Session 4: *Addressing Challenges to Advance Multi-Payer Alignment*

Presenters:

Subject Matter Experts

- **Ben Kornitzer, MD** – Senior Vice President and Chief Medical Officer, Aetna, a CVS Health Company
- **Vivek Garg, MD, MBA** – President and Chief Executive Officer, National Committee for Quality Assurance (NCQA)
- **Emily Transue, MD, MHA, FACP** – Chief Clinical Officer, Comagine Health
- **Rushika Fernandopulle, MD, MPP** – Chief Executive Officer, Liza Health

Session 4: Addressing Challenges to Advance Multi-Payer Alignment

Ben Kornitzer, MD

Senior Vice President and Chief Medical Officer,
Aetna, a CVS Health Company

Addressing Challenges to Advance Multi-Payer Alignment

Ben Kornitzer, M.D.
Senior VP, Aetna Chief Medical Officer

February 2026

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Ben Kornitzer, M.D.

Dr. Benjamin Kornitzer serves as the Senior Vice President and Chief Medical Officer (CMO) of Aetna at CVS Health. Ben is a nationally recognized leader in value-based care, primary care and healthcare transformation. He and his team lead the integration and delivery of clinical and population health solutions in support of Aetna members, customers and provider partners.

He joined CVS Health from agilon health, where he led clinical and quality initiatives across a network of 3,000 primary care physicians in more than 30 markets. In this role, he played a key part in enabling provider organizations to succeed in value-based care, delivering high-quality, cost-effective healthcare.

Prior to his role at agilon health, Ben served as Chief Medical Officer of The Mount Sinai Health Network. He completed his medical residency in internal medicine at Massachusetts General Hospital/Harvard Medical School before joining McKinsey & Company's healthcare practice, where he later returned as a Senior Advisor.

Ben holds an undergraduate degree from Brown University and an M.D. from the Mount Sinai School of Medicine. A sought-after speaker and author, he has lectured extensively on health policy, value-based care and medical innovation. His insights are regularly published in both medical and mainstream literature

Ben Kornitzer, M.D.

Senior VP, Aetna Chief Medical Officer, CVS Health

Why the Current System Isn’t Delivering as Intended

The U.S. health care system must evolve, and the pressures are shared across all stakeholders.

Consumers

Cost remains a barrier

40%

Delay care due to cost [1]

Providers

Administrative tasks take time away from patients

88%

Want to spend more time with patients who have complex conditions [2]

Employers

Need to balance affordability with competitive benefits

7%

Increase in projected health plan costs for 2025 [3]

1. Gallup , 2. Health Care Insights Study, 3. AON

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Why Value-Based Care Is the Right Path Forward

Today's system versus where we need to go in value-based care

	Fee-for-Service	Value-Based Care
Incentives	Volume-driven	Quality and value
Care Focus	Reactive and episodic	Proactive and preventive
Patient-provider Relationship	Fragmented and transactional	Holistic and coordinated
Provider-health Plan Relationship	Transactional and service-driven	Collaborative, shared accountability for outcomes

Core Barriers to Adoption of Value-Based Care

- Fragmented Payment Models
- Operational Complexity & Burden
- Data & Interoperability Challenges
- Misaligned Incentives & Risk Tolerance
- Weakened Financial Incentives
- Provider and Participant Engagement

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How Aetna is Working to Address These Barriers

Aetna centers the health plan/provider relationship on members' health and well-being by leveraging value-based care models that align payments with quality care.

Clinical Collaboration

- Partners with providers to support care transformation
- Aligns clinical strategy, performance management and outcomes

Data Sharing

- Provides actionable insights to support population health
- Enables visibility into utilization, gaps in care and performance

Evidence & Innovation

- Demonstrates improved quality and lower total costs of care
- Invests in new solutions that support care delivery and access

Thank you

Session 4: Addressing Challenges to Advance Multi-Payer Alignment

Vivek Garg, MD, MBA

President and Chief Executive Officer,
National Committee for Quality Assurance (NCQA)

Addressing Challenges to Advance Multi-Payer Alignment in Medicare Advantage

Vivek K. Garg, MD, MBA
President & CEO
National Committee for Quality Assurance (NCQA)
February 24, 2026

Who We Are

The National Committee for Quality Assurance (NCQA) defines and drives health care quality through accreditation, standards, performance measurement, and expert support. For more than 35 years, NCQA has advanced transparency, accountability, and enabled healthcare organizations to deliver better outcomes for patients.

Key Facts

- Founded in 1990
- Is an independent nonprofit
- Offers more than 20 accreditation, certification and recognition programs.
- Has the most widely used performance measurement tool in health care (HEDIS®)

NCQA's Reach & Impact At a Glance

236 Million People

covered in health plans that report HEDIS®

72% of Americans

with health insurance are covered in an NCQA-Accredited plan

58,700+ Clinicians

work in an NCQA-Recognized medical practice

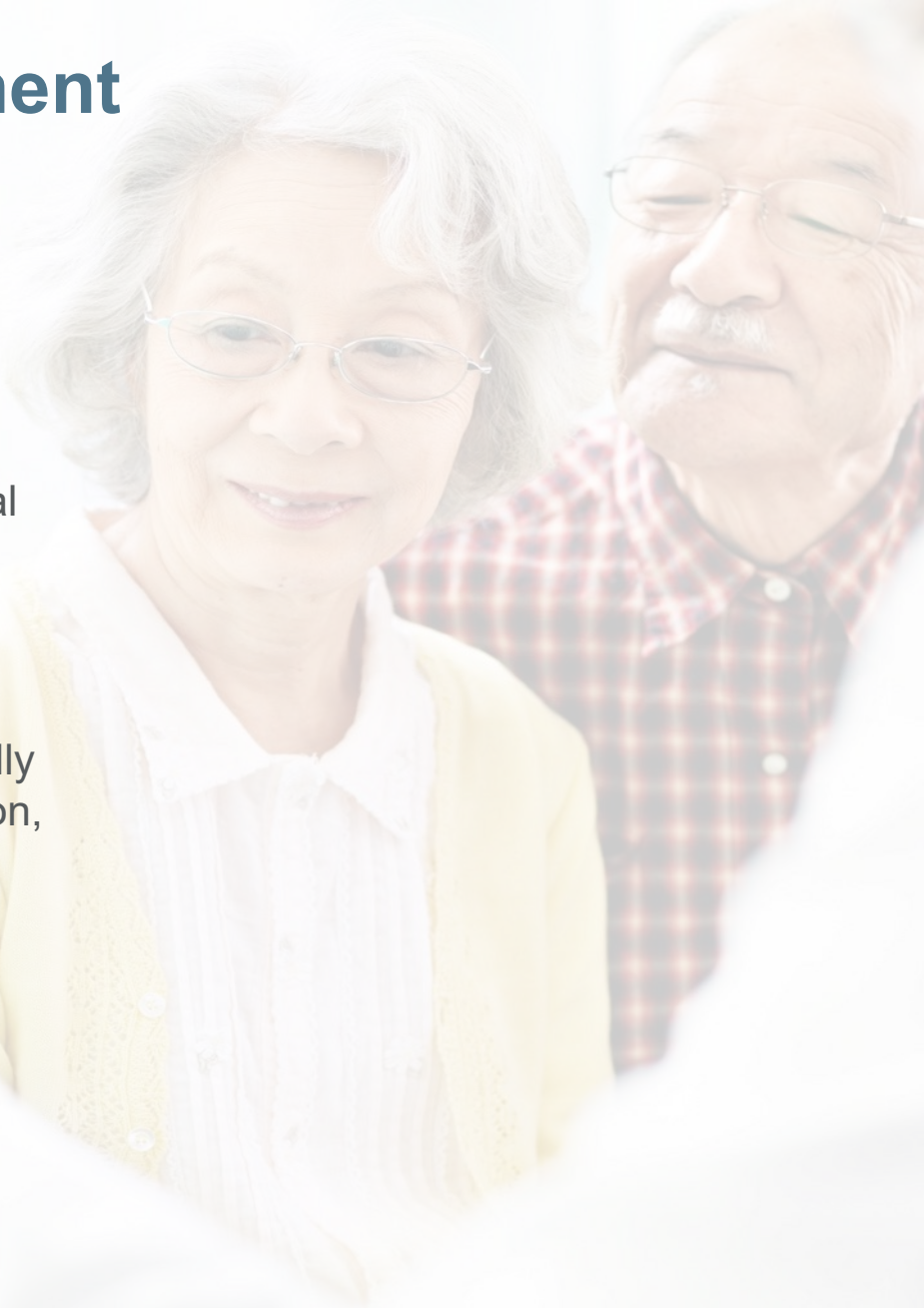
11,700+ Entities

Accredited, Certified or Recognized by NCQA

Last updated September 2025

Challenges in Advancing Multi-Payer Alignment

Themes in Medicare Advantage



Lack of Trust and Transparency in Data

- Providers lack a full, timely view of patient utilization, diagnoses, cost drivers, and risk adjustment inputs.
- Health plans typically aggregate this data but are not viewed as neutral partners and share it with varying timeframes, accuracy, and completeness

Misalignment Between Provider Scope and Full Cost of Care

- Providers are held accountable for cost areas they cannot meaningfully influence (e.g., out-of-network leakage, specialty care & drug utilization, transportation, ancillary benefits).

Variability Across Health Plan Contract Terms

- Contract structures, performance metrics & incentives, reporting requirements, and utilization management policies vary widely across MA plans.

Complexity of the Multi-Payer Ecosystem

- Providers participate across MA, Medicaid, Commercial, and ACO models, each with distinct incentives and requirements.

Opportunities in Advancing Multi-Payer Alignment

Lessons Learned from Quality Efforts

Strengthen Primary Care & Investment

- Align health plan & delegated risk frameworks with national Advanced Primary Care capabilities and population investment goals in primary care

Harmonize Quality & Outcomes Measures for Seniors

- Align on Core Digital Quality Measure Set for Seniors, incorporating prevention, clinical outcomes, patient-centered outcomes, and avoidable events/utilization, across MA and ACO programs
- Standardize, mandate, and enforce minimum data-exchange expectations (USCDI, FHIR) between plans and care delivery for quality reporting

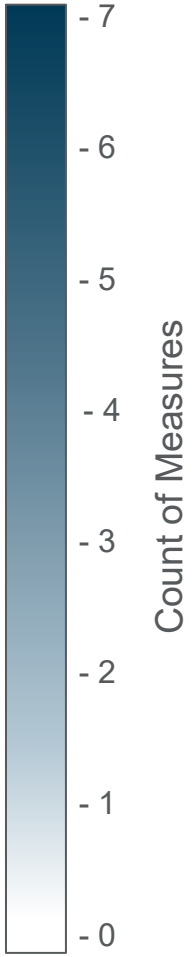
Standardize Delegated Risk Payer-Provider Alignment

- Standardized financial risk & contract terms, tying ownership of risk to ability to impact
- Create unified data standards and requirements across MA plans, ACO programs, to help care delivery groups achieve timely, accurate, complete signals
- Align utilization management and care management rules

The Need for Harmonization is Clear

Differences in Domains and Measures Across Quality Programs

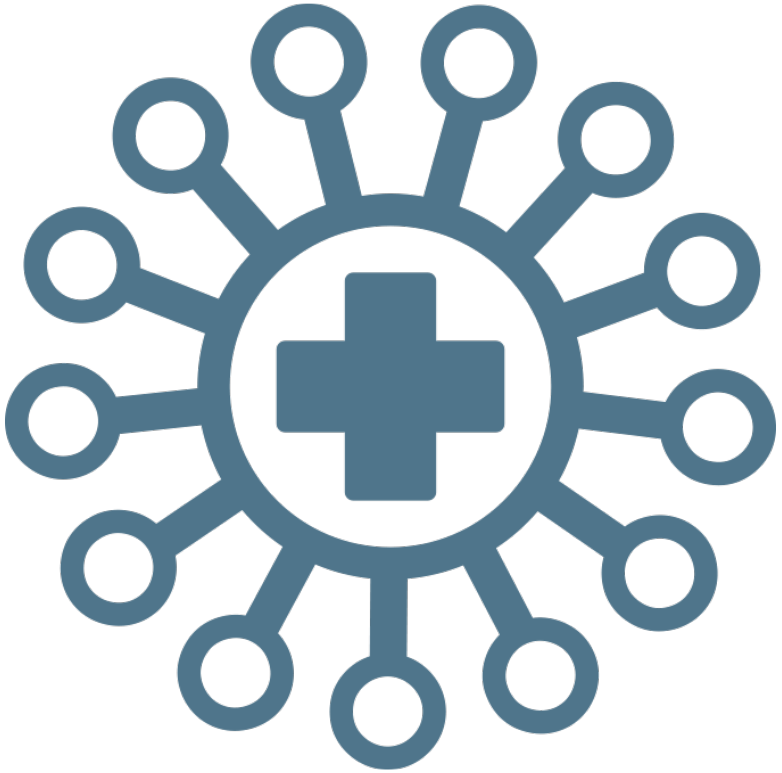
	MA Stars	APP Plus (MSSP)	ACO REACH
Preventive & Screening	3	2	0
Chronic Disease Clinical Management	6	2	0
Utilization & Readmissions	1	2	2
Care Transitions & Follow-Up	3	1	1
Complex & High-Risk Population Management	1	0	1
Functional/Aging/Well-Being	7	0	0
Patient Experience	7	1	1
Operational Performance	5	0	0



Can Multi-Payer Alignment Actually Happen?

A Promising Case Study: New York

- Built under New York's federally funded State Innovation Model, the statewide effort reduced fragmentation by replacing multiple overlapping primary care initiatives with a single, unified framework, giving payers and practices one consistent set of expectations, supports, and transformation standards.
- Standardized quality expectations via a shared Primary Care Core Measure Set across payers.
- Aligned financial incentives with Medicaid and commercial plans all supporting NCQA-based recognition and performance.
- Statewide data exchange backbone (SHIN-NY) enabling consistent care coordination and reporting across payer lines.



Where Do We Go From Here?

How NCQA is Advancing Alignment

- **Digital Quality Transformation**
- **Measure Cohesion and Alignment**
- **Strengthening the Primary Care Backbone**

Thank you

Appendix

	MA Stars	APP Plus (MSSP)	ACO Reach
Preventive & Screening	• Breast Cancer Screening • Colorectal Cancer Screening • Annual Flu Vaccine	• Breast Cancer Screening • Colorectal Cancer Screening	
Chronic Disease Clinical Management	• Diabetes Care – Eye Exam • Diabetes Care – Blood Sugar Controlled • Kidney Health Evaluation for Patients with Diabetes • Controlling Blood Pressure • Statin Therapy for Patients with Cardiovascular Disease • Osteoporosis Management in Women Who Had a Fracture	• Diabetes: Hemoglobin A1c Poor Control • Controlling High Blood Pressure	
Utilization & Readmissions	• Plan All-Cause Readmissions	• Hospital-Wide 30-Day Readmission Rate • Risk-Standardized Admission Rate for MCC	• Risk-Standardized All-Condition Readmission • All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
Care Transitions & Follow-Up	• Medication Reconciliation Post-Discharge • Transitions of Care • Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	• Screening for Depression & Follow-up	• Timely Follow-Up After Acute Exacerbations of Chronic Conditions
Complex & High-Risk Population Management	• Special Needs Plan (SNP) Care Management		• Days at Home for Patients with Complex, Chronic Conditions
Functional/Aging/Well-Being	• Improving or Maintaining Physical Health • Improving or Maintaining Mental Health • Monitoring Physical Activity • Reducing the Risk of Falling • Improving Bladder Control • Care for Older Adults – Medication Review • Care for Older Adults – Pain Assessment		
Patient Experience	• Getting Needed Care • Getting Appointments and Care Quickly • Customer Service • Care Coordination • Rating of Health Care Quality • Rating of Health Plan • Complaints About the Plan	• CAHPS for MIPS	• ACO REACH CAHPS
Operational	• Members Choosing to Leave the Plan • Health Plan Quality Improvement • Plan Makes Timely Decisions About Appeals • Reviewing Appeals Decisions • Call Center – Foreign Language Interpreter and TTY Availability		

Session 4: Addressing Challenges to Advance Multi-Payer Alignment

Emily Transue, MD, MHA, FACP

Chief Clinical Officer,
Comagine Health

Comagine Health

PTAC Public session: Multi-payer efforts (Medicaid perspective)

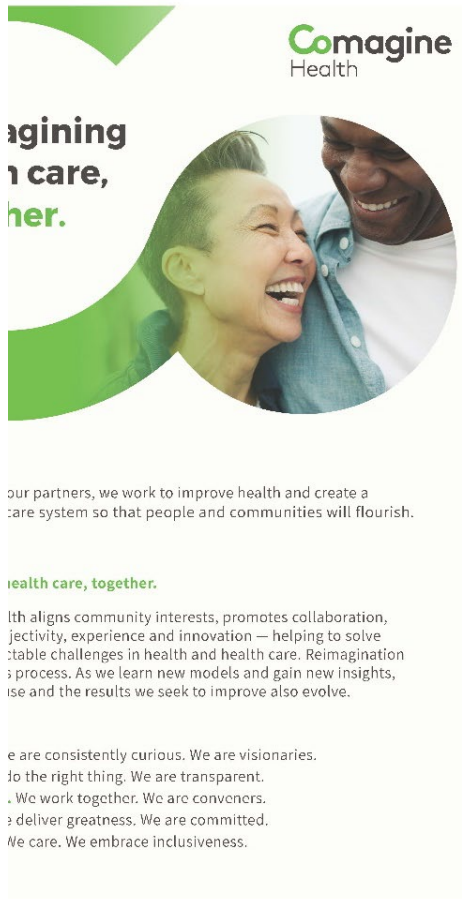
Emily Transue, MD, MHA, FACP

Chief Clinical Officer

Comagine Health

Comagine Health

- Comagine Health is a national, nonprofit, health care consulting firm. We work collaboratively with patients, providers, payers and other stakeholders to reimagine, redesign and implement sustainable improvements in the health care system.
- **Service Lines**:
  - Care Management
  - Data Solutions
  - Systemwide Quality Improvement
  - Research and Evaluation



Emily Transue, MD, MHA, FACP

- Chief Clinical Officer, Comagine Health
- Previous roles:
  - Medical Director, Washington State Health Care Authority (WA HCA)
    - Washington Medicaid and Public/School Employee Benefits
    - Washington Multi-Payer Collaborative (MPC)
    - Primary Care Transformation Initiative (PCTI)
  - Senior Medical Director/Acting CMO, Coordinated Care/Ambetter
    - Washington Centene MCO and exchange plan
  - Primary Care Internist and board member, The Polyclinic, Seattle

Comagine Health

Washington Multi-Payer Collaborative (MPC)

- Beginning in 2019, WA HCA convened a group to develop a new primary care model, in collaboration with the state's payers and primary care provider community
  - Separate and shared meetings with payers and providers
    - All Medicaid MCOs and state-contracted commercial payers
    - Broad variety of providers in size, location, rurality, payer mix
  - Neutral convener (Center for Evidence-Based Policy at Oregon Health and Sciences University)
    - Maintained antitrust guardrails
  - Drew on prior multi-payer experiences in Colorado and elsewhere

WA Multi-Payer Collaborative

- 2 Memorandums of Understanding signed
  - 2020 MOU:
    - Established principles of the Collaborative
    - Agreement on the general structure and key components of the Primary Care Transformation Initiative (PCTI)
    - Commitment to the initiative and good-faith efforts to implement it
  - 2024 MOU:
    - Ongoing and active participation in the Washington Multi-payer Collaborative to foster collaborative support strategies for primary care
    - Adherence to the Washington Multi-payer Collaborative's Alternative Payment Policies for Primary Care
    - Use of the Washington Primary Care Practice Recognition Program to inform provider partnership and contracting strategies

Washington State Health Care Authority, https://www.hca.wa.gov/about-hca/programs-and-initiatives/value-based-purchasing/primary-care-transformation#overview

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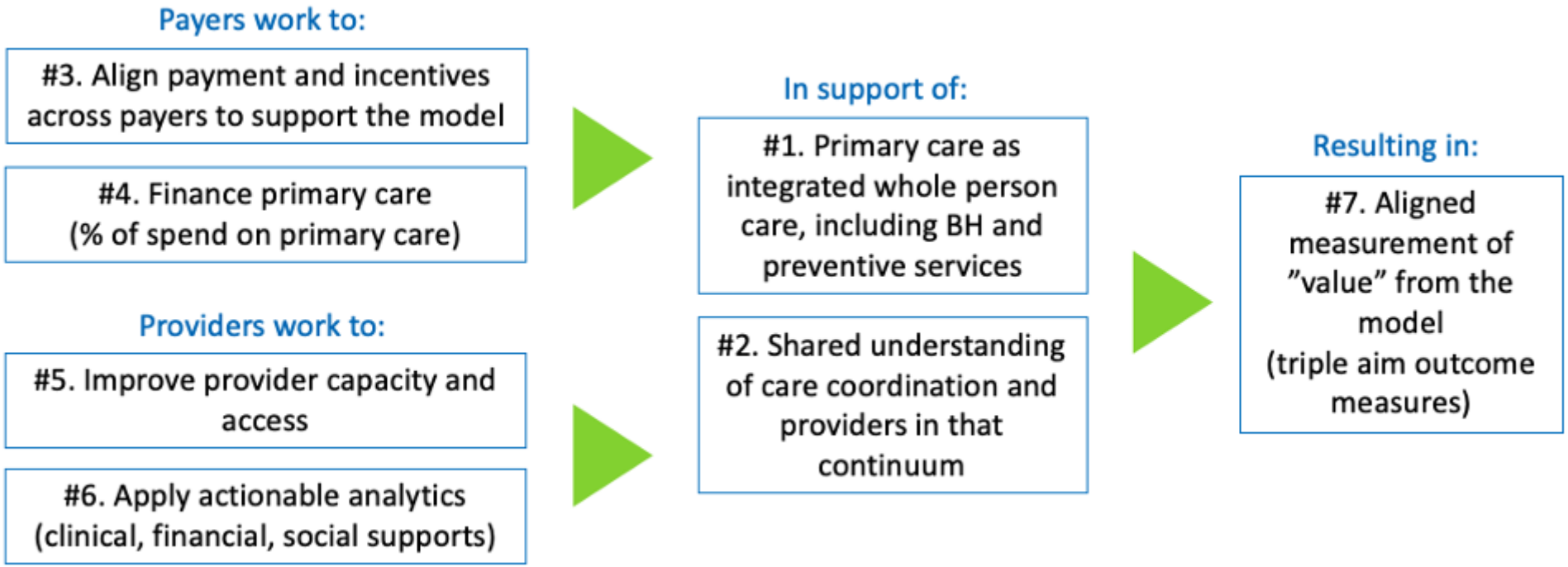
WA Primary Care Transformation Components



Washington State Health Care Authority, https://www.hca.wa.gov/about-hca/programs-and-initiatives/value-based-purchasing/primary-care-transformation#overview

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Addressing Challenges: Multi-Payer efforts

- Alignment
- Convening
- Trust
- Assumptions
- Incentives
- Risk Adjustment
- Sticking points

Comagine Health

Alignment: Double edged sword

- Critical to understand existing alignment relationships and potential conflicts
- Promoting alignment with a given program can pull payers and providers out of alignment with others
  - National payers have payment and contracting models, quality interventions, etc. that cross many states
    - Local alignment may limit use of effective strategies used nationally and efficiencies gained by national scale
  - Providers are accountable to state payers but also federal and other payers
    - E.g., Federally Qualified Health Centers are accountable for Uniform Data System (UDS) measures and Community Health Quality Recognition (CHQR) measures

Alignment: Quality Measures

- Washington State Common Measure Set:
  - Statewide list of measures for contracting mandated by WA legislature in 2013-2014, maintained by a multistakeholder committee
    - Goal to reduce administrative burden on providers from “wild west” of metrics
  - Ad hoc Primary Care Measures workgroup was convened to select measures for the PCTI
    - Core Measures for most contracts, and Alternative Measures for specific populations
- CMS Universal Foundation
- Broadly accepted, parsimonious measure set critical in enabling multi-payer efforts

https://www.hca.wa.gov/assets/program/primary-care-measures-implementation-guidelines.pdf

Comagine Health

Alignment: Medicare

- Medicare often “the elephant in the room”
  - High percentage of payer mix particularly in rural areas
- Alignment to Medicare payment models is a powerful enabler
  - Market share
  - Consistency across states for national payers
  - Time horizon long enough to justify investment

Convening

- "Change happens at the speed of trust" (Stephen Covey)
- Discussion needs to happen both within and between groups
  - More frankness with just providers or just payors
  - Meetings together allow addressing key conflict points
- Neutral convener can support trust and avoid hazards (antitrust, etc)

Washington State Health Care Authority, https://www.hca.wa.gov/about-hca/programs-and-initiatives/value-based-purchasing/primary-care-transformation#overview

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Address unstated assumptions

- Is a model intended to change/increase overall payment amounts, or to rearrange or redistribute existing dollars?
- Are providers expected to increase the number of patients they're caring for?
- Is downside risk a part of the equation, and what does that look like?
- Which services and providers are included in the model?
- These and similar questions can seem obvious in different directions to different participants
- Being explicit, clear, and consistent is critical to a model's success

Incentives: Carrots and Sticks

- Multi-payer efforts are time- and resource-intensive, and can feel risky to both payers and providers
- Both incentives and requirements are important
  - Require payers to come to the table
  - Consider available contract methodologies at the state level
  - Incentivize early adoption, penalize late adoption
- Incentivize participation in early efforts particularly for providers
- Model should be self-sustaining once in place

Social Risk Adjustment

- Risk adjustment critical for equity and to support providers who care for challenging populations
- Social risk adjustment is particularly crucial in Medicaid and similar populations (health exchanges, undocumented programs)
- Even if not standardized across payers, methodology/methodologies must be credible to provider community

Sticking points: Acknowledge and prioritize

- Challenges include whether/how to standardize:
  - Attribution methodology
  - Data platform, reporting, information exchange
  - Risk adjustment methodology
  - Quality measures
  - Inclusion/exclusion of services and providers
- Build on what you have
  - WA: Common Measure Set, Primary Care definitions
- Differentiate essential from nice-to-have

Lessons from the field: Multi-Payer efforts

- Alignment: Think beyond the model
- Move at the speed of trust
- Confirm principles/assumptions/goals
- Convene payers, providers, policy together and separately
- Use both positive and negative incentives
- Social risk adjustment critical in Medicaid population
- Sticking points: Build on what you have, and prioritize

Comagine Health

Thank you!

Session 4: Addressing Challenges to Advance Multi-Payer Alignment

Rushika Fernandopulle, MD, MPP

Chief Executive Officer,
Liza Health

Multi-Payer Alignment in Value-Based Care

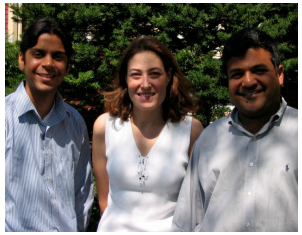
Lessons From the Iora Health Experience

Presentation to the PTAC

Rushika Fernandopulle, MD, MPP

February 24, 2026

A Two-Decades-Long Journey



RENAISSANCE HEALTH
Revolutionizing the art of personal health care.

2004-2007

BOEING

2007-2010

MEDICAL REPORT | JANUARY 24, 2011 ISSUE

THE HOT SPOTTERS

Can we lower medical costs by giving the neediest patients better care?

BY ATUL GAWANDE

iorahealth

2011-2021

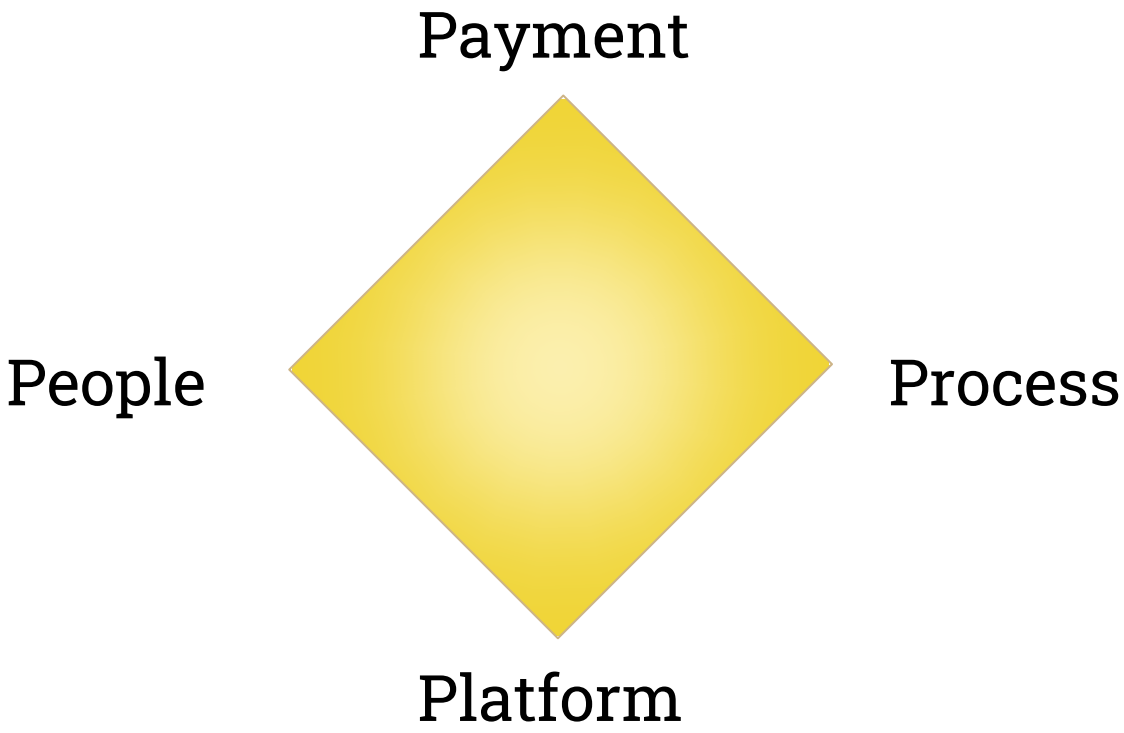
one medical

2021-2023

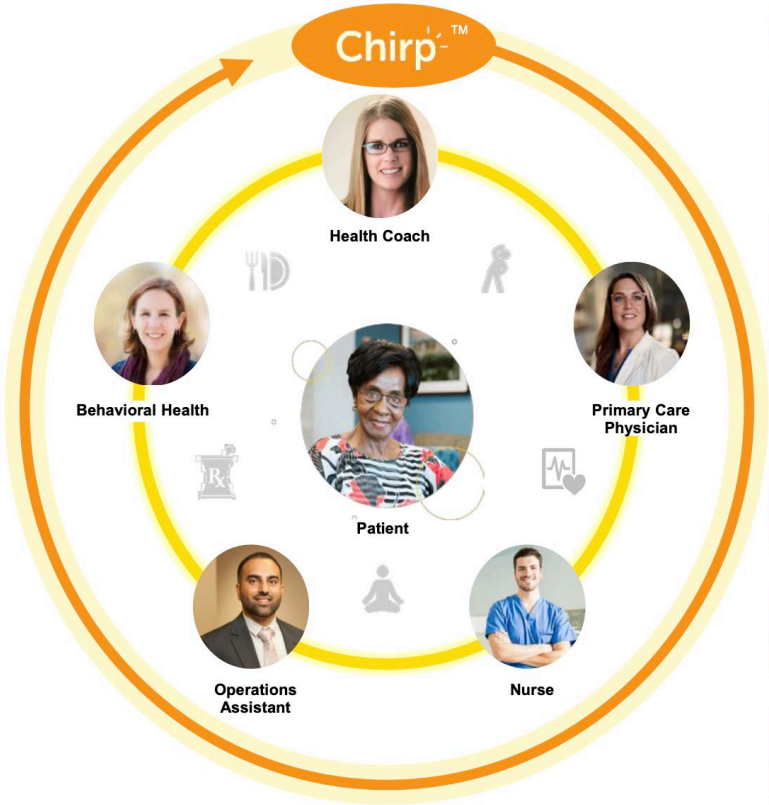
amazon

2023-

The Four P’s of Change



Requires a Very Different Model



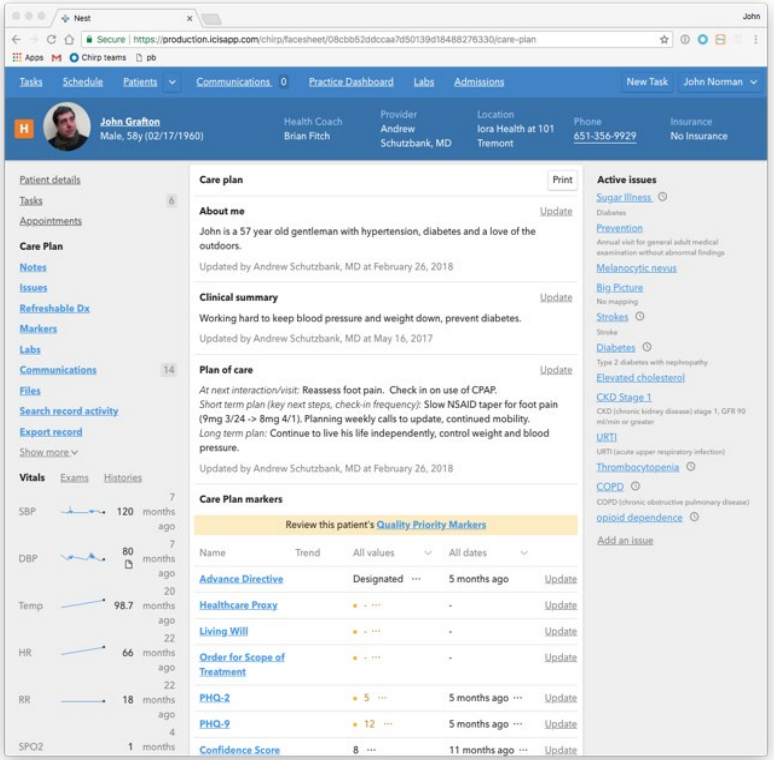
Differentiated patient experience

24 / 7 PCP access	30-60 minute average visit
Chronic condition management	"Iora Plus" home visits
Health coach / personalized health plans	On-site and virtual care
Programs and group events	Behavioral Health services
Transportation (Uber / Lyft)	Drive-through immunization clinics
Fully transparent patient health records	Family and caregiver engagement

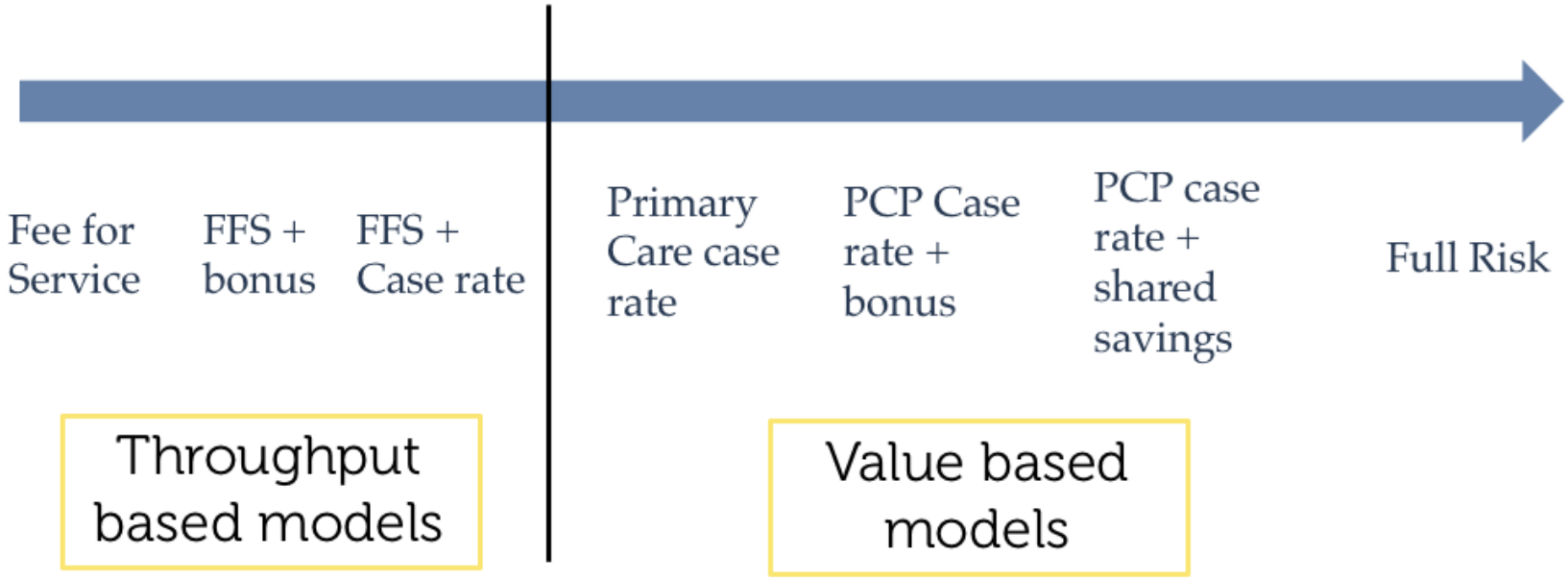
Building a New Operating System

Chirp

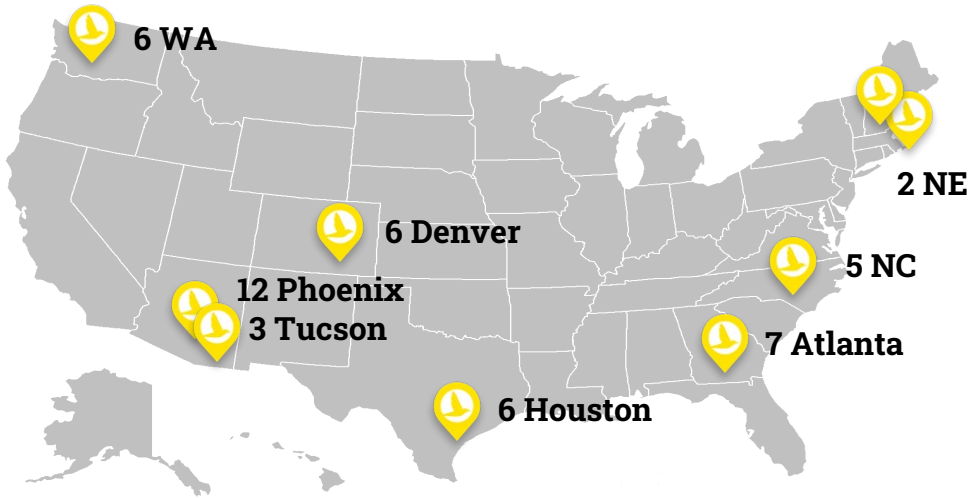
- Iora's Collaborative Care Platform
- Web-based, Available Anywhere
- Communications hub integrating multiple modalities
- Patients get to see their whole record (including all results, notes, documents) as soon as the team does
- Able to send us data, their own notes, which become a part of the collaborative chart
- Collect data from everywhere, prompts patient and team for action



Purely working with Value-Based Payment



We Grew Iora to 49 practices in 8 Markets



Iora partners with MA plans, other payers

Humana.

UnitedHealthcare

CVSHealth CMS

BlueCross BlueShield of North Carolina

TUFTS Health Plan

MASSACHUSETTS

DevotedHealth

BOEING

DARTMOUTH

2022 CMMI Direct Contracting Results

ACO_ID	ACO_NAME	SAV_RATE
D0004	IORA HEALTH NE DCE, LLC	22.3%
D0148	UNITED PHYSICIANS ASSOCIATION, INC	22.0%
D0063	OAK STREET HEALTH MEDICARE PARTNERS LLC	19.4%
D0143	CENTERWELL CARE SOLUTIONS, INC.	18.2%
D0201	ENHANZ DCE	15.4%
D0032	BEST VALUE TRANSPORTATION, LLC, D/B/A MAX HEALTHCARE #2	15.0%
D0010	PRIMARY CARE ALLIANCE, LLC	13.9%
D0172	SUBSERO HEALTHCARE, LLC D/B/A MAX HEALTHCARE #1	13.3%
D0156	AGILON HEALTH MID-ATLANTIC DCE, INC.	11.5%
D0218	RELIANT MEDICAL GROUP, INC.	11.3%

https://data.cms.gov/cms-innovation-center-programs/accountable-care-models/aco-reach-financial-and-quality-results/data/2022; Includes Standard and New Entrant tracks

From the Beginning we decided to practice the same way

Image 1. Four situational categories where health systems fall in their transition to value-based care.

From: *J Clin Pathways*. 2020;6(5):26-29. doi:10.25270/jcp.2020.6.00003

Our Evolution to Multi-payer- Anchor Tenant Model

Hanover NH (1 site)

DARTMOUTH

Phoenix AZ (12 sites)

Humana.

KING ARTHUR FLOUR

United Healthcare

DevotedHealth

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

BOEING

Our Contracting Philosophy

- Relationship is that of a long-term trusted partner, not a vendor
- Long term agreements are key: 3 yrs-> 5 yrs-> 10 yrs
- The seller of the services (i.e., Iora) determines how they need to get paid to deliver their service, and buyers either agree or walk.
- Be willing to say no - goal is to deliver optimal care
- Simplify the arrangements as much as possible, and streamline the reporting
- Be willing to adjust both ways as you learn

Thoughts on Multi-payer alignment for VBC

- This is absolutely necessary to truly transform practices. Cannot practice different ways for different payers. Doing it one (right) way leads to much better outcomes
- Biggest barrier is getting commercial payers onboard with VBC and aligning the arrangements. Needs to be similar for fully insured and ASO lives
- Need to sync on mode of payment (e.g., FFS vs capitation), risk adjustment, quality framework, what to measure and report
- Likely will need some government push and allowance for this (to not fall afoul of anti-trust rules)