Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

February 23, 2026
9:30 a.m. – 4:50 p.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)
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)
David C. Tyson, MA (Senior Director, Policy & Regulatory Affairs, Public Affairs & Government Relations, Novant Health)

PTAC Members in Partial Attendance

Lindsay K. Botsford, MD, MBA (Market Medical Director, One Medical)
Krishna Ramachandran, MBA, MS (Chief Information Officer, UnitedHealth Group)

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)

Department of Health and Human Services (HHS) Guest Speaker

Amy Turner, JD (Deputy Director for Policy, Innovation Center, Centers for Medicare & Medicaid Services [CMS])

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. **PCDT Presentation: Improving Multi-Payer Alignment in Value-Based Care**

   Joshua Liao, MD, MSc, Preliminary Comments Development Team (PCDT) Lead

   Handouts

   - Public Meeting Agenda
   - PCDT Presentation Slides
   - Environmental Scan on Improving Multi-Payer Alignment in Value-Based Care

2. **Session 1: Perspectives on Multi-Payer Alignment Across Programs Within Medicare**

   Nicholas Minter, MPP, Deputy Director, Seamless Care Models Group, CMS Innovation Center
   Dana Rye, MBA, MPP, President, Value-Based Care, Duly Health and Care
   Karthik Rao, MD, Chief Medical Officer, agilon health
   Michael Chernew, PhD, Professor of Health Care Policy and Director, Healthcare Markets and Regulation Lab, Harvard Medical School

   Handouts

   - Expert Biographies
   - Session 1 Presentation Slides
   - Session 1 Discussion Guide

3. **Session 2: Lessons Learned from State Value-Based Care Models That Have Implemented Multi-Payer Alignment: Part 1**

   Katie Wunderlich, MPP, Principal, KKW Consulting
   Joseph DeMattos, MA, Senior Vice President Public Affairs, Marquis Health Consulting Services
   Ena Backus, MPP, Senior Consultant, Freedman Healthcare
   Carrie Weigand, MD, Chief Medical Officer, OneCare Vermont
   Tom Borys, MBA, Chief Executive Officer and Chief Financial Officer, OneCare Vermont

   Handouts

   - Expert Biographies
   - Session 2 Presentation Slides
   - Session 2 Discussion Guide

4. **Session 3: Lessons Learned from State Value-Based Care Models That Have Implemented Multi-Payer Alignment: Part 2**

   Janice Walters, MSHA, Chief Executive Officer, Rural Health Redesign Center
   John Bulger, DO, MBA, Chief Medical Officer, Geisinger Health Plan
   Dawn Stehle, DrPH, MPS, Director, Early Childhood Systems, Policy, and Planning, ZERO TO THREE
   Alicia M. Berkemeyer, Executive Vice President and Chief Health Management Officer, Arkansas Blue Cross and Blue Shield

   Handouts

   - Expert Biographies

- Session 3 Presentation Slides
- Session 3 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 Update

Lee Mills, PTAC Co-Chair, welcomed the Committee members and members of the public to the February 23-24 public meeting. He stated that the Committee members have been exploring themes that have emerged from stakeholder-submitted proposals. Previous PTAC theme-based discussions have focused on topics such as reducing barriers to participation in Alternative Payment Models (APMs) and supporting primary and specialty care transformation. Co-Chair Mills explained that the Committee has convened subject matter experts (SMEs) to gain perspectives on Improving Multi-Payer Alignment in Value-Based Care, a topic of interest to the Center for Medicare & Medicaid Innovation (CMS Innovation Center). He introduced Amy Turner, the Deputy Director for Policy at the CMS Innovation Center, who provided the opening remarks.

Ms. Turner described the progress that the CMS Innovation Center has made in promoting value-based care since Abe Sutton, the Director of the CMS Innovation Center and the Deputy Administrator of the Centers for Medicare & Medicaid Services (CMS), provided the opening remarks during the last PTAC public meeting in September 2025. During the public meeting in September 2025, Mr. Sutton described three strategic pillars in the Innovation Center's Strategic Direction: promoting evidence-based prevention, empowering people to achieve their health goals, and driving choice and competition. These three pillars are built on the foundational principle of protecting taxpayer funds.

Ms. Turner explained that nine new models were launched in 2025, and a 10th model will be launched within the next two months. Four of the recently launched models are focused on drug pricing. These models include the Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model, the Global Benchmark for Efficient Drug Pricing (GLOBE) Model, the Guarding U.S. Medicare Against Rising Drug Costs (GUARD) Model, and the GENErating cost Reductions fOr U.S. Medicaid (GENEROUS) Model. These four models are focused on reducing costs in Medicare and Medicaid and can support multi-payer alignment efforts because the models set principles that payers can follow.

Ms. Turner described several additional models that have launched since September 2025. The Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model leverages technology-supported care to improve care delivery and reduce costs for individuals with original Medicare. The ACCESS Model uses outcome-aligned payments (OAPs), where the payments are tied to outcomes. She shared that CMS recently announced that payers representing 165 million Americans with Medicare Advantage (MA), Medicaid, and private health insurance had adopted an OAP structure aligned with the ACCESS Model.

Ms. Turner explained that the Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence (MAHA ELEVATE) Model is focused on addressing chronic diseases. Through the MAHA ELEVATE Model, the CMS Innovation Center will fund individuals with

interdisciplinary backgrounds to innovate and test interventions designed to slow or prevent chronic diseases. The Long-term Enhanced ACO Design (LEAD) Model aims to integrate Medicare and Medicaid services and work with states to develop a framework for Accountable Care Organization (ACO)-Medicaid partnership arrangements. Ms. Turner concluded that she expects the announcement of approximately the same number of models in 2026 as the number of models announced in 2025.

Co-Chair Mills provided an overview of the agenda for the public meeting. The public meeting will explore a range of topics related to multi-payer alignment in value-based care. The goals of the public meeting are to identify practical steps, lessons learned, and innovative approaches that CMS and other stakeholders can apply to advance and operationalize multi-payer value-based care models. Background materials for the public meeting can be found on the ASPE PTAC website.

Co-Chair Mills noted that a public comment period will be included during the second day of the public meeting. Public comments are limited to three minutes each. Participants must register to provide a public comment.

Co-Chair Mills explained that the discussions, materials, and public comments from the public meeting will inform a report to the Secretary of Health and Human Services (HHS) on improving multi-payer alignment in value-based care. He explained that the Committee members may consider four stakeholder responses it received in response to a Request for Input on improving multi-payer alignment in value-based care. Co-Chair Mills explained that 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. Additional information about submitting proposals is available 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.

Co-Chair Mills invited Committee members to introduce themselves and their experience with multi-payer alignment in value-based care. Following Committee member introductions, Co-Chair Mills shared that four Committee members served on the Preliminary Comments Development Team (PCDT): Joshua Liao (Lead), Lindsay Botsford, Lauran Hardin, and Lee Mills. He introduced Dr. Liao, who presented the PCDT's findings from the background materials.

PCDT Presentation: Improving Multi-Payer Alignment in Value-Based Care

Dr. Liao delivered the PCDT presentation. For additional details, please see the presentation slides, transcript, and meeting recording (21:33-49:00).

- Dr. Liao shared the objectives of the February theme-based discussion: identify successful approaches and solutions for overcoming barriers to multi-payer alignment in value-based care; determine concrete, short-run steps toward achieving multi-payer alignment; and describe long-term aspirational goals for multi-payer alignment and how the goals could be accomplished.
- Dr. Liao explained that PTAC has received 36 proposals for physician-focused payment models (PFPMs), including 28 proposals that PTAC has deliberated during public meetings. Fourteen of the 28 proposals included potential approaches to multi-payer alignment.

- Dr. Liao presented PTAC's working definition of multi-payer alignment, which will evolve as the Committee collects additional information from stakeholders. Multi-payer alignment is defined as, "Agreement among payer programs and products—including those offered through Traditional Medicare, Medicare Advantage, Medicaid Fee-For-Service, Medicaid Managed Care, commercial insurers, and employers—on model alignment areas necessary to promote value-based care. Model alignment areas include but are not limited to goals and strategies, care delivery, financial incentives, quality measures, and data sharing."
- Dr. Liao provided the rationale for multi-payer alignment. Value-based care can help improve population health and reduce spending growth. However, the health care financing landscape remains a mix of fee-for-service (FFS) and value-based care, and value-based care implementation varies by program and payer. Multi-payer alignment can address these issues.
- Dr. Liao described potential benefits of multi-payer alignment. Collaboration and alignment between providers and payers can help serve a wide range of patients by providing strong care pathways for disease prevention and management; allowing time to focus efforts on care transformation; promoting data sharing and informed clinical decisions; lowering costs for investing in capabilities to improve care; and reducing administrative burden and costs.
- Dr. Liao explained different dimensions of multi-payer alignment, including the type, extent, and degree of alignment.
    - The type of multi-payer alignment can include alignment within payers and alignment across payers.
    - The extent of multi-payer alignment can include the number of programs or payers involved, level of payer involvement (e.g., number of staff involved, length of time a payer is engaged), and geographic spread of payers' patient populations.
    - The degree of multi-payer alignment can include exact alignment (i.e., agreement on specific details of model alignment areas) and directional alignment (i.e., agreement on general model alignment areas but can vary on specific details).
- Dr. Liao described a conceptual diagram for multi-payer alignment. To shift from FFS to value-based care, payers and other stakeholders must be involved in multi-payer efforts. Collaboration between payers and other stakeholders impacts factors that influence multi-payer alignment, such as market circumstances and payer competition and trust. There are technical aspects of model design to consider when aligning across payers, including goals and strategies; care delivery approaches; payment methodology and financial incentives; quality and performance measures and reporting; attribution, benchmarking, and risk adjustment methods; and data interoperability and sharing.
- Dr. Liao explained that successful multi-payer alignment models typically include the following components:
    - Broad representation of stakeholders, including payers, providers, purchasers, patients, and state agencies, in collaborative design, implementation, and evaluation of multi-payer models;
    - A governing body to oversee a model's activities and promote transparency and accountability;
    - A trusted facilitator or convener, such as a state agency, to align competing interests, manage expectations, and facilitate collaboration among payers;
    - Measurable goals to monitor progress and ensure stakeholder engagement;
    - Technical assistance for states and payers to support engagement and establish and meet shared goals;

    - Consideration of the characteristics and needs of different patient populations and providers;
    - A common payment model with standardized rates to enhance payer transparency and reduce provider burden;
    - Flexibility in structuring payments to accommodate different payer and provider needs;
    - Performance and quality measure alignment to establish a single set of expectations among payers, improve monitoring, and reduce administrative burden for providers;
    - Alignment of attribution, benchmarking, and risk adjustment methods to decrease administrative burden and increase the effectiveness of financial incentives; and
    - Use of Health Information Exchanges (HIEs) to facilitate data access across payers.
- Dr. Liao described challenges with aligning multiple payers.
    - Payers may have different goals for payment models. Exact alignment on all model areas may be difficult to achieve due to differing payer patient populations and organizational priorities. Directional alignment can allow participants to align but tailor care delivery approaches within a payment model to provide flexibility. In these cases, exact alignment on attribution, benchmarking, and risk adjustment may not be feasible.
    - Payers and providers may encounter financial and technical barriers. Individual payers and providers typically bear the responsibility for developing solutions for data sharing. Payers' measure sets may be proprietary, inhibiting broad use. Existing billing systems may be difficult to adapt across payers and require up-front investments. Workforce shortages and churn can make it challenging for providers to navigate the process of combining payments from different payer sources in multi-payer initiatives.
    - Regions with competitive market conditions may have lower payer collaboration due to payers' lack of trust and concerns about competitive advantage.
    - Commercial payers may find it impractical to customize a model for a small market area (e.g., a single state).
    - A payer's willingness to participate may be influenced by its market share. Payers with a dominant market presence may be more likely to steer decision-making, while payers without a dominant presence may be less likely to benefit from improvements.
    - Federal antitrust laws can restrict collaboration among health care payers to set specific prices and payment levels. The Anti-Kickback Statute and Stark Law prevent health care referrals from involving kickbacks or financial benefit to providers, potentially impeding coordination in value-based care models.
- Dr. Liao described current and previous CMS-led, multi-state, multi-payer initiatives. The programs encompass primary care, state-based transformation collaboratives, and innovation models. Medicare, Medicaid, and commercial payer participants have participated in these models. Lessons learned include the importance of having neutral conveners, a governing body, and data aggregation. Additionally, lessons learned indicate that collaboration and trust building can take time but are critical to the success of multi-payer alignment initiatives. Outcomes are influenced by specific market, community, and patient population factors.
- Dr. Liao described current and previous state-based, multi-payer initiatives. Although many states have engaged in multi-payer initiatives, the presentation focused on nine states that have performed substantial work implementing multi-payer models or initiatives: Arkansas, California, Colorado, Maryland, Minnesota, Pennsylvania, Rhode Island, Vermont, and Washington. The state-based initiatives have engaged many different payer participants. Lessons learned include the importance of having stakeholder buy-in and engagement, reaching stakeholder consensus, and simplifying the design process to allow stakeholders to engage and create partnerships. Barriers to alignment have included a lack of clear goals, market conditions that create a

competitive environment between plans, and technical challenges such as predicting global budgets.
- Dr. Liao concluded the presentation by reviewing the focus areas of the PTAC public meeting: perspectives on multi-payer alignment across programs within Medicare; lessons learned from state value-based care models that have implemented multi-payer alignment; and addressing challenges to advance multi-payer alignment.

Co-Chair Mills invited Committee members to ask questions about the PCDT presentation. Committee members discussed the following topics. For more details on the discussion, see the transcript and meeting recording (49:00-53:21).

- One Committee member expressed interest in learning SMEs' recommendations on how to facilitate culture change among payers, delivery systems, and communities to encourage the transition from FFS to value-based care.
- Perspectives from individuals in health care leadership roles, such as Chief Executive Officers (CEOs) and Chief Financial Officers (CFOs), have indicated that commercial payer involvement is necessary to achieve a sufficient volume of patients and revenue that is needed to transition from FFS to value-based care.
- One Committee member noted interest in learning SMEs' perspectives on whether participation in multi-payer alignment initiatives will need to be mandated to successfully transition from FFS to value-based care.

Session 1: Perspectives on Multi-Payer Alignment Across Programs Within Medicare

SMEs

- Nicholas Minter, MPP, Deputy Director, Seamless Care Models Group, CMS Innovation Center
- Dana Rye, MBA, MPP, President, Value-Based Care, Duly Health and Care
- Karthik Rao, MD, Chief Medical Officer, agilon health
- Michael Chernew, PhD, Professor of Health Care Policy and Director, Healthcare Markets and Regulation Lab, Harvard Medical School

Henish Bhansali moderated the session with four SMEs on perspectives on multi-payer alignment across programs within Medicare. Full biographies and presentations are available.

Nicholas Minter presented perspectives on multi-payer alignment across programs in Medicare.

- Mr. Minter introduced himself and his role at the CMS Innovation Center where he leads the ACO, MA, kidney health, and prescription drug portfolio. He previously led the primary care portfolio.
- Mr. Minter provided the CMS Innovation Center's definition of multi-payer alignment, which refers to the coordination and collaboration among health insurance payers to meet common goals and patient outcomes, such as improving quality and reducing administrative burden. This definition acknowledges that CMS cannot drive changes alone, especially provider-driven changes, as Medicare patients may not represent the majority of a provider's patient panel.
- CMS' key goals for multi-payer alignment are better care coordination and other practice-level interventions for all patients, regardless of payer. Mr. Minter surmises that goals for multi-payer alignment among other payers vary but may include better outcomes and lower cost of care.
- Goals of multi-payer alignment vary by model but typically focus on aligning across three areas:
    - Quality measures to reduce provider administrative burden;

    - Payment to strengthen incentives for achieving goals (e.g., aligned incentives on care coordination); and
    - Data to help providers understand what drives patient outcomes.
- Mr. Minter explained that the end goals of multi-payer alignment are to lower costs and achieve better outcomes. Intermediate goals are to reduce administrative burden and increase provider engagement. When there are different incentives and signals across the payer landscape, it is difficult for providers to implement the changes that lead to better patient outcomes. Multi-payer alignment allows providers to focus on patients rather than managing different incentives.
- Mr. Minter described several current CMS Innovation Center models that incorporated multi-payer alignment, including the:
    - ACO Primary Care Flex (ACO PC Flex) Model, which aligns with the Medicare Shared Savings Program and other payers;
    - Enhancing Oncology Model (EOM), which drives better coordination of care among private payers;
    - Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model, which focuses on global budgets across Medicare and Medicaid to achieve better preventive care;
    - ACCESS Model, which provides access to technology-enabled services across payers to better address chronic care issues; and
    - LEAD Model, a forthcoming ACO model that will work closely with states to align Medicare and Medicaid.
- Prior models that tested multi-payer alignment included Comprehensive Primary Care Plus (CPC+) and Primary Care First (PCF).
    - CPC+ was a five-year model (2017–2021) with two cohorts that offered payment in addition to FFS payments for care coordination in primary care clinics and family medicine. The model also included a small performance-based payment approach. At model start, 63 payers across 18 states and regions signed up to provide similar support in learning, payment, and data to participating practices. Over 3,000 practices were enrolled in the model.
    - PCF, the successor model to CPC+, was a five-year model (2021–2025) that included a partial up-front payment, a capitated payment for primary care, and upside and downside risk. At model start, the model included 1,700 practices across 26 states and regions and 17 aligned payers.
- Mr. Minter shared key takeaways from the CMS Innovation Center's experience implementing multi-payer alignment.
    - Discussion among payers is often stymied by antitrust regulations and concerns with talking to competitors. CMS' involvement can have a tangible impact. In CPC+, collaboration that began during the model has continued to this day, demonstrating the role CMS can play in moving the conversation forward.
    - Multi-payer alignment enhances support for behavioral change. Providers are more excited and willing to participate in models that reduce friction across payers.
    - Medicare FFS accounts for approximately 20% to 40% of a provider's revenue, leaving, on average, 66% of revenue from other payers that may not align similarly with traditional Medicare. Providers appreciate alignment in data, learning, and resources.
    - It is difficult to drive behavioral change without a substantial number of payers that align similarly on model design. In PCF and CPC+, some providers felt that even with multiple payers supporting them, there was not enough momentum to make changes at

the practice level. Additionally, providers felt it was too disruptive to differentiate care at the patient level. This led to some practices leaving the models.
    - Defining multi-payer alignment in each model helps payers and providers. The definition could include having payers be equal partners that contribute equal dollars per patient. In previous models, the CMS Innovation Center defined multi-payer alignment this way, where it aimed to have payers provide equitable support over time. However, this goal was not achieved. For example, throughout CPC+, CMS' financial support was higher, on average, compared with payer partners. In addition, in CPC+, model payments made by other payers were available to non-CPC+ practices. This created confusion among provider participants as they did not receive additional payments from all payers. Providers could either offer additional care coordination and services to CMS patients or use CMS' payments to subsidize practice-wide care transformation for patients who were covered by payers other than Medicare FFS at a lower level.
    - The limited scope of the CMS Innovation Center's models creates administrative fragmentation, particularly for larger Medicare Advantage organizations (MAOs) and national payers. In PCF, six payers left the model due to administrative burden, inability to meet infrastructure requirements, and the slow return on investment (ROI). Particularly for national programs, organizations are focused on driving change at scale. Multi-payer alignment is difficult to achieve when the population is broad, services are numerous, and ROI is slow and uncertain.
- Mr. Minter explained that the CMS Innovation Center is considering how to incorporate these lessons learned for future changes, including in MA and condition-specific populations.
    - MA has eclipsed Medicare FFS over time in terms of the number of beneficiaries covered. CMS would like to increase value-based care and reduce the burden on providers participating in multiple models, including MA. There is friction in areas such as real-time patient outcomes from electronic health records (EHRs) and Star Ratings.
    - Primary care models are characterized by prevention, which has a slow ROI across a broad population. However, there are providers and populations that are at higher risk for acute care issues. The CMS Innovation Center believes it can make a difference in this area, for example, by averting end-stage renal disease (ESRD) and hospital visits among the population with chronic kidney disease (CKD), saving money for Medicare and other payers.

For additional details on Mr. Minter's presentation, see the presentation slides (pages 2-10), transcript, and meeting recording (0:00-17:50).

Dana Rye presented on improving multi-payer alignment in value-based care.

- Ms. Rye explained that Duly Health and Care is the largest independent, multi-specialty provider in the country. Duly Health and Care's value-based care business encompasses over 400,000 patients across payers and risk arrangements. Duly Health and Care is an integrated delivery system (IDS) with 1,800 clinicians, 190 locations, and ancillary services. It serves 1.2 million patients.
- Duly Health and Care places primary care at the center of its model and keeps most office-based professional services in-house because of its multidisciplinary footprint.
- Ms. Rye described the foundation of Duly Health and Care's IDS. She explained that Duly Health and Care's value-based care model wraps services around the physician-patient relationship to ensure that patients receive needed support between physician appointments. Examples of how the value-based care model supports patients include:

    - In-clinic care management teams;
    - The Duly at Home program, which allows a patient to meet with their provider via telehealth while a certified paramedic meets with the patient in-person; and
    - Programs that coordinate hospitalizations, readmissions, post-acute care, and specialty care through primary care.
- Ms. Rye presented results of Duly Health and Care's value-based care program, including the percentage of hospital follow-up visits, orthopedic procedures performed in an ambulatory surgical center (ASC) rather than a hospital setting, and reduced hospitalizations among medically complex patients in the Care Ally program, a Duly care management program.
- Duly Health and Care participates in a range of MA and original Medicare programs, including the ACO REACH Model and the Medicare Shared Savings Program. Duly Health and Care has approximately the same number of patients in MA and original Medicare, allowing for comparisons across populations. Internal programs are deployed consistently across both populations. Duly Health and Care has observed better outcomes in MA compared with original Medicare, such as fewer hospitalizations (35% higher for original Medicare) and readmissions (14% higher for original Medicare), despite similar levels of acuity in both populations. There are three main reasons for these differences:
    - Attribution and the strength of the primary care provider (PCP) relationship: More MA patients have a Duly Health and Care PCP and engage with their PCP more often compared with ACO REACH patients. When there is an aligned Duly Health and Care PCP, outcomes are better, including admissions, readmissions, and emergency room visits. This is observed across payers but is particularly pronounced in original Medicare due to stricter and more formulaic attribution compared with MA and more frequent PCP visits among MA patients.
    - Data accessibility: MA provides more robust and timely data compared with the ACO REACH Model or the Medicare Shared Savings Program. Third-party companies sell these data for original Medicare, but it is expensive and not comprehensive.
    - Supplemental programs: MA plans are incentivized to improve outcomes and lower costs. The use of tools including utilization management and prior authorizations are examples of why Duly Health and Care spent less on skin substitute in MA compared with the ACO REACH population. MA plans offer programs that may supplement Duly Health and Care's internal approach, such as care management and wellness programs, as well as utilization management, which can help avoid wasteful, low-value spending when deployed appropriately.

For additional details on Ms. Rye's presentation, see the presentation slides (pages 11-21), transcript, and meeting recording (17:50-28:27).

Karthik Rao presented agilon health's Total Care Model and lessons learned to align payers.

- Dr. Rao noted that agilon health's mission is to be the trusted, long-term partner of community-based physicians, enabling them to reimagine the care experience for seniors and transform care delivery in their communities. agilon health's Total Care Model focuses on three pillars:
    - Partnership: agilon health works collaboratively with its partners and community-based groups. These partnerships include long-term joint ventures for full risk, multi-payer Medicare lines of business. Forming these partnerships helps align economics with outcomes.
    - Platform: A purpose-built platform for Medicare, across all lines of business, takes disparate data (e.g., claims, electronic medical record [EMR], admission-discharge-

transfer [ADT]) to create patient-level profiles and drive point-of-care insights to improve quality.
    - Network: agilon health has 3,000 physicians who care for 500,000 lives who are all full risk. Innovations and best practices are shared across the network.
- Dr. Rao shared that agilon health is in 28 markets across 12 states. Of the 500,000 lives, 400,000 are in MA full risk, and 100,000 are in the ACO REACH Model. agilon health works with several types of community-based groups, including community-based health systems, multi-specialty groups, large independent practice associations (IPAs), and single taxpayer identification numbers (TINs), creating unique opportunities and challenges.
- agilon health aims to create a single Medicare experience for providers and patients. Dr. Rao described how agilon health has helped community-based groups address challenges, including challenges related to:
    - disparate MA plan contracts with different parameters for success, which can create operational challenges;
    - providing point-of-care insights that support providers in making decisions for patients when data are constrained and providers are operating against different metrics; and
    - reporting against performance when there are many metrics and contracts in place.
- Dr. Rao described potential solutions to these challenges. First, through partnerships with groups, agilon health has created a single line of business for senior lives without differentiating between plans or CMS full risk programs but instead focusing on the right thing for the patient. Second, agilon health has put effort into making sure each patient has a complete dataset that integrates claims, EMR, and ADT data. Third, agilon health has constructed a care model to perform against a set of metrics and outcomes that optimize quality of care and reduce unnecessary care, delivering insights to PCPs at the point of care.
- Dr. Rao shared that the care model consists of a single line of Medicare business with standardized quality metrics and insights delivered at the point of care. agilon health's care model is built on a patient-centered lens to identify opportunities to improve quality of care and reduce spend that does not contribute to better outcomes. The organization applies this approach in several ways:
    - agilon health uses algorithms to risk stratify patients to understand the population and create and match patients to purposeful interventions. The organization makes significant investments in core capabilities to optimize these activities.
    - There are five conditions for seniors that agilon health manages proactively through clinical pathways: congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), dementia, CKD/ESRD, and diabetes. These conditions are highly prevalent, have significant care gaps, and are complex to treat. agilon health employs pharmacists who aid in closing care gaps across these conditions and help find alternatives for patients who have concerns about cost. agilon health has observed positive outcomes, such as increasing guideline-directed therapy rates on three- and four-drug regimens in CHF and reducing admissions and readmissions.
    - agilon health focuses on burden of illness and quality, episodes of care, and high-spend specialties.
- Dr. Rao described agilon health's results. Regarding quality, agilon health has consistently performed above four Stars since 2020, performs 76% above the Medicare FFS average for annual wellness visits received, and has better PCP-to-specialist visit ratios relative to comparison groups. Additionally, readmissions, hospital admissions, and emergency department (ED) visits are all lower than FFS benchmarks.

- Dr. Rao described lessons learned from agilon health's experience with multi-payer alignment. The meaning of full risk in MA can differ by plan, creating complexity and making each plan feel like its own program. Lessons learned cover three main areas:
    - Attribution: Timing of data varies by plan. Some payers share data in January, allowing proactive engagement with patients, while other payers do not provide attribution data until April or May, creating delays for patient engagement and putting contracts at risk.
    - Data asymmetry: Data received from the ACO REACH Model have been timely and complete, while data received from MA plans have been variable (e.g., incomplete claims and risk adjustment datasets, inconsistent data structures).
    - Measuring success: There is variation across MA plans, the Medicare Shared Savings Program, and ACO REACH in quality metrics, their thresholds, and how incentives are paid. This variation creates complexity in contract management, care delivery, and contract performance.
- There are opportunities to improve clarity when defining full risk by stakeholders, whether in data requirements, attribution, or quality metrics. Clarity can create consistency, reduce administrative burden, and allow for a focus on care delivery and physician education.

For additional details on Dr. Rao's presentation, see the presentation slides (pages 22-32), transcript, and meeting recording (28:27-42:15).

Michael Chernew presented on the alignment of programs within Medicare.

- Dr. Chernew stated that his presentation contains his personal views and does not necessarily reflect the views of any organization he is affiliated with, including the Medicare Payment Advisory Commission (MedPAC).
- Dr. Chernew noted that it is difficult to succeed when physicians face varying incentives and requirements from different lines of business, such as traditional Medicare, MA, and value-based care. ACOs can play an important role as conveners in harmonizing multi-payer alignment efforts.
- Dr. Chernew shared that it is easier to align programs when there are fewer programs to align. It is difficult to align population-based health payments, episode payments, MA programs, and other programs.
- There are several alignment areas that can help achieve population-based health, including:
    - Quality measures;
    - Data requirements, which would benefit from CMS modernizing data and data flows;
    - Risk adjustment, which would benefit from overhaul and alignment across similar programs;
    - Attribution, as it is difficult to succeed in a model without knowing who is in the model; and
    - Financial incentives, which should help providers succeed financially for doing the right thing.
- Dr. Chernew described challenges to achieving multi-payer alignment.
    - Programs have different scopes. For example, population-based total cost of care (TCOC) programs for groups that take full risk, such as ACOs and MA plans, differ from episode-based models.
    - There are inherent attribution differences between ACOs and MA. The attribution of patients to MA plans works well; however, the attribution of MA plans to practices varies and is outside of CMS' direct purview. It is important to understand how to align

the attribution methods used for ACOs with the attribution methods used for other models.
    - Challenges can arise when TCOC payments are provided to a delivery system while the delivery system's physicians are still rewarded on a FFS basis.
    - Legacy information technology (IT) systems can create barriers to aligning quality and risk across payers.
    - Alignment requires some degree of standardization, and many organizations do not want to align. Alignment can limit individual innovation on certain model design elements, such as attribution or quality measures. However, more standardization is needed to reduce administrative burden.
- From delivering higher quality and lower-cost care, different APMs provide savings—such as shared savings—to different organizations. These savings are split between organizations. It is important to consider which organizations will receive savings, as this will affect incentives to save and participate in models. APMs should default to population-based models (e.g., TCOC models) with synergistic models (e.g., episode models) added, as applicable. It is difficult to build population-based features into the FFS environment and to align with more direct population-based management programs. This approach can become administratively burdensome and too complex to operate.
- Dr. Chernew closed by reiterating that it is easier to align programs if there are fewer programs. He advised having a general vision and implementing that vision in an aligned way rather than launching many separate programs to address different issues. Ideally, population-based models should have a holistic view that combines different issues.

For additional details on Dr. Chernew's presentation, see the presentation slides (pages 33-42), transcript, and meeting recording (42:15-54:54).

Following the presentations, Committee members asked questions of the experts. For more details on this discussion, see the transcript and meeting recording (54:54-1:30:14).

Ms. Rye described insights gained from the care management infrastructure at Duly Health and Care, including the diversity of staff roles.

- Ensuring that the additive services are well integrated and lead to positive outcomes requires a tremendous amount of coordination. Duly Health and Care has invested in back engines such as data, processes, and the team. It is challenging for smaller organizations to invest in aggregating programs to these levels. It is beneficial to have organizations such as agilon health provide support to smaller organizations.

Experts discussed the benefits of MA in terms of attribution, relationships, and data sharing. Experts also shared whether future multi-payer alignment efforts coordinated by CMS might include weaving MA into programs and streamlining metrics, policies, and philosophy.

- There is great heterogeneity in MA plans. In the top quartile of MA plans that one organization works with, the organization consistently observes standard data requirements such as timely attribution and benefits that align with the organization's view on beneficial care. These standard data requirements enable the organization to focus on patient care with less administrative burden. Lessons learned on what works well should be considered from both MA and the ACO REACH Model. Outdated technology is a common challenge, particularly for small, regional MA plans.

- The CMS Innovation Center has learned that without solving alignment issues, it is difficult to help practices reach the tipping point for behavioral change in how they administer care. CMS regulates systems for MA and FFS, but inertia and incentives make it difficult to achieve change. CMS should consider having fewer pieces of the puzzle and designing those pieces more strategically so they are clearer when viewed together.
- On average, MA is lower-cost and comparable or slightly better quality compared with FFS. However, there is great heterogeneity in MA. There continues to be a need to improve the FFS system and make it as efficient as possible because MA plans use FFS benchmarks.
- Some people prefer to not deal with the challenges of MA, such as legacy systems and attribution. Providing MA plans with the flexibility to innovate limits harmonization. Therefore, improving and harmonizing within the FFS system in areas such as attribution, quality measures, population health incentives, and risk adjustment are important first steps in the process. CMS can then consider exploring alignment with MA and other payers, including Medicaid.

Mr. Minter reflected on how CMS can create uniform quality metrics within MA products and between Medicare patients to minimize provider burden and variability in care delivery.

- Quality is a building block for alignment. CMS should consider combining quality systems between traditional Medicare and MA, which provides large quality bonus payments. CMS will need to consider how to balance the way MA measures quality and distributes payments and address traditional Medicare Star Ratings measures that may potentially focus on the wrong measures. CMS has experience with modifying Star Ratings, such as in the 2015 Enhanced Medication Therapy Management (MTM) Model. CMS can use this experience as a blueprint to aid in improving the quality system.

Dr. Rao discussed whether agilon health has observed a reduction in or the elimination of differences in outcomes between MA and ACO REACH given the organization's focus on creating a single Medicare experience for physicians and patients.

- Although the differences in outcomes have been reduced since agilon health began with the FFS full risk population, there is still a difference between FFS full risk lives and MA full risk lives for reasons such as persisting relationships with PCPs, which drives behavior change. Despite their limitations, utilization management and prior authorization have value.

Experts discussed pragmatic ways to increase standardization and reduce heterogeneity without losing innovation.

- It is important to determine the parameters of standardization needed to promote healthy competition for better quality care. Variation can be removed by having:
    - Common parameters for attribution to reduce administrative burden;
    - Clear care model goals to inform program design and prioritization; and
    - Data requirements, standardization, and exchange to reduce time and effort spent managing different data formats and create interoperability within different data systems.
- In an MA-oriented, competition-driven environment, the lack of coordination is expected and even desired to some extent. One approach to solve this problem includes identifying the most egregious problems and how CMS might prevent them, such as standardizing the data needed for prior authorization. There is also variation in how MA plans prefer to manage patient engagement and referrals. Independent of this, the broader delivery system context includes the integration of the primary care workforce with large health systems and the integration of the primary care workforce with large carriers, including MA plans. There may be advantages to

having an intermediate structure that harmonizes different incentives for providers. It is important to simplify critical decisions that large health systems and organizations must make (e.g., deciding which payment models to participate in); hold delivery systems accountable for clinical and economic outcomes; and focus on removing the most egregious problems, such as attribution, to limit problems caused by the lack of harmonization.
- Standardizing quality measures is challenging but can be overcome with the right data. Without the right data in the right formats with the right components, it is difficult to make operations seamless for providers at the point of care. Standardizing data requirements should be done before standardizing quality measures.
- There is a spectrum of competitive ability and product flexibility that can turn into administrative noise if not tuned properly. It is important to find the right balance.

Ms. Rye and Dr. Rao discussed the percentage of Duly Health and Care's and agilon health's total revenue that is derived from risk-based, value-based care.

- Ms. Rye shared that the percentage is equal at Duly Health and Care.
- Dr. Rao explained that the percentage is between 95% and 98% at agilon health. All of agilon health's lives are full risk, global capitation. The percentage of revenue within each provider group that is derived from risk-based, value-based care is approximately equal.

Experts discussed specialists' participation in models, including whether incentives can encourage specialists to participate.

- If model participation is mandatory, more people will be involved. Some larger organizations should be required to participate, but it is difficult to make participation mandatory for smaller organizations. If programs are designed better, there will be more participation.
- It is important to be cognizant about how changes in FFS impact participation in other models. There is an interesting question about the extent to which hospitals and some specialists need to participate versus simply be influenced by the primary care group. For example, as a hospital, it is difficult to keep people out of the hospital. It is not necessarily bad to have risk borne by independent primary care groups that can engage hospitals.
- Current model changes within the CMS Innovation Center have potential for success. One expert recommended that CMS resist the urge to add new components when progress is made. Recommendations to consider include eliminating the Merit-based Incentive Payment System (MIPS), transforming the Star Ratings program, improving attribution and risk adjustment methods, and allowing the system to practice in a stable environment with models that last beyond a few years.

Session 2: Lessons Learned from State Value-Based Care Models That Have Implemented Multi-Payer Alignment: Part 1

SMEs

- Katie Wunderlich, MPP, Principal, KKW Consulting
- Joseph DeMattos, MA, Senior Vice President Public Affairs, Marquis Health Consulting Services
- Ena Backus, MPP, Senior Consultant, Freedman Healthcare
- Carrie Weigand, MD, Chief Medical Officer, OneCare Vermont
- Tom Borys, MBA, Chief Executive Officer and Chief Financial Officer, OneCare Vermont

Ms. Hardin moderated the session with five SMEs on lessons learned from state value-based care models that have implemented multi-payer alignment. Full biographies and presentations are available.

Katie Wunderlich presented on advancing multi-payer alignment in TCOC models and lessons learned from the Maryland TCOC Model.

- Ms. Wunderlich outlined three learning objectives: identifying strategies used in Maryland's TCOC Model to facilitate multi-payer alignment, examining how those strategies strengthened the model, and considering how these lessons can inform future CMS value-based care models.
- Ms. Wunderlich provided an overview of Maryland's TCOC Model, which operated from 2019 to 2025, and followed the Maryland All-Payer Model (2014–2018). She noted that Maryland reduced TCOC and unnecessary utilization, enhanced primary care, and coordinated statewide population health interventions. The model met or exceeded its contractual goals and transitioned into participation in the AHEAD Model. Although the CMS contract focused on Medicare-specific metrics, she emphasized that success depended on alignment with Medicaid and commercial payers, which strengthened statewide transformation. She then outlined four major strategies Maryland used to support multi-payer alignment and engagement:
    - First, Ms. Wunderlich highlighted the importance of using existing infrastructure. Maryland built on its long history as an all-payer state and leveraged existing care delivery and payment platforms, long-standing regulatory structures that supported payer alignment, and the state-designated HIE, which enabled data sharing, care coordination, and risk stratification.
    - Second, she discussed developing an inclusive governance structure. CMS Innovation Center models require ongoing workgroup governance with multi-sector representation—payers, providers, health systems, state agencies, and community organizations—to ensure transparent and adaptable methodology. Maryland combined a high-level governor's stakeholder group with ongoing, multi-payer, multi-provider workgroups that developed payment and delivery models and addressed real-world operational challenges.
    - Third, she emphasized generating buy-in through strategic, early, and ongoing engagement with providers and payers. Engagement strengthened model stability, reduced fragmentation, and supported consistent quality and financial targets. As examples, she noted that the Maryland Primary Care Program aligned Medicare and CareFirst initiatives, and a bundled payment program for specialists was developed using episode groupers that supported alignment with private payers.
    - Fourth, Ms. Wunderlich stressed the importance of identifying statewide or regional shared priorities, which increases feasibility and long-term success. She highlighted the Statewide Integrated Health Improvement Strategy as an example, which brought payers and partners together to address diabetes management and control as a key driver of cost and quality.
- Ms. Wunderlich summarized why multi-payer alignment matters, noting that it reduces administrative burden for providers, creates consistent incentives, strengthens provider participation, enables broader population impact, and supports the long-term sustainability of value-based care.
- Ms. Wunderlich closed with several key takeaways from Maryland's experience with multi-payer alignment, including the importance of clear and shared goals across payers, standardized quality and performance metrics, transparent data exchange and reporting, transparent quality and financial methodologies, strong state or regional conveners, and early and frequent provider engagement.

For additional details on Ms. Wunderlich's presentation, see the presentation slides (pages 2-11), transcript, and meeting recording (0:00-16:47).

Joseph DeMattos presented on bending the chronic disease curve and lessons from Maryland's experience supporting post-acute and long-term care providers under the TCOC Model.

- Mr. DeMattos noted that he was speaking from his experience as President and CEO of the Health Facilities Association of Maryland, representing the state's skilled nursing, rehabilitation, senior living, and assisted living providers.
- Mr. DeMattos outlined Maryland's skilled nursing landscape, explaining that the state has 226 skilled nursing facilities (SNFs) supported by a workforce of roughly 72,000, making these facilities major employers.
- Mr. DeMattos noted that because Maryland does not have long-term acute care hospitals, the state's skilled nursing and rehabilitation centers have provided higher-level post-acute care for nearly 40 years; he emphasized that this long-standing capacity was essential to supporting hospitals under the TCOC contract.
- Mr. DeMattos described the burden of chronic disease and noted that physician-led models, such as the primary care model under Maryland's TCOC model, aim to provide cost-effective, clinically efficient management. He stated that Maryland's efforts have shown measurable improvement, but emphasized that significant challenges remain in reducing incidence and cost growth.
- Mr. DeMattos highlighted that Maryland's population is aging more quickly than the national average and that prediabetes is prevalent across the state.
- Mr. DeMattos emphasized the severity of the workforce crisis, noting long-standing shortages across clinical and direct-care occupations. He explained that growth in the nursing workforce is constrained by limited numbers of nurse educators and added that medical schools receive tens of thousands of applications for only a few hundred slots.
- Mr. DeMattos described longstanding financing challenges in federal programs, noting that Medicare requires significant reform and that the nation lacks a comprehensive long-term care financing system. He explained that long-term care is largely funded through Medicaid, often requiring individuals to spend down assets, and that, despite a population of more than 300 million people, the country has only about 15,000 nursing homes and just over one million beds.
- Mr. DeMattos stressed that collaboration and shared goals are essential, noting that people, providers, payers, and families all seek predictability in care, which depends on aligning financial and clinical priorities across stakeholders.
- Mr. DeMattos emphasized the value of long-standing relationships among state leaders, hospitals, SNFs, and other partners, noting that regular collaboration created trust and enabled candid conversations that helped stakeholders reach meaningful agreement.
- Mr. DeMattos stated that advancing multi-payer alignment requires establishing clear, shared parameters for quality, cost, utilization, and outcomes. He emphasized shifting from transactional upstream-and-downstream vendor-like relationships to long-term, strategic partnerships across a unified continuum.
- Mr. DeMattos highlighted innovations in chronic disease management across the post-acute sector, including physician-led programs for conditions such as CHF, pulmonary disease, and diabetes. He noted that only a small number of providers have implemented Institutional Special Needs Plans (iSNPs) due to regulatory and capital requirements. He then described the growing use of artificial intelligence (AI) to assess risk and match patients to appropriate clinical pathways, with opportunities to expand AI across the continuum of care.
- Mr. DeMattos concluded that stakeholders must act as true partners at the intersection of quality and cost by committing in advance to shared opportunities and risk and collaboratively defining success, including metrics, financial accountability, and reinvestment strategies.

For additional details on Mr. DeMattos' presentation, see the presentation slides (pages 12-27), transcript, and meeting recording (16:47-32:50).

Ena Backus presented on cultivating multi-payer alignment through Vermont's All-Payer ACO Model Agreement.

- Drawing on her prior roles as Vermont's Director of Health Care Reform and Chief of Health Policy at the Green Mountain Care Board, Ms. Backus described how the state worked with the CMS Innovation Center to negotiate and implement the All-Payer ACO Model Agreement, a statewide transition to value-based care.
- Ms. Backus opened with a high-level overview of the All-Payer ACO Model Agreement, developed alongside Vermont's State Innovation Model (SIM) initiative. Vermont followed Maryland in pursuing a state-specific alternative payment arrangement. She described four structural pillars of the agreement: shifting away from FFS reimbursement, aligning payer programs for ACOs, setting ambitious scale targets to ensure sufficient attributed lives, and establishing all-payer and Medicare TCOC growth targets. Vermont committed to an all-payer per-capita growth rate of 3.5% (with a 4.3% ceiling) and to keeping Medicare spending slightly below projected national growth. The model also included population health goals focused on expanding access to primary care, reducing deaths from drug overdose and suicide, and reducing the prevalence and morbidity of chronic conditions such as COPD, diabetes, and hypertension.
- Ms. Backus explained that Vermont's SIM grant provided the foundational groundwork for entering the All-Payer ACO Model Agreement by funding an extensive system of workgroups that tested value-based payment models; convened payers, providers, community organizations, and state officials; and developed aligned structures for ACO governance, payment methodology, shared savings, attribution, financial stability provisions, and cross-payer quality and performance measures. She noted that SIM also supported care coordination, practice transformation, regional infrastructure, EHR adoption, data standardization, and analytics capacity, and that the standards first developed for Vermont's Shared Savings Program—aligned across Medicaid, commercial payers, and Medicare—ultimately served as the springboard for the state's ACO model.
- Ms. Backus explained that Vermont developed standards for governance, payment methodology, attribution, financial provisions, and quality and performance metrics. She noted that this work was convened, supervised, and supported by the state, with contracted assistance funded through the SIM grant. Commercial payers, providers, and the Medicaid program all participated in creating the aligned standards, which enabled the state to pursue its All-Payer ACO Model Agreement.
- Ms. Backus then highlighted opportunities and challenges encountered during implementation of the All-Payer ACO Model. She noted that regular stakeholder participation funded by the SIM initiative initially fostered shared understanding, collaboration, and joint problem-solving, but these structures were not sustained. Key challenges included stakeholder dependability on FFS; inconsistent stakeholder participation and difficulty meeting scale targets; scope creep, as the model was expected to address broader system issues; and patient perception, as many residents could not discern how the reforms affected their care. She noted that the model nonetheless produced many opportunities and positive outcomes, including Medicare savings, quality gains, strong participation, a successful primary care model, improved data analytics capacity, and better access to appropriate levels of care supported by waivers.

- Ms. Backus concluded that sustaining all-payer or multi-payer reform requires continued focus on alignment, dedicated workgroup time, and strong state supervision to sustain stakeholder engagement.

For additional details on Ms. Backus' presentation, see the presentation slides (pages 28-36), transcript, and meeting recording (32:50-50:15).

Carrie Weigand and Tom Borys presented lessons learned from Vermont's experience with multi-payer alignment.

- Mr. Borys explained that OneCare Vermont is an administrative entity that manages multiple ACO contracts on behalf of provider organizations. Formed in 2012, it simultaneously managed Medicare, Medicaid, and commercial arrangements across Vermont and part of New Hampshire. The Vermont All-Payer ACO Model served a test of scale, examining whether broad regional ACO participation could slow cost growth and improve quality. OneCare operated as a "come-one-come-all" ACO to support the model's scale targets. OneCare was not a signatory on the Vermont All-Payer ACO Model Agreement. OneCare is now winding down after completing 2025 operations.
- Mr. Borys stated that multi-payer alignment is beneficial because it gives providers a holistic, patient-centered paradigm instead of an insurance-centered one. With alignment, collaboration across providers increases, and pilots and innovations become feasible. OneCare designed and operated a blended monthly fixed payment for primary care that combined Medicare, Medicaid, and commercial revenue. The model simplified revenue management for practices and was successful in Vermont's context. The model also allowed funding to be redirected within the system.
- Mr. Borys emphasized the value of a centralized contracting entity. Without such an entity, each payer must contract separately with each provider, creating a burdensome matrix. Placing OneCare between payers and providers—one upstream contract per payer and one downstream contract per provider—streamlined network growth and spared small and rural providers from extensive administrative negotiations.
- Mr. Borys outlined several challenges. The work requires substantial administrative effort that should not fall on small practices. Willingness to commit, invest, innovate, and collaborate is needed, supported by an appropriate funding model. Broad buy-in from payers, providers, regulators, and state government is essential, sometimes requiring a policy push to bring all participants to the table. He added that consistency and stability are critical, as constant change hinders progress, and noted that OneCare maintained multi-year priorities (e.g., hypertension control) to stay focused.
- Dr. Weigand summarized lessons from OneCare's experience. First, gaining alignment is effortful. Progress was real, but the ideal state was not reached, and it takes time, trust, consistent relationships, and an appreciation that stakeholders have different motivations. Second, attribution should be simplified and run in the background so busy clinicians are not checking who is included. Third, data and analytics require clear governance—ownership, access, and funding—and are costly. Fourth, oversight matters; leaders should understand operations, support the model, and bring health care experience.
- Dr. Weigand highlighted that the model produced benefits in alignment, efficiency, and innovation. Providers across sectors—including Visiting Nurse Associations (VNAs), mental health agencies, Area Agencies on Aging (AAAs), primary care (including independent, hospital-owned, and Federally Qualified Health Centers [FQHCs]), the Department of Health, and Medicaid—collaborated more over time. She noted that payer buy-in varied, but Vermont Medicaid

participated throughout. She added that patient confidence lagged, and more education is needed to help residents understand the reforms. Alignment across payers on quality metrics supported progress in diabetes control, hypertension control, and preventive visits. She reported gains in efficiency through shared data and analytics, consolidated quality efforts, and unified payment streams. As alignment and efficiency improved, the model created room for innovation, including waiver projects such as the 3-day SNF waiver—used for more than 300 patients and estimated to save at least $2 million—and refinement of the population health model.

For additional details on Dr. Weigand and Mr. Borys' presentation, see the presentation slides (pages 37-45), transcript, and meeting recording (50:15-1:10:07).

Following the presentations, Committee members asked questions of the experts. For more details on this discussion, see the transcript and meeting recording (1:10:07-1:31:04).

Experts discussed how multi-payer alignment efforts could accelerate trust-building and move stakeholders more quickly toward meaningful collaboration.

- A policy-level push can help bring hesitant organizations off the fence and into alignment efforts. Early participants sometimes joined with reservations, but trust grew over time as intentions became clear and organizations experienced the model firsthand.
- Vermont's post-single-payer environment made payers and providers more willing to work together. Consistent, frequent, structured stakeholder meetings built shared understanding and accountability. Progress had to be visible each week. When that intensity diminished, trust weakened.
- Consistent transparency, including during challenges, is central to trust-building. Transparent communication prevents stakeholders from feeling that decisions are being made without them.
- One expert recommended combining regular formal and informal conversations to maintain trust. Although transparency is critical, sometimes sensitive issues are best discussed privately to avoid derailing group progress. The expert emphasized being data-driven and approaching discussions through shared interests, not positional stances, to accelerate alignment and collaboration.

Experts discussed how data ownership should be addressed in multi-payer alignment models.

- Questions of data ownership and data-sharing authority must be addressed through a clear governance structure. Centralized data entities—such as all-payer claims databases (APCDs) or HIEs—can be funded through broader mechanisms so that providers without resources to build their own systems can still participate. Understanding who can share data, who owns them, and how access is managed is essential.
- In an ACO environment, organizations receive substantial data and must determine how to use the data effectively. In Vermont, the ACO became the de facto data aggregator because it held contracts with multiple payers. Data governance is complex and resource-intensive, especially when determining appropriate access for participants and establishing care relationships when multiple providers may have legitimate access needs. A more comprehensive shared data infrastructure beyond the ACO level, such as a state HIE, could better support consistent and governed data access.
- When models aim to monitor total cost and quality performance across entire populations, data must extend beyond attributed patients. Different models may route claims or other data to different entities, creating challenges in integrating payer data with other data sources. It is

important to have a broad, coordinated source of data capable of supporting population-level analysis and program operations.

Experts discussed strategies to maintain full involvement of payers and providers throughout the process.

- The pre-implementation phase involved frequent meetings with the state actively supervising the work. During implementation, the state stepped back under a provider-led approach, leaving day-to-day engagement to providers. A key lesson is that a more consistent state presence throughout the model would have been helpful.
- More support from the state, as a cheerleader, and requiring ongoing weekly meetings and alignment would have been helpful. Requiring participation and engagement would have contributed to more success.
- One expert highlighted challenges with Vermont's All-Payer ACO Model. The model was a test of scale, relying on attribution, which misses people. The model should instead have been built around a critical mass of committed provider participants.

Experts discussed the types of investments needed to sustain regional convening and an ongoing integrator role.

- Engaging providers required meaningful financial investment. Sustaining that investment was difficult because it relied heavily on funding from hospitals, whose worsening financial position made ongoing support increasingly difficult to maintain.
- One expert emphasized the importance of declaring a long-term commitment to process and outcome change, regardless of the framework. He described the evolution of Maryland's experience over many years. The expert also discussed the challenges related to regulatory mismatches in post-acute care, which create structural barriers to providing care.
- States have a significant opportunity to support the integrator role by using Medicaid's Implementation Advance Planning Document (IAPD) process to fund integrated data models and data interoperability. When Medicaid participates in an all-payer model, states can draw down the 90–10 federal match to build and sustain better data infrastructure, which is a major funding pathway to strengthen ongoing regionalization and convening efforts.

Session 3: Lessons Learned from State Value-Based Care Models That Have Implemented Multi-Payer Alignment: Part 2

- Janice Walters, MSHA, Chief Executive Officer, Rural Health Redesign Center
- John Bulger, DO, MBA, Chief Medical Officer, Geisinger Health Plan
- Dawn Stehle, DrPH, MPS, Director, Early Childhood Systems, Policy, and Planning, ZERO TO THREE
- Alicia M. Berkemeyer, Executive Vice President and Chief Health Management Officer, Arkansas Blue Cross and Blue Shield

Larry Kosinski moderated the session with four SMEs on lessons learned from state value-based care models that have implemented multi-payer alignment. Full biographies and presentations are available.

Janice Walters presented lessons learned from the Pennsylvania Rural Health Model (PARHM).

- Ms. Walters summarized the work conducted by the Rural Health Redesign Center (RHRC). She noted that health care is vital to broader economic development; ensuring access to health care services in rural communities is fundamental to achieve thriving rural communities. The RHRC

staffs over 40 individuals, works with technical partners, and holds a combined 500 years of rural-relevant experience across staff. RHRC was formed in response to the CMS Innovation Center's development of the PARHM to create an entity that could serve as a technical assistance center both for the PARHM and for other states implementing similar programs.

- Ms. Walters outlined three goals of PARHM: to improve rural hospital financial viability and stability; to improve population health outcomes for individuals served by participating hospitals; and to reduce the TCOC over time. To accomplish these goals, PARHM required all participants to use global budget agreements and transformation plans.
- Ms. Walters presented health care utilization trends over the span of PARHM, including results from metrics related to readmissions, emergency room use, and ambulatory sensitive conditions. One goal of PARHM was to provide the right care at the right time. Over the course of the program, most hospital and payer relationships reduced avoidable utilization. Ms. Walters noted that these accomplishments were achieved during the COVID-19 public health emergency (PHE).
- Ms. Walters noted that lessons learned from PARHM included the importance of engaging stakeholders, developing broader infrastructure, and planning effectively. While PARHM will sunset shortly, RHRC's work will continue in Pennsylvania to develop a next-generation strategy for rural APMs, independent of CMS involvement.
- Ms. Walters raised six key requirements of a next-generation program based on the lessons learned from PARHM. She highlighted that, initially, PARHM may not have preserved the needed care in each community, which would have required defining for each community the essential services needed by residents by which types of providers. She added that PARHM's revenue model was unable to predict true revenue realized by model participants. She underscored that the ideal program would achieve less administrative burden while still accomplishing its goals.
- Ms. Walters discussed the new CMS licensure designation of a Rural Emergency Hospital. CMS provides these hospitals with a fixed facility payment to help the hospitals stabilize cash flow. To date, roughly one quarter of the hospitals in Pennsylvania have requested this designation, which has allowed some of the hospitals to implement population health and wellness efforts.
- Ms. Walters outlined five essential elements needed to successfully implement APMs: leadership skills, transparent communication, alignment of purpose, demonstrated relevant expertise, and stakeholder input.

For additional details on Ms. Walters' presentation, see the presentation slides (pages 2-12), transcript, and meeting recording (0:00-13:32).

John Bulger presented lessons learned from the PARHM from a payer perspective.

- Dr. Bulger highlighted that Geisinger Health Plan was a key payer involved in PARHM, committed to making health care better in rural Pennsylvania. He described the 10-year journey of the PARHM.
- Dr. Bulger outlined four stakeholder value propositions of PARHM participation, particularly for hospitals and payers. Propositions included increased access to care for rural residents, improved population health (e.g., what services are needed in specific communities), realized maintenance of employment and economic benefit where hospitals are the main economic engine of the community, and measurable results from payment reform that will inform future policy decisions.
- Dr. Bulger explained that payers are interested in participating in models similar to PARHM because the model helps them understand financial risk with more certainty. For example, the global budget model used in PARHM created more certainty about expected payments for

payers. Dr. Bulger added that payers also want members to achieve better health outcomes, so participation helps improve communication between the providers and the payers to achieve that goal. He also noted that topics related to care management, access to care, ED utilization, social determinants of health (SDOH), substance use disorders, and behavioral health are lacking in rural communities and were key focus areas of hospitals and payers working together under PARHM.

- Dr. Bulger stated that the global budget mechanism was considered a vehicle to preserve the right care in the rural Pennsylvania communities under PARHM.
- Dr. Bulger explained results from a survey that was administered to payers and hospitals to identify successes and areas for improvement in the PARHM. Survey participants noted that successes included the ability for all rural hospitals to remain open during PARHM's period of performance and improved communication between payers and providers; however, survey participants also listed this as an area for improvement. Another area for improvement noted was budget and payment methodology.
- Dr. Bulger shared how stakeholders—including the state, hospitals, payers, and other partners—are currently working together to determine the next solution within Pennsylvania.
- Dr. Bulger summarized that the reasons why payers are interested in participating in models such as PARHM include better member health care outcomes and improved collaboration with hospitals. He added that providers and hospitals benefit from participation by achieving greater financial stability, which allows them to implement programs that are needed in the community (e.g., palliative care programs, behavioral health programs) instead of focusing on the programs that earn hospitals the most money under a FFS structure.

For additional details on Dr. Bulger's presentation, see the presentation slides (pages 13-21), transcript, and meeting recording (13:32-25:21).

Dawn Stehle and Alicia Berkemeyer presented Arkansas' movement toward value-based care.

- Ms. Berkemeyer and Dr. Stehle collaborated on the Arkansas initiative. Dr. Stehle previously served as Arkansas' Medicaid Director.
- Dr. Stehle mentioned that, of the 3.1 million residents who live in Arkansas, 18% are over 65 years old, and 44% live in rural areas. Compared with the national average, more people in Arkansas live at or below the poverty line. She noted that the state has a shortage of PCPs.
- Ms. Berkemeyer explained that the initiative started when the governor brought together the public and private health care sectors to develop a strategy to improve health care in Arkansas.
- Ms. Berkemeyer outlined the initiative's building blocks of value (slide 4). The dark blue boxes on the slide represented two Arkansas Blue Cross and Blue Shield initiatives, and the red boxes indicated programs that are still in operation today. She noted Blue Cross Blue Shield's involvement in the CMS Innovation Center's Comprehensive Primary Care (CPC) initiative, CPC+ Model, and PCF Model.
- Dr. Stehle highlighted the condition-specific episodes initiatives that Arkansas implemented. The state's first exposure to value-based purchasing was through these condition-specific initiatives, which helped align the state's reporting systems.
- Ms. Berkemeyer emphasized that all programs throughout the state have focused on aligning quality measures, data and reporting to practices, and attribution methods. She also explained that the APCD and HIE help support the state's multi-payer alignment efforts.
- Ms. Berkemeyer discussed Arkansas' state HIE, which is housed within the Arkansas Health Department. The HIE includes a monthly attribution roster of patients and provides daily summary reports (e.g., utilization, insurance coverage changes), as well as tracks patient

immunizations. Over 95% of hospitals and some independent practices contribute to Arkansas' HIE. Patient-centered medical homes are required to contribute to the HIE.

- Ms. Berkemeyer noted that one key success in Arkansas is the collaboration achieved across stakeholders. For example, stakeholders held a 2017 Arkansas Hospital Association meeting, which comprised payers, employers, and patients. Goals of this meeting included identifying successes and areas for improvement, such as collaboration, data interoperability, and behavioral health integration.
- Ms. Berkemeyer highlighted additional examples of collaboration in the state, including CMS' participation and a stakeholder group visit to the Fayetteville Police Department to learn about social workers included in police field work.
- Ms. Berkemeyer added that Blue Cross and Blue Shield has shared its lessons learned with neighboring states.
- Dr. Stehle outlined how specific programs were better suited to be implemented statewide through legislative requirements compared with other programs. These programs included episodes of care, patient-centered medical homes, and use of the statewide HIE. Additionally, the state has increased spending on primary care. Recent legislation established a committee that is responsible for defining the parameters of primary care spend, identifying the clinicians involved in primary care, and creating a structure for all payers to submit data to the insurance department.
- Dr. Stehle discussed challenges in Arkansas' movement toward value-based care. First, encouraging multi-payer participation was difficult but necessary to accomplish results across the entire population. Second, achieving self-insured employer buy-in was a challenge, which was mitigated by the development of an employer-sponsored health council to help design the initiative (e.g., Walmart participated in this council). Additional challenges included simplifying the handling of patient-provider communications, identifying appropriate outcome measures, finding the resources needed to establish health IT infrastructure, and managing antitrust issues across participating stakeholders.
- Ms. Berkemeyer emphasized the importance of CMS' involvement in multi-payer alignment efforts.
- Ms. Berkemeyer concluded by highlighting successes of the initiative, including collaboration across stakeholders, development of the state HIE, and use of learning and diffusion sessions.

For additional details on Dr. Stehle and Ms. Berkemeyer's presentation, see the presentation slides (pages 22-41), transcript, and meeting recording (25:21-53:54).

Following the presentations, Committee members asked questions of the experts. For more details on this discussion, see the transcript and meeting recording (53:54-1:23:14).

Experts discussed advice they would offer to other states attempting to scale similar models.

- Consider how to provide resources and build a framework for cohort-based learning opportunities coupled with individual learning opportunities. For example, a nationwide technical assistance program enables cross-sharing of lessons learned so no state is starting from the beginning. There are available templates and tools that can be customized to a specific state.
- Health care may need to be tailored for each community. Tools should be developed and customized to the community of interest.

Experts discussed how states can consider financing convener roles within communities that conduct cross-stakeholder activities such as capacity building, trust building, developing shared outcome metrics, and implementing integrated system improvements.

- It is important to consider financing convener roles, taking into account the infrastructure and time commitment needed to assume this role. Arkansas Medicaid and Arkansas Blue Cross and Blue Shield collaboratively financed the convener role at the start of the initiative before receiving a SIM grant from CMS to fund it. Arkansas also developed a reporting infrastructure to efficiently standardize reporting.
- Not all CMS Innovation Center models funded convener efforts. It is important to build trust and communication across all convener participants to support multi-payer alignment efforts.
- PARHM included funding for convener programs such as the RHRC. The next generation work is currently funded by the Appalachian Regional Commission and the state. In the future, there may be opportunities for funding to be supported through the Rural Health Transformation Hub.
- One expert recommended including all payers, including the state and federal government, in multi-payer alignment efforts. Savings from implementing the models can be spent on infrastructure.
- Since the goal is for these programs to be self-sufficient, there needs to be up-front investment. Shared savings can be established later.

Experts discussed actionable contracting approaches that encourage broad stakeholder engagement in multi-payer alignment initiatives.

- For PARHM, two payment mechanisms were used. The first mechanism—called a Virtual Cap—was paid by the commercial part of the program. The second mechanism—a bi-weekly, standardized payment provided to participating hospitals—was paid by the Medicaid part of the program. The second mechanism was preferred because it allowed hospitals to know exactly the level of funding they would receive every other week. This approach helped hospitals more accurately predict funding capacities and minimize retrospective reconciliation at the end of the year. Payers expressed similar interests in having predictability in the funds received. This predictability helps them better forecast investment opportunities across the entire continuum of care. More straightforward approaches to calculating payments also reduce the “black box” calculations of these payments and help providers understand how the calculations are made.
- Care management fees allow for flexibility to meet patients where they are. Examples include the ability to establish gyms or laundromats near hospitals to allow care coordinators to meet with health plan members at these locations.
- Funding is needed for hospitals to invest in practice transformation. For example, funding is needed to design tools and resources required to adapt a National Committee for Quality Assurance (NCQA) model. Providers are willing to adopt new models but require up-front funding to implement them. It is also important to allow practices to implement programs customized to their community, which also supports long-term participation.

Experts discussed whether there are prospective payments for providers similar to the prospective payments received by Pennsylvania hospitals.

- Since PARHM was a hospital-based program, there were no provider payments established. The inclusion of prospective provider payments (e.g., budget or incentive-type payments) will be considered in the development of the next generation of the state model.
- It is important to identify an approach, such as a clinically integrated network, to better involve providers. Many rural providers are independent and not associated with hospital networks, so

those entities need to be brought together. Furthermore, community services such as physical therapy offices or skilled nursing facilities need to be included in the network.
- ACOs combine hospital and provider networks and, therefore, shared payments. Each year, Blue Cross and Blue Shield completes an annual assessment for each provider that outlines metrics such as attributed lives, care management fees, and utilization and quality incentives. This report is also shared with the aligned hospital to support financial discussions between the two entities.

Committee Discussion

Krishna Ramachandran 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 (0:00-24:34).

- One Committee member explained the importance of shifting communities and integrated health care systems from having transactional relationships to adopting partnership models. This shift requires building trust among partners and providers and having effective payment models and metrics.
- Conveners play a critical role in multi-payer alignment efforts. It is important to understand how to continue to invest in this type of role.
- Aligning payers requires investment in practice change, capacity building, and systems change. Taking away infrastructure after initial investments have been made can hinder sustainability of the changes that were made.
- Shared infrastructure is important in multi-payer alignment efforts.
- Advanced payment can help equalize financial risk.
- Integrated care coordination structures can help equalize access to specialty care, particularly among rural communities.
- Multi-payer alignment requires culture change throughout an entire community, including community leaders, employers, state and federal government agencies, and providers at multiple levels.
- MA must be included in the portfolio to reach a critical mass and drive change among health systems and providers.
- One Committee member described different elements that are necessary to impact the practice environment and drive culture change, including multi-year, reliable revenue; process simplification for both providers and patients; and reducing burden associated with program administration. Aligning payers is a multi-year process that requires predictability.
- One Committee member emphasized the importance of simplifying the health care system.
- Having strong leadership, including involvement from Medicare and Medicaid, is critical for multi-payer participation and progress.
- Predictable revenue is needed to build infrastructure for hospitals and physicians. The structure of prospective payments should be updated.
- One Committee member described different model components that should be simplified, including attribution, quality, and risk adjustment. Reducing the number of programs would also help simplify the system. There are components of MA that could be standardized, such as attribution, without stifling innovation. Although innovation is important, standardization would support better population-based management.
- When considering approaches to multi-payer alignment, there is a tendency to favor standardization (i.e., exact alignment) over flexibility (i.e., directional alignment). However, standardization and flexibility are not opposing principles; they are complementary design

levers. Policymakers can support the calibration that is needed between standardization and flexibility. This calibration will have trade-offs. For example, although simplification allows standardization and reduces administrative burden, simplification can also limit choice and responsiveness to local needs.

- Although there are opportunities to simplify and align attribution, risk adjustment, and quality measurements, payment models are inherently complex and will require actuaries and statistics.
- One Committee member recommended that CMS consider standardizing risk adjustment rules.
- Multi-payer alignment is essential to scale value-based care. Multi-payer alignment must be pragmatic. CMS and regional conveners have the potential to accelerate collaboration. However, progress requires standardization across timely data, attribution methods, core quality measure sets, and equitable payer cost-sharing approaches so that providers do not have to cross-subsidize transformation efforts.
- A focus on primary care may be critical in multi-payer alignment. Strong relationships with PCPs and reliable attribution methods promote early engagement and reduce utilization.
- One Committee member noted that MA often outperforms Medicare ACOs. Relative to Medicare ACOs, MA has better attribution methods, timelier data, and an expanded toolbox that includes utilization management and narrow networks.
- State multi-payer alignment efforts have demonstrated how to operationalize multi-payer reform. A strong, neutral convener and inclusive governance facilitate sustained engagement from payers and providers.
- Predictable, prospective payment structures and aligned primary care funding are important to reduce provider burden and enable transformation efforts.
- Shared metrics, interoperable data, infrastructure, up-front investments, and practice transformation analytics are important to scale and sustain progress in multi-payer alignment efforts.
- One Committee member proposed several questions for the Committee members to consider, including how to operationalize MA engagement and scale by managing MA plan heterogeneity; which specific core quality measures should be standardized across Medicare product lines without stifling innovation; and what type of legal waiver or market flexibilities are needed to sustain payer collaboration and long-term financing and convening.
- Long-term stability is needed to transform the health care system.
- HIE-enabled data sharing increases communication and reduces low-value care by identifying what has been done before in the broader health care ecosystem.
- One Committee member inquired how HIE and common data can support multi-payer alignment efforts.
- State and federal governments provide meaningful support in multi-payer alignment efforts.
- Participation and communication among payers are key to success in multi-payer alignment efforts.
- Stakeholder motivation is important to bring payers and providers together.
- There are opportunities for regional or broader conveners to align contracting.
- Shared infrastructure and consistent technology, such as HIEs, serve as enablers in multi-payer alignment efforts.
- Advanced payments are important for multi-payer engagement and alignment.
- One Committee member emphasized the importance of planning, organization, and strong governance in multi-payer alignment initiatives.
- Multi-payer alignment efforts rely on support from state policymakers, as well as stability from both policymakers and payers.

Closing Remarks

Co-Chair Mills adjourned the meeting.

The public meeting adjourned at 4:50 p.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