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.

<u>Lessons Learned From State VBC Models</u>

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.

<u>Aligning Attribution, Benchmarking, Financial Incentives, and Risk Adjustment Methods</u>

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.

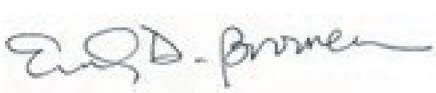
These models work because they demonstrate clear value to all parties. **Payers benefit from reduced avoidable utilization and improved quality performance; providers benefit from simplified workflows and consistent expectations; and patients receive more coordinated care they can effectively engage 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,



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