Improving Multi-Payer Alignment in Value-Based Care

Request for Input (RFI) Responses

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) requested input from the public about improving multi-payer alignment in value-based care.

Prior to PTAC's February 23-24 public meeting on this topic, PTAC received four responses from the following stakeholders:

1. American Society of Nephrology (ASN)
2. National Association of ACOs (NAACOS)
3. California Quality Collaborative (CQC)
4. Integrated Healthcare Association (IHA)

For additional information about PTAC's request, see PTAC's solicitation of public input.

January 30, 2026
Physician-Focused Payment Model Technical Advisory Committee (PTAC)
200 Independence Avenue SW
Washington, D.C. 20201
Sent Via Electronic Mail: PTAC@HHS.gov

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

Dear Physician-Focused Payment Model Technical Advisory Committee,

On behalf of the more than 37,000,000 Americans living with kidney diseases and the nearly 22,000 nephrologists, scientists, and other kidney health care professionals who are members of the American Society of Nephrology (ASN), thank you for the opportunity to provide comments in response to your public comment period with reference to 'Improving Multi-Payer Alignment in Value-Based Care' Request for Input (RFI).

The nephrology community has significant experience in value-based care arrangements. The first specialty-specific Accountable Care Organization (ACO) was created for dialysis patients through the ESRD Seamless Care Organizations (ESCOs) in 2015[i]. Since that time, the nephrology community has gained extensive experience with both voluntary and mandatory federal models as part of the Trump Administration's Advancing American Kidney Health Initiative[ii] through the Center for Medicare and Medicaid Innovation (CMMI), including the Kidney Care Choices (KCC), End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model and Increasing Organ Transplant Access (IOTA) models. These experiences have generated important insights to inform model design and implementation. Below are several points ASN would like to share regarding each of the seven questions that you have posed.

1. What are approaches to multi-payer alignment that CMS and other parties could use to test and implement multi-payer models in value-based care?

ASN encourages PTAC to use existing tools developed by CMMI that address core elements of value-based care. These tools include performance measurement, payment methodologies, risk adjustment, and data sharing. ASN encourages PTAC to build on this foundation by considering shared performance measures, quality metrics, and learning collaboratives that support multi-payer alignment.

ASN also encourages PTAC to leverage CMMI-supported State-Based Total Cost of Care Models. These models draw on the experience of states that have served as

value-based care hubs and coordinated participation across multiple payers. This experience offers practical lessons for aligning incentives and reducing fragmentation.

In nephrology, ASN encourages PTAC to consider approaches that build on CMMI's KCC model and align with private insurer Value-Based Insurance Design (VBID) initiatives. By using the Comprehensive Kidney Care Contracting (CKCC) framework within the KCC model as a baseline, PTAC could recommend strategies that encourage commercial payers to adopt comparable capitated payment structures for patients with chronic kidney disease (CKD) stages 4 and 5. Such alignment would reduce administrative burden for nephrology practices that currently navigate differing quality measures and payment requirements across Medicare and commercial plans, while supporting a consistent focus on home dialysis and transplant readiness across a provider's full patient panel.

Finally, ASN encourages CMMI to continue to explore value-based care impacts for Medicare Advantage beneficiaries, now representing the majority of patients with kidney failure requiring dialysis. There are limited data available within United States Renal Data System related to comorbid conditions and clinical outcomes for Medicare Advantage beneficiaries as compared to traditional Medicare beneficiaries. Ensuring data transparency will allow for effective comparisons and iteration of models.

2. What are lessons learned from state value-based care models that have implemented multi-payer alignment?

ASN encourages PTAC to consider lessons learned from state value-based care models that have implemented multi-payer alignment. Several states have served as central coordinators by improving payer alignment, reducing administrative burden, and supporting the adoption of value-based arrangements.

State models, such as those in Maryland and Vermont, have demonstrated that multi-payer alignment requires a neutral convener to facilitate trust between competing insurers. A key lesson learned from the nephrology community is that state-led approaches may lack the disease-specific focus needed for high-cost, low-volume chronic conditions. Experience suggests that mandatory participation by major payers may be necessary to achieve the patient scale required for practices to invest in care coordination infrastructure. In kidney care, state or national models should consider successful lessons learned from ESCOs, which demonstrated that focused, integrated, and tailored care for a defined patient population can significantly reduce hospitalizations and reduce associated costs more effectively than broad all-payer primary care models[iii].

ASN encourages PTAC to support the use of Pre-Implementation Periods that include pre-payment mechanisms of sufficient length to provide participants with the necessary time and financial resources to establish the infrastructure needed to successfully implement the model[iv].

ASN also emphasizes the importance of health equity in multi-payer value-based care models. PTAC should consider how performance metrics can be linked to social determinants of health (SDOH)-related benchmarks and supported by risk adjustment. This is essential to ensure that centers serving beneficiaries with higher social risk are not disadvantaged.

The importance of this approach was demonstrated in the mandatory ETC Model. Separate scoring strata were created for facilities in which 50 percent or more of patients are dually enrolled in Medicare and Medicaid or receive Low-Income Subsidies. The ETC Model marked the first time in CMS payment model history that performance adjustments were explicitly used to address differences driven by socioeconomic factors (for example, the lower utilization of home dialysis among Medicare beneficiaries with unstable housing). Following the ETC Model, CMS went on to incorporate payment and benchmark adjustments based on Medicare-Medicaid dual eligibility status and area deprivation indices in several other models[v].

3. What are effective strategies that have been used in practice to align financial incentives, benchmarking, attribution, and risk-adjustment methods within and across multiple payers?

ASN believes effective alignment requires a shift from retroactive reconciliation to prospective, risk-adjusted payments. For example, in nephrology, financial incentives must be aligned to reward "optimal starts," defined as initiating dialysis with a permanent access or through home modalities. Upfront resourcing is particularly relevant to nephrology given the need to invest in structural changes to care models (e.g. care coordination, implementation of educational programming etc). While the ETC model attempted to align incentives through mandatory payment adjustments, it lacked the sophisticated risk adjustment necessary for medically complex and dual-eligible patients. Lessons from the 2026 evaluations suggest that benchmarking should be based on regional historical spending rather than national averages in order to better account for local factors, including poverty and access to care. Alignment is most effective when attribution is patient-centered, allowing the nephrologist to serve as the principal care provider for the duration of the kidney disease journey among individuals with advanced kidney disease.

ASN also recommends the use of uniform and transparent benchmarking formulas. The frameworks of existing models, such as the Medicare Shared Savings Program (MSSP) and the Comprehensive Kidney Care Contracting (CKCC) options within the KCC Model, provide relevant examples on how this can be achieved. Adopting similar, transparent, shared attribution rules would help align clinicians and reduce administrative variation across models Finally, ASN believes CMS should use a standardized risk adjustment approach with appropriate caps, applying CMS's standard methodology consistently across payers.

4. What methods have been effectively used to standardize performance measures and reporting across multiple payers?

ASN believes that standardization can be best achieved through the adoption of a "Kidney-Specific Core Set" of measures agreed upon by CMS and private payers. The nephrology community has experienced fragmented reporting requirements that have led to metric fatigue and a lack of parsimonious, specific metrics. To address this challenge, future models should leverage the KCC Model's focus on transplant waitlisting and home dialysis rates as quality indicators. These measures, when well-constructed, reflect outcomes that matter most in terms of opportunities for optimal care delivery, improved quality of life, and lower costs to both patients and health systems. Utilizing a single reporting portal and standardized EHR data pulls would allow providers to report once for multiple payers, reducing administrative burden. This approach would also help prevent the "failure of focus" observed in earlier models, where clinicians were distracted by conflicting clinical targets across different insurance providers.

In addition, core performance and quality measures should be clearly defined and designed for application across payers. The use of shared data platforms and standardized reporting templates should be encouraged to further streamline reporting and promote consistency. Finally, SDOH and economic indicators should be incorporated into standardization and/or risk adjustment where able and where appropriate.

5. How are antitrust regulations and the use of safe harbor waivers navigated to effectively implement multi-payer alignment?

CMS should host cross-payer discussions and pattern safe harbor structures on CMMI models. This approach would allow for alignment on quality metrics, benchmarks, and reporting requirements without violating antitrust regulations. In addition, CMS should be permitted to allow shared learning systems to further support collaboration and dissemination of best practices. Kidney care, particularly dialysis, is exceptionally consolidated; it is critical to allow entities to engage fully in models while also not promoting further consolidation.

6. What are examples of approaches that have been successfully used to overcome competitive market dynamics and promote collaboration among payers?

The Medicare ESCO Model demonstrated that when providers and payers operate within a shared-savings framework, the competitive incentive to "cherry-pick" healthier patients is mitigated by the financial rewards associated with effectively managing the most complex and highest-cost patients. Similarly, the CMMI CKCC model has demonstrated meaningful improvements in year one, including a 32% increase in home dialysis rates and a 16% increase in "optimal" starts for Americans living with kidney

failure (transplant and home dialysis), reflecting the impact of a CMS-led capitated, incentive-based model.[vi].

With respect to a true collaborative model across multiple payor types, AHEAD (Achieving Healthcare Efficiency through Accountable Design)[vii] is a voluntary state total cost of care (TCOC)[viii] initiative involving six states: Maryland, Connecticut, Hawaii, Vermont, Rhode Island, and New York. The model aims to manage care across Medicare, Medicaid, and commercial payors. While still in its early stages, AHEAD offers an opportunity to learn from a collaboration across payors.

7. What are examples of effective approaches used to overcome other factors that may influence collaboration and engagement among payers in multi-payer alignment initiatives (e.g., a desire for product differentiation from competitors, elements of payment design considered proprietary)?

Establishing certain shared measurement with standard and clearly defined measures can support alignment across payers. In addition, shared governance structures should be encouraged to facilitate collaboration and coordinated decision-making. Finally, simplified and aligned reporting and submission that aims to reduce burden for provider groups is critical.

ASN offers additional observations that were not explicitly requested in the RFI, but that are informed by experience in existing kidney models and are critical to achieving the RFI's stated goals.

- ***Care Coordination and Patient Selection:*** Physician-focused payment models must be structured to prioritize robust care coordination services for all patients, particularly those in underserved areas. Unlike traditional Fee-for-Service structures that often disadvantage complex patients by failing to support non-clinical coordination, new models should utilize geographic indices of social risk to adjust payment rates. This ensures that physicians are adequately resourced to identify social needs and connect patients with community-based services that can help improve patient outcomes.
- ***Financial Methodology and Risk Adjustment:*** To maximize participation and ensure sustainability, payment models should incorporate risk-adjusted target costs and provide both upside and downside risk options. It is critical to include protections such as risk corridors and stop-loss provisions to shield practices from financial harm caused by factors beyond their control, such as significant social drivers of health. These risk corridors and stop-loss provisions are particularly important in kidney care, where there are relatively small numbers of individuals with advanced kidney disease who are at very high risk of adverse medical events, such that a handful of catastrophic events can move an otherwise successful provider to failure.

- ***Specialty Integration and Accountability:*** Future models should encourage collaborative, team-based care that aligns primary care and specialty physicians. By utilizing enhanced condition-based payments, specialists can focus on accurate diagnosis and long-term patient management rather than volume-driven procedures. This whole-person approach is essential for managing chronic conditions effectively and reducing the total cost of care while improving patient and caregiver satisfaction.

ASN also offers an overview of the successes and failures of the value-based care models in the kidney space:

1. ESRD Treatment Choices (ETC) Model

Dates: January 1, 2021 – December 31, 2025 (terminated early)

Limitations: The ETC model, a mandatory program intended to increase home dialysis and transplant waitlisting through payment adjustments, has been deemed largely unsuccessful in meeting its primary goals. Evaluation reports through 2025 showed no statistically significant impact on home dialysis modality use or transplant waitlisting.

Current Status: Due to its limited results, CMMI finalized the termination of the ETC Model as of December 31, 2025.

2. ESRD Seamless Care Organization (ESCO) Model

Dates: October 15 – March 31, 2021

Successes: As one of the first major kidney care demonstrations, the ESCO model proved that a coordinated care design focused on dialysis could successfully reduce Medicare spending and hospital utilization. Relative to the comparison group, CEC beneficiaries had 5.01 fewer hospitalizations per 1,000 beneficiaries per month (95% CI, −8.45 to −1.56; P = .004), experienced fewer catheter placements (a 0.78 percentage point decrease for beneficiaries using a catheter as vascular access for more than 90 days; 95% CI, −1.36 to −0.19; P = .01), and were 0.11 percentage points less likely to be hospitalized for ESRD complications in a given month (95% CI, −0.20 to −0.02; P = .01). It also improved readmission rates and dialysis adherence[ix].

Limitations: While ESCO was effective for patients already on dialysis, it lacked the "upstream" focus on CKD stages 4 and 5 that the newer CKCC models aimed to address to prevent progression to kidney failure altogether, or smooth transition to end stage care.

3. Kidney Care Choices Model (KCC)

Dates: January 1, 2022- December 21, 2027 (model extended)

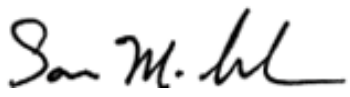
Successes: The KCC model has successfully increased the proportion of patients receiving home dialysis training and increased "Optimal ESRD Starts" (planned transitions to dialysis) by 16%.

Limitations: Despite quality gains, the model resulted in significant net losses to Medicare (approx. $304 million in 2023). Consequently, for 2026, CMMI has reduced the CKD Quarterly Capitation Payment by 50% and eliminated the $15,000 kidney transplant bonus to improve fiscal sustainability. The Kidney Care First (KCF) option was also terminated early, effective December 31, 2025. ASN has voiced the importance of maintaining financial resourcing to enable coordination of care, educational programming, structural changes to dialysis initiation processes etc. We have concerns about the long-term health of the model without recognizing the financial support required to improve clinical outcomes, which will stem long-term costs.

Conclusion

ASN emphasizes that, for a PFPM to succeed in 2026 and beyond, it must balance the expenditure reductions mandated by the KCC updates with the care coordination successes demonstrated under the ESCO model. Strong consideration should also be given to “upstream” models that address chronic kidney disease or the risk of CKD earlier in the disease course, with the goal of slowing or preventing progression to kidney failure. Such progression is costly not only from a financial perspective, but also in terms of quality of life and survival for patients. Aligning payment models with early intervention, coordinated care, and meaningful outcomes will be essential to achieving sustainable improvements for patients and the health care system. Lastly, it is critical that any future model related to kidney disease examines long-term cost savings by slowing the rate of kidney disease progression, avoiding crash starts into dialysis, and fostering transplantation. Partnering with organizations like ASN is crucial to ensure there is frontline provider input, as well as experiential perspective on feasibility and potential impact on cost and outcomes. To discuss this letter further, please contact Lauren Ahearn, ASN Policy and Government and Affairs Coordinator, at lahearn@asn-online.org.

Sincerely,



Samir M. Parikh, MD, FASN
President

[i] Comprehensive ESRD Care Model | CMS
[ii] AdvancingAmericanKidneyHealth.pdf
[iii] https://www.healio.com/news/nephrology/20190911/esco-demonstration-shows-reduction-in-hospitalizations-more-dialysis-sessions
[iviv] https://www.ncbi.nlm.nih.gov/books/NBK566221/
[v] https://www.healthaffairs.org/content/forefront/advancing-health-equity-through-value-based-care-cms-innovation-center-update
[vi] kcc_ar1_executive_summary_508_updated_10.25.24.pdf
[vii] https://www.cms.gov/priorities/innovation/innovation-models/ahead
[viii] https://www.cms.gov/priorities/innovation/key-concepts/total-cost-care-and-hospital-global-budgets
[ix] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2763414

January 30, 2026

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Submitted electronically to: PTAC@HHS.gov

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

Dear Members of the Physician-Focused Payment Model Technical Advisory Committee:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the RFI for improving multi-payer alignment in value-based care (VBC). NAACOS is a member-led and member-governed nonprofit of nearly 500 accountable care organizations (ACOs) and VBC entities in Medicare, Medicaid, and commercial insurance working on behalf of physicians, health systems, and other providers across the nation to improve quality of care for patients and reduce health care costs. NAACOS represents more than 10 million beneficiaries through Medicare's population health-focused payment and delivery models, such as the Medicare Shared Savings Program (MSSP) and the ACO Realizing Equity, Access, and Community Health (REACH) Model, specialty care models, and other alternative payment models (APMs). Beyond Medicare, our members participate in accountable care arrangements across payers, including Medicaid and Medicare Advantage (MA) programs.

Advancing multi-payer alignment in value-based care is essential to optimizing patient care and strengthening reimbursement opportunities across all value-based contracts, including Medicare VBC programs, MA, Medicaid, and commercial payers. NAACOS appreciates PTAC's focus and advisory efforts to the Centers for Medicare and Medicaid Services (CMS) on these important topics and encourages further discussions to address barriers, lift burden, and ensure physician payments continue to support the transition to accountable care. Our comments below reflect key recommendations from our members to advance alignment and articulate long-term goals for building a cohesive, interoperable, and sustainable multi-payer value-based care system.

Testing and Implementing Multi-Payer Models in VBC

Growing and sustaining VBC models across multi-payers require continued refinement of models, structures, and policies, including pulling forward the lessons learned in accountable care to continue to broaden these models throughout providers' whole practice. In our last survey, approximately 75% of the NAACOS' member ACOs responded that they have similar value-based contracts with MA and other commercial plans. Furthermore, a 2023 Health Care Payment Learning and Action Network (HCP-LAN) report found that 24.5 percent of all payments for medical care stem from two-sided financial risk arrangements. This reflects a five-percentage point increase from 2022. Investments in accountable care and value-based payment models will lead the way to complete transformation in health care delivery.

Improving transparency across value-based care arrangements is foundational to advancing multi-payer alignment. VBC providers need clear, consistent visibility into benchmarks, risk adjustment methodologies, and quality scoring in VBC arrangements across all lines of business to manage populations effectively and make informed investment choices. Today, plan processes are often opaque and inconsistent, making it difficult for providers to assess financial risk, produce precise predictive modeling, and allocate resources and investments to meet population needs, especially among the growing high-risk, high-cost patients.

NAACOS encourages CMS to pursue approaches that expand available data and provide greater transparency into VBC arrangements. VBC providers need a seamless and reliable pathway to maintain and sustain long-term investments in risk-bearing arrangements across payers. This is especially crucial when VBC providers are evaluating participation in risk contracts where margins are uncertain, methodologies lack clarity, or underlying data sets are incomplete.

As providers take on greater levels of risk and their VBC portfolios grow across payers, the need for transparent, comprehensive, timely, and streamlined data becomes even more critical. Today, MA plans, Medicaid agencies, and federal programs all use different data-exchange rules, file formats, and reporting expectations. These inconsistencies force providers to navigate a fragmented and inconsistent data environment.

To support multi-payer alignment, VBC providers need:

- **Aligned and standardized data sets to reduce administrative burden, improve analytic capabilities, and give providers the transparency needed to manage total cost and quality across diverse patient populations**. To do so, Medicare ACO, MA, Medicaid, and commercial programs must have aligned data standards including access to data sets, consistent data elements, definitions, file formats, and timing**.** Additionally, providers need real-time, point-of-care visibility into all supplemental benefits data so they can integrate services into care plans, avoid duplicative or misaligned interventions, and better communicate updated benefit information to patients.
- **Standard data-submission standards to ease reporting burden.** Providers in VBC arrangements face overlapping documentation requests and conflicting reporting requirements. These inconsistencies create unnecessary burden and divert resources away from patient care. Creating uniform data-submission standards and reporting timelines across multi-payers would prevent providers from having to submit similar information multiple times in different formats. Furthermore, requiring transparency in methodologies, calculations, and algorithms, particularly for utilization management and prior authorization, will help to reduce repeated clarification cycles.
- **Solutions to fragmented ecosystems of portals and proprietary data tools.** A major barrier to multi-payer alignment is the use of various platforms from different payers to meet access and reporting requirements. Payers can reduce fragmentation by coordinating with health IT vendors and Health Information Exchanges (HIEs) to ensure systems meet interoperability requirements and support standardized data exchange. Automated data feeds, consistent definitions, data timeliness all help to address fragmented systems, especially for VBC providers managing risk across multiple contracts.

- **Interoperable data ecosystem to support real-time insights, digital quality reporting, and bi-directional data exchange.** Examples range from advancing digital quality measurement to promoting adoption of HL7 FHIR standards and open APIs to supporting integration of advanced technologies such as AI-enabled analytics, protected by quality and clinical oversight. Unified electronic health record (EHR) environments, integrated patient-facing tools, and embedded population-health analytics can dramatically reduce provider burden, improve patient outcomes, and sustain multi-payer VBC models.

Lessons Learned From State VBC Models

State VBC models with multi-payer alignment share a unified approach to population health, establish trusted and credible relationships, demonstrate consistent expectations across payers, and rely on shared vision and infrastructure. These principles include:

- **Consistent expectations enable both providers and payers to grow and innovate across programs**. When payers and providers agree on the path to improving patient care, they can establish credibility and develop a trusted working relationship. This partnership approach provides the foundation to bring disparate systems and approaches into alignment across standard data sets, care management workflows, quality and reporting requirements, and shared vision for program investments.
- **Standardized, timely, and actionable data is foundational**. Multi-payer alignment only works when all payers agree to provide timely, accurate, and auditable claims and encounter data in standardized formats. States that have implemented service-level agreements for data delivery show that providers can meaningfully manage risk only when data is understandable, actionable, and consistent across contracts. Real-time tools – such as EHR prompts, admission, discharge, and transfer (ADT) notifications, and automated care-gap alerts – depend on this level of data standardization.
- **Integrated financial models can create predictability and shared accountability**. Successful state models use transparent upside and downside risk arrangements that apply consistently across payers. When financial incentives are aligned, providers can invest confidently in care management infrastructure, establish narrow networks, and participate in innovative payment models that reward keeping people healthy. Delegated care management becomes feasible only when risk is shared in a predictable, integrated model.
- **Enablement of scalable care management teams and integrated clinical care pathways**. States that align requirements across Medicare, Medicaid, and commercial payers allow providers to build multidisciplinary care teams (e.g., medical directors, RN care coordinators, social workers, community health workers (CHWs), pharmacists, etc.) without having to redesign workflows for each payer. This alignment supports consistent care pathways for focus areas such as high-risk pregnancy, behavioral health, asthma, substance use, polypharmacy, and transitions of care for complex and chronically ill patients. It also enables targeted outreach and comprehensive care plans across entire patient panels.
- **Reducing quality measure fragmentation supports population-level improvement**. States that harmonize quality measures across payers reduce administrative burden and allow providers to focus on improving outcomes rather than managing multiple reporting systems. Population-level measures such as avoidable ED use, chronic-disease control, behavioral health integration, and health-equity metrics become more meaningful when applied consistently. This

alignment also supports risk adjustment that reflects true population complexity across behavioral health, pediatric conditions, and substance use.

- **Addressing social determinants of health (SDOH) requires a shared responsibility across payers, providers, and community-based organizations (CBOs)**. State models consistently show that social determinants, such as housing instability, food insecurity, and transportation barriers, drive utilization and outcomes. Multi-payer alignment allows providers to invest in CHWs and social workers who address SDOH from a peer-to-peer perspective. Evidence-based CHW programs demonstrate reductions in ED visits and hospitalizations, improved chronic-disease management, and strong patient engagement when supported across payers. States that align VBC expectations across Medicaid, Medicare, and commercial payers are better positioned to address disparities in colorectal cancer screening, diabetes control, vascular care, and behavioral health outcomes. Shared expectations around SDOH screening, referral systems, and care-management pathways ensure that vulnerable populations receive consistent support from providers across multiple payers.

Aligning Attribution, Benchmarking, Financial Incentives, and Risk Adjustment Methods

Major differences across lines of business stem from payment structures and how incentives are deployed, making cross-payer alignment challenging. Below are short- and long-term considerations for multi-payer alignment across attribution, benchmarking, financial incentives, and risk adjustment.

CMS can play a central role by encouraging greater alignment across programs and payers by working with providers and payers to develop standard contracts for VBC arrangements that could be voluntarily adopted. This approach would help reduce fragmentation and scale VBC adoption by developing unified approaches across all payers. Key areas for alignment include:

- **Making attribution more transparent and consistent across payers** by encouraging plans to align around clear, standardized attribution rules across Medicare ACOs, MA, and commercial products. More consistent attribution reduces administrative burden and allows providers to manage populations more effectively and consistently, leading to more predictable benchmarks, more accurate risk adjustment, and more reliable performance measurement.
- **Making benchmarks sustainable, predictable, comparable, and fair, so providers are not penalized for success** and can confidently remain in accountable care. VBC providers need greater standardization, so providers are not forced to manage to different benchmark rules across programs. Benchmarks should also reflect true cost patterns rather than program specifications. Finally, benchmarks should use consistent baseline periods and transparent trend methodologies.
- **Moving toward a single, modernized risk adjustment model** that captures the strengths of each method and applies them similarly across programs. A shared, updated risk adjustment model should reflect patient complexity, promote fairness, ensure accuracy, and support high-quality care delivery across all beneficiaries.

CMS can also alter its VBC programs to better align with private sector arrangements by:

- **Enhancing patient choice through education and clearer marketing guidelines** to ensure patients understand their options and make informed decisions about their care. When patients knowingly align with a VBC entity, attribution becomes more stable, and financial incentives across payers become easier to harmonize.
- **Providing explicit guidance and practical examples for Stark Law and anti-kickback rule waivers so that providers have similar flexibilities as in private sector VBC models.** Many organizations remain reluctant to leverage existing waivers because their legal and compliance departments tend to take conservative positions. Clearer guidance on how existing waivers can be applied in practice and used consistently across payers would give providers greater confidence to leverage these flexibilities appropriately.

Standardizing Performance Measures and Reporting

One of the most effective strategies for standardizing performance measurements across payers has been the deliberate effort to align quality measures, reporting methodologies, and data requirements across value-based care programs. Providers consistently cite quality alignment as one of the most powerful nonfinancial incentives for adopting accountable care, because it reduces administrative burden and frees them from the fragmented reporting requirements that characterize FFS programs. Key approaches include:

- **Standardizing quality measures and methodologies to reduce burden:** When payers use consistent and transparent metric specifications, timelines, and reporting formats, providers can leverage the same data infrastructure across all value-based contracts. Payers can build on this by collaborating with VBC providers to structure measurement and data collection so that one set of quality data can be used across multiple programs and shared to support timely interventions.
- **Leveraging already created standardized measure sets, where appropriate:** National initiatives such as the Universal Foundation and the Core Quality Measures Collaborative (CQMC) have developed standardized quality measures across domains. While adoption has been uneven – often due to operational challenges or misalignment with payer incentive programs – these frameworks remain important tools for driving consistency.
- **Advancing technology-enabled approaches to quality reporting:** Electronic health records (EHRs), digital platforms, and real-time analytics tools have become essential for standardizing reporting. Providers already rely on predictive analytics and care navigation tools to close care gaps and identify early indicators of illness; aligning quality measures ensures these tools can function effectively across all payer arrangements.

Overcoming competitive Market Dynamics and Promoting Collaboration Among Payers

VBC providers can drive coordinated care and beneficiary engagement, but only when they are empowered to manage both clinical and financial risk. CMS can help by creating more pathways and support for providers to assume and operationalize that risk across payers. One of the most effective ways to overcome competitive market dynamics is to center collaboration around patient needs rather than payer silos. VBC providers have demonstrated that when care delivery is organized around the

patient, rather than the contract, payers are more willing to align processes, share data, and coordinate interventions.

A key strategy has been the use of personalized, interdisciplinary care teams that engage patients across all lines of business. These teams – often composed of primary care clinicians, specialists, care managers, pharmacists, and social workers – operate as a unified support system regardless of coverage type. By coordinating care across payers, VBC entities reduce duplication, streamline communication, and create consistent experiences for patients who often move between plan types.

Another successful approach is the creation of a seamless continuum of care through co-management of services. Rather than each plan managing its own care transitions, VBC providers have worked with multiple payers to jointly coordinate and support high-risk, chronically ill patients through shared care pathways, standardized discharge protocols, and aligned care-management expectations. This reduces friction for patients and eliminates the fragmentation that typically arises when payers compete rather than collaborate.

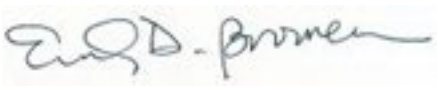
These models work because they demonstrate clear value to all parties. **Payers benefit from reduced avoidable utilization and improved quality performance; providers benefit from simplified workflows and consistent expectations; and patients receive more coordinated care they can effectively engage in.** Over time, these shared wins have helped soften competitive dynamics, build trusted relationships, and establish collaborative strategic partnerships.

It is imperative that patient-centered care teams, shared care coordination infrastructures, and aligned clinical workflows have the necessary data, investments, and resources for promoting cross-payer collaboration.

Conclusion

Thank you for the opportunity to provide feedback on improving multi-payer alignment in VBC. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. We look forward to our continued engagement in driving sustainability, innovation, and alignment in VBC across payers. If you have any questions, please contact Aisha Pittman, senior vice president of government affairs at aisha_pittman@NAACOS.com.

Sincerely,



Emily D. Brower
President and CEO
NAACOS

California Quality Collaborative

January 30, 2026

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
c/o Assistant Secretary for Planning and Evaluation (ASPE)
U.S. Department of Health and Human Services
200 Independence Avenue SW Washington, DC 20201

RE: Response to RFI – Improving Multi-Payer Alignment in Value-Based Care

Dear Members of the PTAC,

The California Quality Collaborative (CQC), a program of the Purchaser Business Group on Health (PBGH), is pleased to submit this response regarding the critical need for multi-payer alignment in value-based care (VBC).

As a multi-stakeholder statewide organization dedicated to healthcare delivery transformation, CQC serves as a neutral convener with two decades of experience. Our insights are grounded in a proven track record of facilitating deep collaboration among commercial and public payers, purchasers, and providers. We are currently leading several initiatives that serve as proof-of-concept for the technical frameworks necessary for successful VBC alignment:

- The **California Advanced Primary Care Initiative**: In partnership with Integrated Healthcare Association (IHA), CQC leads this statewide multi-payer alignment and collaboration effort involving major payers. Central to this effort is the **Payment Model Demonstration Project**, which utilizes a common value-based payment model co-designed by seven payers and piloted by three health plans from October 2024 through December 2026. The model standardizes payment for direct services, a population health management payment and a financial performance incentives on a common measure set. This initiative currently supports over 100 practice locations across California, providing a testing ground for a standardized payment structure and paired with common technical assistance and a common data platform for reporting and measurement- all within the Commercial PPO population.
- The **California Hospital and Multi-Plan Partnership (CHAMP)**: A collaboration between CQC, five health plans and 12 hospitals designed to improve patient safety and quality performance through health plan alignment.
- **Regional Medicaid Alignment**: Facilitating coordinated action among Medicaid managed care plans in Los Angeles County to address quality performance and disparity reduction.
- **Strategic Payer Workgroups**: Focused on co-designing implementation standards for high-priority areas, including Behavioral Health Integration and Postpartum Population Support.

Our experience in California demonstrates that when payers align on a "North Star," they create a multiplier effect that reduces administrative waste and allows clinical teams to focus on patient outcomes rather than fragmented requirements. We believe the technical frameworks we have developed offer a scalable blueprint for federal alignment efforts.

Sincerely,

Crystal Eubanks

Executive Director, California Quality Collaborative (CQC)
Vice President, Care Transformation
Purchaser Business Group on Health

California Quality Collaborative

Response to RFI Questions

Approaches to Implementation: The "Collective Impact" Model (Response to Q1 & Q2)

CQC recommends a **Payer-Led, Voluntary Collective Impact Model** for successful multi-payer alignment. Our experience suggests that state-led mandates often lack the operational "teeth" necessary and the neutral forum for deep transformation. We have pivoted toward a model where payers are the primary drivers and investors in the effort.

- **The "Go Together" Vision:** Our aspirational goal is a strong and resilient primary care system that reduces total cost of care through increased primary care investment, co-resourced transformation, and public transparency. As we have learned in California: to go fast, go alone; but to go far, **we must go together through collective impact.**
- **Neutral Brokerage:** State entities are often ineffective conveners because inherent regulatory tension prevents plans from being vulnerable. CQC acts as a neutral expert that brokers "matchmaking" between competitors, facilitating the sharing of "bright spots"—such as one plan sharing successful hybrid payment results to serve as the blueprint for a common model.
- **Establishing a "Common Definition":** Through the California Advanced Primary Care Initiative, CQC and IHA successfully convened competing health plans to agree on a shared definition of "Advanced Primary Care." This established a unified framework for high performance, effectively eliminating the conflicting requirements that historically hindered transformation.
- **Evolution of the MOU:** Building on the Washington State MOU framework, CQC developed a version that moved from a conceptual state-led vision to a payer-led commitment. By agreeing to finance the collaborative work proportionally, health plans transitioned from "optics-based participation" to invested stakeholders with "skin in the game."
- **Purchaser Adoption as a Catalyst:** While alignment was co-designed by stakeholders, real action was catalyzed when major purchasers integrated multi-stakeholder standards into their contract requirements. This created a shared market demand, motivating plans to internalize aligned standards into their core operations.

Operationalizing the "Shared Practice" (Response to Q3 & Q4)
CQC focuses alignment on "shared practices"—provider sites serving patients from multiple participating plans.

- **The Three-Pillar Payment Model:** We utilize a common model consisting of (1) payment for direct services, (2) a population health management payment, and (3) a financial performance incentive based on a common measure set.
- **Standardization with Physician Input:** We leveraged physician workgroups to ensure incentives aligned with clinical interests. This resulted in "whole-number" benchmarks—targets that are easy for clinical teams to remember and act upon.
- **Aligned Benchmarks:** Aligning on methodology is insufficient. Plans must align on specific performance goals so practices have a clear target. We facilitate this by cascading benchmarks from major purchasers through a neutral data partner.
- **Equity-Centered Payment Design:** The CAPCI model treats equity as a core financial component. We incorporate **social risk adjustment** (including deprivation indexing) to ensure practices serving vulnerable populations are not penalized. Furthermore, equity-sensitive quality measures are weighted more heavily for performance incentives to direct resources where they are most needed.
- **Bidirectional Data Exchange:** Plans co-implemented bidirectional data exchange between practices and all participating health plans to enhance care coordination and close care gaps in real-time.
- **A Unified Technical "Control Center":** Our **Common Data Platform** aggregates data from all participating plans into a single interface. Providers use one dashboard for attribution, care gap analysis, and financial modeling, allowing them to manage their full panel in one place.
- **Unified Technical Assistance:** CQC provides a single TA coach per practice who understands all participating plans. This reduces the administrative noise of having five separate plan-specific coaches. This is significantly more cost-effective and efficient; the coach has an "all-payer" view and can navigate each plan's internal bureaucracy to resolve issues faster than five separate coaches could.

Governance and the "Room Silence" Protocol (Response to Q5 & Q6)
Navigating "legal anxiety" and antitrust concerns is a primary barrier to multi-payer work. CQC bypasses these hurdles through a governance protocol.

- **Defining Room Silence:** This protocol allows participants to share the *substance* of a discussion outside the meeting but strictly prohibits attributing specific data or strategies to a particular health plan.
- **The "Vault" for Vulnerability:** Room Silence creates a protected space where a Medical Director can share unpolished results or admit to a failure in a current model so the group can learn from it. This psychological safety allows representatives to speak as system-transformers rather than corporate defenders.
- **Operational Guardrails:** We exclude purchasers and regulators from deep-dive design sessions, as their presence often triggers legal restrictions on what plans can share. We rely on the established data agreements of the Integrated Healthcare Association (IHA) to manage data exchange without the need for complex new legal frameworks.
- **Navigating Antitrust via Neutral Brokerage:** To maintain a competitive and compliant marketplace, CQC and IHA acted as neutral conveners to recommend payment *structures* (not rates). Health plans determined their final rates independently and kept them confidential, allowing for structural alignment while fully complying with antitrust regulations.

Risk Transition and Financial Sustainability (Response to Q7)
CQC's approach to risk is grounded in regulatory reality and provider protection:

- **Solving Financial Instability:** Our demonstration utilizes a **Hybrid Capitation Model** (prospective PMPM) alongside a "Fee for Service Plus" track. This provides the predictable revenue necessary to fund care coordination infrastructure.
- **Rewarding Progress, Not Just Perfection:** We recommend that CMS incorporate "on-ramps" that reward improvement alongside attainment. Our model includes financial incentives for year-over-year improvement to encourage participation from practices not yet at the performance peak.
- **Incentivizing Care for High-Needs Patients:** Our model recommends a **potential 30% increase** to base payments to address social drivers of health (SDOH). Alignment is critical here: if only one payer supports SDOH, the practice cannot afford a sustainable equity program for its entire patient panel.
- **Regulatory Barriers:** Current California regulations effectively prohibit individual providers from taking downside risk in PPO contracts.
- **The "Size and Scale" Glide Path:** While we support downside risk for large provider organizations, CQC does not support cascading that risk to individual physicians or small, struggling practices. The path to risk must be contingent on the financial scale required to safely absorb potential losses.

IHA's multi-payer programs and learnings for PTAC

Who is IHA

Integrated Healthcare Association (IHA) is a 501c6 business league funded by the healthcare industry to take on big, systemic challenges that stand in everyone's way. As a trusted convener, we bring the healthcare community together to overcome barriers to high-value, equitable care. For the past 25+ years, we've championed a more integrated care system that improves quality and affordability for patients in California and beyond.

- We align the healthcare community around shared goals and new possibilities.
- We use data and insights to help everyone improve.
- We build what's needed to drive lasting change.

IHA's members include leading healthcare organizations across California. We bring a diverse group of key decision-makers to the table—hospitals, health systems, health plans, physician organizations, purchasers, consumer groups, universities and research organizations, government, and pharmaceutical and technology companies. Together, we are working to come up with bold, innovative ways to make healthcare better for everyone.

> *IHA's AMP program created trust between consumers, health plans, purchasers, regulators, providers… it's really unique. - Dr. Hector Flores*

IHA's Align. Measure. Perform. (AMP) Program

IHA's Align. Measure. Perform. (AMP) program is the nation's largest and longest-standing non-governmental provider performance measurement, reporting, and incentive program, serving as a foundational platform for value-based care advancement. AMP includes 15 health plans and over 200 provider organizations, capturing nearly 15 million commercial members. Since 2003, AMP has tracked provider performance for quality, resource use, and cost of care measures that have the biggest impact on care outcomes.

AMP is distinguished by its robust, multi-stakeholder governance structure, which brings health plans, providers, purchasers, and other industry subject matter experts together to collaboratively define, refine, and implement program design and policies—ensuring credibility, relevance, and durability across the market.

The program integrates multiple data sources including patient cost sharing information and sophisticated processes to account for the high levels of capitated payments in California. AMP also has a formal data review and reconciliation process, enabling participants to validate results and ensuring that AMP produces the most complete, accurate, and trusted performance information possible.

AMP is grounded in a strong commitment to transparency, not only in its program design and methodologies but also in the public reporting of provider performance, which equips stakeholders with actionable insights and drives continuous performance improvement across the care delivery system.

- **Alignment** across payers, lines of business, and key industry partners to create a strong signal and reduce fragmentation; importance of emphasizing provider perspective and ramifications (see attachment: IHA AMP Value)
    - Providers generally contract with many different payers across all lines of business. Alignment across payers, lines of business, and regulator requirements **reduces provider abrasion and administrative burden** and **increases impact of programs**.
    - Trying to understand and respond to complex and varied program requirements for each payer and line of business wastes provider resources, decreasing time for patient care. Alignment allows providers to **focus on closing patient care gaps**.
    - AMP **measures everyone by the same standards** to create clear, reliable, and comparable performance information and benchmarks.
        - A common measure set allows the **aggregation of provider results** across plans for more reliable results.
        - Standardized measurement and benchmarks based on aggregated results enable **meaningful comparison** of performance against peers as well as variation in performance, highlighting specific outliers and room for improvement.
    - **Main lessons learned:** Including providers, payers, lines of business, regulators, and other partners in a voluntary multi-payer initiative creates buy-in, reduces administrative and reporting burden, and creates aligned goals. This enables providers to focus on patient care and performance improvement, thereby increasing impact on quality and affordability of care.
- **Governance** by committees comprised of subject matter experts and program participants, facilitated by a trusted convener
    - Two **technical committees** (measurement and incentive design) that contain experts in their respective fields, thoroughly discuss various elements of program design enhancements, and then provide recommendations to the **Program Governance Committee** for approval.
    - Each committee has **equal representation** of health plans and provider organizations, supplemented by other **subject matter experts** (NCQA, RAND, patient advocates, etc.), and is led by a committee-nominated chair.
    - **Formal votes** are held for all decisions that are not unanimous, inclusive of committee member selection.
    - An **annual public comment period** is held to allow all participants and stakeholders to voice their thoughts and ideas.
    - **Main lessons learned:** To foster buy-in, all parties must have the opportunity to participate in the decision-making process and all feedback must be vetted and responded to. Having a neutral convener facilitate the process and help build consensus increases trust and credibility.

- **Incentive design** with aligned measure set, benchmarks with percentiles, and deliverables to support turn-key implementation
    - The AMP incentive design has always been upside only. The design has **evolved over the years** reflecting the evolution of the broader healthcare landscape. It started as a quality only program in 2003; expanded to include a separate shared savings component based on utilization in 2009; combined into a single value-based shared savings program based on utilization, with quality and cost as gates in 2012; and finally in 2024, transitioned to a program re-focused on quality inclusive of utilization, with cost as an adjuster.
    - The 2024 redesign was prompted by **new health plan accountability programs** established by the state purchasers, namely Covered California and CalPERS. Large dollar amounts are at risk for plans based on performance on specific measures. It was **essential to align** the AMP provider accountability program with the plan accountability programs.
    - AMP **incentive payments have varied** over the years, with a downward trend due to less inappropriate utilization to remove. With the return to a focus on quality in the recent redesign, IHA has facilitated discussions on **establishing a recommended maximum payment** potential of 5% of average professional capitation amounts. For most plans, it will take several years to reach this recommended amount and will be contingent on them seeing continued improvements in performance.
    - IHA provides **documentation and tools** to help plans and providers understand the incentive design and model how payments will be affected with different design changes.
    - By adopting an aligned multi-payer incentive program, plans do not have to expend the resources to design, communicate, implement, and defend their own incentive program across all of their contracted providers, **saving resources** that are increasingly spread thin.
    - **Main lessons learned:** An aligned, thoughtfully designed incentive program that reflects the evolving healthcare landscape and reinforces accountability programs across different levels of the health care delivery system can be impactful and make effective use of resources. Establishing recommended payment amounts helps create a value proposition. Providing clear and accessible program documentation and modeling tools is vital to supporting understanding and adoption.
- **Trusted results** made possible by plan and provider data submissions, appropriate attribution and adjustments, ongoing data anomaly identification and correction, and a comprehensive review process
    - For use in all AMP accountability uses, IHA selects the better of (1) plan-submitted results aggregated across contracted plans for a provider organization or (2) the provider organization's self-reported, audited results across all contracted plans. Using **aggregated provider organization results** including members of all contracted health plans leads to far more reliable results (see attachment: Power of Aggregation).
    - **Attribution** of members based on both plan and provider enrollment brings about buy-in for providers to feel they can improve patients' care within the period allotted.
    - Clinical and geographical **risk adjustment** for cost measurement, and clinical risk adjustment for resource use measures, mitigates performance variation due to differences in patient population and the healthcare landscape.

- **Data discrepancies** between plans and POs are resolved during an **appeals period**, leading to fair and agreed-upon results based on appeals panel adjudication. Plans can use these final AMP results without any further challenges.
- **Main lessons learned:** Trusted methodology and results are critical for effectively supporting provider accountability use cases. Adopting agreed-upon, industry best practice methods for things like member attribution and risk adjustment; aggregating results across payers; and offering an appeals process to challenge and resolve discrepancies all significantly contribute to building trust. Clear documentation and availability of all methods and processes is also critical for building trust.

- **Antitrust** issues can be mitigated with a neutral convener facilitating the process to create recommendations for voluntary adoption by payers versus requirements
    - IHA plays the **role of a neutral convener** to research and present options, facilitate discussions of the committees, and seek additional information from individual participants to determine recommendations for voluntary adoption.
    - **Recommendations** include the incentive design elements and methodology, recommended measures used for determining performance, and recommended payment amount.
    - Actual **adoption** of the recommendations is up to each individual health plan, and may be full adoption, partial adoption, or no adoption. Each plan communicates its decision to its contracted providers and is responsible for making its own payment calculations and disbursements.
    - IHA, as **neutral convener, collects and reports information** from participating plans on their intentions related to adoption ahead of the measurement year, as well as their actual adoption status after the measurement year. This provides transparency and a single place for providers to find a summary of all the adoption information.
    - **Main lessons learned**: There is quite a bit of latitude in terms of multiple payers coming together to discuss and develop common payment models with recommended methodologies and payment amounts, as long as adoption of the recommendations is completely voluntary for each payer and payments to providers are made individually by each payer. A neutral convener facilitating this process can help mitigate any perceived antitrust risk.

For more information on IHA's AMP program, please navigate to the Align. Measure. Perform. website.

IHA and CQC's California Advanced Primary Care Initiative (CAPCI)

Convened by IHA and the California Quality Collaborative (CQC), the California Advanced Primary Care Initiative (CAPCI) is an effort comprised of a group of California-based health care payers — predominantly health plans — who have voluntarily partnered to support providers in strengthening primary care delivery. The group shares a common definition for Advanced Primary Care based on attributes and measures that were collaboratively developed by care providers, health plans and other health system partners. The group also developed a value-based payment model for primary care practices that is applicable across all payer types and products and provides increased resources, more flexibility, and rewards for performance.

As part of the broader CAPCI work, Aetna, Blue Shield of California, and Health Net are conducting a two-year demonstration project of the common value-based payment model that was co-developed by the CAPCI conveners and participants. The model will be live from January 1, 2025 through December 31, 2026 in a population of practices with one or more Commercial PPO contracts with the three health plans. These contracts account for a significant portion of the practice panel, which enables practices to make business and clinical transformation across the whole practice.

- **Alignment** in measurement of a multi-payer population under a shared value-based payment model utilizing a common reporting platform and jointly funded practice coaches
    - A **standard measure set** aligned across participating health plans who agreed to pay incentives on performance aggregated across all members under the model.
    - A **shared value-based payment model** adopted across participating health plans increases payment by up to 30% to primary care practices with prospective population health management payment and incentives for value-based performance.
    - A **common reporting platform** was jointly selected to provide payer agnostic member attribution, insights on care gaps, measure performance, and incentive modeling. One login and a unified view across health plans reduces administrative burden for practices.
    - A **practice coach jointly funded** by the participating health plans to provide technical assistance and guidance to the practices on implementing value-based care focuses efforts.
    - **Main lessons learned:** By aligning measurement, payment model, reporting, and technical assistance across payers and coordinating recruitment of practices, this demonstration project is showing that the multi-payer approach is creating greater interest and impact than individual payer efforts, which can accelerate the needed change in primary care.
- **Incentive model** designed with primary care provider interest in mind, with consistent whole number benchmarks and an incentive that rewards improvement as well as attainment
    - To **gain primary care provider buy-in**, the conveners formed a physician workgroup to develop incentive design recommendations to the health plans.
    - The **provider recommendations** resulted in the following adaptations in the incentive design: rewarding improvement in addition to attainment to encourage continued effort and investment toward meeting value-based benchmarks; whole number benchmarks that are consistent throughout the demonstration so they can be easily remembered and communicated in care teams.

    - **Main lessons learned:** Strategically incorporating the physician's voice into the performance of incentive design leads to physician buy-in and a stronger recruitment strategy but also requires tough discussions to obtain acceptance amongst the payers.
- **Antitrust** issues can be avoided with recommendations versus requirements and payer confidentiality during practice recruitment and reporting
    - IHA and CQC as **neutral conveners recommended** base rates for both the prospective population health management payment (15%) and the value-based performance incentive payment maximum potential (15%). The recommended total amount of up to 30% represents a meaningful increase in payment from the average statewide commercial primary care spending amount.
    - Each **health plan determined** its own payment rate. The three participating health plans generally followed the overall 30% potential increase, with varying distributions between the population health management payment and the value-based performance incentive. Each plan's payment decisions were kept confidential from the other plans.
    - Joint **practice recruitment** was led by neutral conveners, with IHA identifying appropriate practices for recruitment, and IHA and CQC conducting the initial recruitment. Once practices expressed interest in participating, health plans were connected directly with practices to finalize contracting.
    - **Restricted reporting** of aggregated results to participating health plans to share only rates and not numerator or denominator which would reveal a plan's portion of the practice's panel.
    - **Main lessons learned:** For multi-payer voluntary payment designs, neutral conveners are essential for facilitating determination of recommended design and payment rates and for identifying practices that meet agreed upon criteria. Payment design and rates can be recommended but must be adopted voluntarily, with each payer establishing its own rates. Conveners help maintain confidentiality and trust amongst the payers.

For more information on the California Advanced Primary Care Initiative demonstration project and the common payment model, please navigate to the CAPCI Common Value-Based Model Guide.

Integrated Healthcare ASSOCIATION

Align. Measure. Perform.

A unified approach to healthcare performance.

It's hard to improve what you can't measure. And measuring value-based healthcare performance isn't easy. Before IHA's Align. Measure. Perform (AMP) program, a cacophony of different measurement and incentive programs existed, often with conflicting interpretations of performance. The resulting noise scattered provider organization (PO) focus, wasted precious resources, and diluted the impact of individual plan programs.

Before AMP, health plans faced obstacles in making progress in healthcare performance

Lack of provider focus on measures that matter

Different measure sets and methodologies meant POs had to pick and choose which measures to focus on across their 5+ contracted health plans.

Resource-intensive incentive designs

Plans needed staffing to develop and administer their incentive program, including getting buy-in from over 100 POs. POs were often less engaged due to unclear expected incentive earnings.

Dealing with data discrepancies

Plans risked significant problems if providers disagreed with results, from managing and resolving discrepancies to potential lawsuits.

Decreased Impact

Navigating complex and varied requirements wasted significant resources that POs could have used for improving patient care, decreasing the impact of a plan's incentive program.

AMP provides a complete picture of healthcare performance

AMP measures everyone by the same standards to create clear, reliable, and comparable performance information and benchmarks, addressing the complexity of California's landscape. It helps drive high-value care through a standard, industry-approved incentive design, public reporting of results, and public recognition of top performers.

How health plans benefit from AMP participation

Increased standardization and alignment

Standardized measurement and benchmarks enable plans to examine their performance against peers, PO performance against peers, and variation in a PO's performance across plans—highlighting specific outliers and room for improvement.

Through IHA's committees, plans and POs align on PO incentives, ensuring alignment with purchaser and regulator plan incentives. Most POs then prioritize the AMP measure set to inform their quality improvement (QI) strategies, essentially aligning industry QI strategy.

Improved performance results

A common measure set allows the aggregation of results across plans for more reliable results and meaningful comparisons.

Data discrepancies between plans and POs are resolved during an appeals period, leading to fair and agreed-upon results based on appeals panel adjudication. Plans can use these final AMP results without any further challenges.

IHA's ongoing focus on improving encounter data leads to better and more accurate clinical quality and risk score rates.

AMP's public recognition and awards engage POs, creating healthy competition to improve patient outcomes.

Reduced administrative burden

With one measure set and incentive design, POs can focus on closing care gaps and caring for plans' members rather than navigating multiple measure sets and QI strategies.

NCQA-approved auditors audit AMP PO self-reported clinical data. Plans participating in HEDIS and other mandatory reporting can use the PO data without having to re-audit it, closing plan performance data gaps without additional effort.

Provider Organizations focus on AMP measures:

75% of AMP HMO measures improved over 5 years, even during the COVID-19 pandemic.

Benefits extend beyond the AMP program

Industry innovation, leadership, and alignment

Health plans have a seat at the table with competitors, regulators, and industry trading partners such as DMHC, NCQA, Covered California, other health plans, and provider organizations to influence and get prepared for future regulatory requirements and data submission requirements, including Electronic Clinical Data Systems (ECDS) reporting.

IHA thought partnership

Health plans often rely on IHA's subject matter experts and industry experience, alongside data insights, to help inform business decisions. Our team of experts is passionate about what we do and available to provide timely input on a wide variety of situations.

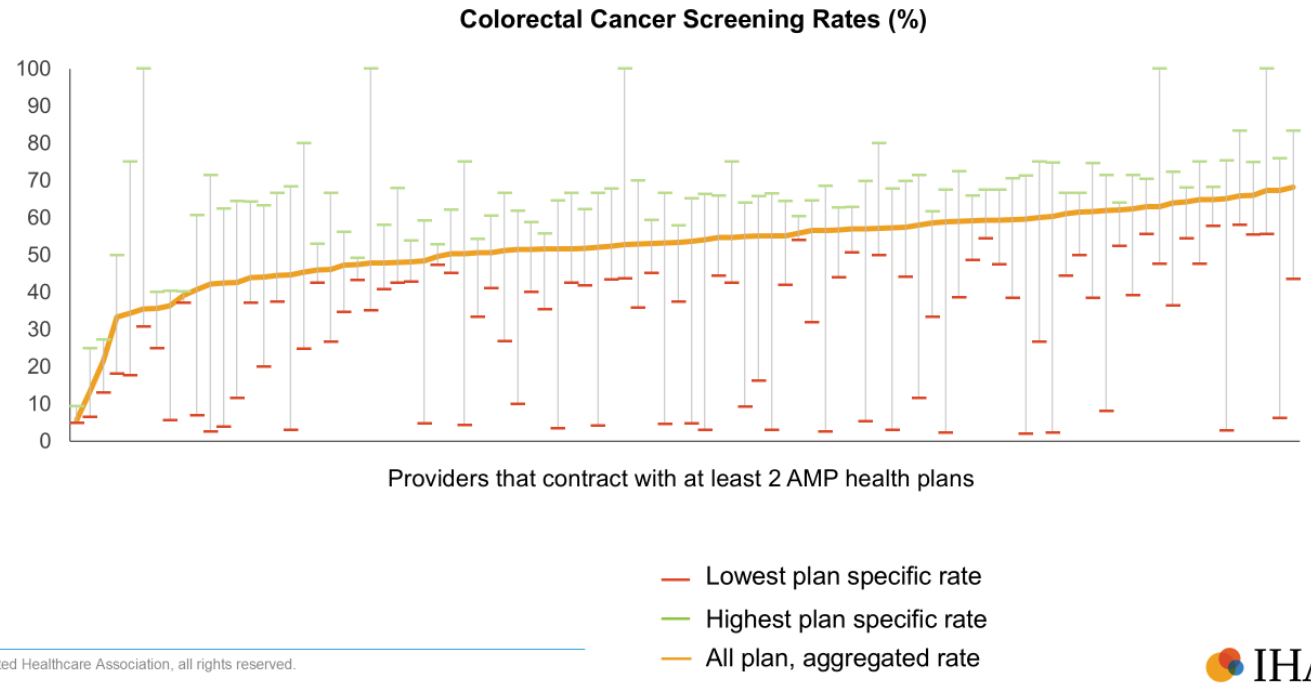
IHA

At Integrated Healthcare Association (IHA), we bring the healthcare community together to solve industry-wide challenges that stand in the way of high-value care. As a non-profit industry association, we use our decades of expertise, objective data, and our unique role as a trusted facilitator to make the healthcare system work better for everyone.

180 Grand Avenue, Suite 1365, Oakland, CA | 510-208-1740 | www.iha.org

Aggregating rates across plans provides more accurate provider performance

All-plan, aggregated rate makes provider performance more reliable for incentives



IHA

- Without aggregation across plans, there is large variability in provider results that creates noise and scatters provider focus on improvement efforts.
- Smaller denominator sizes for an individual plan results in less reliable results for a provider that can vary by more than 60 percentage points for the same measure for the same provider across different plans.
- Using results aggregated across plans smooths out the variability and provides a truer measure of actual performance.