Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

February 24, 2026
9:02 a.m. – 11:17 a.m. EST
Virtual Meeting

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)
Henish Bhansali, MD, FACP (Independent Consultant)
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)
Joshua M. Liao, MD, MSc (National Associate Vice President of Clinical Transformation, Ascension)
Walter Lin, MD, MBA (Chief Executive Officer, Generation Clinical Partners)
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

Soujanya R. Pulluru, MD, PTAC Co-Chair (President, CP Advisory Services, and Co-Founder, My Precious Genes)
Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)

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: Addressing Challenges to Advance Multi-Payer Alignment**

   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

   Handouts

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

[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 members and members of the public to the second day of the February 23-24 public meeting. He explained that, during the first day of the public meeting, experts shared their perspectives on opportunities to improve multi-payer alignment in value-based care. Co-Chair Mills then reviewed the agenda for the day, noting that the final session of the public meeting will focus on addressing challenges to advance multi-payer alignment.

Co-Chair Mills indicated that a public comment period would be held later in the morning. Public comments are limited to three minutes each. Participants must register to provide a public comment. He stated that the meeting would conclude with Committee members' discussion of comments and recommendations for a report to the Secretary of Health and Human Services (HHS).

Co-Chair Mills invited Committee members to introduce themselves and their experience with multi-payer alignment in value-based care. Following Committee member introductions, he noted that background materials for the public meeting are posted on the ASPE PTAC website. He explained that the Committee is prepared to receive proposals on possible innovative approaches and solutions related to care delivery, payment, or other policy issues. Additional information about submitting proposals can be found on the ASPE PTAC website.

Co-Chair Mills shared that the Committee is producing a series of Issue Briefs that summarize the latest information related to value-based care topics that the Committee members and experts have explored during public meetings. To date, six Issue Briefs and highlights from PTAC's 2020 through 2025 theme-based discussions have been posted on the ASPE PTAC website. The Committee plans to publish new Issue Briefs on additional topics soon.

Session 4: Addressing Challenges to Advance Multi-Payer Alignment

- 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

Lindsay Botsford moderated the session with four subject matter experts (SMEs) on challenges to advance multi-payer alignment. Full biographies and presentations are available.

Ben Kornitzer presented on addressing challenges to advance multi-payer alignment.

- Dr. Kornitzer shared his experience working within Accountable Care Organization (ACO) and clinically integrated network (CIN) models.
- Dr. Kornitzer acknowledged that the current health care system is not delivering the care that patients expect or deserve. He highlighted that 40% of consumers delay receiving care due to costs. He also noted that 88% of physicians would prefer more time to spend with patients who have complex needs rather than spend time on administrative tasks. Employers face challenges finding a balance between ensuring that employees receive high-quality care and managing predicted spending increases.
- Dr. Kornitzer outlined the difference between fee-for-service (FFS) and value-based care. He noted that FFS is driven by volume, while value-based care is driven by quality and value. Additionally, FFS is reactive and focused on episodic care, while value-based care is provided more proactively and preventively. He explained that a patient's downstream health care utilization can be better managed when their provider considers their relationship as ongoing and long-term rather than transactional. Dr. Kornitzer reflected on providers' relationships with health plans, where FFS arrangements dictate transactional relationships, and value-based care arrangements support a collaborative team-based relationship.
- Dr. Kornitzer highlighted barriers to value-based care model adoption. First, models are often fragmented by the type of coverage a patient has, which is particularly challenging for primary care providers (PCPs) who treat patients with multiple coverage types. Second, participants in value-based care models, particularly smaller practices, may face operational complexity and burden. Third, data interoperability and data sharing are needed to support collaborative care across practices (e.g., health information exchanges [HIEs], aligned ACO networks). Fourth, practices require financial stability to invest in long-term primary care models. Last, a large number of collaborative providers are needed to achieve outcomes.
- Dr. Kornitzer described how Aetna addresses barriers to value-based care model adoption. First, Aetna strives to deliver timely data (e.g., readmissions, medication adherence) to providers to support patient management. Second, Aetna establishes a high-quality provider network that is successful in collaborative value-based care arrangements. Third, Aetna identifies evidence-based solutions that improve care for patients.

For additional details on Dr. Kornitzer's presentation, see the presentation slides (pages 2-9), transcript, and meeting recording (9:13-21:37).

Vivek Garg presented approaches to address challenges with advancing multi-payer alignment in Medicare Advantage (MA).

- Dr. Garg described his experience with building the clinical programs at One Medical and Oscar Health. He also served as Chief Medical Officer (CMO) in national value-based care groups, including CareMore and CenterWell.
- Dr. Garg highlighted that the design of the health care system is a core challenge to advance multi-payer alignment. The design includes various programs that incentivize different quality and outcomes across different levels of health care.
- Dr. Garg explained that the National Committee for Quality Assurance (NCQA) is an independent organization that works to define and drive health care quality through accreditation standards, performance measurement, and expert support. Currently, over 200 million people are covered by health plans that report Healthcare Effectiveness Data and Information Set (HEDIS) quality measurement, and approximately 70% of Americans are enrolled in an NCQA-accredited health plan. Nearly 60,000 clinicians work across more than 11,000 practices that are accredited or recognized by NCQA programs.
- Dr. Garg described several issues associated with MA participation in value-based care.
    - Providers and health plans lack trust and transparency in data. For example, clinicians are unsure which patients are attributed to them because health plans share data on varying timelines and with different degrees of completeness. Data-related issues can result in clinicians being held accountable for outcomes without sufficient time to make an impact.
    - There is misalignment between the party that is financially accountable and the party that controls costs. For example, clinicians and medical groups under risk-sharing agreements may be accountable for costs that they cannot meaningfully influence (e.g., out-of-network leakage, specialty care visits, prescription drugs, transportation).
    - Despite uniformity enforced by the Medicare Star Ratings framework, MA contract terms vary widely across structures, performance metrics and incentives, and reporting requirements.
    - The health care system makes it difficult to identify a provider's success in value-based care arrangements that are tailored to each payer.
- Dr. Garg discussed three opportunities to address the gap in MA participation in value-based care:
    - Strengthening investments in primary care can help align payment models with primary care capabilities. For example, countries that spend over 10% of health care expenditures on primary care achieve improved population health outcomes.
    - Quality and outcome measures used for the same patient population should be harmonized across payers. For example, a core digital measure set with specified clinical areas (e.g., prevention, clinical outcomes, patient-reported outcomes) can be used across MA and ACO programs. Measure reporting should be supported by a standardized data exchange that leverages established national contracts such as United States Core Data for Interoperability (USCDI) or Fast Healthcare Interoperability Resources (FHIR) interoperability standards.
    - Policy can standardize peer-provider alignment under delegated risk, which will help clarify ownership of risk, unify the data standards, and make clinical policy and guidelines more consistent.
- Dr. Garg illustrated the differences in domains and measures across three major value-based care programs for older adults: traditional Medicare, MA, and the ACO REACH Model. The MA Star Ratings program emphasizes experience, function, plan operations, and clinical outcomes, while the Medicare Shared Savings Program has a narrower focus on clinical and utilization

outcomes. In contrast, the ACO REACH Model prioritizes a smaller subset of outcome and utilization measures. The variation results in providers focusing on and investing in different areas of interest for the same patient population. The variability creates noise, which is compounded by different levels of data quality, timeliness, and incentive frameworks.

- Dr. Garg underscored the need to establish a shared, standardized measurement framework. He highlighted New York's State Innovation Model (SIM), which standardized primary care initiatives into a single framework to set a consistent set of expectations, supports, and transformation standards across plans and practices. The model also aligned incentives across Medicaid and commercial plans, leveraged the NCQA Patient-Centered Medical Home program, and established a statewide data exchange. He noted that implementation of the model still allowed for regional variation.
- Dr. Garg presented three areas in which NCQA is focused on advancing alignment:
    - Transitioning to digital quality measurement reporting that uses established standardized structures to reduce burden;
    - Developing measure cohesion and alignment, such as through revised HEDIS measures that focus on specific populations and work across programs and timeframes; and
    - Strengthening primary care to align incentives across payers on a set of uniform quality and outcome measures.

For additional details on Dr. Garg's presentation, see the presentation slides (pages 10-20), transcript, and meeting recording (21:37-33:24).

Emily Transue presented multi-payer alignment efforts from a Medicaid perspective.

- Dr. Transue described her previous experience as a Medical Director at Washington State Health Care Authority (HCA) during implementation of Washington's Multi-Payer Collaborative (MPC) and the Primary Care Transformation Initiative (PCTI).
- Dr. Transue shared that the Washington MPC was enacted in 2019 and included Medicaid managed care organizations, commercial payers, and PCP representatives. Provider perspectives represented different geographic locations, urbanicity, and payer mix. The MPC developed two memoranda of understanding (MOUs) to establish the general principles and structures of the collaboration. One MOU was updated and renewed in 2024 to continue ongoing efforts of the MPC. Signatories agreed to adhere to the alternative payment policies for primary care that the group developed and agreed to use the Washington Primary Care Practice Recognition Program to inform their provider partnerships and contracting strategies.
- Dr. Transue outlined the components of the Washington PCTI. Participation included both payers and providers. Payers committed to aligning payment and incentives and increasing financing in primary care measured as a percentage of spend. Providers committed to increasing capacity and access and applying actionable analytics across clinical, financial, and social domains to support integrated whole-person primary care. The goal of PCTI was to develop aligned measurement of value that incorporated the Triple Aim in outcome measures.
- Dr. Transue discussed several potential solutions to address challenges in multi-payer alignment initiatives.
    - Alignment approaches: Health care systems face risk when attempting to implement new alignment strategies that interfere with existing alignment procedures, such as implementing a state-based data platform that does not align with a national platform. It is critical to be aware of the larger picture and consider the impacts of new alignment measures.

- Quality measure identification: The Washington Common Measure Set was an existing statewide quality measure set legislatively mandated in 2014. The measure set aimed to reduce reporting burden. A multi-stakeholder group, the Performance Measures Coordinating Committee, maintains the measure set.
  - Alignment to Medicare: The use of the Centers for Medicare & Medicaid Services (CMS) Universal Foundation measures can facilitate multi-payer alignment efforts to establish a commonly accepted small set of measures. Alignment with Medicare measures creates efficiencies for national payers and multi-payer initiatives that can increase adoption and justify investments.
  - Having a neutral convener: Dr. Transue quoted Stephen Covey, highlighting that, "change happens at the speed of trust." Discussions should be held with a neutral convener and occur both within and between stakeholder groups to support trust building and avoid certain hazards such as noncompliance with antitrust regulations.
  - Addressing unstated assumptions: It is important to ensure that all stakeholders in multi-payer initiatives understand the goals, objectives, and levers used in the model. For example, the intent to increase overall finances rather than redistribute finances across provider areas should be communicated.
  - Incentives: To support the time and resources required to participate in multi-payer alignment efforts, both incentives and risks to participate should be considered. Models should be self-sustaining and reward all participants.
  - Social risk adjustment: Risk adjustment is critical to equity and helps avoid penalizing providers who care for populations with complex needs. Risk adjustment should account for social risk in Medicaid and other populations, such as programs for individuals who are undocumented.
- Dr. Transue outlined challenges that should be acknowledged and prioritized, including attribution methodology, data platforms and reporting, risk adjustment, quality measures, and identification of the services and providers that should be included and excluded in multi-payer alignment initiatives. Dr. Transue recommended that states consider building on existing programs and identifying essential components that lead to success.
- Dr. Transue summarized the lessons learned in Washington. She recommended developing a global alignment structure outside of specific models; progressing at the speed of trust; being explicit with the principles, assumptions, and goals of an initiative; convening stakeholders both within and across groups; considering both positive and negative incentives for participation; utilizing social risk adjustment for specific patient populations; using existing systems and infrastructures; and prioritizing what is most important.

For additional details on Dr. Transue's presentation, see the [presentation slides] (pages 21-38), transcript, and [meeting recording] (33:24-49:38).

Rushika Fernandopulle presented lessons learned from Iora Health's experience with achieving multi-payer alignment in value-based care.

- Dr. Fernandopulle explained that he created Renaissance Health to address issues in the primary care model, including the model's focus on transactions instead of patient-provider relationships. Renaissance Health improved patient care and lowered costs compared with the traditional primary care practice model. Furthermore, he demonstrated this model to Boeing, which helped it gain public interest. He established Iora Health in 2011, which merged with One Medical in 2021, and was sold to Amazon in 2023.

- Dr. Fernandopulle outlined four P's of change: payment, process, platform, and people. He noted that correct payment is necessary to fund models.
- Dr. Fernandopulle explained the original structure of the primary care model established in 2004. The model shifted from treating a single patient and billing for services rendered to caring for a population of people with a team of providers, including community-residing health coaches, health care providers, and social workers.
- Dr. Fernandopulle discussed the creation of Chirp, a care coordination collaboration platform. Chirp better supported the way that the care team managed its patient population relative to the existing electronic health record (EHR) system, which was developed for the FFS billing system.
- Dr. Fernandopulle summarized the payment approaches used over time across his primary care model locations. First, primary care case rates were used in an independent primary care practice, where patients paid a monthly standard fee based on income. As the model grew, agreements were negotiated with payers and large self-insured employers that added bonus structures and shared savings to the monthly case rate payment model. The model expanded to include full upside and downside risk-sharing agreements with Medicare. The practices invested 10% to 15% in primary care, which reduced hospitalization and emergency department (ED) visit rates and decreased total cost of care (TCOC).
- Dr. Fernandopulle highlighted that the care model expanded to 49 practices in eight different markets. Iora Health participated in ACO-based CMS Innovation Center models such as the ACO REACH Model, where it realized the highest estimated net savings rate (approximately 22%) of any participating ACO. He believes that the CMS Innovation Center's determination for expanding a demonstration to full implementation is flawed because it is based on the average outcome across all participants. Participants are varied in their approaches, and not all participants are successful. He recommended that only successful participants should continue through the demonstration period.
- Dr. Fernandopulle explained that Iora Health succeeded because it did not try to optimize FFS and value-based care models at the same time. Instead, Iora Health transitioned all patient care to a value-based care model. He cautioned that it is a mistake for the industry to move slowly toward value-based care models.
- Dr. Fernandopulle acknowledged that the evolution of Iora Health's model started with establishing an anchor location. Other employers and payers were then added to the model, which allowed the growth needed to serve multiple populations.
- Dr. Fernandopulle noted that Iora Health achieved multi-payer alignment by establishing partnerships rather than viewing participants as short-term vendors. With partners, Iora Health established long-term contracts that were initially three years in length but evolved into five-year and 10-year agreements.
- Dr. Fernandopulle underscored the importance of providers rather than payers determining payment mechanisms. Accepting one form of payment simplifies payment arrangements.
- Dr. Fernandopulle summarized key considerations for multi-payer alignment in value-based care. First, transforming practices is necessary to achieve value-based care and outcomes. Second, the largest barrier to accomplishing multi-payer value-based care is commercial payer participation. Third, he recommended standardizing models on payment, risk adjustment, quality frameworks, and reporting expectations. Lastly, he noted that government oversight is needed to reduce concerns related to antitrust laws.

For additional details on Dr. Fernandopulle's presentation, see the [presentation slides] (pages 39-51), transcript, and [meeting recording] (49:38-1:04:26).

Following the presentations, Committee members asked questions of the experts. For more details on this discussion, see the transcript and [meeting recording] (1:04:26-1:37:54).

Experts discussed recommendations to reduce the nationwide fragmentation of data infrastructure.

- Rebuilding the health care system should begin with consumers and primary care. Coordination is needed between primary care and other health care settings. This coordination requires data; however, current information blocking policies inhibit data sharing. Information blocking occurs because many health IT companies believe that they own patient data; however, patients own their health data. Although efforts are underway to solve this problem in the U.S., many patients do not trust the platforms. Policies such as the 21st Century Cures Act, the Office of the National Coordinator for Health Information Technology (ONC)'s Cures Act Final Rule, and Trusted Exchange Framework and Common Agreement (TEFCA) are helping progress this effort.
- NCQA has invested in the digitization of quality measurement and will continue to focus on data quality issues. Because meaningful clinical decisions rely on data beyond claims data, interoperability is needed across various health data types. To restructure data to align with FHIR guidance, plans and health systems will need to make large financial, skill set, and infrastructure investments; however, many plans and health systems cannot afford to make these investments.
- One expert emphasized the need to exchange social data. Community-based organizations should be involved in discussions on improving data sharing systems.

Dr. Garg discussed the measure development timeframe from identification of the metric to its incorporation into EHRs.

- It is important to work toward shortening the length of time required to develop new measures while still maintaining scientific and feasibility testing integrity. External forces also impact the timeline, including the CMS consensus process. Medical professional societies should be included in discussions on measure development.

Experts discussed strategies to better engage commercial payers' participation in developing new standardized value-based care payment policies.

- It is important to first identify information considered proprietary by commercial payers before asking specific questions about payer programs to determine topics open for discussion in a group setting.
- The patient should be at the center of care delivery discussions, where information is generally not proprietary. Quality measures and data interoperability platforms should be standardized to remove proprietary frameworks and permit collaboration. Long-term relationships between payers and providers should be established to further promote collaboration.

Experts discussed how to include specialists in full-risk value-based care arrangements.

- In value-based care models, PCPs serve as the patient's partner in selecting specialists. It is problematic when models are structured in ways that make primary care providers responsible for stakeholders other than the patient (e.g., hospital systems, payers). The model framework must focus on allowing the PCP to help patients navigate the health care system. PCPs can then focus on building a network of specialists who have strong performance metric data. The agreements can also incentivize specialists' participation, such as by transferring certain activities (e.g., pre-operative care instructions, follow-up visits) from the specialist to the primary care physician. Specialists can also be hired on retainers.

- A significant gap in trust exists between payers and providers. It is important to identify how the two parties can support each other. For example, physicians can help payers identify provider incentives to improve care.
- In the absence of alignment between payers and providers on meaningful clinical outcomes, and without data sharing capabilities, people are required to rely on claims data and measure costs to evaluate outcomes. This approach will not drastically improve population health.
- One expert emphasized that selecting specialists for value-based contracts requires the existence of different independent specialists in a geographic area. Some areas do not have a variety of specialists.

Experts discussed adaptations made to value-based care arrangements for rural populations.

- There are fundamental differences in the way care is provided in a rural versus urban setting that impact the ability to establish rural value-based care contracts. For example, it may not be possible to identify a gastroenterologist with high performance ratings if there is only one gastroenterologist within a 500-mile radius. The lack of competition can break down contracting mechanisms because the mechanisms used to control costs depend on the capacity to negotiate participation. It can also be challenging to establish aggressive performance expectations used in urban settings because, for example, rural providers face challenges with maintaining financial stability and having patients return for follow-up visits. These challenges necessitate less strict rules for participation. Additionally, performance should focus on metrics such as maintaining access to care or provider retention.
- Health care is local. It is important to customize arrangements and not over-specify alignment. For example, communities differ in their expectations for health care, disease burden, provider landscape, and logistics. For rural areas, it is important to ensure that telemedicine and home visits are covered. Additional work is needed to solve provider shortages in rural communities.
- NCQA has created a managed care and care delivery program called Health Outcomes Accreditation. Many states are adopting the program for Medicaid managed care plans to create a baseline of stratified data by demographics. The baseline data allow for the development of improvement plans to target identified gaps, particularly in rural areas.
- One expert recommended permanently implementing the telehealth provisions, given the need to meet patients where they are in an increasingly diverse population.

Experts discussed the current landscape of value-based care, including progress toward full-scale implementation of value-based care.

- To support a timeline for implementing changes in the system and infrastructure, one expert recommended using a road-to-risk model—a model that increases risk over time. He described an example of a three-year road-to-risk model. In the first year, a primary care capitation payment would be provided without upside or downside risk. In the second year, the organization might have 25% upside risk with no downside risk. In the third year, the organization might have 50% upside and downside risk. By the fourth year, the organization would be operating at full risk. These models can provide clear expectations for future risk-sharing agreements.
- The threshold to make a full switch to a value-based care arrangement is different for a provider versus payer. The pathway to risk-sharing agreements can help providers choose value-based care arrangements. Payers can then establish different agreements with providers based on their

current capacity to take on risk, which will differ. Establishing capitated rates from the beginning is beneficial for providers; however, it is important to be specific about how capitated rates are paid.
- The primary outcome in health care is whether patients receive better care. Value-based care is a powerful tool that can be used to align people to that outcome. It is important to reframe the mindset of financial agreements from a zero-sum game to a more trustworthy dynamic. The focus should be on establishing partnerships between payers and providers that leverage the strengths of each party to produce better outcomes together. This partnership may require payers to offer data or analytic support to providers that help achieve outcomes.
- One expert noted the importance of engaging commercial insurers to increase the implementation of value-based care arrangements.

Public Comment Period

Co-Chair Mills opened the floor for public comments. No public comments were provided.

Committee Discussion

Co-Chair Mills 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 (0:00-26:47).

- Extending telehealth provisions would help improve value and meet patients where they are.
- A neutral convener, such as a state entity, neutral party, or the federal government, is important in multi-payer alignment initiatives.
- Trust between payers and providers, particularly among those with long-term relationships, is critical to multi-payer alignment initiatives.
- Use of both positive and negative incentives can accelerate progress.
- It is important to consider social risk adjustment, particularly in Medicaid populations.
- There are opportunities to build on what already exists in the system as opposed to inventing and trying new approaches.
- Efforts should be made to simplify what exists in the current system.
- There are alternative ways of evaluating CMS Innovation Center models and innovations. Instead of focusing on average performance, examining the top performers could shed light on models that may be successful.
- Issues related to information blocking and data asymmetries should be addressed to improve data sharing.
- There is a need to align models across Medicare and commercial payers.
- Financial stability is important in multi-payer alignment initiatives. There is a need to understand how to adequately provide up-front incentives that meaningfully impact transformation.
- Data interoperability is critical in multi-payer alignment efforts.
- The speed at which change can occur depends on trust building. Conveners can facilitate trust building.
- There are opportunities to harmonize and streamline a common set of quality measures.
- CMS can help bring stakeholders together.
- In multi-payer initiatives, efforts should be made to create transparency, build trust, and set clear goals.
- There is substantial variability within MA. Innovation and creativity should not be stifled in MA, but standardized processes are needed for MA payers. For example, data sharing should be

standardized in MA. Additionally, risk-bearing entities should understand who the attributable population is early so that the population can be managed.

- The commercial sector has low penetration in value-based care. Leadership from CMS and the CMS Innovation Center can help to improve value-based care options for the commercial sector.
- Consistency is key in multi-payer alignment efforts. Instead of continuing to create new approaches that require providers to change directions, CMS should consider providing consistent leadership and guidance in a single direction.
- Commitment from CMS is key in multi-payer alignment efforts as these efforts are not successful if there is a lack of commitment from leading organizations.
- It is important to recognize the success of providers' business models. Doing so will promote collaboration.
- There are opportunities to better define the role of conveners in multi-payer alignment initiatives. CMS has indicated that participants must be providers. However, there may be opportunities for entities that do not provide care to serve as conveners.
- One Committee member contrasted incremental change with rapid adoption among payers and providers in multi-payer alignment efforts. The speed at which change is implemented depends on trust, including trust in incentives and data. There are opportunities to identify additional ways to support and build trust among providers. The Committee member inquired whether PTAC could serve in a convening role to bring together different stakeholders to help build trust and instill more confidence in providers.
- Multi-payer alignment requires change to occur longitudinally. Infrastructure must be in place for a long time for the system to shift.
- Trust building and investment are important to achieve shared outcomes and value propositions.
- Neutral conveners are necessary to improve the system.
- Social risk adjustments or other local context adjustments should be considered to drive long-term change.
- One Committee member explained the importance of simplifying metrics. There may be opportunities for CMS and policymakers to better align measure sets, such as Star Ratings in MA.
- It is important to include MA in multi-payer alignment efforts to achieve a critical mass and drive change in the health care system and providers.
- One Committee member indicated that once basic capacities are built, change occurs quickly rather than incrementally. Additional consideration is needed to understand the elements that indicate that a provider is approaching a tipping point for rapid change.
- Primary care serves as the anchor for multi-payer alignment. Sustained investment in primary care to support team-based care and the creation of longitudinal relationships with patients will reduce utilization and improve outcomes.
- Data are key to success in multi-payer alignment. Timely, interoperable clinical and social needs data are required for providers to deliver proactive care.
- There is a need to harmonize quality measures and performance incentives. A parsimonious measure set and a transition to digital quality measurement are critical to reducing administrative burden and sending consistent signals to providers across payers, including Medicare, Medicaid, and commercial plans.
- One Committee member emphasized the importance of payment design. A pathway from case rate payments to full risk contracts that include risk adjustment, including social risk adjustment, can help providers make the necessary investments to transform care.
- Trust and durable partnerships between payers and providers are essential to multi-payer alignment.

- There are opportunities to improve transparency on specialist quality. This transparency can guide specialist referrals, improve care coordination, and protect patients from low-value or harmful care. One Committee member described the potential utility of a CMS-developed, specialty-level performance data list for PCPs to use to identify local high-value and low-value specialists. Using claims data and other sources, CMS could identify key metrics for specialist performance. Such a list would help primary care practices reliably build high-value referrals without compromising access and equity.
- Multi-payer alignment may not require uniformity. Flexibility is needed in product design, benefit structure, and network configurations. Variation in quality metrics, attribution methods, risk adjustment methods, and reporting cadences creates challenges for clinicians and organizations that are already operating across Medicare, Medicaid, and commercial lines. In multi-payer alignment initiatives, standardization and flexibility are on a continuum. PTAC and policymakers have opportunities to calibrate the continuum. Variation in some elements is necessary to preserve product integrity, provide the public with choice, and meet statutory requirements. However, variation in other elements due to issues such as competitive signaling can be reduced. Components of payment models are inherently complex; harmonizing certain elements, such as attribution, risk adjustment, risk corridors, and spending adjustments, may not be possible. Standardization should be considered when it is possible.
- Multi-payer alignment requires financial investment. Payments and incentives are important signals in health care. Shared expectations without financial consequences or accountability may not drive durable change. There has been disproportionate leadership and focus from CMS in multi-payer alignment efforts, while other segments, such as commercial payers, trail in scale and financial commitment. There are opportunities to consider how to make more comparable financial commitments across payers.
- One Committee member described an alternative way of thinking about alignment. There are opportunities to consider coherence as a step along the way toward exact alignment. While exact alignment could serve as the ideal form of alignment, coherence—consistent signals, harmonized core elements, and deconflicting operations—could serve as an intermediate, pragmatic, and durable step in the process. This alternative way of thinking about alignment could address the risk of paralysis in the face of complexity. The Committee member indicated that coherence can help build the conditions under which deeper alignment is feasible.

Closing Remarks

Co-Chair Mills adjourned the meeting.

The public meeting adjourned at 11:17 a.m. EST.

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

5/18/2026

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Date

//Terry Mills//

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

5/12/2026

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Date