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

Presenters:

Subject Matter Experts

- **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

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

Nicholas Minter, MPP

Deputy Director, Seamless Care Models Group,
CMS Innovation Center

Perspectives on Multi-Payer Alignment Across Programs in Medicare

Physician-Focused Payment Model Technical Advisory Committee

February 23rd, 2026

CMS
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Speaker

- **Nicholas Minter**, Deputy Group Director, Seamless Care Models Group
  - Served past 10 years with CMS Innovation Center
    - Currently leads CMMI's accountable care organization, Medicare Advantage, kidney health, and prescription drug portfolio.
    - Previously designed and led CMMI primary care portfolio.
  - Before CMMI, served 5 years as Senior Budget Analyst for Medicare in HHS Budget Office.

What is Multi-Payer Alignment?

Multi-Payer Alignment: Refers to the coordination and collaboration among health insurance payers to meet common health care delivery goals and patient outcomes, like improving quality of care and reducing administrative burden.

- Pursuit of multi-payer alignment is an acknowledgement that in traditional provider settings, **CMS success has a higher ceiling when working with other payers.**

- While the goals of multi-payer alignment vary by model and the specific needs of model participants, historically, CMMI multi-payer alignment efforts have focused on aligning:
  - **Quality measures** –Type of measure (process vs. outcome) as well as the specific targeted outcome.
  - **Payment** – One-sided vs. Two-sided risk? Size of incentives vs. FFS payment?
  - **Data provision** – Making payer data easily available and comparable across payers.

- The intended outcomes of multi-payer alignment are similar across models
  - **Reduced administrative burden** – When incentives conflict across payers, providers must do or invest more.
  - **Provider engagement** –When payers align, it sends a **clearer signal** to the provider **about what to prioritize**.

CMS Innovation Center Models that Incorporate Multi-Payer Alignment

- **Current Models**
  - ACO Primary Care Flex (ACO PC Flex Model)
  - Achieving Healthcare Efficiency through Accountable Design Model (AHEAD)
  - Advancing Chronic Care with Effective, Scalable Solutions (ACCESS)
  - Enhancing Oncology Model (EOM)
  - Long-term Enhanced ACO Design (LEAD)

- **Past Models**
  - Comprehensive Primary Care Plus (CPC+)
  - Primary Care First (PCF)
  - Making Care Primary (MCP)

Past Examples from Medicare FFS Primary Care Models

- **Comprehensive Primary Care Plus**
  - 5-year model
  - Additional payment for care management, small performance-based payments/debits
  - 2,900 practices enrolled across 18 states and regions
  - 63 payers aligned at model start

- **Primary Care First**
  - 5-year model
  - Partial upfront capitated payment for services plus significant upside/small downside based on performance
  - 1,700 practices enrolled across 26 states and regions
  - 17 payers aligned at model start

Takeaways from Multi-Payer Alignment Efforts – Part 1

- Multi-payer alignment fosters important discussion and collaboration
  - Anti-trust concerns often stymie payer discussion
  - CMS participation helps focus efforts and conversations that would not exist otherwise
  - In some CPC+ states, payer participation continued long after the model ended

- Multi-payer alignment enhances support for behavioral change
  - Provides support for 60-80% of practice enrollment not in Medicare FFS
  - Aligns data, learning, and other resources

- Driving provider behavioral change requires a critical mass of payer alignment
  - Despite significant payer participation, on average <33% of CPC+ patients received model-related payments in participating practices
  - PCF practices reported a lack of other payer support for model-required changes being a significant driver of attrition

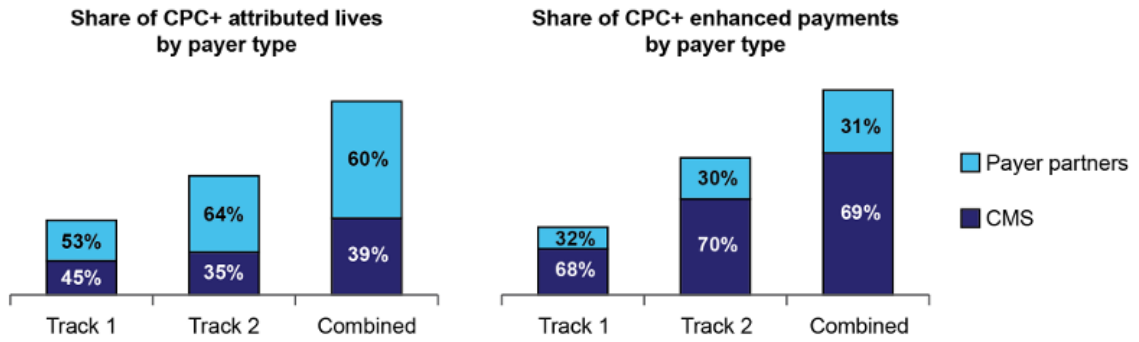
All takeaways sourced from:

1. Final CPC+ Evaluation Report
2. 3rd PY Primary Care First Evaluation Report

Takeaways from Multi-Payer Alignment Efforts – Part 2

- Definition of Multi-Payer Alignment critical – Equal partners or just swimming the same way?
  - In both models, CMS financial support was much higher on average than payer partners
  - In CPC+, 90% of model payments by other payers were also available to non-CPC+ practices

Throughout CPC+, CMS's share of CPC+ payments far exceeded its share of CPC+ attributed lives.



Sources: Mathematica's analysis of practice-reported financial data for all five program years submitted to CMS and Medicare FFS beneficiary attribution lists payment data for all five program years provided by CMS.

Notes: N = 2,905; 2,716; 2,675; 2,599; and 2,419 CPC+ practices that were participating at the end of PYs 1, 2, 3, 4, and 5, respectively.

FFS = fee-for-service.

- Limited scope of CMMI tests creates more administrative fragmentation for national MAOs
  - In PCF, six payers left in the first 2 years due to a lack of staffing resources and other priorities
  - Low level of enrollment in each state made investment less compelling for PCF payers
  - Continued presence of STARS ratings made new quality measures additive to the existing provider workload

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Future areas of interest for Multi-payer alignment?

- The CMS Innovation Center is researching potential for more alignment in…
- **Medicare Advantage**
  - Increase value-based care as Medicare enrollment continues to surpass FFS
  - Reduce the administrative burden of providers participating in multiple quality incentive systems across Medicare Advantage and Fee-for-Service

- **Condition-specific populations**
  - Primary care models are characterized by prevention across a broad population
  - Focusing providers on more narrow activities with high potential return on investment may drive greater interest from payers and providers alike

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

Dana Rye, MBA, MPP

President, Value-Based Care,
Duly Health and Care

duly HEALTH AND CARE

Improving Multi-Payer Alignment in Value-Based Care

Dana Rye – President, Value-Based Care

Dana Rye
President, Value-Based Care

- **Current Role:** Dane Rye serves as President, Value-Based Care for Duly Health and Care and leads Duly's value-based care strategy and program management, including analytics, care management, and population health management.
- **Education and Credentials**: Dana holds an MBA from Harvard Business School, an MPP from Harvard's Kennedy School of Government, and a BA from Middlebury College.
- **Prior Leadership Experience**: Joined Duly from US Renal Care, a national provider of kidney and dialysis services. She served as Senior Vice President, Value-Based Care Operations, where she led multiple value based care programs and was responsible for strategy, operational execution, and physician relationships. Prior to US Renal Care, Dana held Business Development and Operations roles at OneOncology, an MSO for community oncologists. She held earlier roles at McKinsey & Company and Credit Suisse.

Duly is an independent care delivery system for patients & employers

Overview

- **Leading & diversified delivery system with density** across Chicagoland, Quincy, IL & South Bend, IN
- **Trusted brand** with **30+ year reputation** for **affordable, high-quality** patient care
- **Highly engaged provider community with 94% retention rate,** underpinned by unique shareholder model
- **Best-in-class patient access** across our specialties & ancillary services
- **Multifaceted, high performing** value-based care platform
- **World class customer satisfaction and experience** performance

Geographic Footprint

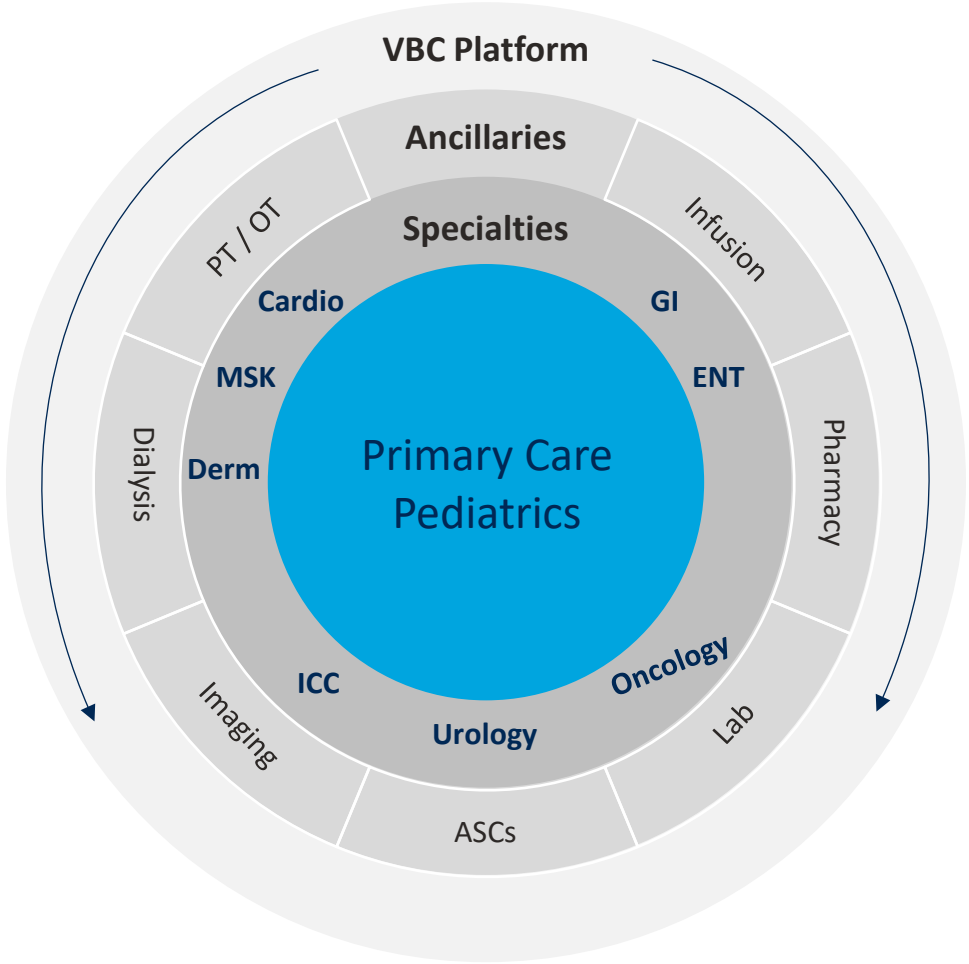
- **190** *Sites of Service*
- **15** *Medical Office Buildings*
- **7** *Ambulatory Surgery Centers*
- **11** *Immediate Care Centers*
- **17** *Imaging Centers*
- **30** *Lab draw sites*
- **40** *Physical Therapy Locations*
- **100** *Ambulatory Infusion Chairs*

Key Metrics

- **1,800+** Employed Clinicians
- **~$3.0bn+** '25E Revenue
- **1.2M** FFS Patients
- **390k+** Value-Based Care Lives
- **76** Net Promoter Score *(+ 6 pts since 2023)*
- **9 .5m+** Annual Patient Visits
- **30+** Physician Specialties

Built on primary care, our service offerings support patients across their lifetime

Duly's Comprehensive & Complimentary Outpatient Model Drives Growth



- **We develop long-term relationships with patients via Primary Care,** and retain them across our service offerings
- Comprehensive care model **entirely centered around patient outcomes,** serving patients across **Commercial, MA and original Medicare**
- **Downstream volume** from **primary care to specialty** and **ancillary services**
- **Patients engage through activation campaigns to seek preventative services** across our specialties & ancillaries
- **Clinicians seamlessly serve both FFS and VBC** patients through our fully integrated model
- **10-year average patient tenure** with Duly

Duly's foundation enables top-tier value-based care performance

Elements of our integrated, multi-specialty delivery system

Mature Patient Base

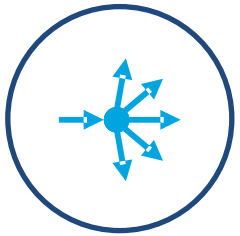
Patients have consistently been under the care of Duly PCPs, allows us to provide continuous, high-quality care

Primary & Specialty Care

The range of physicians across primary and specialty care supports high quality, coordinated care within the Duly ecosystem

Aligned Physicians

Alignment with Duly's shareholder physicians enables coordination and fast adoption of new tools and programs



Established FFS Platform

Our strong physician base has enabled growth in value-based care contracts, primarily through existing clinical workflows

Ancillary Footprint

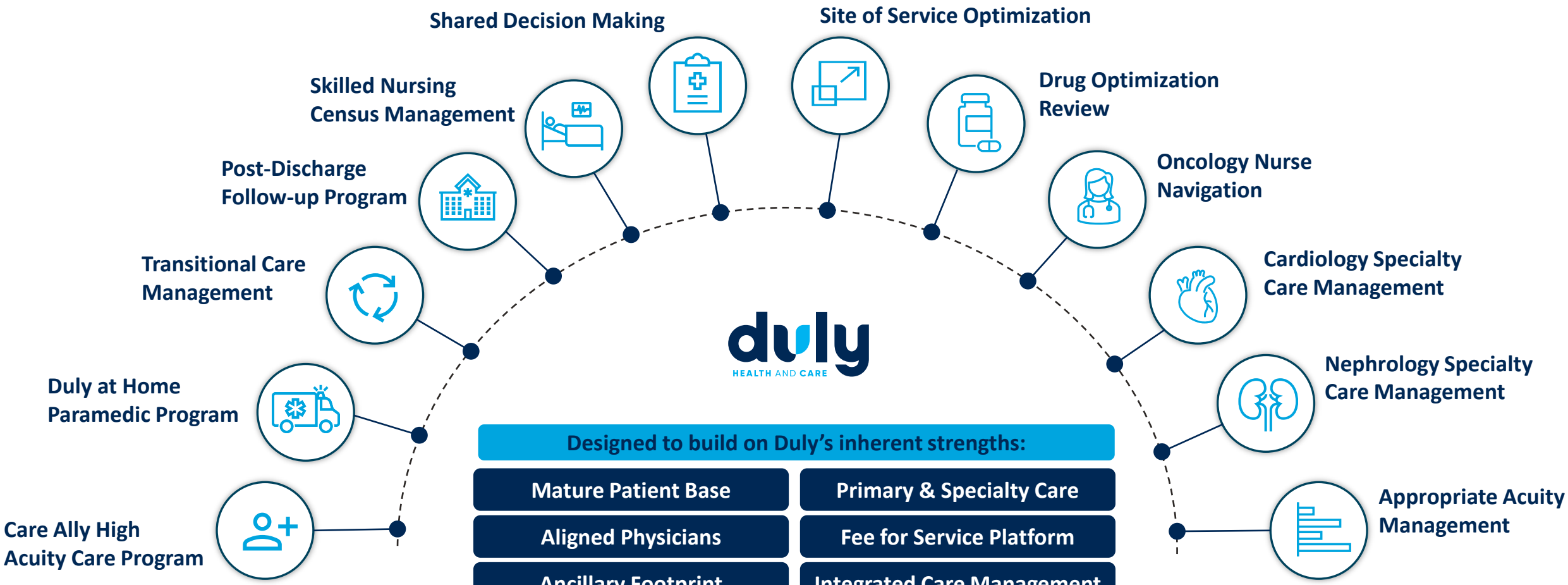
Access to a range of in-house ancillaries has only increased, allowing patients to receive care at the most appropriate, affordable site

Integrated Care Management

Care teams, processes, and data are seamlessly placed at the point of care, increasing effectiveness and patient impact

Our VBC model wraps services around the strengths of our foundation

Patient-centered initiatives driving at-scale impact



Our VBC model, combined with our core foundation, generates outstanding results

Duly's Initiatives Drive Superior VBC Outcomes

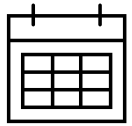
Proven population-wide strategies with specific emphasis on the highest risk patients

★ ★ ★ ★

4+ Star Quality
performance with MA partners

Consistent Top Performing ACO

53% Fewer
readmissions for patients receiving a Duly at-home visit

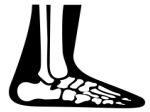


90% Hospital Follow-up
within 7-days for all core facilities

30% reduction
in ER visits for active chemo patients with Duly nurse navigation

93% Recapture
of critical diagnoses to support care programs and revenue continuity

43% reduction
in admissions for patients engaged in the Care Ally Program

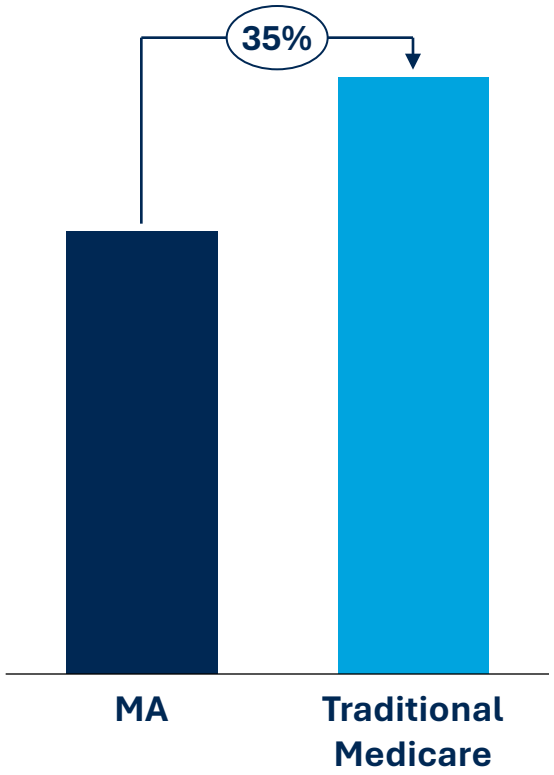


52%
of applicable Ortho procedures performed at ASCs

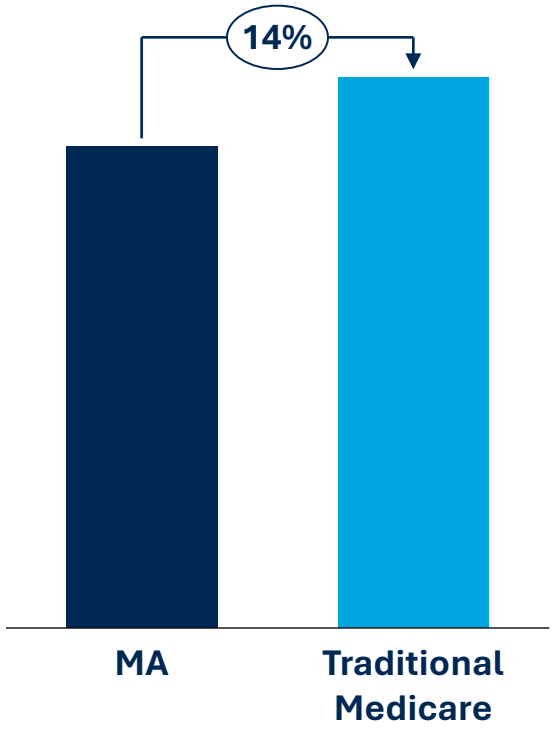
Alignment of Medicare Programs – Key Differences between MA and Traditional Medicare

Comparing MA vs Original Medicare Population

Admissions
(Admissions per Thousand)



30-Day Readmission Rate
(% Readmission Rate)



Key program differences that likely drive variation:

1 Patient Attribution and Strength of PCP Relationship

- MA plan attribution is updated more frequently and typically has better PCP alignment
- Patients from MA plans traditionally have a stronger relationship with their PCP due to improved alignment

2 Data Accessibility

- MA plans provide timely, actionable patient-level data beyond claims, including daily census files and provider data

3 Supplemental Programs to Improve Outcomes

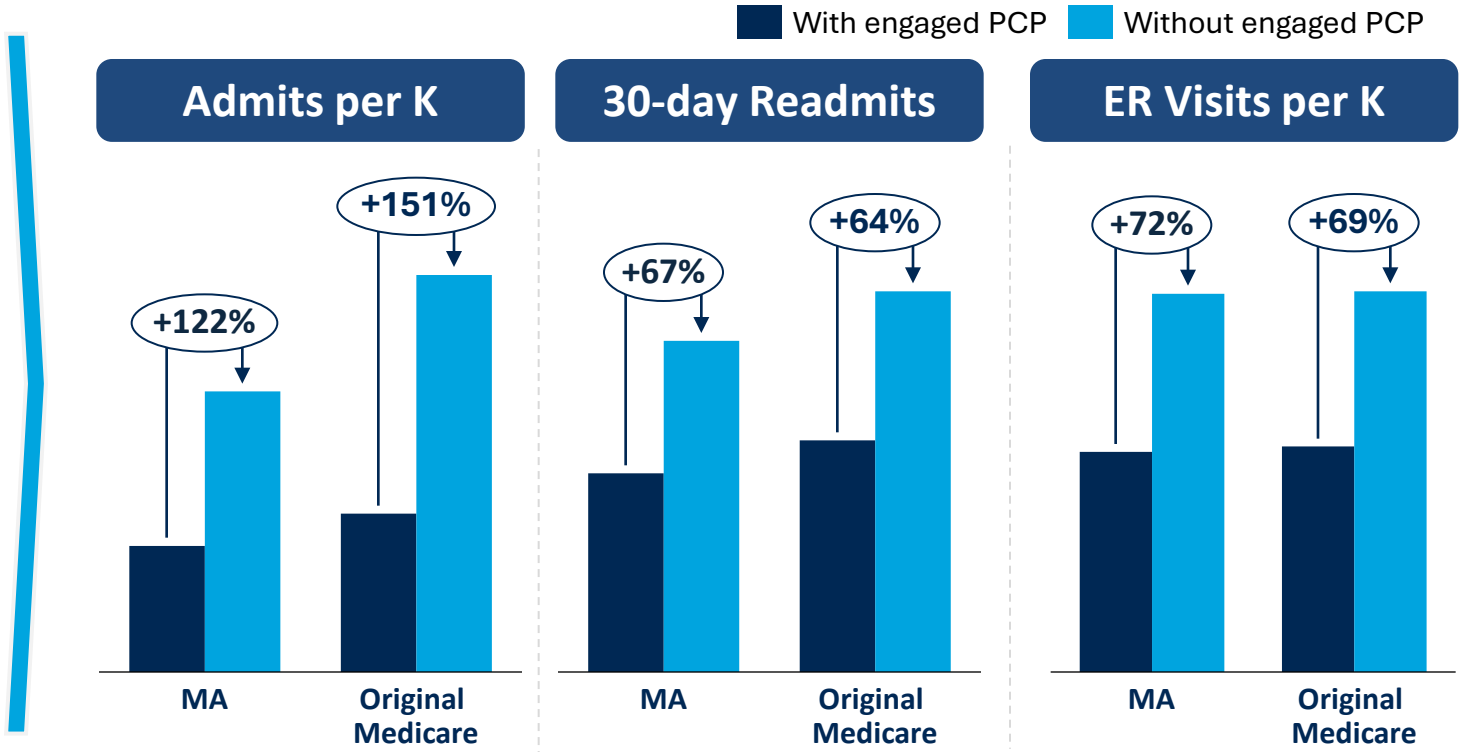
- MA plans offer additional support programs that help to improve overall outcomes

1 | Importance of Coordinated Care - Accurate Patient to PCP Attribution

Accurate Patient to PCP Attribution

- Although less of an issue with MA, PCP attribution misalignment remains a challenge in both Original Medicare and Medicare Advantage
- It is less of an issue in Medicare Advantage because more patients have a stronger PCP relationship
- Patients benefit the most from VBC programs when they have an engaged PCP within the ACO

Utilization Outcomes with and without engaged PCP



Improved Alignment from MA Payers

2 | MA-provided reports that enable better coordination of care

Value of Census / ADT Data

- Enables proactive discharge planning and care coordination
- Schedule PCP follow-up within three days of discharge
- Track performance and opportunities in real time

Ongoing Challenges with Census / ADT Data

- HIE coverage is not universal or compulsory, resulting in blind spots
- No industry standard data file specification, resulting in inconsistencies
- Complex rules need to be applied to create reliable and actionable admissions and census data

3 | MA supplemental programs help to improve patient outcomes

Example MA Programs

- Care / Case Management
- Utilization Management
- Post-Acute Management
- Wellness Programs
- Non-Emer. Transport
- Pharmacy Management

We do best to manage consistently internally, but MA programs offer supplemental programs that can help organizations improve patient management

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Karthik Rao, MD

Chief Medical Officer,
agilon health

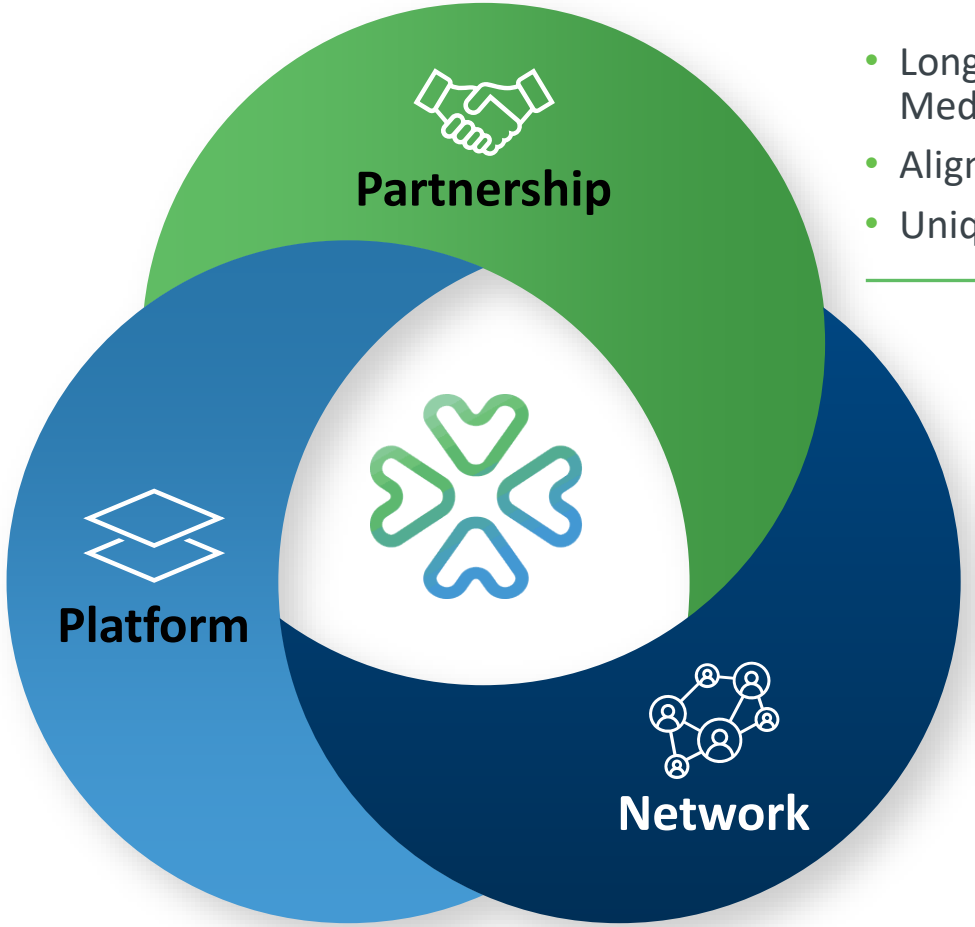
agilon health

agilon health

Karthik Rao, MD
Chief Medical Officer

February 23, 2026

agilon health Total Care Model



- Long-term JV for full risk, multi-payor Medicare line of business
- Aligns physician economics with outcomes
- Unique proximity to primary care physicians

- Purpose-built platform specific to Medicare
- Broad capabilities: Technology, People, Process, Capital
- Built by doctors for doctors

- Like-minded group of entrepreneurial physicians
- Share best practices to drive clinical innovation

Create a Single and Purposeful **Senior Experience**	**Reframe Processes** Around Aligned Physician Relationship	Align Through Powerful Physician Governance to **Drive Outcomes**

Our Platform is the Solution for PCPs in VBC

agilon Network: 28 Markets in 12 States

Local Scale and Market Infrastructure

National Network of Existing Practices

Technology & Data

Single Medicare Experience for Physicians and Patients

Before agilon Partnership

Payor 1
- *P4P reporting*
- *PMPM Fees*
- *HCC Gaps*
- *Patient Eligibility*

Payor 2
- *P4P reporting*
- *Shared Savings*
- *Payor Quality Gaps*
- *Patient Eligibility*

Payor 3
- *P4P reporting*
- *FFS payment*
- *HEDIS Gaps*
- *Patient Eligibility*

Contract *Contract* *Contract*

Must fulfill disparate requirements across all payors; high admin burden for limited, if any, upside

Fragmented patient experience
- Limited data visibility
- Poor coordination
- No accountability
- No team support

After agilon Partnership

Humana. UnitedHealthcare

First Medicare Direct FIRSTCAROLINACARE INSURANCE COMPANY aetna™ CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

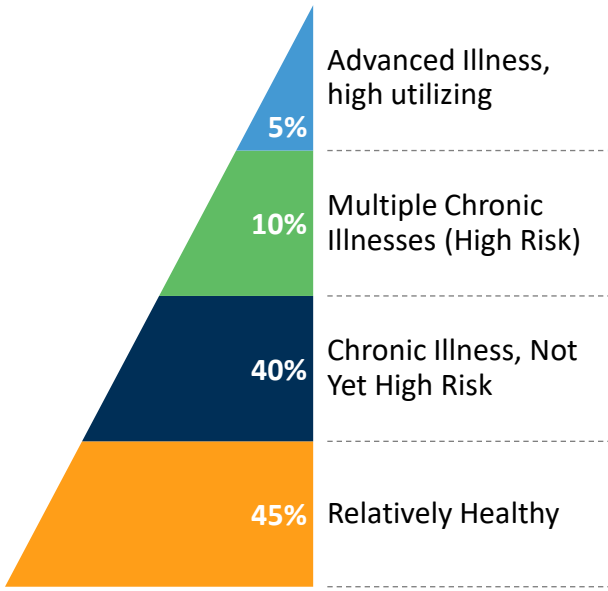
PCP-Led MA Risk Line of Business

- ✓ **Single MA line of business**
- ✓ **Single brand identity; aligned with practice, not payor**
- ✓ **Consistent patient and physician experience across payors**
- ✓ **Single reporting platform**

Improved care delivery & access
- High data visibility and actionable insights
- Coordinated care team
- High efficiency
- PCP and patient accountability
- Clinical & community programs

Pending contracts

Clinical model is built on a patient centric lens of understanding where we have the biggest opportunities to improve quality of care and reduce spend that does not contribute to better outcomes



% Seniors in each Risk Stratification Category	Complex patients	Clinical pathways	BOI and Quality	Episodes of Care	High spend specialties
Advanced Illness, high utilizing	**Key subgroups of patients that require additional care delivery infrastructure**	**~5 conditions that we must be best in class at managing proactively and end to end**	**Fundamentals of succeeding in risk where we have to be best in class**	**Moments of vulnerability that we can take an active role in better coordinating and managing**	**High spend categories with variability in quality and spend per episode**
Multiple Chronic Illnesses (High Risk)	Advanced illness support and palliative care	CHF	Appropriately and accurately documenting Burden of Illness	Transitions of Care	Musculoskeletal
Chronic Illness, Not Yet High Risk	Proactive Visits	COPD	Quality performance	Inpatient	Oncology
Relatively Healthy	High risk patient access and in home care	Dementia	Annual wellness visits	Post Acute Care	
		CKD/ESRD			
		Diabetes			

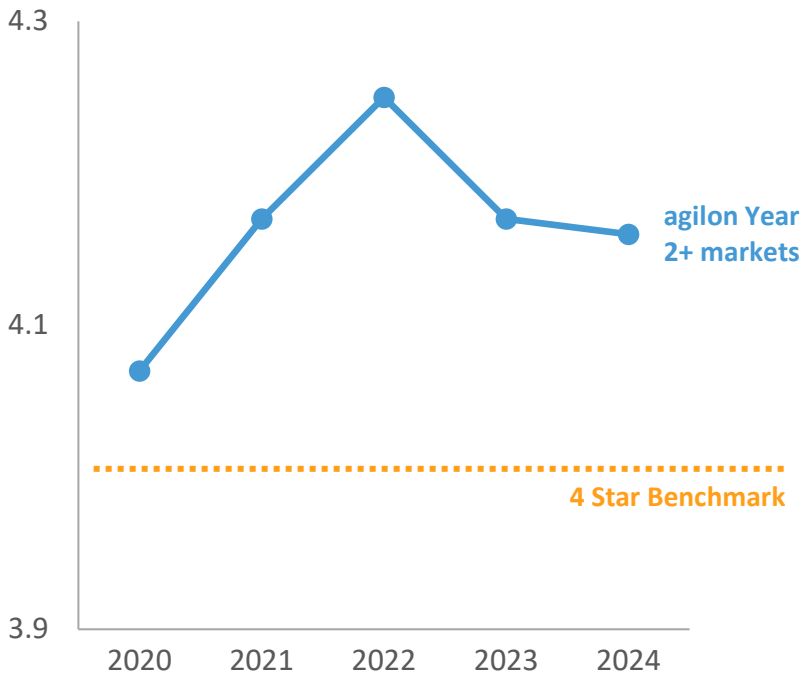
Core capabilities to support execution of opportunity (owned or via partnership)

	Expanded in office diagnostics	Quality gap reporting		
In Home Care	Virtual Pharmacy	Condition identification, coding, and compliance	Real time data (ADT)	Sub-cap arrangements
Provider engagement and education				
Integrated data platform + point of care insights + financial and operational reporting				

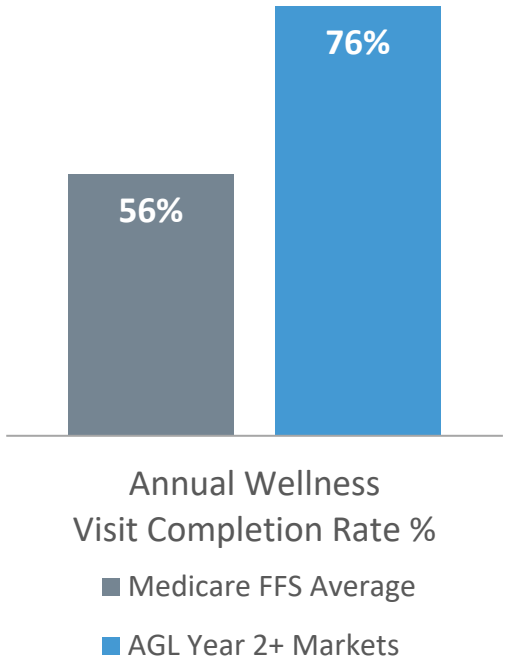
agilon Partnership Drives Clinical Outcomes; Measurable Improvements on Quality, Cost, and Utilization

Quality

STARs Performance

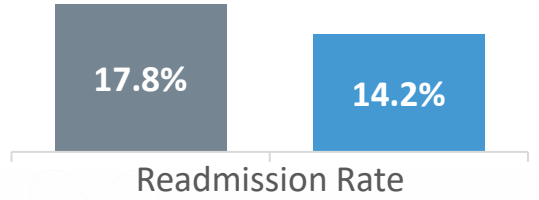


Patient Access

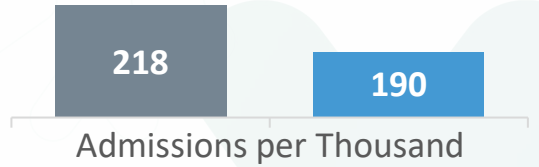


Inpatient / ER Utilization

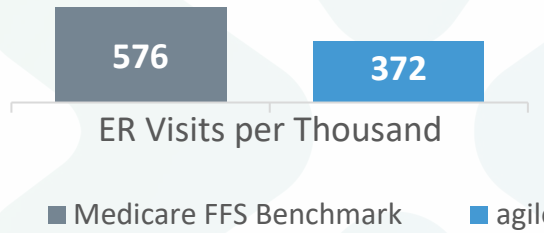
Readmissions



Hospital Admissions



Emergency Department Visits



Notes: 2024 Stars performance is an estimate as of Jan 2025. Utilization data is as of December 2024.

Multi-payer Alignment: Barriers and Opportunities

Contract Variability

- Significant variation between and among MA contracts within a single provider group and/or RBE
- Impacts providers' ability to develop uniform population health approach
- MA contracts dissimilar from ACO model contracts, including what providers are at-risk for

MA Data Asymmetry

- Risk-bearing providers lack standard, timely data across MA payor partners
- CMS & payers already exchange this data on regular cadence
- MA lacks incentives for plans to exchange this data with providers, potentially signaling a need for CMS/CMMI intervention

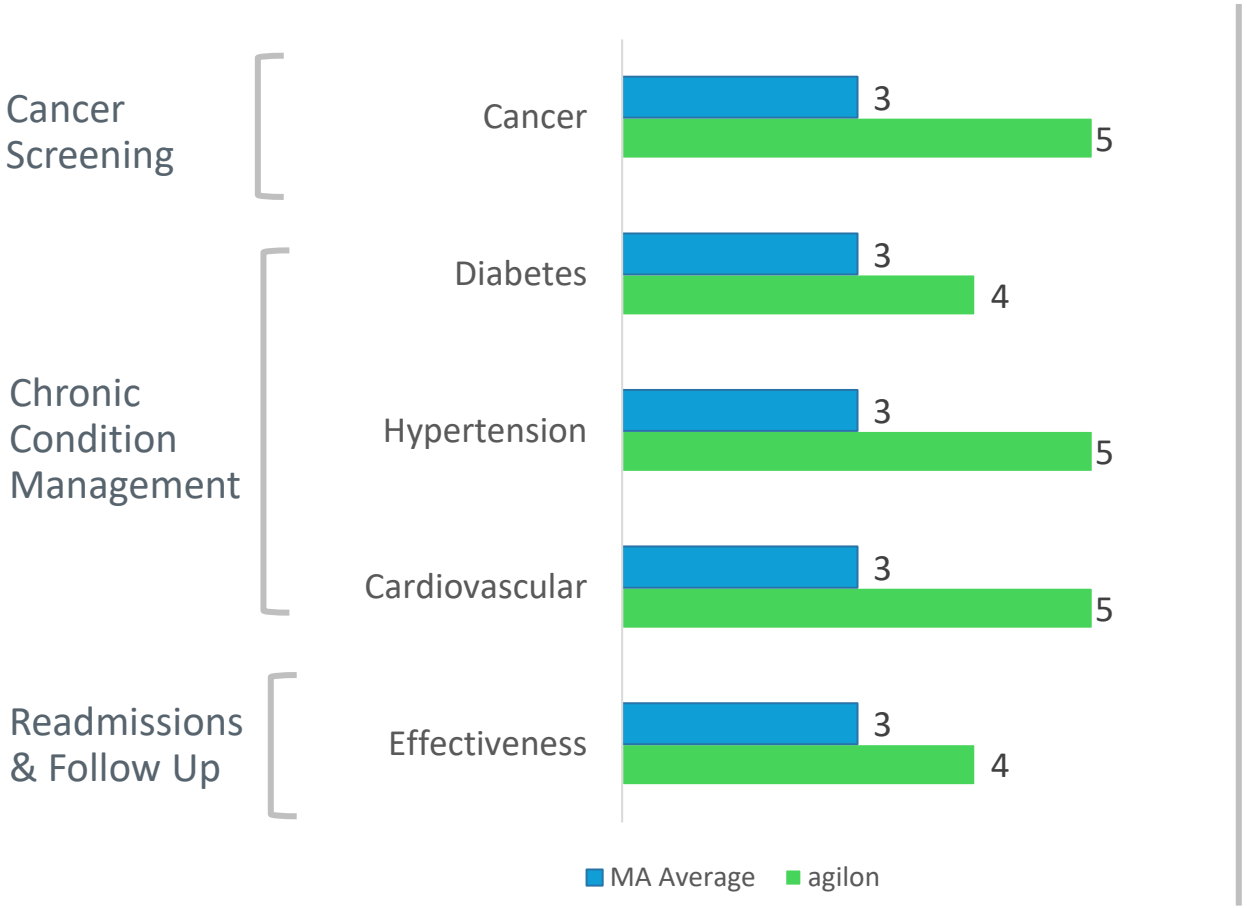
Measuring Success

- Quality measurement across programs is burdensome; learn from successes ACO REACH using claims-based measures
- Evaluating success across programs is non-standard, causing significant challenge for CMMI ACO model expansion

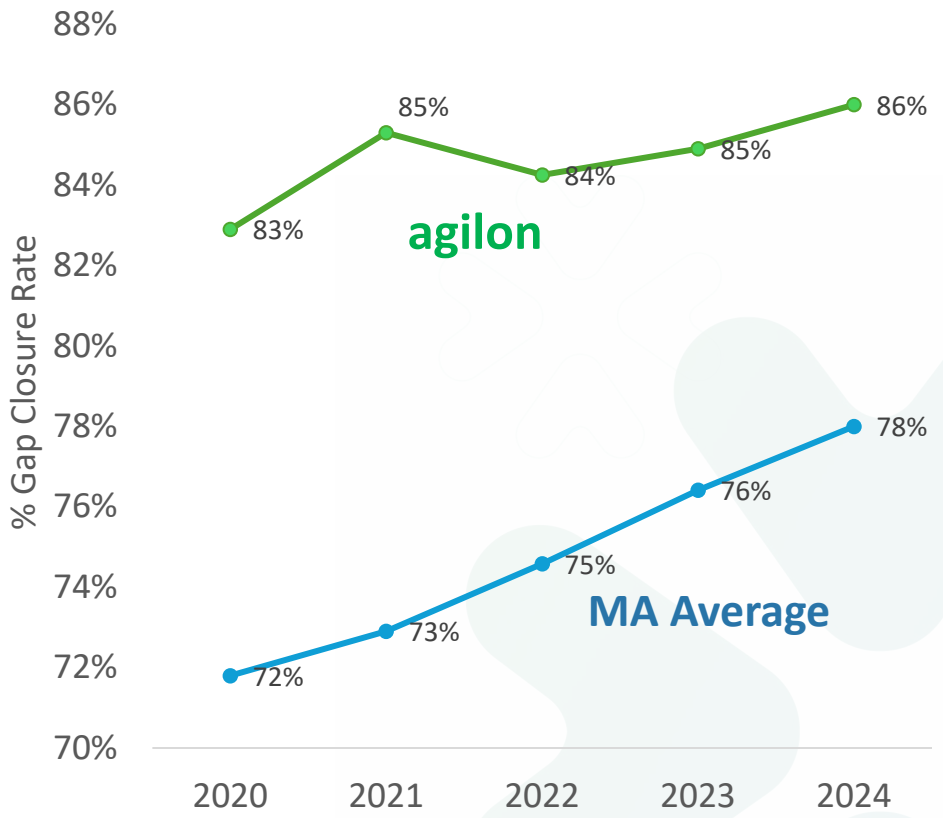
Appendix

Scaling Quality Outcomes Across Our Network

agilon Outperforming MA on Key Star Measures



Gap Closure Rate above MA, while growing 4x



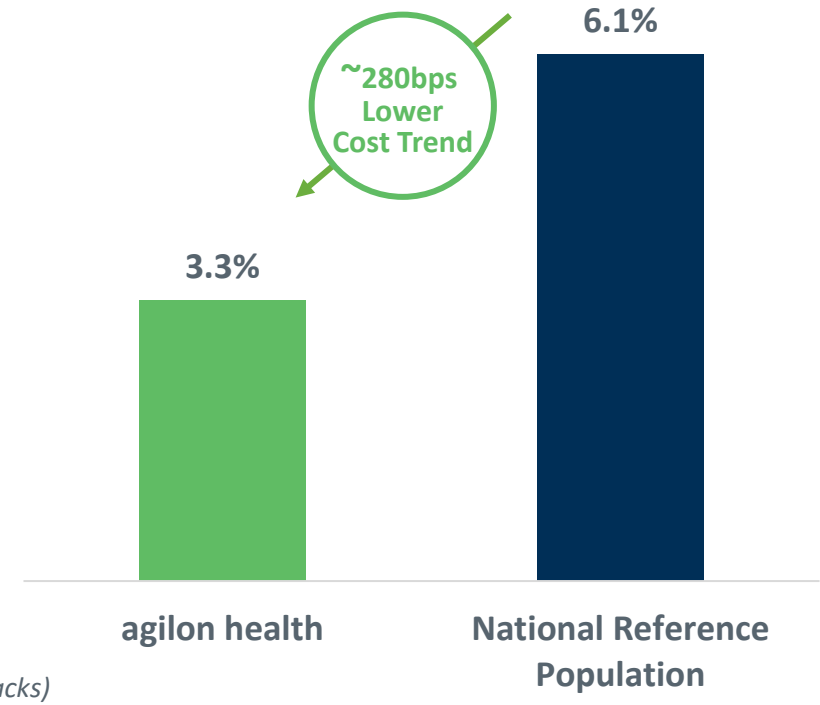
Source: agilon health quality data, includes subset of all stars measures

ACO Reach Achieves Significant Saving and Relative Performance

- **ACO Reach: $150mm** in gross savings (**13%** gross savings %); **$37mm** savings to Medicare Trust Fund; beat national trend by **~280 bps**
  agilon was **one of only three** Standard ACO parent companies that drove meaningful results at scale
- agilon 2023MY STARs shows majority of partners above 4.25 STARs

2023 Standard ACO Gross Savings Rate* by Membership

2023 agilon REACH Cost Trend vs National Reference Pop.



**Gross Savings Rate is savings rate after removing all model discounts (comparable across models and tracks)*

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Michael Chernew, PhD

Professor of Health Care Policy and Director,
Healthcare Markets and Regulation Lab,
Harvard Medical School

ALIGNMENT OF PROGRAMS WITHIN MEDICARE

Michael Chernew, PhD
Harvard Medical School

February 23, 2026

DISCLAIMER

The opinions presented represent my personal views and do not necessarily reflect the views of organizations I am affiliated with, most importantly, MedPAC

IT'S HARD TO SUCCEED WHEN FACING MIXED SIGNALS

IT'S EASIER TO ALIGN PROGRAMS IF THERE ARE FEWER PROGRAMS

DIMENSIONS OF ALIGNMENT

- Quality measures
- Data requirements
- Risk adjustment
- Attribution
- Financial incentives

CHALLENGES TO ALIGNMENT

- Different scope
  - Pop-based (TCOC) vs episode-based
- Inherent attribution differences
  - ACOs vs MA
- Multilayer nature of care
  - Pop-based program → Provider group/ health system → doctor/ other professional
  - FFS
- Legacy systems
- Competitive advantage
  - Innovation

WASTE IS AN ASSET: THE 'PIE' OF SAVINGS IS LIMITED

- Different APMs assign gains from efficiencies to different stakeholders

- How waste is assigned affects incentives to save and participate

- APMS should be synergistic, default to pop based, add synergistic episodes (or other models)

IT'S EASIER TO ALIGN PROGRAMS IF THERE ARE FEWER PROGRAMS

END