have a top-down initiative that is led by CMS, the Director, and leadership to ensure national attention on patient safety. Using a top-down approach can involve developing a framework to both embed patient safety in existing models and programs and create a new model focused on patient safety. One Committee member inquired whether there is a way to embed patient safety into multiple levels by using a bottom-up approach that leverages what already exists as the chassis while also developing a new model.
- There are opportunities to design systems that capture patients' and families' voices at the point of care to identify risk in real time. It is important to make identifying and elevating risk safe for patients and families so that they do not fear abandonment or being labeled by the system.

Closing Remarks

Co-Chair Pulluru adjourned the meeting.

The public meeting adjourned at 11:33 a.m. EDT.

Approved and certified by:

//Marsha Clarke//
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Marsha Clarke, PhD, MBA, COR III
Designated Federal Officer
Physician-Focused Payment Model Technical
Advisory Committee

7/21/2026
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Date

//Terry Mills//
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Terry L. Mills Jr., MD, MMM, Co-Chair
Physician-Focused Payment Model Technical
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Date

//Soujanya Pulluru//
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Soujanya R. Pulluru, MD, Co-Chair
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