Physician-Focused Payment Model Technical Advisory Committee

July 2, 2026

Robert F. Kennedy Jr., Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Kennedy:

On behalf of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), we are pleased to submit PTAC's report on Improving Multi-Payer Alignment in Value-Based Care. Section 1868(c) of the Social Security Act directs PTAC to: 1) review physician-focused payment models (PFPMs) submitted to PTAC by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary.

PTAC's February 2026 public meeting focused on improving multi-payer alignment in value-based care. The information that PTAC has gleaned from a review of previous PFPM proposals, other literature that addressed this important topic, as well as input received from the subject matter experts who participated in the public meeting, has informed the Committee members' comments, which are summarized in the following broad topic areas in this report:

- Topic 1: Promoting Localized, Patient-Centric Care Delivery;
- Topic 2: Fostering Long-Term System Change;
- Topic 3: Building Essential Foundational Elements to Promote Alignment;
- Topic 4: Ensuring Sufficient Funding and Reliable Practice Revenue; and
- Topic 5: Balancing Simplification and Flexibility in Model Design.

Key highlights include:

- Multi-payer alignment is essential to promote a shift to value-based care.
  - Multi-payer alignment creates more opportunities for care delivery that is patient-centric rather than insurer-centric.
  - Long-term commitment by all stakeholders—including payers, providers, and community organizations—is needed to support value-based care.
  - Participation in Alternative Payment Models (APMs) across government and private payers creates a critical volume of patients and the business case needed to motivate providers to join value-based care models.
  - Providers want predictability in program requirements and financial incentives to justify their transition to value-based care.
- Model design and implementation should balance standardization and flexibility.
  - Payer alignment on payment program purpose and shared goals are essential for success.
  - Standardization can help reduce administrative burden for payers and providers.
  - Building on existing infrastructure and past program success can support payer alignment.
  - Flexibility in some program components, such as patient engagement approaches, allows customization to local community needs, promotes innovation, and can alleviate payer concerns about competitive advantage.
- Trust and communication are paramount to achieving multi-payer alignment.
  - Trust across payers, as well as between payers and providers, is a primary driver of whether and how quickly a multi-payer initiative/program succeeds.
  - Transparency, regular and honest communication, and positive experiences can help build trust.
- A shared data infrastructure and data interoperability are foundational to multi-payer APMs.
  - Shared data infrastructure can be supported by centralized data aggregators, such as accountable care organizations (ACOs), all-payer claims databases (APCDs), and health information exchanges (HIEs).
  - Funding for data infrastructure should be considered during the program planning phase.
- Government leadership can facilitate multi-payer alignment in multiple ways.
  - The Centers for Medicare & Medicaid Services (CMS) and states can bring together stakeholders and provide consistent leadership and guidance for multi-payer APMs.
  - Public payers can help all payers navigate issues such as antitrust regulations.
  - CMS and states can hold the role of convener to facilitate collaboration among diverse stakeholders in a multi-payer initiative.

The members of PTAC appreciate your support of our shared goal of improving the Medicare program for both beneficiaries and the physicians who care for them. PTAC would be happy to discuss any of these observations with you. However, the Committee appreciates that there is no statutory requirement for the Secretary to respond to these comments.

Sincerely,

//Terry Mills//

Terry L. Mills Jr., MD, MMM
Co-Chair

//Soujanya Pulluru//

Soujanya R. Pulluru, MD
Co-Chair

Attachment

Physician-Focused Payment Model Technical Advisory Committee

REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

Improving Multi-Payer Alignment in Value-Based Care

July 2, 2026

About This Report

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to: 1) review physician-focused payment models (PFPMs) submitted by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary. PTAC reviews submitted proposals using criteria established by the Secretary in regulations at 42 CFR §414.1465.

Within this context, from time to time, it may be beneficial for PTAC to reflect on proposed PFPMs that have been submitted to the Committee to provide further advisement on pertinent issues regarding effective payment model innovation in Alternative Payment Models (APMs) and PFPMs. Given that, in the past, at least 14 of the proposals that have been submitted to PTAC mentioned multi-payer alignment, PTAC now sees value in reviewing these elements in previously submitted proposals related to this topic, along with current information on improving multi-payer alignment in value-based care. To ensure that the Committee was fully informed, PTAC's February 2026 public meeting included a theme-based discussion on improving multi-payer alignment in value-based care.

This report summarizes PTAC's findings and comments regarding improving multi-payer alignment in value-based care. This report also includes: 1) a summary of the characteristics related to improving multi-payer alignment in value-based care from proposals that have previously been submitted to PTAC; 2) an overview of key issues relating to improving multi-payer alignment and value-based care transformation; and 3) a list of additional resources related to this theme-based discussion that are available on the Assistant Secretary for Planning and Evaluation (ASPE) PTAC website.

Table of Contents

SUMMARY STATEMENT

On February 23 and 24th 2026, PTAC's public meeting focused on multi-payer alignment for value-based care and alternative payment models. This report provides PTAC's findings and valuable information on best practices for improving multi-payer alignment in value-based care. The information that PTAC has gleaned from a review of previous PFPM proposals and other literature that addressed this important topic, as well as input received during the theme-based discussion, will help to inform PTAC in its review of future proposals. This material has informed the Committee members' comments, which are summarized in the following broad topic areas in this report:

- Topic 1: Promoting Localized, Patient-Centric Care Delivery;
- Topic 2: Fostering Long-Term System Change;
- Topic 3: Building Essential Foundational Elements to Promote Alignment;
- Topic 4: Ensuring Sufficient Funding and Reliable Practice Revenue; and
- Topic 5: Balancing Simplification and Flexibility in Model Design.

Key highlights include:

- Multi-payer alignment is essential to promote a shift to value-based care.
  - Multi-payer alignment creates more opportunities for care delivery that is patient-centric rather than insurer-centric.
  - Long-term commitment by all stakeholders—including payers, providers, and community organizations—is needed to support value-based care.
  - Participation in Alternative Payment Models (APMs) across government and private payers creates a critical volume of patients and the business case needed to motivate providers to join value-based care models.
  - Providers want predictability in program requirements and financial incentives to justify their transition to value-based care.
- Model design and implementation should balance standardization and flexibility.
  - Payer alignment on payment program purpose and shared goals are essential for success.
  - Standardization can help reduce administrative burden for payers and providers.
  - Building on existing infrastructure and past program success can support payer alignment.
  - Flexibility in some program components, such as patient engagement approaches, allows customization to local community needs, promotes innovation, and can alleviate payer concerns about competitive advantage.
- Trust and communication are paramount to achieving multi-payer alignment.

    - Trust across payers, as well as between payers and providers, is a primary driver of whether and how quickly a multi-payer initiative/program succeeds.
    - Transparency, regular and honest communication, and positive experiences can help build trust.
- A shared data infrastructure and data interoperability are foundational to multi-payer APMs.
    - Shared data infrastructure can be supported by centralized data aggregators, such as accountable care organizations (ACOs), all-payer claims databases (APCDs), and health information exchanges (HIEs).
    - Funding for data infrastructure should be considered during the program planning phase.
- Government leadership can facilitate multi-payer alignment in multiple ways.
    - The Centers for Medicare & Medicaid Services (CMS) and states can bring together stakeholders and provide consistent leadership and guidance for multi-payer APMs.
    - Public payers can help all payers navigate issues such as antitrust regulations.
    - CMS and states can hold the role of convener to facilitate collaboration among diverse stakeholders in a multi-payer initiative.

I. PTAC REVIEW OF IMPROVING MULTI-PAYER ALIGNMENT IN VALUE-BASED CARE

In developing the comments in this report, PTAC considered information from the theme-based discussion during the February 2026 public meeting, an environmental scan developed to provide information on improving multi-payer alignment in value-based care, and four responses from external stakeholders[i] to a Request for Input (RFI) on improving multi-payer alignment.

PTAC formed a Preliminary Comments Development Team (PCDT) for the February 2026 theme-based discussion, which was comprised of Joshua Liao, MD, MSc (Lead); Lindsay Botsford, MD, MBA; Lauran Hardin, MSN, FAAN; and Terry (Lee) Mills, MD, MMM (see Appendix 1 for a list of the Committee members). The PCDT reviewed the environmental scan and delivered a summary presentation to the full Committee during the theme-based discussion. The theme-based discussion featured perspectives from a diverse group of SMEs

[i] External stakeholders who submitted responses to the RFI included the American Society of Nephrology (ASN), National Association of ACOs (NAACOS), California Quality Collaborative (CQC), and Integrated Healthcare Association (IHA).

and provided an opportunity for public comments. At the end of the theme-based discussion, Committee members identified comments to be included in this Report to the Secretary (RTS).[ii]

The Committee members synthesized information from PTAC proposals, the environmental scan, and sessions with SMEs during the February 2026 public meeting on improving multi-payer alignment in value-based care. This RTS summarizes Committee members' comments from its findings, which are organized in five topics:

- Topic 1: Promoting Localized, Patient-Centric Care Delivery;
- Topic 2: Fostering Long-Term System Change;
- Topic 3: Building Essential Foundational Elements to Promote Alignment;
- Topic 4: Ensuring Sufficient Funding and Reliable Practice Revenue; and
- Topic 5: Balancing Simplification and Flexibility in Model Design.

For each topic, relevant issues are highlighted. Appendix 2 includes information on CMS-led and state multi-payer models and initiatives. Appendix 3 includes information about proposals that were previously submitted to PTAC that mention multi-payer alignment. Appendix 4 provides a list of additional resources related to PTAC's multi-payer alignment theme-based discussion that are available on the Assistant Secretary for Planning and Evaluation (ASPE) PTAC website. Appendix 5 includes a complete list of the Committee members' comments.

II. BACKGROUND: DEFINITIONS AND CONTEXT RELATED TO IMPROVING MULTI-PAYER ALIGNMENT IN VALUE-BASED CARE

In the transition from traditional fee-for-service (FFS) to value-based care, achieving large-scale change in providers' practice patterns can be difficult because individual payers often represent a small proportion of providers' revenue. The transition to value-based care is further complicated by the lack of standards in key components of value-based models, such as performance measures and reporting; data interoperability and sharing; and methods for attribution, benchmarking, and risk adjustment. Multi-payer alignment on value-based care can help providers achieve a threshold patient volume and revenue from value-based payments to initiate delivery system investments and care transitions, establish common value-based payment features, and encourage provider participation in value-based care.[1,2] PTAC developed the following working definition for multi-payer alignment:

- *Agreement among payer programs and products—including those offered through Traditional Medicare, Medicare Advantage, Medicaid Fee-For-Service, Medicaid*

[ii]Soujanya (Chinni) Pulluru, MD, PTAC Co-Chair, and Jay Feldstein, DO, were not in attendance at the February 23-24, 2026, public meeting.

Managed Care, commercial insurers, and employers—on model alignment areas necessary to promote value-based care.

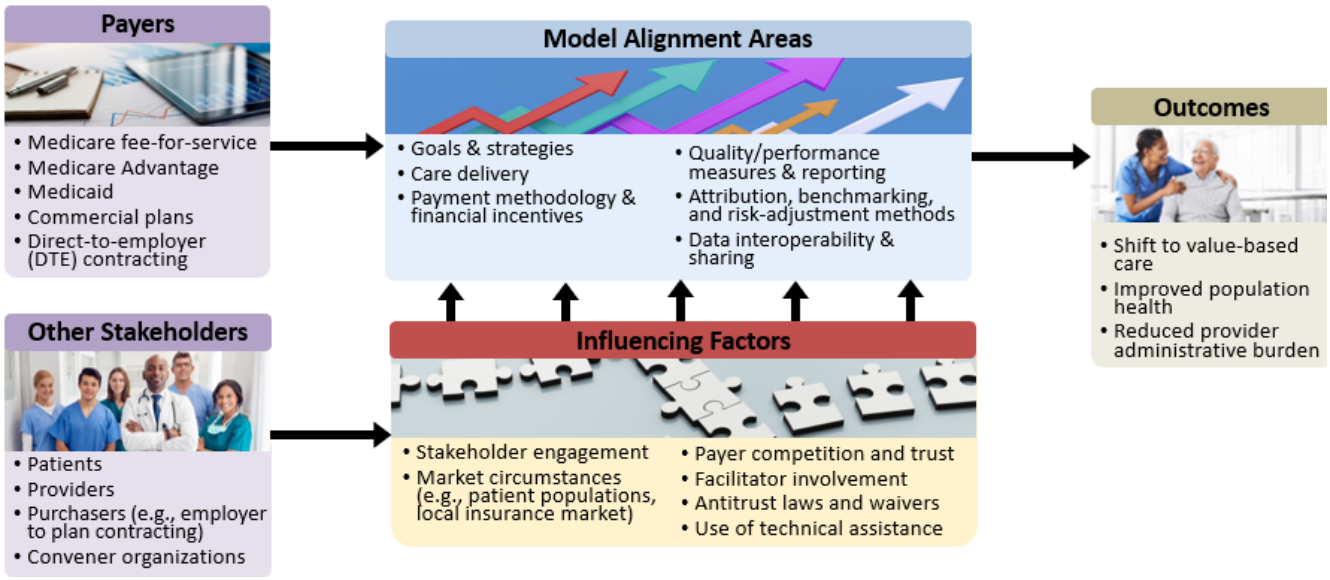
- *Model alignment areas include but are not limited to goals and strategies, care delivery, financial incentives, quality measures, and data sharing.*

Aligning payers around value-based payment models can be beneficial for payers, providers, ACOs, purchasers (e.g., employers), and patients. Potential benefits include:

- Improving affordability, access, equity, quality of care, and population health;
- Simplifying care delivery and reducing fragmented care;
- Allowing health care organizations and clinicians to focus on care transformation activities instead of managing different requirements across multiple payment models;
- Reducing administrative burden and costs by promoting consistency in billing and payment systems;
- Reducing the cost of investing in new health system capabilities to improve care; and
- Encouraging the use of patient data to inform clinical decision-making.[3,4,5,6]

Core areas of alignment with value-based payment models include goals and strategies, care delivery, financial incentives, quality measures, and data sharing. Successfully achieving multi-payer alignment with a value-based model can be influenced by the breadth of stakeholder engagement, market-specific issues (e.g., patient populations, local insurance market), the extent of payer competition and trust, facilitator involvement, antitrust laws and waivers, and availability and use of technical assistance. A conceptual diagram for multi-payer alignment, including payers and other stakeholders, key areas of alignment, factors influencing alignment, and outcomes, is provided in Exhibit 1.

Exhibit 1. Multi-Payer Alignment Conceptual Diagram



Source: PTAC Preliminary Comments Development Team (PCDT) Presentation, February 23, 2026

The CMS Innovation Center and several states have undertaken various multi-payer alignment initiatives over the last two decades. To date, there have been eight CMS-led initiatives that involved multi-payer alignment efforts. These initiatives have evolved over time. For example, the Comprehensive Primary Care (CPC) Initiative started in 2012 and was succeeded by the CPC Plus (CPC+) Model in 2017. Two primary care-focused models followed the conclusion of CPC Plus: Making Care Primary (MCP) and Primary Care First (PCF). CMS' most recent initiative promoting multi-payer alignment is the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model, which operates at the state level and was preceded by state-specific all-payer models (e.g., Maryland Total Cost of Care [TCOC] Model and Vermont All-Payer ACO Model).

Further, many states have designed multi-payer initiatives to support their transition to value-based care and transform health care delivery. Nine states—Arkansas, California, Colorado, Maryland, Minnesota, Pennsylvania, Rhode Island, Vermont, and Washington—have undertaken substantial work implementing a multi-payer model or initiative. Most states included Medicare, Medicaid, and commercial payers in their multi-payer alignment efforts. Large and diverse stakeholder participation was critical to success, as well as states that had the support of high-level leadership (e.g., state governor, health insurance commissioner).

Appendix 2 provides information on the approaches to multi-payer alignment, participating payers, and successes and challenges for the CMS-led and state multi-payer initiatives.

III. CHARACTERISTICS OF PTAC PROPOSALS RELEVANT TO IMPROVING MULTI-PAYER ALIGNMENT IN VALUE-BASED CARE

Between 2016 and 2025, PTAC received 36 proposed PFPMs submitted by stakeholders. PTAC voted on the extent to which 28 of these proposals meet the Secretary's 10 regulatory criteria.[iii] At least 14 of the 28 proposals referenced multi-payer alignment.

The clinical focus of these 14 proposals varied. Six proposals focused on episode-based care (e.g., oncology, chronic obstructive pulmonary disease, Crohn's disease). Two proposals focused on primary care and two proposals focused on inpatient services in the home setting. Two others addressed more than one care condition and/or care setting. One proposal focused on serious illness and palliative care, and one proposal focused on cerebral emergency care and telemedicine.

Proposals varied in their approach to multi-payer alignment. Several proposals aimed to create common value-based care objectives across payers and align some combination of performance measures, payment criteria, incentives, and clinical treatment pathways. One proposal noted that its implementation design would be similar to existing models: the multi-payer CPC and CPC+ models. One proposal included the formation of a group of stakeholders including all payers, providers, and employers to collaborate on the development and implementation of value-based care methodologies.

See **Appendix 3** for additional information on the 14 proposals.

IV. COMMENTS FOR CONSIDERATION BY THE SECRETARY

Based on findings from the Committee members' analysis of PTAC proposals, information in the literature, and information from sessions involving SMEs during the February 2026 public meeting, this section summarizes Committee members' comments regarding improving multi-payer alignment in value-based care. Committee members' comments are organized by five topics:

- Topic 1: Promoting Localized, Patient-Centric Care Delivery;
- Topic 2: Fostering Long-Term System Change;
- Topic 3: Building Essential Foundational Elements to Promote Alignment;
- Topic 4: Ensuring Sufficient Funding and Reliable Practice Revenue; and
- Topic 5: Balancing Simplification and Flexibility in Model Design.

For each topic, relevant issues are highlighted. **Appendix 5** includes a complete list of the Committee members' comments.

[iii] The remaining eight proposals were withdrawn prior to the Committee's deliberation.

IV.A. Topic 1: Promoting Localized, Patient-Centric Care Delivery

PTAC identified an overarching theme—localized and patient-centric care delivery—when considering muti-payer alignment in value-based care models:

- Care delivery needs to be patient-centric and not insurer-centric; and
- Care delivery models must be tuned to the local community.

Committee members' specific comments on promoting localized, patient-centric care delivery are listed in Appendix 5.

Care delivery needs to be patient-centric and not insurer-centric. Subject matter experts emphasized the need for consistent approaches to care delivery regardless of payer. Complexity in care delivery arises when there are inconsistencies in how payer-specific value-based care policies measure quality, define thresholds, and apply payment incentives. Experts discussed how uniform quality metrics and performance incentives are critical to reducing provider burden and sending consistent signals to providers across payers. A main factor in promoting patient-centric, value-based care arrangements is the ability to reduce model fragmentation, operational complexity, and burden resulting from the patient's type of coverage or payer.

Care delivery models must be tuned to the local community. PTAC discussed the need for localized care delivery models that meet patients where they are, regardless of payer type. Communities differ in their expectations for health care, level of disease burden, and provider market landscape. Experts shared that health care may need to be tailored for each community so that care delivery approaches are customized to meet specific community needs. For example, one PTAC member mentioned the potential importance of telehealth for providing patient-centered care in some communities. Overall, Committee members agreed on the importance of establishing a model of care grounded within the local community regardless of payer type.

IV.B. Topic 2: Fostering Long-Term System Change

PTAC emphasized the importance of promoting long-term system change to improve multi-payer alignment:

- A long-term commitment to culture change is needed; and
- Government involvement is essential to achieve the level of participation needed for multi-payer initiatives to succeed.

Committee members' specific comments on fostering long-term system change are listed in Appendix 5.

A long-term commitment to culture change is needed. PTAC and experts stressed that long-term stability and consistency in model goals, infrastructure, and outcomes are needed to transform the health care system and align across multiple payers, such as Medicare FFS, Medicare Advantage (MA), Medicaid, and commercial payers. This may be accomplished by establishing multi-year priorities and reducing constantly changing environments. Further, achieving effective multi-payer alignment requires commitment and involvement from multiple stakeholders. Payers, providers, regulators, state and federal governments, supporting organizations/conveners, and the community at large must be ready to commit, invest, and collaborate.

To drive culture change within the practice environment, one Committee member described the importance of having multi-year, reliable revenue; process simplification for both providers and patients; and burden reduction associated with program administration. The Committee member stressed that aligning payers is a multi-year process needed to achieve this.

Additionally, Committee members discussed the importance of shifting health care systems away from transactional relationships and toward partnership models. This shift will require building trust and establishing effective value-based care payment models with aligned performance metrics. Advancing multi-payer alignment requires multiple stakeholders, including payers and associated providers, to establish consistent and clear parameters for quality, cost, utilization, and outcomes. This means a shift from having transactional relationships (e.g., vendor-like relationships where payers are upstream and providers are downstream) to long-term, strategic partnerships across a unified continuum.

PTAC also discussed what is necessary to implement long-term change to achieve the objectives of multi-payer alignment: investment from payers, providers, and other stakeholders that influences practice change; technology/data readiness; and infrastructure support. Change often occurs incrementally at the start of a multi-payer initiative, and then, when basic infrastructure and capabilities mature, change can accelerate. Committee members noted contrasting views among experts on the approach to implementing multi-payer alignment. Some experts favored starting with incremental change and identifying the elements necessary for payers and providers to approach a "tipping point" where change can proceed more rapidly. Others favored skipping this first step and moving to full multi-payer alignment immediately, thus forcing rapid change from the beginning.

Government involvement is essential to achieve the level of participation needed for multi-payer initiatives to succeed. Committee members noted the importance of CMS' involvement in multi-payer alignment efforts. CMS has a unique capacity to reach a broad audience by bringing stakeholders together. Experts emphasized the need for a strong leader stating that CMS involvement in multi-payer alignment efforts was critical to their success. Among the challenges for stakeholders to navigate are antitrust regulations and competitive concerns that

limit private payers' ability to coordinate on a common strategy for value-based payment. One Committee member noted that, in practice, there has been relatively little engagement in value-based care models among commercial payers. To change this, Committee members believe that involvement and/or leadership from CMS would help commercial entities navigate challenges and move planning forward. According to one Committee member, it is important for leadership from CMS to point consistently toward a single direction and avoid creating new value-based care strategies, recognizing that new developments require costly and continual adaptation from providers and can significantly hamper progress.

State governments also can offer meaningful support and leadership in multi-payer alignment efforts. Having buy-in from the state governor and Medicaid program gives multi-payer alignment initiatives an advocate and the strong leadership needed to achieve consequential results.

PTAC convened a session during the February 2026 public meeting specifically to address multi-payer alignment within Medicare programs (e.g., traditional Medicare and MA). Experts shared several approaches to improve alignment (e.g., shared goals, standardized quality measures). These approaches do not differ from approaches to align across all payers. PTAC emphasized that only with MA involvement with value-based care efforts can multi-payer alignment reach the payer and provider participation levels necessary to drive change among health systems and providers. Experts discussed opportunities to include MA in value-based care and multi-payer alignment efforts, such as strengthening investments in primary care and harmonizing quality and outcome measures within MA contracts and across payers. One expert who leads an organization that enables providers to transition from FFS to value-based care described how their business created a single care model used across its traditional Medicare, APM (e.g., ACO REACH), and MA populations, making it easier to focus on the patient. This single line of business standardizes quality metrics across different plans and programs.

Committee members and experts noted that the potential to mandate participation in value-based care models would facilitate alignment across payers and providers who would have no choice other than to participate. However, they also indicated that any participation mandates should start with larger organizations as it may be difficult for smaller organizations to participate in value-based care arrangements.

Supporting Policy: PTAC emphasized that primary care should anchor multi-payer alignment. Continued investment in primary care, particularly to support team-based care and develop long-term relationships between providers and patients, is essential. Strong patient-provider relationships and reliable attribution methods would also improve health outcomes and reduce utilization.

IV.C. Topic 3: Building Essential Foundational Elements to Promote Alignment

PTAC discussed crucial elements for a successful multi-payer alignment initiative:

- Trust and relationships among payers and between payers and providers are critical;
- Stakeholder communication is essential;
- Payers must be aligned on program/model purpose;
- Conveners play a key role in multi-payer efforts; and
- Planning and good governance are central to success.

Committee members' specific comments on building essential foundational elements to promote alignment are listed in Appendix 5.

Trust and relationships among payers and between payers and providers are critical. Committee members emphasized that successful multi-payer alignment requires trust among stakeholders, including between different payers and between payers and providers. According to experts, transparency around details such as the data used to establish attribution is a particularly important component of trust-building. Without timely and complete information on attribution, providers may not fully understand which patients are attributed to them, which can lead to erosion of trust in payers. Neutral conveners can serve as a conduit to help build trust among stakeholders.

PTAC and experts emphasized that trust develops over time. Building and maintaining trust requires continued attention to transparency and ensuring that progress is consistently visible to stakeholders, not only at the beginning but also across the duration of a multi-payer initiative. As stakeholders have positive experiences with other parties participating in the initiative, and as different stakeholders' motivations and intentions become clear, trust builds. Multi-payer efforts will not succeed without trust among the parties, and the speed at which a multi-payer initiative proceeds will be in direct proportion to the speed at which trust among stakeholders is built.

Stakeholder communication is essential. Related to trust-building, Committee members also conveyed the critical role of communication in multi-payer efforts. Regular formal and informal communication is necessary to build and maintain trust, ensuring that input is received from all stakeholders and that all stakeholders stay informed. Clear, honest, and consistent communication is also a central factor in promoting transparency. Experts noted the importance of holding regular meetings early, as well as ongoing throughout the multi-payer initiative to engage stakeholders, build shared understanding and accountability, and ensure that all participants feel part of the decision-making process. Meetings also should be held within stakeholder type (e.g., only payers), as well as across different stakeholders (e.g., payers and providers).

Experts emphasized a range of preferred communication practices for optimal success with multi-payer initiatives. First, it is important to engage commercial payers and identify the information that they consider proprietary so that topics in group settings can be determined accordingly. Communication can focus on the patient at the center of care delivery as a means to help avoid proprietary topics. Second, relatedly, although group meetings are critical, sensitive issues should be flagged and discussed in private with a stakeholder. Third, consistent involvement of a key government party—either CMS or a state entity—throughout the initiative can have a significant positive impact by helping address participant concerns (e.g., regarding antitrust regulations and competition) and ensuring an ongoing supporter. Fourth, breakout work groups can be an effective way to further engage stakeholders, promote collaboration, and ensure momentum for the initiative.

Payers must be aligned on program/model purpose. Committee members and experts discussed the importance of ensuring that payers are aligned on the purpose of the multi-payer program. Payers may have different goals or objectives for what they hope to achieve when embarking on a new initiative. The success of multi-payer alignment initiatives can suffer if the goals are not clearly specified and shared across stakeholders. Communications should focus on shared interests to facilitate collaboration.

Shared goals help promote predictability for all participants and facilitate program design and prioritization of activities. Having shared priorities also increases the feasibility of long-term success. One expert suggested that a government policy push can help bring stakeholders together. Another expert shared that when implementing a multi-payer initiative, they used a memorandum of understanding (MOU) to help establish the general principles and structures of their collaboration. Clearly stating all assumptions is essential to ensure alignment of goals and objectives. Finally, it is important for stakeholders to have a shared and collaboratively defined vision for what success looks like when the program or initiative has been implemented, focusing on desired outcomes.

Conveners play a key role in multi-payer efforts. PTAC emphasized the critical role that a convener—a neutral, trusted party that facilitates collaboration among stakeholders—plays in multi-payer alignment efforts. Conveners can help stakeholders with aligning potentially competing interests, managing expectations, sustaining engagement, and driving participants toward a shared vision and collaborative program implementation. Conveners, such as ACOs, also can serve an aggregator role, acting as a centralized contracting and data entity between multiple participating payers and multiple participating providers. This can streamline implementation and particularly help facilitate involvement of small and rural providers by alleviating the administrative burden of engaging with multiple payers.

One challenge programs may face is how to fund the convener role; it is important to consider this during the initial planning phase. Start-up funds and grants for the program or initiative can be used for this purpose. Another approach is to employ CMS or states, both of which

commonly participate as payers in multi-payer programs, as conveners. Experts emphasized that CMS and/or state participation is typically essential to achieve a threshold level of payers and other stakeholders necessary for multi-payer initiatives to succeed. In the convener role, CMS and states also can help stakeholders avoid challenges such as noncompliance with antitrust regulations or hindered payer discussions due to antitrust concerns.

Planning and good governance are central to success. Committee members and experts noted the importance of good planning and organization, as well as strong governance, to the success of multi-payer initiatives. An inclusive governance structure that guides the overall program, model development, and implementation should involve all relevant stakeholder groups. Strong, clear, and ongoing leadership, including through use of a convener, is essential to develop and sustain stakeholder engagement. Leadership also helps promote transparency and accountability, ensure that implementation is feasible and that model operations are sustainable, and address challenges that arise with the program. Additionally, strong governance is essential to address issues related to data ownership and data sharing.

An important component of strong governance is good organization, coordination, and effective planning. One expert noted the importance of promoting consistency and stability. Another expert emphasized the need to create strong artifacts, such as templates, tools, and lessons learned, to support program participants. These resources can serve as a base and allow customization and tailoring to suit individual communities.

IV.D. Topic 4: Ensuring Sufficient Funding and Reliable Practice Revenue

PTAC discussed the importance of up-front, reliable, and predictable funding to support multi-payer alignment efforts:

- Up-front funding is needed to support conveners and infrastructure; and
- A significant, reliable revenue stream supports provider shift to value-based care.

Committee members' specific comments on ensuring sufficient funding and reliable practice revenue are listed in Appendix 5.

Up-front funding is needed to support conveners and infrastructure. Committee members expressed the need to understand how to adequately provide up-front funding to support multi-payer efforts. Up-front investments are critical to advancing the development of multi-payer alignment efforts, including the work to develop multi-payer tools and resources.

Experts representing various state perspectives discussed the importance of receiving up-front funds from CMS (through State Innovation Model [SIM] grants or other model initiatives). Because of this up-front funding, some states were able to develop standards for governance, payment methodology, attribution, and quality metrics. Up-front funding also helped support regular stakeholder participation.

One expert noted that states have a significant opportunity to receive funding by using Medicaid's Implementation Advance Planning Document (IAPD) process to fund integrated data models and data interoperability. When the state's Medicaid program participates in multi-payer models, states can receive the 90-10 federal match to build and sustain data infrastructure.

A significant, reliable revenue stream supports provider shift to value-based care. Committee members conveyed the importance of predictable, prospective payment structures and aligned primary care funding to enable transformation efforts. Financial stability is important to shift providers to and align payers within value-based care arrangements.

Aligning payers is a multi-year process that requires predictability. One expert shared that a state's Medicaid program provided a bi-weekly, standardized payment to participating hospitals. This approach allowed hospitals to know the level of funding they would receive, more accurately predict their funding capacities on a regular basis, and minimize retrospective reconciliation at the end of the year. Payers also preferred this approach because the predictability allowed them to better forecast investment opportunities across the entire continuum of care.

Another expert shared that their state model required that all participants, largely rural hospitals, use global budget agreements to improve financial stability. Rural hospitals may consider requesting a Rural Emergency Hospital designation from CMS. CMS provides these hospitals with a fixed facility payment to help stabilize cash flow. The expert noted that about one-fourth of their state's hospitals have requested this designation. Committee members stressed that it is important to recognize the need to prioritize the success of providers' business models as this promotes collaboration across stakeholders in a multi-payer value-based care initiative.

To encourage participation in value-based care and ultimately align multiple payers within value-based care arrangements, it is essential to provide meaningful and timely incentives to providers for achieving goals. PTAC and experts expressed that the use of both positive (e.g., bonuses) and negative (e.g., payment reductions) incentives can accelerate progress.

Multi-payer alignment requires significant financial investment. It is important to provide predictable, reliable, and stable payments and incentives. Shared goals and expectations without financial consequences or accountability may not drive durable change.

IV.E. Topic 5: Balancing Simplification and Flexibility in Model Design

PTAC discussed the need to simplify multi-payer models but also allow opportunities for flexibility and innovation:

- Models should be simplified where possible; and
- Models should remain flexible, and alignment should not be over-specified.

Committee members' specific comments on balancing simplification and flexibility in model design are listed in Appendix 5.

Models should be simplified where possible. Committee members and experts highlighted the need for multi-payer models to be simple and practical. Operational complexity and administrative burden are primary barriers to adopting value-based care. Providers are challenged to participate in APMs when multiple models with different requirements and incentives exist across different payers. Moreover, lack of alignment can lead to providers diluting their value-based care efforts when attempting to meet differing program requirements. For example, differences in clinical, utilization, and outcome performance measures in various programs can lead providers to invest and focus on different areas for the same patient population. One expert suggested developing a global alignment structure—a strategic alignment framework—that could guide alignment when developing specific models.

Maintaining payer involvement in a program can be challenging. Slow return on investment (ROI), inability to meet infrastructure requirements, and administrative burden are cited as common challenges. ROI for primary care models, focused on broad population-based prevention and chronic care programs, can take many years to realize, and payers may not be interested in making these long-term investments. This can lead to development of more programs, with an emphasis on acute or condition-specific issues, which can make cross-program alignment more difficult. One expert recommended having fewer programs overall, noting that it is easier to align programs when there are fewer of them. These programs could be strategically designed in alignment with each other. Another option is implementing a long-term population-based model that incorporates acute components that may yield more rapid ROI.

Experts highlighted the importance of building upon existing infrastructure and prior successful programs—such as using existing care delivery, care coordination, and payment platforms—to support alignment and program success. This approach also helps minimize risk for payers as they know more about existing infrastructure, processes, systems, and measures. Experts also suggested prioritizing the most important areas for alignment. Clear model goals can help with this prioritization process.

Alignment across programs can reduce administrative burden for both payers and program participants and facilitate participation among payers. Alignment within a program can also reduce administrative burden for payers when programs are harmonized on key program elements, such as data infrastructure, attribution approaches, quality measures, risk adjustment, and payment incentives. Alignment on these elements also reduces administrative

burden on providers who can focus on one set of program specifications rather than having to meet and negotiate differing requirements with multiple payers. Experts also recommended that models should be designed to be easily understood by providers. For instance, providers typically prefer payment mechanisms based on straightforward calculation methods so they can accurately predict the level of program funds they will receive each period.

Finally, effective learning and diffusion activities can support model simplification. Technical assistance to payers can support program engagement by facilitating collaboration and implementation. Learning diffusion can allow programs to share lessons learned, as well as templates and tools that can be used to support more efficient and successful model development and implementation.

Models should remain flexible, and alignment should not be over-specified. Although Committee members noted that alignment requires some degree of standardization and harmonization, they also cautioned that alignment should not be over-specified; flexibility is important to encourage payer involvement. One Committee member stressed that standardization and flexibility should not be viewed as opposites but as complements at different ends on a continuum, with the need for calibration to achieve the right balance. Alignment does not require uniformity in all aspects of the program, nor is exact alignment necessarily beneficial in all cases. For example, commercial payers may be more concerned about their competitive advantage relative to public payers. During development, it is important to determine which program components should be standardized and where to allow flexibility and innovation. For example, aligning on the attribution approach and quality measures may be essential to minimize participant burden, but building in flexibility for how to approach patient engagement may be beneficial. Flexibility may also help account for community differences such as allowing options for the use of care management fees so that care coordinators can connect with patients in a way that makes sense for their community.

Committee members and experts also discussed the degree of alignment that is useful across specific model components—infrastructure and data, quality measures, risk adjustment, and attribution. Committee members and experts recognized the importance of alignment on data infrastructure and giving providers access to the data they need to participate in value-based care. Clear specification of the program's data requirements, data standardization, and data exchange are essential to reduce time and effort in managing different data sources and formats. Robust, timely, and complete data underlie essential needs, such as giving providers an understanding of patient outcomes to support care delivery, optimizing patient attribution, and ensuring accurate quality performance results and risk adjustment.

Creating interoperability across different data systems and data types, including social needs data, is critical and can be challenging and costly to enact. Moreover, information-blocking policies that inhibit data sharing may need to be addressed. Shared data infrastructure can be

supported through use of centralized data aggregators, such as ACOs that have financial relationships with multiple payers and providers, or state-wide through use of entities such as APCDs or HIEs.

Committee members and experts discussed the need to standardize quality and performance measures across programs and payers. Measure alignment is often cited as a key area to reduce administrative burden and cost. CMS and some states have developed common measure sets, such as the CMS Universal Foundation measures and Washington Common Measure Set, to support multi-payer alignment. Relatedly, consistency in rules used to risk-adjust performance results is desirable to decrease administrative burden and support the effectiveness of financial incentives. Social risk adjustment was also noted as particularly important for certain patient populations.

Finally, experts described multiple challenges associated with patient attribution. Providers and payers may have limited trust in attribution results due to lack of transparency in data and attribution methods. There are also concerns about the timeliness, quality, and completeness of data used to attribute patients to providers in value-based care programs. Factors such as the strength of the relationship between patients and their primary care provider, which can vary by type of payer, can also affect trust in program attribution methods. Clarity on which patients are attributed to a given provider is essential to model success.

APPENDIX 1. COMMITTEE MEMBERS AND TERMS

Terry L. Mills Jr., MD, MMM, *Co-Chair*
Soujanya R. Pulluru, MD, *Co-Chair*

Term Expires October 2026

Jay S. Feldstein, DO
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Lauran Hardin, MSN, FAAN
HC² Strategies
Maysville, KY

Joshua M. Liao, MD, MSc
Ascension
Dallas, TX

Walter Lin, MD, MBA
Generation Clinical Partners
Saint Louis, MO

Terry L. Mills Jr., MD, MMM
Aetna Better Health of Oklahoma,
Strategic Health, LLC
Tulsa, OK

Term Expires October 2027

Henish Bhansali, MD, FACP
Independent Consultant
Chicago, IL

Lawrence R. Kosinski, MD, MBA
VOCnomics, LLC
Scottsdale, AZ

Soujanya R. Pulluru, MD
CP Advisory Services, My Precious Genes
Sarasota, FL

Krishna Ramachandran, MBA, MS
UnitedHealth Group
Piedmont, CA

Term Expires November 2028

Lindsay K. Botsford, MD, MBA
One Medical
Houston, TX

David Tyson, MA
Novant Health
Winston-Salem, NC

APPENDIX 2. CHARACTERISTICS OF CMS-LED AND STATE MULTI-PAYER MODELS AND INITIATIVES

Table 2A. CMS-Led Multi-State Multi-Payer Models and Initiatives

CMS Model	Approaches to Multi-Payer Alignment	Participating States/Regions	Participating Payers	Successes and Challenges
Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model[7] 2026–2035	• Builds upon Maryland TCOC and Vermont All-Payer ACO Models • Aligns Medicaid and commercial payers with Medicare • Participation of Medicaid and other payers in hospital global budgets	• Connecticut • Hawaii • Maryland • New York • Rhode Island • Vermont	• Medicare • Medicaid • Commercial	• Performance window for this model does not start until 2026.
Comprehensive Primary Care (CPC)[8,9] 2012–2016	• Population-based care management fees provided by Medicare and other payers • Payers agreed to collaborate on an approach to align goals, financial incentives, and performance measures.	• Arkansas • Colorado • New Jersey • New York (North Hudson-Capital Region) • Ohio & Kentucky (Cincinnati-Dayton Region) • Oklahoma (Greater Tulsa Region) • Oregon	• Medicare • Medicaid (except NJ and NY region) • Commercial	<u>Successes</u> • Payers established valuable relationships with each other in their respective state/region. • Payers in CO and the OH/KY and OK regions were able to create a single tool to aggregate data across payers. • Payers in AR and OR aligned cost and utilization measures in payer feedback reports. <u>Challenges</u> • CMS' dual role as convener and participating payer made collaboration and trust-building difficult. • CPC administrative reporting was burdensome to providers.
Comprehensive Primary Care Plus (CPC+)[10,11,12] 2017–2021	• Population-based care management fees and performance payments provided by Medicare and other payers • Additional payments during COVID-19 • Payers agreed to collaborate on an approach to align goals, financial incentives, and performance measures.	• Arkansas • Colorado • Hawaii • Kansas & Missouri (Greater Kansas City Region) • Louisiana • Michigan • Montana • Nebraska • New Jersey • New York (North Hudson-Capital Region)	• Medicare • Medicaid • Commercial	<u>Successes</u> • Broad participation from public and private payers • Payers in 12 states/regions aggregated data with Medicare FFS data into one single tool. • Having a neutral convener to facilitate data aggregation among payers is important. <u>Challenges</u> • While many large payers participated in CPC+, they did not include all lines of business so multi-payer

CMS Model	Approaches to Multi-Payer Alignment	Participating States/Regions	Participating Payers	Successes and Challenges
		• New York (Greater Buffalo Region) • North Dakota • Ohio & Kentucky (Cincinnati-Dayton Region) • Oklahoma • Oregon • Pennsylvania (Greater Philadelphia Region) • Rhode Island • Tennessee		efforts were not as effective as they could have been. • Inability of many payers to implement population-based payments due to practices' opposition to accepting capitated payments and the investment needed to develop compatible data systems • Need for more transparency in private payers' performance-based payment models
Making Care Primary (MCP) Model[13,14] 2024–2025	• Built upon CPC, CPC+, PCF, and Maryland Primary Care Program • Gradual implementation of prospective, population-based payments • Directional alignment on primary care payment, performance measures, financial incentives, data aggregation, and learning systems	• Colorado • Massachusetts • Minnesota • New Jersey • New Mexico • New York • North Carolina • Washington	• Medicare • Medicaid • Commercial	<u>Successes</u> • N/A (no evaluation reports were completed during the 1.5 year run of this model). <u>Challenges</u> • Prematurely ended after less than two years, which did not allow it to progress to its full potential.
Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration[15,16] 2011–2014[iv]	• CMS joined state-sponsored multi-payer initiatives involving Patient-Centered Medical Homes (PCMHs).	• Maine • Michigan • Minnesota • New York • North Carolina • Pennsylvania • Rhode Island • Vermont	• Medicare • Medicaid • Commercial	<u>Successes</u> • Most states had stable payer participation (about 3-7 payers involved, as well as Medicare and Medicaid). <u>Challenges</u> • Practices did not receive data from states and payers in a timely manner. • Multi-payer alignment is complex and takes substantial time to see progress; participants felt that they were just getting started when the demonstration ended.
Primary Care First (PCF)[17,18,19] 2021–2025	• Aligned payment methodology, performance measurements, and data sharing approach	• Alaska • Arkansas • California • Colorado	• Medicare • Medicaid[v] • Commercial	<u>Successes</u> • Private payer collaboration with CMS and CMS Innovation Center Models <u>Challenges</u>

[iv] Five states (Maine, Michigan, New York, Rhode Island, and Vermont) participated through 2016.

[v] State Medicaid agencies that participated in PCF were Louisiana, Maine, and Ohio.

CMS Model	Approaches to Multi-Payer Alignment	Participating States/Regions	Participating Payers	Successes and Challenges
	• Flat primary care visit fee, a population-based payment, and performance-based adjustment	• Delaware • Florida • Hawaii • Kansas & Missouri (Greater Kansas City Region) • Kentucky (Northern Region) • Louisiana • Maine • Massachusetts • Michigan • Montana • Nebraska • New Hampshire • New Jersey • New York (Greater Buffalo Region • New York (North Hudson-Capital Region) • North Dakota • Ohio • Oklahoma • Oregon • Pennsylvania (Greater Philadelphia Region) • Rhode Island • Tennessee • Virginia		• Limited payer participation and alignment; only three state Medicaid agencies and 17 commercial payers participated across 26 states/regions. • About one-quarter of payers withdrew from the model citing: 1) PCF was not a priority compared with their own initiatives; 2) low practice participation as many practices opted to join ACO REACH; and 3) issues paying capitated payments for PCF using their own billing systems.
State Innovation Models (SIM) Initiative[20,21,22] 2013–2020	• Three types of awards: model testing, model pre-testing, model design[vi] • Engaged public and commercial payers, providers, and patients to develop or implement a state innovation plan • States were provided flexibility to use CMS funds to build their state innovation plan to meet the needs of their states.	• Arizona • Arkansas • California • Colorado • Connecticut • Delaware • District of Columbia • Hawaii • Idaho • Illinois • Iowa • Kentucky • Maine • Maryland	• Medicare • Medicaid • Commercial	<u>Successes</u> • States' planning and implementation efforts resulted in the development of relationships that would serve as a starting point for future state multi-payer initiatives. <u>Challenges</u> • Only three states (AR, OR, and VT) aligned payment models across multiple payers.

[vi] Model test awards gave funds for states to implement and test health system transformation strategies; model pre-test and design awards gave funds for states to plan and design health system transformation strategies.

CMS Model	Approaches to Multi-Payer Alignment	Participating States/Regions	Participating Payers	Successes and Challenges
	• States needed to submit a Medicare alignment proposal to gain the ability to align with Medicare.	• Massachusetts • Michigan • Minnesota • Montana • Nevada • New Hampshire • New Jersey • New Mexico • New York • Ohio • Oklahoma • Oregon • Pennsylvania • Rhode Island • Tennessee • Texas • Utah • Vermont • Virginia • Washington • West Virginia • Wisconsin		
State Transformation Collaboratives (STCs)[23,24] (Joint effort between CMS and Health Care Payment Learning & Action Network [HCPLAN]) 2023–present	• Collaboratives within each state to test approaches to multi-payer alignment focused on specific needs of each state • Stakeholder convenings and work groups that connect large groups of stakeholders for each state (e.g., payers, providers, purchasers, patient advocates, and community-based organizations)	• Arkansas • California • Colorado • North Carolina	• Medicare • Medicaid • Commercial	<u>Successes</u> • HCPLAN was able to compile a multi-payer alignment blueprint based on approaches taken by the STC states. • The Arkansas STC built on CPC+ and PCF efforts to develop aligned performance measures. • The California STC engaged new commercial payers to join STC alignment efforts. • The Colorado STC facilitated sessions to receive feedback on legislation that would set standards to align primary care APM model design components, including aligned performance measures. • The North Carolina STC focused on aligning performance measures and standardizing health equity data collection efforts.

Table 2B. Single State Multi-Payer Models and Initiatives

State Model/Initiative	Approaches to Multi-Payer Alignment	Participating Payers	Successes and Challenges
Arkansas Health Care Payment Improvement Initiative[25,26,27,28] 2012–present	• Aligned on design elements and implementation strategy • Standardized reporting tools and targets for quality outcomes • Episode-based payment structure for acute conditions and PCMH payment model (prospective per-member-per-month payment) for chronic conditions • Mandatory participation for episode payments system • Does not align/share cost targets among payers to avoid antitrust issues	• Medicare FFS • Medicaid FFS • Medicaid Managed Care • Ambetter • Arkansas Blue Cross Blue Shield • Humana • QualChoice	<u>Successes</u> • CPC participant, which was critical in AR's development of this initiative • Leadership stemming from the AR governor • Buy-in from AR's largest private employer (Walmart) • Stakeholder consensus on key model design components • AR's commercial insurance market is consolidated to a few carriers, which helped simplify design process. • Episode-based payments improved quality and contained costs. <u>Challenges</u> • Private payers do not participate in every care episode.
California Advanced Primary Care Initiative (The Payment Model Demonstration Project)[29,30,31,32] 2022–present	• Involvement of Purchaser Business Group on Health's California Quality Collaborative (CQC), Integrated Healthcare Association (IHA), and health plans in designing payment model(s), developing performance metrics, and developing/executing implementation strategy • Shared platform/reporting system across payers so practices have a complete view of patient information • Walmart, Covered California (marketplace), CA Public Employees' Retirement System, and CA Department of Health Care Services (Medicaid) will monitor demonstration progress. • Builds upon the Advanced Primary Care Measurement Pilot, which began in January 2022	• Medicare FFS • Medicare Advantage • Medicaid FFS • Medicaid Managed Care • Aetna • Blue Shield of California • CA Public Employees' Retirement System (CalPERS) • Centene Health Net • Covered California (marketplace)	<u>Successes</u> • Including independent practices in the model, which constitute a substantial portion of primary care providers (PCPs) in California <u>Challenges</u> • TBD; evaluations to commence in 2026
Colorado APM Alignment Initiative[33] 2021–present	• Flexibility to providers and payers to implement any APM on the HCPLAN APM continuum • Prospective payment methodology is encouraged. • Standardized quality measures across payers	• Medicare FFS • Medicare Advantage • Medicaid FFS • Medicaid Managed Care • Anthem	<u>Successes</u> • Formed an APM alignment advisory group and two sub-groups (focused on primary and maternity care) representing a broad range of stakeholders to

State Model/Initiative	Approaches to Multi-Payer Alignment	Participating Payers	Successes and Challenges
	• Attribution by patient attestation; when not available, payers should use claims. • Risk-adjust by health conditions, age, and gender • Medicare was included as a payer when the state participated in the CMS Making Care Primary Model.	• CVS/Aetna • Denver Health • Employment Retirement Income Security Act (ERISA) & state employee self-funded plans • Kaiser Permanente • Rocky Mountain Health Plans	develop consensus-based recommendations <u>Challenges</u> • Stakeholders recognized that it is hard to align across national health plans that want consistency across their markets.
Maryland Total Cost of Care (TCOC) Model[34,35,36,37,38,39] 2019–2026	• All-payer global budget pays hospitals annual fixed amount. • Used a waiver to establish shared hospital payment rates where all payers in Maryland pay hospitals based on same/similar rates • Standardized billing and reporting requirements across payers • Standardized quality measures across payers • Payer alignment on bundles and primary care • Convened a payer alignment work group to propose recommendations, such as communication of model to other stakeholders in MD	• Medicare FFS • Medicaid FFS • Medicaid Managed Care • CareFirst • UnitedHealthcare • Wellpoint	<u>Successes</u> • Set the groundwork for health care delivery system transformation • Established community partnerships <u>Challenges</u> • Initially, the all-payer rate system created the perverse incentive to increase volume of services. Maryland introduced global budgets to negate this incentive. • Budgets should be determined locally and consider local cost of living (e.g., urban vs. rural vs. in-between areas). • Improving population health requires the need to identify the 5% of the population that is accountable for almost half of health care spending.
Minnesota Accountable Health Model[40,41,42] 2013–2017	• Aligned risk adjustment, attribution, financial incentives, and ACO contract requirements • Standardized performance measures across payers • Standardized data analytics content and format	• Medicare FFS • Medicaid FFS • Medicaid Managed Care	<u>Successes</u> • Engaged a broad stakeholder group • Several state efforts took place around a similar timeframe, such as the Multi-Payer Alignment Task Force (mostly focused on improving exchange of data) and the Health Care Homes (HCH) Program, which also participated in the CMS MAPCP demonstration from 2011-2014; it is still active and focuses on primary care clinics that involve Medicaid and commercial payers

State Model/Initiative	Approaches to Multi-Payer Alignment	Participating Payers	Successes and Challenges
			(and Medicare during the CMS MAPCP timeframe). Challenges • Lack of clear goals and competitive nature of plans stalled progress to align payment methodologies and performance measures.
Pennsylvania Rural Health Model[43,44,45,46,47] 2017–2024	• All-payer global budget payments for rural hospitals • Independent entity (PA Rural Health Redesign Center Authority [RHRCA]) to administer the model	• Medicare FFS • Medicare Advantage • Medicaid FFS • Medicaid Managed Care • Aetna • Geisinger Health Plan • Highmark • Highmark Wholecare • UPMC Health Plan	Successes • Provided technical assistance to rural hospital participants • Improved quality outcomes Challenges • Commercial payers expressed concerns about the sustainability and administrative burden of the model. • Difficulty with predicting global budgets due to factors such as unexpected changes in market competition and clinician turnover, as well as complex reconciliation methodology that resulted in hospitals and payers having to repay Medicare at end-of-year reconciliation
Rhode Island Chronic Care Sustainability Initiative (CSI-RI)[48,49,50,51] 2008–2014	• PCMH model • Medicaid and commercial payers used a common contract that listed standard practice requirements and performance measures. • Commercial payers required to invest increasingly more of their total spend on primary care and non-FFS payments as years progress • Medicare was a payer when the model participated in the CMS MAPCP demonstration from 2011-2014. • Aligned on goals, performance measures, practice transformation resources, and incentives	• Medicare FFS • Medicare Advantage • Medicaid FFS • Medicaid Managed Care • Blue Cross Blue Shield RI • Neighborhood Health Plan • Tufts Health Plan • United Health Plan	Successes • Engaged leadership of key stakeholders and the RI health insurance commissioner • Participation by all commercial plans in the state because participation was mandated • Substantial investment in health information technology to support health care transformation • Efforts were continued after model end through the Care Transformation Collaborative Rhode Island (CTC-RI). Challenges • No documentation of challenges/lessons learned could be located.
Vermont All-Payer Accountable Care Organization (ACO) Model[52,53,54,55]	• Prospective value-based reimbursement system • Aligned incentives across payers • Standardized quality measures across payers	• Medicare FFS • Medicare Advantage • Medicaid FFS	Successes • Collaboration among stakeholders • Improved population health and quality outcomes

State Model/Initiative	Approaches to Multi-Payer Alignment	Participating Payers	Successes and Challenges
2017–2025	• Creation of an independent regulatory board (Green Mountain Care Board) to develop the model framework and targets	• Medicaid Managed Care • BlueCross BlueShield of VT • MVP Health Care	Challenges • The majority of payers and providers need to participate for the model to succeed. • Key health reform activities, such as integration of clinical and claims data, need an overarching agency/ organization to lead efforts.
Washington Multi-Payer Collaborative Primary Care Transformation Initiative[56,57,5859] 2019–present	• Aligned payment methodologies • Standardized performance measures across payers • Expectation to gradually transition from FFS to prospective payments	• Medicare FFS • Medicaid FFS • Medicaid Managed Care • Community Health Plan • Coordinated Care • Kaiser Permanente • Molina • Regency BlueShield • UnitedHealthcare Premera Blue Cross • Wellpoint	Successes • Formation of multi-payer collaborative learning cohort involving primary care practices and payers • Developed MOU for participating payers Challenges • Collaboration among agencies and different stakeholders can be time- and resource-intensive. • Operation of initiative without federal or external funding • Clear and attainable goals should be made.

APPENDIX 3. CHARACTERISTICS OF SELECTED PTAC PFPM PROPOSALS IDENTIFIED AS BEING RELEVANT TO IMPROVING MULTI-PAYER ALIGNMENT IN VALUE-BASED CARE

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-Based Care Components
American Academy of Family Physicians (AAFP) *(Provider association and specialty society)* **Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care** Recommended for limited-scale testing, 12/19/2017	**Clinical Focus**: Primary care **Providers**: Physicians with a primary specialty in family medicine, general practice, geriatric medicine, pediatric medicine, or internal medicine **Setting**: Primary care practices **Patient Population**: Medicare FFS beneficiaries	**Overall Model Design Features**: APC-APM builds on concepts tested through CPC and CPC+ models. Primary care medical homes work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange. **Financial Methodology**: Capitated per-beneficiary-per-month (PBPM) with shared risk options for accountability **How Payment is Adjusted for Performance**: Participants assume performance risk. APMs that meet or exceed agreed-upon benchmarks retain incentive payment. Failure to meet benchmarks would involve repaying all or part of the incentive payment. **Approaches to Incorporate Multi-Payer Alignment**: APC-APM is intended to be a multi-payer model that adds to the design of the multi-payer CPC and CPC+ models, which promote longitudinal, comprehensive, and coordinated care with primary care teams.
American College of Physicians-National Committee for Quality Assurance (ACP-NCQA) *(Provider association and specialty society/other)* The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version) Recommended for testing to inform payment model development, 9/15/2020	**Clinical Focus**: Improved coordination in primary and specialty care practices **Providers**: Primary and specialty care practitioners **Setting**: Primary and specialty care practices **Patient Population**: Medicare FFS beneficiaries with multiple chronic conditions	**Overall Model Design Features**: The model builds on the CPC+, PCMHs, and Patient-Centered Specialty Practice (PCSP) concepts. **Financial Methodology**: Participants receive a monthly PBPM care coordination fee and a retrospective positive or negative payment adjustment. Track 1 includes fee-for-service payments, while Track 2 has a reduced fee-for-service payment and a comprehensive specialty care payment (CSCP). **How Payment is Adjusted for Performance**: Performance-based payment adjustment is based on spending relative to a financial benchmark, adjusted for performance on quality and utilization metrics. **Approaches to Incorporate Multi-Payer Alignment**: Medical Neighborhood is a multi-payer initiative that aims to achieve better coordination between primary and specialty care practices. The model intends to align performance measures, payment criteria, and incentives across payers.
The American College of Surgeons (ACS)	**Clinical Focus**: Cross-clinical focus with sets of procedural episodes of care	**Overall Model Design Features**: Focused on procedural episodes, leveraging the EGM software developed by CMS and Brandeis University, the model is based on shared accountability, integration, and care coordination.

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-Based Care Components
(Provider association/specialty society) The ACS–Brandeis Advanced Alternative Payment Model Recommended for limited-scale testing, 4/11/2017	**Providers**: Single or multispecialty practices and groups of small provider practices **Setting**: Inpatient, outpatient, ambulatory **Patient Population**: Medicare FFS beneficiaries from over 100+ conditions or procedures	**Financial Methodology**: Retrospective payment that compares episode target prices to the actual cost of the care provided **How Payment is Adjusted for Performance**: Performance (e.g., unacceptable, acceptable, good, excellent) determines the shared savings retained by the APM entity or the amount to repay CMS for losses. **Approaches to Incorporate Multi-Payer Alignment**: This advanced APM is a multi-payer model that nests acute condition episodes within chronic condition episodes and clusters episodes in an advanced APM (rather than a single episode comprising the APM) to facilitate business efficiencies in a multi-payer system.
American Society of Clinical Oncology (ASCO) *(Provider association/specialty society)* Patient-Centered Oncology Payment Model (PCOP) Recommended for testing to inform payment model development, 9/15/2020	**Clinical Focus:** Oncology **Providers:** Clinicians, including hematologists and oncologists **Setting:** Oncology specialty practices **Patient Population:** Oncology practice patients	**Overall Model Design Features**: The model proposes to create PCOP communities that include several providers, payers, and other entities to provide high-quality, coordinated care. **Financial Methodology**: Providers receive three payments: monthly care management payments (CMPs), performance incentive payments (PIPs), and adjustments to FFS reimbursement. A portion of the CMP will be allocated to a PIP. PIPs will be positively or negatively adjusted based on provider success in adherence to clinical treatment pathways, quality metrics, and cost reduction. There are two tracks: Track 1 participants continue to receive FFS reimbursement in addition to the CMPs; Track 2 participants participate in the Consolidated Payments for Oncology Care (CPOC) where practices can bundle 50% or 100% of the value of specified services. 10% of the amount bundled will be subject to the same performance adjustment as PIPs times a 1.4 multiplier. **How Payment is Adjusted for Performance**: If providers do not meet minimum expectations, CMP and PIP amounts may be suspended, and providers will need to develop an improvement plan. **Approaches to Incorporate Multi-Payer Alignment**: PCOP is a multi-payer model that aims to align on payment incentives, performance measures, and clinical treatment pathways. The model proposes the formation of a group of stakeholders that would include all payers, providers, and employers to collaborate on the development and implementation of methodologies.
Coalition to Transform Advanced Care (C-TAC) (*Coalition*)	**Clinical Focus**: Advanced illness, palliative care, end-of-life care **Providers**: PCPs, specialists	**Overall Model Design Features**: An interdisciplinary care team implements the ACM care delivery services.

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-Based Care Components
Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model Recommended for limited-scale testing, 3/26/2018	**Setting**: Hospitals, health systems, hospices, home health **Patient Population**: Medicare FFS beneficiaries with advanced illness in the last year of life	**Financial Methodology**: A non-tiered per-member-per-month (PMPM) payment with downside risk for TCOC and an upside bonus for quality, subject to maximum payment and loss amounts **How Payment is Adjusted for Performance**: Pay-for-quality structure, where participants are eligible for a quality-based bonus funded by shared savings and determined by performance measure performance **Approaches to Incorporate Multi-Payer Alignment**: The ACM proposes multiple payers to participate and align on payment model design.
Dr. Jean Antonucci, MD *(Independent individual)* An Innovative Model for Primary Care Office Payment Recommended for limited-scale testing, 9/6/2018	**Clinical Focus:** Primary care **Providers:** Primary care providers, nurse practitioners **Setting:** Primary care practices **Patient Population:** Medicare beneficiaries	**Overall Model Design Features**: The model aims to provide office-based primary care with a capitated payment structure and proposes to use a HowsYourHealth (HYH) tool to ascertain risk and quality. **Financial Methodology**: $60 PMPM for low- and medium-risk patients, and $90 PMPM for high-risk patients **How Payment is Adjusted for Performance**: 15% of annual income will be withheld; if participants do not meet quality and cost benchmarks, they may lose this income. **Approaches to Incorporate Multi-Payer Alignment:** The model includes all payers who choose to participate.
Illinois Gastroenterology Group and SonarMD, LLC (IGG/SonarMD) *(Regional/local single specialty practice; Device/technology company)* Project Sonar Recommended for limited-scale testing, 4/10/2017	**Clinical Focus**: Chronic disease (Crohn's disease) **Providers**: Specialty physicians **Setting**: Outpatient settings and specialty care practices **Patient Population**: Medicare FFS beneficiaries	**Overall Model Design Features**: The model integrates evidence-based medicine with proactive patient engagement. It allows physicians to participate in chronic disease management that is not triggered by a surgical procedure or on an inpatient or outpatient basis. **Financial Methodology**: Add-on PBPM payment with two-sided risk, plus a payment to support remote monitoring **How Payment is Adjusted for Performance**: Payments would be adjusted based on quality and financial performance. **Approaches to Incorporate Multi-Payer Alignment**: Blue Cross Blue Shield (BCBS) of Illinois is already using the model.
Innovative Oncology Business Solutions, Inc. (IOBS) *(For-profit corporation)* Making Accountable Sustainable Oncology	**Clinical Focus**: Oncology **Providers**: Oncologists, surgeons, PCPs, pathologists, radiologists **Setting**: Oncology practices	**Overall Model Design Features**: Builds off the Community Oncology Medical Home (COME HOME) CMS Innovation Center project **Financial Methodology**: Determined by the oncology payment category (OPC), consisting of FFS payments for physician visits, imaging, lab, radiation therapy, surgery; infusion with a facility fee; ambulatory payment

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-Based Care Components
Networks (MASON) Referred for further development and Implementation, 12/10/2018	**Patient Population**: Medicare FFS beneficiaries	classifications (APCs) for hospital outpatient care; diagnosis-related groups (DRGs) for inpatient care; and the PCOP for medical home infrastructure **How Payment is Adjusted for Performance**: 2% of the OPC, which includes all expenses related to cancer care except drugs, is reserved for a quality pool. If quality measures are not met, the 2% is not rewarded. **Approaches to Incorporate Multi-Payer Alignment**: This model could be adopted by other payers without requiring substantial process changes.
Icahn School of Medicine at Mount Sinai (Mount Sinai) (*Academic institution*) "HaH-Plus" (Hospital at Home-Plus): Provider-Focused Payment Model Recommended for implementation, 9/17/2017	**Clinical Focus**: Inpatient services in the home setting **Providers**: Physicians and HaH-Plus providers, including nurse practitioners, registered nurses, social workers, and physical, occupational, and speech therapists **Setting**: Patient homes **Patient Population**: Medicare FFS beneficiaries who have one of the 44 acute conditions	**Overall Model Design Features**: Multidisciplinary care around an acute care event to reduce complications and readmissions **Financial Methodology**: Bundle payment covering the acute episode and an additional 30 days of transition services. Two components are in the payment model: 1) a new DRG-like HaH-Plus payment to substitute for the acute inpatient payment to the hospital and attending physician; and 2) the potential for a performance-based payment linked to the total Medicare spend for the entire HaH-Plus episode and the APM performance on quality metrics. **How Payment is Adjusted for Performance**: The APM entity's performance on quality metrics influences payment. **Approaches to Incorporate Multi-Payer Alignment**: Submitters worked to adapt the payment model to other payers. Medicare Advantage and Medicaid Managed Care plans expressed interest, and the model was implemented at the Department of Veterans Affairs (VA).
Large Urology Group Practice Association (LUGPA) *(Provider association and specialty society)* LUGPA APM for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer Not recommended, 2/28/18	**Clinical Focus:** Urology/Oncology (treatment of prostate cancer) **Providers:** Eligible professionals (including urologists) at large and small urology and multispecialty practices **Setting:** Large and small urology and multispecialty practices **Patient population:** Newly diagnosed prostate cancer patients with localized disease	**Overall Model Design Features**: The model aims to identify those newly diagnosed prostate cancer patients with low-risk localized disease to receive active surveillance rather than active intervention. **Financial Methodology**: An episode-based payment that would retrospectively compare actual initial episode spending against a target amount **How Payment is Adjusted for Performance**: Participants earn performance-based payments or owe performance-based repayments based on the number of quality performance targets achieved/exceeded. **Approaches to Incorporate Multi-Payer Alignment:** Submitters worked with other payers to implement the model beyond the Medicare population.

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-Based Care Components
Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group Inc. (PMA) (*Regional/local single specialty practice*) The COPD and Asthma Monitoring Project (CAMP) Not recommended, 4/11/2017	**Clinical Focus:** Chronic obstructive pulmonary disease (COPD) and/or asthma **Providers:** Pulmonary physicians **Setting:** Patient home **Patient Population:** COPD and asthma patients	**Overall Model Design Features**: The model proposes remote interactive monitoring for patients with COPD, asthma, and other chronic lung diseases. **Financial Methodology**: Two-sided risk arrangement that would permit CMS to recoup up-front costs first and then allow participants to share in remaining savings or losses up to a stop loss percentage amount **How Payment is Adjusted for Performance**: The proposal does not specify how quality measures would affect payment. **Approaches to Incorporate Multi-Payer Alignment:** The model involved other payers beyond Medicare and looked to align payers on goals and performance measures.
Personalized Recovery Care (PRC) (*Regional/local single specialty practice*) Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home Recommended for implementation, 3/26/2018	**Clinical Focus**: Inpatient services in the home setting or skilled nursing facility **Providers**: Admitting physicians at facilities receiving personalized recovery care (PRC) payments; on-call physicians; recovery care coordinators **Setting**: Patient home or skilled nursing facility **Patient Population**: Commercial and Medicare Advantage patients with one of 150 acute conditions	**Overall Model Design Features**: This is a home hospitalization care model that proposes to provide inpatient hospitalization-level care and PRC at home or a skilled nursing facility for patients with certain conditions through an episodic payment arrangement. **Financial Methodology**: Bundled episode-based payment not tied to an anchor admission, replacing FFS with shared risk. Bundled payment has two components: 1) risk payment for delivering care compared to the targeted cost of care; and 2) a per-episode payment made for care provided instead of an acute care hospitalization. **How Payment is Adjusted for Performance**: A portion of physician compensation is tied to quality metrics and outcomes. **Approaches to Incorporate Multi-Payer Alignment**: PRC is currently available in commercial and Medicare Advantage plans, and submitters considered including other payers, such as Medicaid Managed Care.
The University of Massachusetts Medical School (UMass) (*Academic institution)* Eye Care Emergency Department Avoidance Not recommended, 11/8/2019	**Clinical Focus:** Eye care **Providers:** Optometrists and ophthalmologists **Setting:** Practices and other entities employing eye care professionals **Patient Population:** Patients with non-emergent eye conditions	**Overall Model Design Features**: The model aims to reduce emergency department (ED) utilization for ED-avoidable eye conditions and provide incentives for optometrists and ophthalmologists to increase urgent care access for these conditions. **Financial Methodology**: Providers who meet or exceed the target number of qualifying ED-avoidable visits and upheld or improved quality performance will receive shared savings payments.

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-Based Care Components
		How Payment is Adjusted for Performance: Providers must meet quality performance thresholds; if providers do not meet these thresholds, their financial loss will equal the minimum of 8% of payments for qualifying visits during the performance year. **Approaches to Incorporate Multi-Payer Alignment:** The model is open to Medicare, Medicaid, and private payers. Payers would work to establish goals for participating providers.
The University of New Mexico Health Sciences Center (UNMHSC) (*Academic institution*) ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Emergencies Recommended for implementation, 9/16/2019	**Clinical Focus**: Cerebral emergency care; telemedicine **Providers**: Neurologists, neurosurgeons, and providers in rural and community systems **Setting**: Inpatient, outpatient, or emergency department **Patient Population**: Patients with neurological emergencies	**Overall Model Design Features**: Rural EDs can consult neurologists via teleconsultation and assess patients' condition when they present at the hospital ED. The model aims to reduce costs in hospital transfers and ambulatory medicine. **Financial Methodology**: Additional one-time payment without shared risk **How Payment is Adjusted for Performance**: Performance is monitored but does not impact payment. **Approaches to Incorporate Multi-Payer Alignment**: The model is available for Medicare and other payers to use a new bundled code for telemedicine consultations. Performance measures are shared between payers to provide transparency.

APPENDIX 4. ADDITIONAL RESOURCES RELATED TO PTAC'S THEME-BASED DISCUSSION ON IMPROVING MULTI-PAYER ALIGNMENT IN VALUE-BASED CARE

The following is a summary of additional resources related to PTAC's theme-based discussion on improving multi-payer alignment in value-based care. These resources are publicly available on the ASPE PTAC website:

Environmental Scan

Environmental Scan on Improving Multi-Payer Alignment in Value-Based Care

Request for Input (RFI)

Improving Multi-Payer Alignment in Value-Based Care — Request for Input (RFI)

Materials from the Public Meetings

Materials from the Public Meeting on February 23, 2026

Presentation: Improving Multi-Payer Alignment in Value-Based Care — Preliminary Comments Development Team Findings

Presentation: Session 1 Slides

Presentation: Session 2 Slides

Presentation: Session 3 Slides

Session Participants' Biographies

Session 1 Discussion Guide

Session 2 Discussion Guide

Session 3 Discussion Guide

Materials from the Public Meeting on February 24, 2026

Presentation: Session 4 Slides

Session Participants' Biographies

Session 4 Discussion Guide

Other Materials Related to the Public Meeting

Public Meeting Minutes

Public Meeting Transcripts

APPENDIX 5. SUMMARY OF PTAC COMMENTS ON IMPROVING MULTI-PAYER ALIGNMENT IN VALUE-BASED CARE

The Committee members' comments have been summarized in the following broad topic areas:

- Topic 1: Promoting Localized, Patient-Centric Care Delivery;
- Topic 2: Fostering Long-Term System Change;
- Topic 3: Building Essential Foundational Elements to Promote Alignment;
- Topic 4: Ensuring Sufficient Funding and Reliable Practice Revenue; and
- Topic 5: Balancing Simplification and Flexibility in Model Design.

Topic 1: Promoting Localized, Patient-Centric Care Delivery	
1A	Extending telehealth provisions would help improve value and meet patients where they are.
1B	Social risk adjustments or other local context adjustments should be considered to drive long-term change.

Topic 2: Fostering Long-Term System Change	
2A	Long-term stability is needed to transform the health care system.
2B	Multi-payer alignment requires change to occur longitudinally. Infrastructure must be in place for a long time for the system to shift.
2C	Multi-payer alignment is essential to scale value-based care.
2D	Multi-payer alignment requires culture change throughout an entire community, including community leaders, employers, state and federal government agencies, and providers at multiple levels.
2E	There is a need to align models across Medicare and commercial payers.
2F	It is important to shift communities and integrated health care systems from having transactional relationships to adopting partnership models.
2G	There is a contrast between incremental change and rapid adoption among payers and providers in multi-payer alignment efforts.
2H	Once basic capacities are built, change occurs quickly rather than incrementally. Additional consideration is needed to understand the elements that indicate a provider is approaching a tipping point for rapid change.
2I	CMS can help bring stakeholders together.
2J	The commercial sector has low penetration in value-based care. Leadership from CMS and the CMS Innovation Center can help to improve value-based care options for the commercial sector.
2K	Having strong leadership, including involvement from Medicare and Medicaid, is critical for multi-payer participation and progress.
2L	Consistency is key in multi-payer alignment efforts. Instead of continuing to create new approaches that require providers to change directions, CMS should consider providing consistent leadership and guidance in a single direction.
2M	Commitment from CMS is key in multi-payer alignment efforts as these efforts are not successful if there is a lack of commitment from leading organizations.
2N	State and federal governments provide meaningful support in multi-payer alignment efforts.

2O	Multi-payer alignment efforts rely on support from state policymakers, as well as stability from both policymakers and payers.
2P	State multi-payer alignment efforts have demonstrated how to operationalize multi-payer reform.
2Q	Medicare Advantage (MA) must be included in the portfolio to reach a critical mass and drive change among health systems and providers.
2R	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.
2S	Multi-payer alignment requires financial investment. Payments and incentives are important signals in health care. Shared expectations without financial consequences or accountability may not drive durable change. There has been disproportionate leadership and focus from CMS in multi-payer alignment efforts while other segments such as commercial payers trail in scale and financial commitment. There are opportunities to consider how to make more comparable financial commitments across payers.
2T	Primary care serves as the anchor for multi-payer alignment. Sustained investment in primary care to support team-based care and the creation of longitudinal relationships with patients will reduce utilization and improve outcomes.
2U	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.

Topic 3: Building Essential Foundational Elements to Promote Alignment	
3A	This shift requires building trust among partners and providers and having effective payment models and metrics.
3B	Trust between payers and providers, particularly among those with long-term relationships, is critical to multi-payer alignment initiatives.
3C	Trust and durable partnerships between payers and providers are essential to multi-payer alignment.
3D	Trust-building and investment are important to achieve shared outcomes and value propositions.
3E	The speed at which change is implemented depends on trust, including trust in incentives and data. There are opportunities to identify additional ways to support and build trust among providers. A Committee member inquired whether PTAC could serve in a convening role to bring together different stakeholders to help build trust and instill more confidence in providers.
3F	The speed at which change can occur depends on trust-building. Conveners can facilitate trust-building.
3G	Participation and communication among payers are key to success in multi-payer alignment efforts.
3H	There are unstated assumptions in multi-payer efforts. Efforts should be made to create transparency, build trust, and set clear goals.
3I	Stakeholder motivation is important to bring payers and providers together.
3J	A neutral convener, such as a state entity, neutral party, or the federal government, is important in multi-payer alignment initiatives.
3K	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.
3L	A strong, neutral convener and inclusive governance facilitate sustained engagement from payers and providers.

Topic 3: Building Essential Foundational Elements to Promote Alignment	
3M	There are opportunities to better define the role of conveners in multi-payer alignment initiatives. CMS has indicated that participants must be providers. However, there may be opportunities for entities that do not provide care to serve as conveners.
3N	There are opportunities for regional or broader conveners to align contracting.
3O	Planning, organization, and strong governance in multi-payer alignment initiatives are important.

Topic 4: Ensuring Sufficient Funding and Reliable Practice Revenue	
4A	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.
4B	There is a need to understand how to adequately provide up-front incentives that meaningfully impact transformation.
4C	It is important to recognize the success of providers' business models. Doing so will promote collaboration.
4D	Financial stability is important in multi-payer alignment initiatives.
4E	Multi-year, reliable revenue is necessary to impact the practice environment and drive culture change.
4F	Aligning payers is a multi-year process that requires predictability.
4G	Predictable revenue is needed to build infrastructure for hospitals and physicians. The structure of prospective payments should be updated.
4H	Predictable, prospective payment structures and aligned primary care funding are important to reduce provider burden and enable transformation efforts.
4I	Advanced payments are important for multi-payer engagement and alignment.
4J	Advanced payments can help equalize financial risk.
4K	A pathway from case rate payments to full risk contracts that include risk adjustment, including social risk adjustment, can help providers make the necessary investments to transform care.
4L	Use of both positive and negative incentives can accelerate progress.

Topic 5: Balancing Simplification and Flexibility in Model Design	
5A	It is important to simplify the health care system.
5B	Efforts should be made to simplify what exists in the current system.
5C	Multi-payer alignment must be pragmatic.
5D	Process simplification for both providers and patients, and reducing burden associated with program administration, are necessary elements to impact the practice environment and drive culture change.
5E	There are opportunities to build on what already exists in the system as opposed to inventing and trying new approaches.
5F	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.
5G	Shared metrics, interoperable data, infrastructure, up-front investments, and practice transformation analytics are important to scale and sustain progress in multi-payer alignment efforts.

Topic 5: Balancing Simplification and Flexibility in Model Design	
5H	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 tradeoffs. For example, although simplification allows standardization and reduces administrative burden, simplification can also limit choice and responsiveness to local needs.
5I	Multi-payer alignment may not require uniformity. Flexibility is needed in product design, benefit structure, and network configurations. Variation in quality metrics, attribution methods, risk-adjustment methods, and reporting cadences creates challenges for clinicians and organizations that are already operating across Medicare, Medicaid, and commercial lines. In multi-payer alignment initiatives, standardization and flexibility are on a continuum. PTAC and policymakers have opportunities to calibrate the continuum. Variation in some elements is necessary to preserve product integrity and provide the public with choice, and for statutory requirements. However, variation in other elements due to issues such as competitive signaling can be reduced. Components of payment models are inherently complex; harmonizing certain elements, such as attribution, risk adjustment, risk corridors, and spending adjustments, may not be possible. Standardization should be considered when it is possible.
5J	As an alternative way of thinking about alignment, there are opportunities to consider coherence as a step along the way toward exact alignment. While exact alignment could serve as the ideal form of alignment, coherence—consistent signals, harmonized core elements, deconflicting operations—could serve as an intermediate, pragmatic, and durable step in the process. This alternative way of thinking about alignment could address the risk of paralysis in the face of complexity. Coherence can help build the conditions under which deeper alignment is feasible.
5K	Some questions to consider include 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.
5L	Different model components could 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.
5M	There is substantial variability within MA. Innovation and creativity should not be stifled in MA, but standardized processes are needed for MA payers. For example, data sharing should be standardized in MA. Additionally, risk-bearing entities should understand early who the attributable population is so that the population can be managed.
5N	Shared infrastructure is important in multi-payer alignment efforts.
5O	Data are key to success in multi-payer alignment. Timely, interoperable clinical and social needs data are required for providers to deliver proactive care.
5P	Data interoperability is critical in multi-payer alignment efforts.
5Q	There is interest in how HIE and common data can support multi-payer alignment efforts.
5R	Shared infrastructure and consistent technology such as HIE serve as enablers in multi-payer alignment efforts.
5S	HIE-enabled data sharing increases communication and reduces low-value care by identifying what has been done before in the broader health care ecosystem.

Topic 5: Balancing Simplification and Flexibility in Model Design	
5T	Issues related to information blocking and data asymmetries should be addressed to improve data sharing.
5U	It is important to simplify metrics. There may be opportunities for CMS and policymakers to better align measure sets, such as Star Ratings in MA.
5V	There are opportunities to harmonize and streamline a common set of quality measures.
5W	There is a need to harmonize quality measures and performance incentives. A parsimonious measure set and a transition to digital quality measurement are critical to reducing administrative burden and sending consistent signals to providers across payers, including Medicare, Medicaid, and commercial plans.
5X	CMS could consider standardizing risk adjustment rules.
5Y	It is important to consider social risk adjustment, particularly in Medicaid populations.

REFERENCES

[1] Japinga M, Pokam Tchuisseu Y, Saunders R, & McClellan M. A Path Forward for Multipayer Alignment to Achieve Comprehensive, Equitable, and Affordable Care. Duke-Margolis Center for Health Policy. 2022. https://healthpolicy.duke.edu/sites/default/files/2022-12/A%20Path%20Forward%20for%20Multipayer%20Alignment%202.pdf

[2] Physician-Focused Payment Model Technical Advisory Committee (PTAC). Report to the Secretary: Optimizing Population-Based Total Cost of Care (PB-TCOC) Models in the Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs) . Published 2023. Accessed October 13, 2025. https://www.aspe.hhs.gov/sites/default/files/documents/4b65476c58e363735aa9065a82a35df4/PTAC-TCOC-RTS.pdf

[3] Centers for Medicare & Medicaid Services. Multi-Payer Alignment. October 18, 2024. https://www.cms.gov/priorities/innovation/key-concepts/multi-payer-alignment

[4] Japinga M, Pokam Tchuisseu Y, Saunders R, & McClellan M. A Path Forward for Multipayer Alignment to Achieve Comprehensive, Equitable, and Affordable Care. Duke-Margolis Center for Health Policy. 2022. https://healthpolicy.duke.edu/sites/default/files/2022-12/A%20Path%20Forward%20for%20Multipayer%20Alignment%202.pdf

[5] Physician-Focused Payment Model Technical Advisory Committee (PTAC). Report to the Secretary: Optimizing Population-Based Total Cost of Care (PB-TCOC) Models in the Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs). Published 2023. Accessed October 13, 2025. https://www.aspe.hhs.gov/sites/default/files/documents/4b65476c58e363735aa9065a82a35df4/PTAC-TCOC-RTS.pdf

[6] Bailit MH, Flahert G, Hwang A. Adopting Multipayer Value-Based Payment Models. The Commonwealth Fund. January 2023. https://www.commonwealthfund.org/sites/default/files/2023-01/Bailit_implementation_guide_multipayer_VBP.pdf

[7] AHEAD (Achieving Healthcare Efficiency through Accountable Design) Model. Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/innovation-models/ahead

[8] Comprehensive Primary Care Initiative. Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/innovation-models/comprehensive-primary-care-initiative

[9] Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report. Mathematica Policy Research. May 2018. https://downloads.cms.gov/files/cmmi/CPC-initiative-fourth-annual-report.pdf

[10] Comprehensive Primary Care Plus. Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/innovation-models/comprehensive-primary-care-plus

[11] Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Final Report. Mathematica Policy Research. December 2023. https://www.cms.gov/priorities/innovation/data-and-reports/2023/cpc-plus-fifth-annual-eval-report

[12] Centers for Medicare & Medicaid Services. Comprehensive Primary Care Plus (CPC+) Model: Evaluation of the Fifth Year (2021). Findings at a Glance. https://www.cms.gov/priorities/innovation/data-and-reports/2023/cpc-plus-fg-fifth-annual-eval-report

[13] Making Care Primary (MCP) Model. Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/innovation-models/making-care-primary

[14] Centers for Medicare & Medicaid Services. Making Care Primary (MCP) Guide to Alignment for Payer Partners. https://www.cms.gov/files/document/mcp-payer-partners-alignment-guide.pdf

[15] Multi-Payer Advanced Primary Care Practice. Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/innovation-models/multi-payer-advanced-primary-care-practice

[16] Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: Final Report. RTI International. June 2017. https://downloads.cms.gov/files/cmmi/mapcp-finalevalrpt.pdf

[17] Primary Care First Model Options. Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/innovation-models/primary-care-first-model-options

[18] Primary Care First (PCF) Participating Regions & Payer Partners. Centers for Medicare & Medicaid Services. Updated January 2024. https://www.cms.gov/priorities/innovation/media/document/pcf-participating-regions-payers
[19] Evaluation of Primary Care First: Third Annual Report. Mathematica Policy Research. May 2025. https://www.cms.gov/priorities/innovation/data-and-reports/2025/pcf-third-eval-rpt
[20] State Innovation Models Initiative: General Information. Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/innovation-models/state-innovations
[21] Medicare Participation in State-Sponsored Payment and Service Delivery Models Proposed under the State Innovation Models Initiative. Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/files/x/sim-guidance-statesponsored.pdf
[22] State Innovation Models (SIM) Initiative Evaluation: Model Test Year Five Annual Report. RTI International. December 2018. https://downloads.cms.gov/files/cmmi/sim-rd1-mt-fifthannrpt.pdf
[23] Past HCPLAN Initiatives. Health Care Payment Learning & Action Network. https://hcp-lan.org/past-initiatives/
[24] Multi-Payer Alignment Blueprint. Health Care Payment Learning & Action Network. July 2023. https://hcai.ca.gov/wp-content/uploads/2023/08/HCP-LAN-Multi-Payer-Alignment-Blueprint-Executive-Summary.pdf
[25] Thompson J, Golden W, Motley M, Fendrick A, Mathis C, Chernew, M. Arkansas Payment Improvement Initiative: Private Carriers Participation In Design and Implementation. Health Affairs Blog. October 15, 2014. https://www.healthaffairs.org/content/forefront/arkansas-payment-improvement-initiative-private-carriers-participation-design-and
[26] Golden W, Thompson J, Olsen S, Hill R, Fendrick A, Mathis C, Chernew, M. Patient-Centered Medical Homes in Arkansas. Health Affairs Blog. May 20, 2014. https://www.healthaffairs.org/content/forefront/patient-centered-medical-homes-arkansas
[27] Arkansas Center for Health Improvement. Report: Arkansas Health Care Payment Improvement Initiative Improving Quality, Efficiency. September 13, 2019. https://achi.net/newsroom/report-ahcpii-improving-quality-efficiency/
[28] Bachrach D, du Pont L, Lipson Manatt M, Phelps & Phillips LLP. Arkansas: A Leading Laboratory for Health Care Payment and Delivery System Reform. The Commonwealth Fund. August 2014. https://www.commonwealthfund.org/publications/issue-briefs/2014/aug/arkansas-leading-laboratory-health-care-payment-and-delivery
[29] Emerson J. 'Pay attention to what we're doing here': 3 payers come together on new payment model in California. Becker's Payer Issues. February 2025. https://www.beckerspayer.com/payer/pay-attention-to-what-were-doing-here-3-payers-come-together-on-new-payment-model-in-california/
[30] Tong N. California insurers join forces on value-based primary care model. Fierce Healthcare. February 2025. https://www.fiercehealthcare.com/payers/california-insurers-join-forces-value-based-primary-care-model
[31] California Advanced Primary Care Initiative. Purchaser Business Group on Health California Quality Collaborative. https://www.calquality.org/initiative/ca-advanced-primary-care-initiative/
[32] Advanced Primary Care: Measurement Pilot. Purchaser Business Group on Health California Quality Collaborative. November 2022. https://www.calquality.org/wp-content/uploads/2023/01/Advanced-Primary-Care-Measurement-Pilot.pdf
[33] Colorado Alternative Payment Model (APM) Alignment Initiative: Final Report. Bailit Health. June 2022. https://doi.colorado.gov/sites/doi/files/documents/Colorado-Alternative-Payment-Model-Alignment-Initiative-Final-Report-June-2022.pdf
[34] Centers for Medicare & Medicaid Services. Maryland Total Cost of Care Model. https://www.cms.gov/priorities/innovation/innovation-models/md-tccm
[35] Maryland's Total Cost of Care: Background and Summary. Maryland Health Services Cost Review Commission. May 2018. https://hscrc.maryland.gov/documents/modernization/tcoc%20background%20and%20summary%20_5_23_18%20.pdf

[36] Payer Alignment Workgroup Written Recommendation. Maryland Total Cost of Care Model. May 2023. https://hscrc.maryland.gov/Documents/Modernization/Progression/2023-04-07_Payer%20Alignment_DRAFT%20Workgroup%20Report%20v0.pdf

[37] Hospital Rate Setting: Successful in Maryland, but Challenging to Replicate. Altarum Healthcare Value Hub. May 2020. https://healthcarevaluehub.org/wp-content/uploads/2020_Update_Altarum-Hub_RB_1_-_Hospital_Rate_Setting_Final.pdf

[38] Evaluation of the Maryland Total Cost of Care Model: Quantitative Only Report for the Model's First Three Years (2019 to 2021). Mathematica. December 2022. https://www.mathematica.org/publications/evaluation-of-the-maryland-total-cost-of-care-model-quantitative-only-report-for-the-models-first

[39] Jones R. Total Cost of Care: Lessons from the Maryland Model. Ascendient. https://www.ascendient.com/higher-thinking/total-cost-of-care-lessons-from-the-maryland-model

[40] Evaluation of the Minnesota Accountable Health Model: Final Report. State Health Access Data Assistance Center (SHADAC). September 2017. https://www.leg.mn.gov/docs/2018/other/180336.pdf

[41] Minnesota Health Care Homes. October 2022. https://www.health.state.mn.us/facilities/hchomes/documents/hchfactsheet.pdf

[42] Minnesota Health Care Homes (HCH). Primary Care Collaborative. https://archive.thepcc.org/initiative/minnesota-health-care-homes/2

[43] Pennsylvania Rural Health Model. Commonwealth of Pennsylvania. https://www.pa.gov/agencies/health/facilities/in-patient-healthcare-facilities/hospitals/rural-health-model

[44] Rural Health Redesign Center. A Snapshot of the Pennsylvania Rural Health Model (PARHM). July 2024. https://rhrco.org/a-snapshot-of-the-pennsylvania-rural-health-model-parhm/

[45] Rural Health Redesign Center. PARHM and AHEAD Models: A Comparison of Programs and Lessons Learned from the PA Implementation Experience (part 1 of 2). August 14, 2024. https://rhrco.org/event/parhm-and-ahead-models-a-comparison-of-programs-and-lessons-learned-from-the-pa-implementation-experience-part-1-of-2/

[46] The Pennsylvania Rural Health Model (PARHM): Second Annual Evaluation Report. NORC at the University of Chicago. June 2022. https://www.norc.org/content/dam/norc-org/pdf2024/PARHM-SecondAnnualReport.pdf

[47] The Pennsylvania Rural Health Model (PARHM): Fourth Evaluation Report. NORC at the University of Chicago. December 2024. https://www.norc.org/content/dam/norc-org/pdf2024/parhm-fourthannualreport_12_19_24.pdf

[48] The Rhode Island Chronic Care Sustainability Initiative (CSI-RI). April 2013. https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/HIAC-CSI-Fact-Sheet-April-2013.pdf

[49] Multi-Payer Investments in Primary Care: Policy and Measurement Strategies. Center for Health Care Strategies & State Health Access Data Assistance Center. July 2014. https://www.chcs.org/media/Primary-Care-Infrastructure-Investment-SIM-TA-Paper-7-1-14.pdf

[50] Paradise J, Gold M, Wang W. Leveraging Medicaid in a Multi-Payer Medical Home Program: Spotlight on Rhode Island's Chronic Care Sustainability Initiative. Kaiser Family Foundation. November 2013. https://www.kff.org/medicaid/leveraging-medicaid-in-a-multi-payer-medical-home-program-spotlight-on-rhode-islands-chronic-care-sustainability-initiative/

[51] The Rhode Island Chronic Care Sustainability Initiative: Building an Advanced Medical Home Pilot in Rhode Island. Presentation. Quality Partners of Rhode Island. Slides 22-34. July 2007. https://www.chcs.org/media/Redesigning_Chronic_Care_at_the_Practice_Level.pdf

[52] Green Mountain Care Board. Vermont's All-Payer Model. February 2023. https://gmcboard.vermont.gov/sites/gmcb/files/documents/APM_Summary_20230201.pdf

[53] Backus E, Gobielle A, Hogan C, Holmes J, Rambur B. The All-Payer Accountable Care Organization Model: An Opportunity for Vermont and An Exemplar for the Nation. Health Affairs. November 2016. https://www.healthaffairs.org/content/forefront/all-payer-accountable-care-organization-model-opportunity-vermont-and-exemplar-nation

[54] Green Mountain Care Board. Implementation Improvement Plan: Vermont All-Payer Accountable Care Organization Model Agreement. November 2020. https://gmcboard.vermont.gov/sites/gmcb/files/documents/APM%20Implementation%20Improvement%20Plan%20Final%2011.19.20.pdf

[55] Evaluation of the Vermont All-Payer Accountable Care Organization Model (VTAPM): Second Evaluation Report. NORC at the University of Chicago. December 2022. https://www.norc.org/content/dam/norc-org/pdf2024/VermontAllPayerModel-SecondEvalReportv2_1_4_23.pdf

[56] Washington State Health Care Authority. Primary Care Transformation. https://www.hca.wa.gov/about-hca/programs-and-initiatives/value-based-purchasing/primary-care-transformation

[57] Haran C, Gilburg ML. Eight Washington Health Plans Align to Transform Primary Care. Milbank Memorial Fund. July 30, 2024. https://www.milbank.org/news/eight-washington-health-plans-align-to-transform-primary-care/

[58] MEMORANDUM OF UNDERSTANDING AMONG WASHINGTON STATE HEALTH PLANS IN SUPPORT OF MULTI-PAYER COLLABORATIVE PRIMARY CARE REFORM WORK. Washington Multi-Payer Collaborative. July 2024. https://www.hca.wa.gov/assets/program/primary-care-transformation-mou-with-signatures-2024.pdf

[59] Eisenstein J, Chang D. Case Study: Improving Population and Individual Health Through Health System Transformation in Washington State. National Academy of Medicine. April 2017. https://nam.edu/perspectives/case-study-improving-population-and-individual-health-through-health-system-transformation-in-washington-state/