# 2026 AMA Interim Meeting of the
## Integrated Physician Practice Section

## Slides for Attendees

**November 6, 2026**

# Federal and Commercial Value-Based Models: Navigating the New Payment Landscape

# Navigating the New Payment Landscape:
## Federal and Commercial Value-Based Models for Integrated Health Systems

**Alyssa Neumann**

**Director, Federal Affairs, NAACOS**

# About NAACOS

**472**
ACO MEMBERS (79%)

**10.2 M**
BENEFICIARY LIVES IN MEMBER ACOS

**32**
VALUE-BASED CARE ENTITIES

**147**
PARTNER ORGANIZATIONS



## THOUGHT LEADERSHIP

NAACOS works to advance and promote coordinated, patient-centered, value-based care through research, publications, and other forms of thought leadership.



## EDUCATION

NAACOS offers a variety of educational webinars, conferences, and other events to help value-based care entities stay up-to-date on the latest developments in the field and learn from experts and peers.



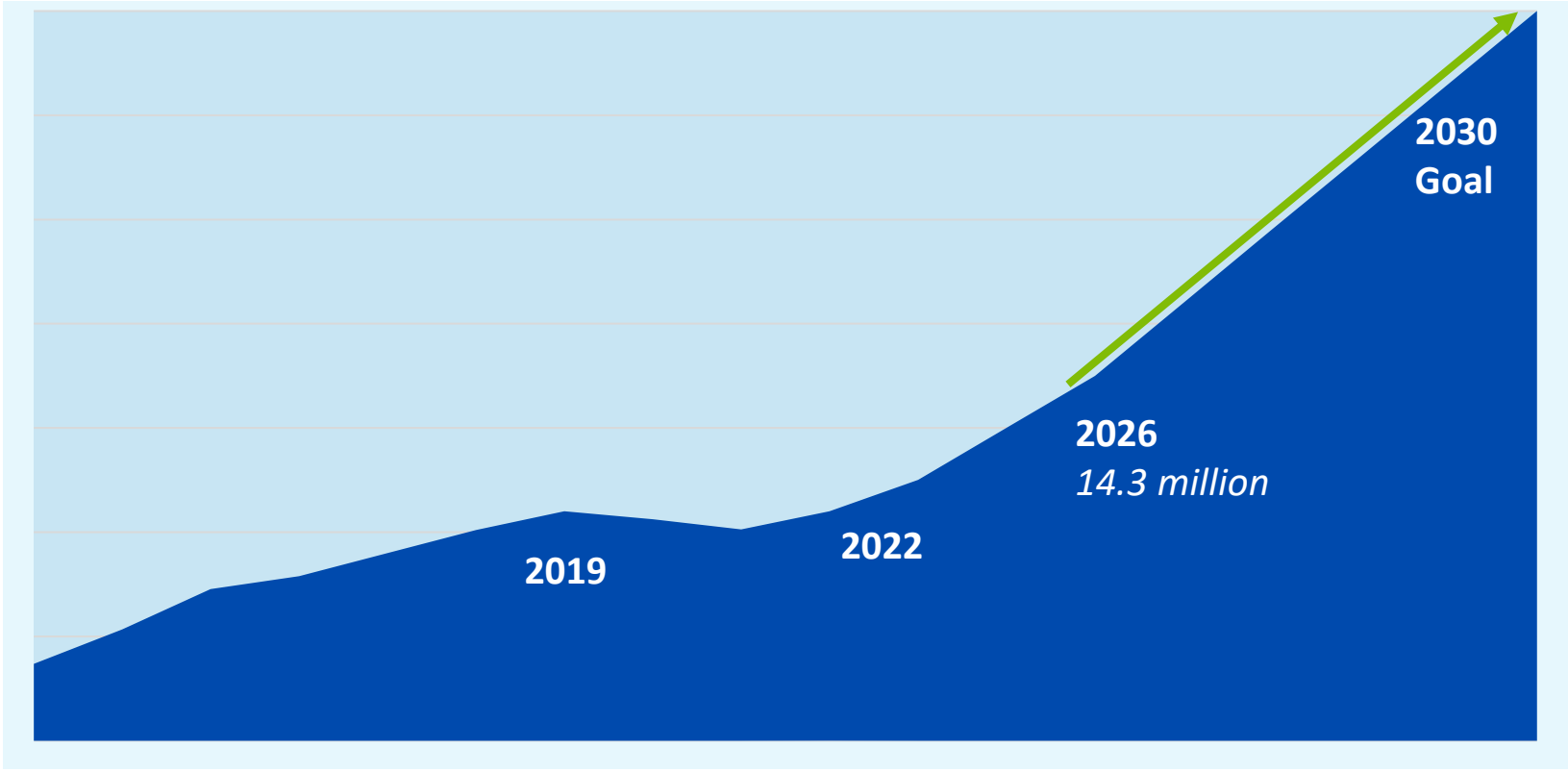
## ADVOCACY

NAACOS advocates through various means, such as engaging with policymakers, participating in rulemaking, collaborating with other organizations, and communicating with the public.

*Founded in 2012, the National Association of ACOs (NAACOS) is a member-led and member-owned nonprofit helping ACOs succeed in efforts to coordinate and improve the quality of care for their patient populations.*

# Getting to 100% Accountability

**BOTTOM LINE** CMS wants all Medicare beneficiaries in accountable care relationships by 2030. Currently, more than 53% of attributable traditional Medicare beneficiaries are in ACOs.




- Accountable care **reduces fragmentation** in patient care and cost by giving providers the incentives and tools to deliver high-quality, coordinated, team-based care.
- **Quality of care and health outcomes** are meaningful and reflected in patient values and perspectives.
- New and existing models must look to engage **smaller practices** and **specialty care** to move the needle.

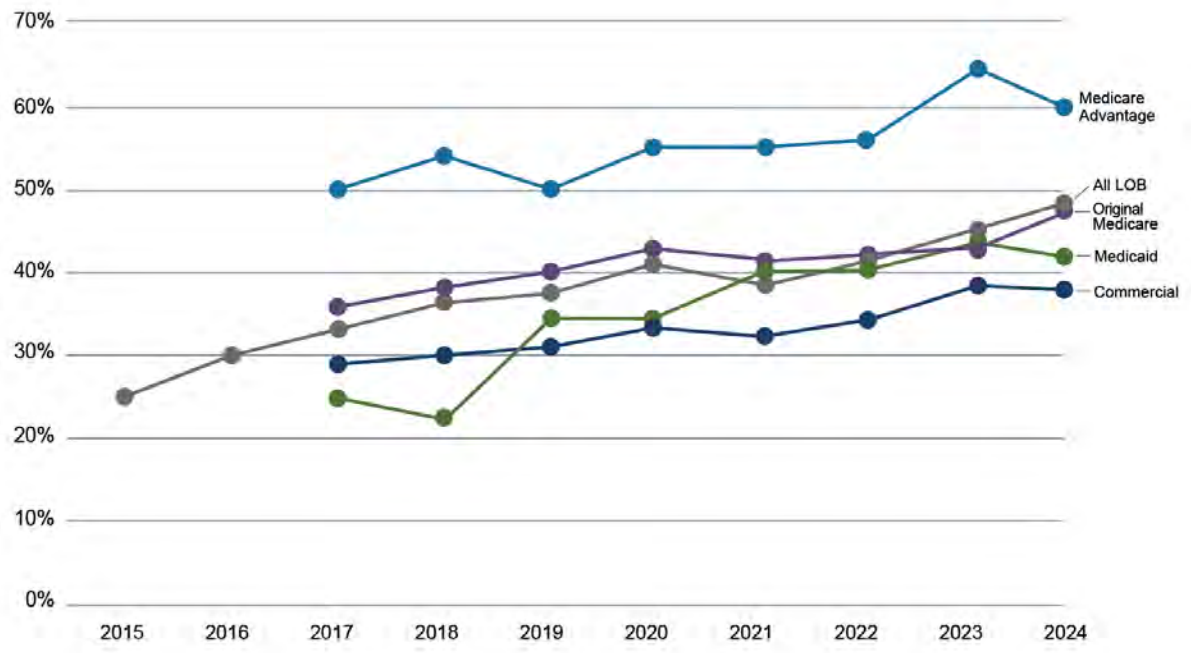
# APM Market Trends

**44.9% of care payments in the U.S.** flowed through an APM contract (Categories 3-4) in 2024

**28.7% flowed through a downside risk** APM contract across all lines of business in 2024

**Spending in Categories 3-4 by Year and by LOB**

Data Years 2015-2024




https://www.ahip.org/resources/2025-apm-measurement

# Where Accountable Care Leaders Can Focus

**BOTTOM LINE** Continued adoption of accountable care creates synergies to use infrastructure investments to support value-based care across payers. Diverse plan structures require strong leadership to see benefits from multi-payer sustainability.

1

**APM Alignment** to align payment with performance on quality, cost, and patient experiences across lines of business through best practices.

2

**Medicare Advantage** cycles through opportunistic times for VBC adoption.

3

**Medicaid** inconsistency follows MCO market, but with RHTP grants new opportunities are emerging.

4

**Practice Engagement & Network Management** strategies are central for CIN optimizations and establishing preferred partners.

# Multi-Payer VBC Resources







Access these resources

- AHIP, AMA, and NAACOS established a collaboration to identify principles and voluntary best practices to foster sustainable success in value-based care (VBC).
- Intended to advance adoption of VBC and includes best practices for overcoming key challenges that persist today, taken directly from the expertise of those participating.
  - Playbook of Voluntary Best Practices to Advance Data Sharing—Focused on data sharing, as a fundamental building block of VBC
  - Playbook of Voluntary Best Practices for VBC Payment Arrangements—Focused on underlying payment arrangements that seek to align payment with performance on quality, cost, and patient experiences

# Modernize ACOs

Accountable care has transformed care delivery with meaningful savings and better patient outcomes.

Continued success depends on modernizing ACO programs to deepen engagement and impact on patient care and drive greater long-term value.

| Sustainability | Burden Reduction | Innovation |
| --- | --- | --- |
| More predictable benchmarks with guardrails on trend adjustments | More resources directed to patient care with streamlined quality requirements | Addressing patient affordability with beneficiary cost sharing support |
| Address benchmark ratchet for long-term participants and create stronger fraud protections | Promote beneficiary awareness of ACOs and aligning data requirements with reality | Engage specialists and support tech-enabled care |

# Innovation Center Strategy




## Evidence-based prevention models will:

- Embed preventive care in all model designs
- Measure the impacts of preventive care

## Health goal models will:

- Unlock data access
- Align financial incentives with health outcomes

## Choice and competition models will:

- Increase independent provider participation in value-based payment programs
- Promote patient choice in care
- Improve administration of value-based payment programs

# Landscape of CMMI Models

## Total Cost of Care Global Budget

| | |
|---|---|
| ACO REACH Model (formerly Direct Contracting) | *Through 2026* |
| Comprehensive Kidney Care Contracting | *Through 2027* |
| Enhancing Oncology Model | *Through 6/2028* |
| AHEAD Model | *Through 2035* |
| Long-term Enhanced ACO Design (LEAD) | *1/1/2027 – 12/31/2036* |

## Episode-Based & Condition-Specific

| | |
|---|---|
| GUIDE (Dementia Care Model) | *Through 6/2032* |
| Transforming Episode Accountability Model (TEAM)* | *Through 2030* |
| Transforming Maternal Health (TMaH) | *Through 2034* |
| Innovation in Behavioral Health (IBH) | *Through 2032* |
| Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) | *7/5/2026 – 6/30/2036* |
| Ambulatory Specialty Model (ASM)* | *1/1/2027 – 12/31/2031* |
| Increasing Organ Transplant Access (IOTA) | *7/1/2025 – 6/30/2031* |
| WISeR | *Through 2031* |
| CJR-X* (permanent, nationwide) | *Begins 10/1/2027* |

## Primary Care & Lifestyle Medicine

| | |
|---|---|
| ACO Primary Care Flex (within MSSP) | *Through 2029* |
| MAHA ELEVATE | *9/2026 – 2030* |

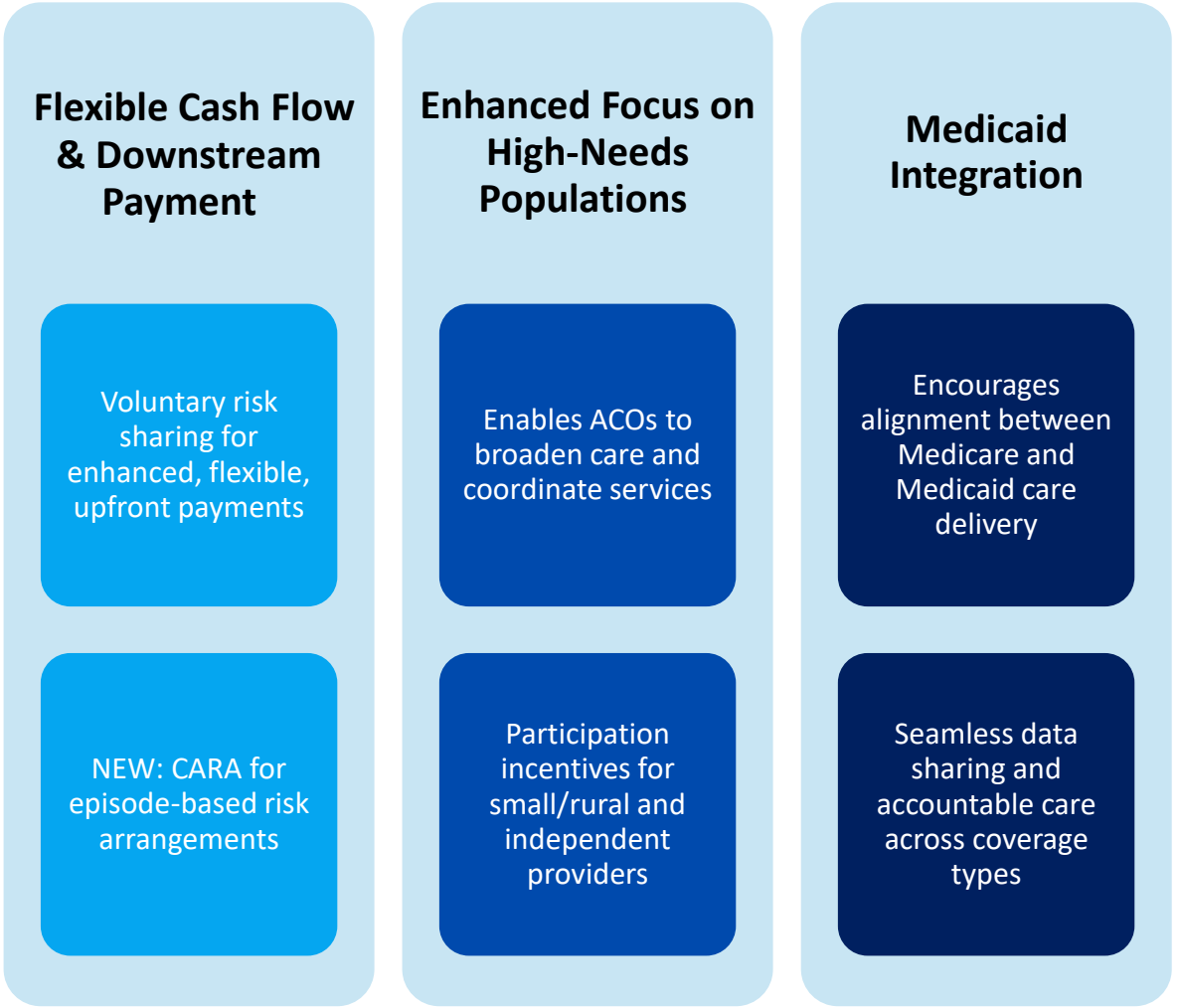
## Prescription Drug

| | |
|---|---|
| Cell and Gene Therapy Access (CGT) | *Through 2035* |
| GENEROUS (Medicaid) | *Through 2031* |
| BALANCE (GLP-1s) | *5/1/2026 – 12/31/2031* |
| GLOBE (Part B)* | *10/1/2026 – 12/31/2031* |
| GUARD (Part D)* | *1/1/2027 – 12/31/2031* |

*indicates mandatory model

# LEAD Model

- The LEAD Model is the next ACO total cost of care AAPM
  - Replaces ACO REACH
  - 10-year voluntary model
  - Runs from 1/1/2027 – 12/31/2036
- Many ACOs have a two-pronged strategy
  - MSSP: Long-standing TINs who are regionally efficient
  - LEAD: Practices with high needs beneficiaries or regionally efficient
  - Next application cycle* is critical to take advantage of add-on payments and stronger underlying benchmark that does not account for hospital payment cuts
- LEAD resources:
  - NAACOS: model overview webinar and slides; ACO comparison chart; monthly REACH/LEAD Roundtable
  - CMS: FAQs; factsheet; RFA and webinar; CARA factsheet; payment factsheet; ACO comparison



# LEAD vs. MSSP

| Model Component | LEAD | MSSP |
|---|---|---|
| **Model** | 10-year CMMI model succeeding ACO REACH; 2027 - 2036 | Permanent statutory program; revised annually through PFS rulemaking, 5-year agreements |
| **Participation** | TIN-level (for Participant Providers) | TIN-level |
| **Risk Track** | Global (100%), Professional (50%) | Basic A-E, Enhanced |
| **Discount** | 1.75% - 3% in Global Track | None, shared savings/losses |
| **Alignment** | Prospective, Hybrid, SVA option | Retrospective, Prospective |
| **Risk Adjustment** | 3% cap, 4% for HN | +3% |
| **Payment Mechanism** | PCC, TCC, APO, NPCC, Administrative Add-on | FFS |
| **Quality** | 3% withhold<br>4 claims-based, CAHPS, 2 eCQMs/dQMs (P4R in Y3-4, P4P by PY5) | APP Plus quality measures, CAHPS<br>Quality performance determines shared savings/losses |
| **Unique Model Features** | High spend vs. low spend designation<br>Medicare-Medicaid integration, CARA, expanded BE/BEIs | Broad entry point for Traditional Medicare ACO models |

# Considerations for LEAD vs. MSSP

## Historical cost and projected financial performance

- High spending organizations may benefit from LEAD methodology's administrative add-on payment, while efficient organizations may perform better under MSSP; can depend on composition and population
- Examine prior savings history and regional efficiency

## Risk tolerance

- Global (100% savings/losses) or Professional (50% savings/losses) in LEAD, no upside only options
- BASIC Levels A-E, ENHANCED in MSSP, Levels A/B are upside only, more gradual progression to downside risk

## Cash flow

- Capitation options only available in LEAD currently

## Operational readiness

- Quality reporting capabilities and # of EHRs—LEAD phases in eCQM reporting, MSSP has additional options for reporting measures (MIPS CQMs/Medicare CQMs)
- Ability to leverage model benefit enhancements—additional BEs/BEIs in LEAD, but there is some operational burden to implement

# AHEAD: State-Based Transformation with a New Geographic ACO Path

**MAIN TAKEAWAY** **AHEAD combines primary care investment, hospital global budgets and Geo AHEAD. Implementation readiness varies, creating uncertainty for health systems as states move the components forward at different speeds.**

WHAT WE ARE SEEING

## AHEAD increases uncertainty for health systems

1. **Maryland is the most ready to launch:** because AHEAD revises an existing state approach.
2. **Primary care has a smoother pathway:** while buy-in for hospital global budgets remains inconsistent.
3. **Geo AHEAD is well suited for health systems:** but organizations may lack capacity while adopting other AHEAD components.
4. **Watch for new Geo AHEAD entrants:** as the geographic component moves toward implementation.

THE THREE COMPONENTS

| PRIMARY CARE AHEAD | HOSPITAL GLOBAL BUDGETS | GEO AHEAD |
|---|---|---|

**Participating states: MD, CT, HI, VT, RI and NY**

GEO AHEAD: DEEPER DIVE

## The "last mile" of accountable care

1. **Voluntary alignment** → 2. **Claims-based alignment** → 3. **Geographic alignment**

**Geographic attribution is the final step for beneficiaries not otherwise aligned.**

**MSSP-LIKE ENTITY**
Accountable for total cost and quality; competitive selection.

**PAYMENT APPROACH**
Primary care payments, shared savings/losses and quality.

**FLEXIBILITY**
Downstream arrangements with Participant and Affiliate providers.

**TIMELINE**
RFA in 2027; first contract period begins January 1, 2028.

**WATCH: attribution across models • benchmarking unmet need • interaction with hospital global budgets • provider-led participation capacity**

# ACCESS Model Overview and Goals

- The ACCESS Model launched July 1, 2026.
- New 10-year voluntary model targeting technology vendors as participants
- Aims to improve the health of people with Original Medicare with chronic disease through technology-supported care
- Emphasizes outcomes and results over activities
- **Could foster greater partnerships with technology vendors or risk increasing fragmentation**

### Four Original Clinical Tracks:

1. Early Cardio-Kidney-Metabolic Conditions (eCKM)
2. Cardio-Kidney-Metabolic Conditions (CKM)
3. Musculoskeletal Conditions (MSK)
4. Behavioral Health Conditions (BH)

### New Clinical Tracks (April 2027):

1. Heart Failure
2. Chronic Obstructive Pulmonary Disease
3. Substance Use Disorder
4. Tobacco Cessation
5. Chronis MSK Pain

### Review CMS Resources

- Detailed FAQs
- Model Payment Amounts and Performance Targets
- Request for Applications (accepted on a rolling basis)
- ACCESS Accepted Applicants

### ACCESS Coalition

- Advancing collaboration and shared learning in the ACCESS Model
- Launched by NAACOS, HCTTF, APG, A4H

# Early Feedback from ACOs and Clinicians

| | |
|---|---|
| **Early-stage uncertainty** | Interest is mixed, many ACOs/physicians are proceeding cautiously while beneficiary enrollment is limited and evidence on partnership models, outcomes, and ROI develops. ***One cause of weariness: CMS has had little to no provider education on the model and has instead focused first on participants and beneficiaries.*** |
| **Care coordination, program overlap, and provider burden** | ACOs want ACCESS participants to complement, not create a parallel pathway to, existing care relationships, digital health, RPM, CCM/APCM, and care-management investments. ***Need clear referral, escalation, and handoff processes; co-management payment may not offset added workflow, reporting, and technology burden.*** |
| **Data integration, clinical responsibility, and liability** | ACOs/physicians want participant-generated data to flow through existing ACO/EHR workflows, with clear expectations for what clinicians must review, who monitors and responds to abnormal findings, how follow-up is coordinated, and where medical-legal responsibility sits. |
| **Financial, operational, and role clarity** | ACOs need clearer clinician-facing guidance on how ACCESS works, the respective roles of ACCESS participants and clinicians, billing implications, benchmark effects, and whether the model complements or duplicates existing population-health investments. |

# Mandatory Specialty Models

CMMI's mandatory, specialty-focused models may overlap with one another and with other models, and necessitate integrating value-based strategies across your organization

- ✓ Strong vendor partnerships to develop innovative solutions across models
- ✓ Physician leadership, clinical engagement and education
- ✓ Focus on success factors – effective care pathways, predictive analytics, attention to PAC partners

## TEAM

- 5 surgical episodes – inpatient and outpatient
- 30-day episodes
- Launched Jan. 2026 in select CBSAs; runs through 2030
- 3 Tracks with increasing risk

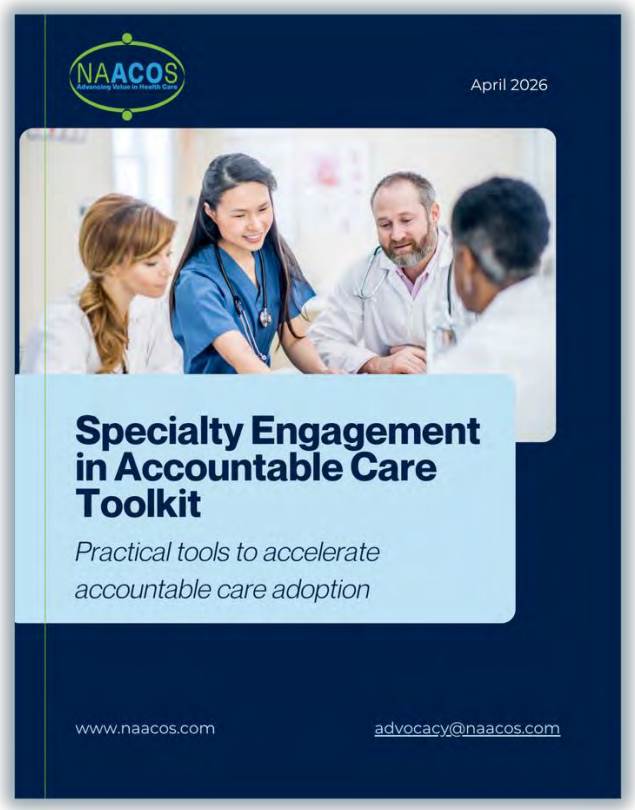
## ASM

- Two conditions (low back pain and heart failure)
- Participation at individual physician level; MVP-like format
- Launching Jan. 2027 in select geographies; runs through 2031

## CJR-X

- Lower extremity joint replacements – inpatient and outpatient
- 90-day episodes
- Launching nationwide Jan. 2028; permanent expansion of CJR Model
- No overlap with TEAM hospitals

# Specialty Engagement in Accountable Care Toolkit




New toolkit harnesses regulatory moment to support meaningful specialty engagement across clinical teams to build on strong primary care foundation.

- Practical, adaptable tools
- Step-by-step guidance
- Voluntary best practices

Download the toolkit now!

# TEAM began Jan. 1, 2026



**Mandatory, 5-year episode-based payment model (CYs 2026-2030) focused on acute care hospitals in selected geographic areas, with limited opt-in option.**

**Full list of participating hospitals is available here.**



**TEAM Implementation Priorities:**

- ✓ Leveraging IT and analytics systems around implementing regulatory requirements
- ✓ Beneficiary notification approaches
- ✓ Discharge planning from hospital and from SNFs
- ✓ Post-acute care strategies and network optimization
- ✓ Referrals with PCP for continuity of care
- ✓ Analytics to understand risk pool and accounting for low volumes
- ✓ Engaging specialists
- ✓ Developing gainsharing program



**Episodes triggered by an inpatient or outpatient hospital stay for one of the following procedures:**

- ✓ Coronary Artery Bypass Graft (CABG)
- ✓ Lower extremity joint replacement *(inpatient & outpatient)*
- ✓ Surgical hip femur fracture treatment
- ✓ Spinal fusion *(inpatient & outpatient)*
- ✓ Major bowel procedure



**TEAM model design features:**

- ✓ Initial hospital stay or outpatient procedure + 30 days post-discharge (All Medicare A&B)
- Allows for **gainsharing arrangements with TEAM collaborators** (e.g., ACOs or other providers) if certain conditions are met
- **SNF 3-Day Rule Waiver and Telehealth Waivers**

# Ambulatory Specialty Model (ASM)

## Model Participation

- Mandatory model for specialists treating patients with **low back pain (LBP) and heart failure (HF)** in outpatient settings
- Approximately one quarter of core-based statistical areas (CBSAs) and metropolitan divisions selected for participation
- Volume threshold: historically treated at **least 20 Medicare FFS patients** (HF or LBP) over a 12-month period

## Model Timeline

- 5 *performance* years **beginning January 1, 2027**, to December 31, 2031
- 5 *payment* years beginning January 1, 2029, to December 31, 2033

## Model Parameters

- Performance assessed at the individual physician level and not at the practice level
- Leverages MIPS Value Pathway (MVP) framework– final scores across 4 performance years **determines positive/neutral/negative payment adjustments** on future Medicare Part B payments for covered services
- Enhance data feedback by requiring specialists to execute Collaborative Care Agreements with PCPs

List of mandatory geographic areas

| ASM Performance Year | ASM Payment Year | ASM Risk Level |
|---|---|---|
| 2027 | 2029 | 9 percent |
| 2028 | 2030 | 9 percent |
| 2029 | 2031 | 10 percent |
| 2030 | 2032 | 11 percent |
| 2031 | 2033 | 12 percent |

# CJR-X: Key Design Elements

**LEJR EPISODE DEFINITION**

- **Initial hospital stay or outpatient procedure + 90 days post-discharge**
- **All Medicare Parts A & B items and services** included with limited exceptions
- Low volume hospitals excluded (< 31 LEJR episodes)

**OTHER KEY DESIGN FEATURES**

- Extend nationally to start **January 1, 2028** (TEAM exempt)
- Allows for **gainsharing arrangements with CJR-X collaborators** (e.g., ACOs, specialists, PAC facilities, or other providers) if certain conditions are met
- **Post-Discharge Home Visits, SNF 3-Day Rule Waiver, and Telehealth Waivers**

**PAYMENT STRUCTURE**

- Providers continue to bill under Medicare FFS
- Actual spending reconciled against **target price** to determine whether the hospital receives or owes money.
- 2% discount applied to episodes – represents Medicare Savings
- Discount may vary based on quality performance – with highest performing participants eligible for 0% discount

**TARGET PRICE**

- Based on regional historical spending (during baseline period)
- Target prices set at MS-DRG and HCPCS level
- Risk adjusted based on beneficiary-level and hospital-level factors
- Additional adjustments applied (e.g., trending, outlier caps, normalization, etc.)

**NAACOS Resources:**

- NAACOS comments
- NAACOS webinar
- Specialty Toolkit
- Toolkit webinar

**CMS Resources:**

- Final Rule
- Proposed Rule
- CMS Fact Sheet
- CMS Press Release
- CJR-X Model Page
- CJR-X email: CJR-X@cms.hhs.gov
- CJR-X listserv

# Thank you!

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# Team of Mission Driven Healthcare Experts



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**Brad Sadoughian, MD MSc**

Senior Director, Product Development



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Chief Medical Officer



**Reza Rahimi, PhD**

Chief Operating Officer



**Marie Parker, PharmD, PhD**

Senior Director, Quality & Care Management



**Alex Drohobyczer, MBA**

Vice President, Operations and Member Experience

## Experienced, Engaged Advisors



**Thomas Price, MD**

Former Secretary of Health and Human Services, US Congressman (GA)



**Edmund Becker, PhD**

Professor, Emory University, Health Policy & Management



**David Kaplan, MD**

Former Global Leader for Clinical Services and Solutions, Mercer

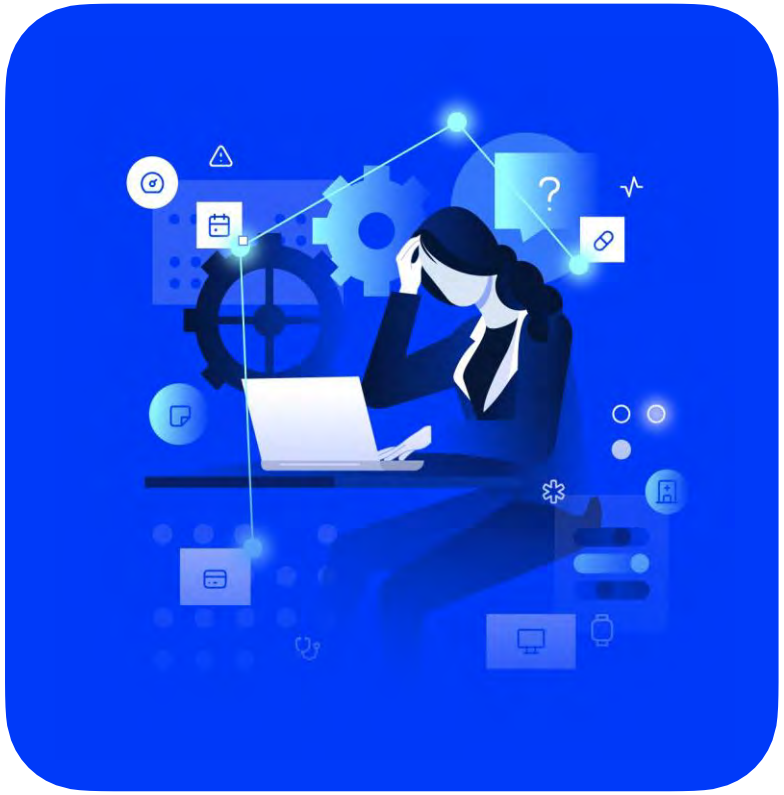


**Omar Khawaja, MBA, MS**

VP Security, DataBricks

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# Healthcare Has a Major Challenge



Individuals visit their Doctors 4 times a year

360 days of care gaps compounded between visits

Individuals and families suffer sub-optimal health outcomes

Providers, payers and employers losing budget and mission

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# Patient Story: Engagement & Adherence





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# Cardiovascular Care is Prime for Value

## U.S. healthcare system is shifting—fast—from fee-for-service to value-based reimbursement

For cardiovascular care, shift isn't just policy change—it's a financial and clinical tipping point



### Economic Weight

CVD costs $378B annually, projected to hit $1.1T by 2035



### Sky-high Prevalence

Nearly 127M Americans live with some form of heart disease



### Preventable Reality

80% of premature heart disease and stroke could be avoided through lifestyle changes and better management



### Readmissions

Heart failure readmission rates 25%, triggering costly HRRP penalties

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# Value Based Care Rewards Outcomes

Prevention and early intervention aren’t “nice-to-haves”—they’re survival strategies

Aggressive prevention could cut coronary heart disease incidence by **63% over 30 years**

## THE CHALLENGE?

Traditional care models don’t scale prevention efficiently or personalize it effectively.

## THE OPPORTUNITY?

Digital health tool that combines clinical data, behavioral science, and patient-centered design to:

- Deliver proactive, personalized engagement 24/7/365 to elevate the care experience
- Identify care gaps upstream with Empowered Patient managing conditions before they escalate
- Improve quality of care, health outcomes including reducing avoidable readmissions at SCALE and LEAN

**In medicine, that means making primordial to secondary cardiovascular prevention a priority and profitable**

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# The Business of Prevention

## Prevention isn't just good medicine—it's good business

- In a old fee-for-service world, a congestive heart failure admission means more revenue.
- In a value-based world, it means operational congestion, missed targets, financial penalties, and—most importantly—avoidable patient harm.

**THE DATA IS CLEAR:**

Providers who implemented robust cardiovascular prevention programs saw **$3,456 lower total cost of care per patient**.

**HERE'S WHY:**



**37% fewer admissions**
for cardiovascular events



**29% lower ED utilization**



**17% fewer unnecessary tests**



**22% reduction in costs**
thru better adherence

*And it's not just incremental—The New England Journal of Medicine found comprehensive PREVENTIVE cardiovascular care reduced hospital admissions for acute cardiac events by 42% among Medicare beneficiaries*

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# How To Transform Cardiovascular Care

To achieve optimal cardiovascular care, success hinges on what happens *between* office visits

Extend clinical reach, maintain daily touchpoints, and turn passive data into proactive intervention

## A meta-analysis in the Journal of the American Heart Association looked at 35 studies of digital cardiovascular interventions and found:



**31%**

fewer CV-related hospitalizations



**29%**

higher medication adherence



**38%**

greater completion of cardiac rehab



**27%**

better hypertension control



**18%**

improvement in cholesterol management

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# Medicare ACCESS Model: Win for Patient and System

## Advancing Chronic Care with Effective, Scalable Solutions

— Medicare ACCESS Model creates payment pathway for managing chronic conditions through approved digital health tools

— 10 year voluntary program for traditional Medicare beneficiaries

— ACCESS reimburses digital tech providers — 50% during first six months, 50% reconciled on end of year Outcomes = OAP

**1**

### You Refer

Traditional Medicare patients with Hypertension, Pre-Diabetes, Diabetes, Dyslipidemia, CKD or ASCVD

**2**

### We Manage

Enrollment, 24/7 patient engagement, device data, billing and outcomes reporting — all handled by ALYKA.

**3**

### You Benefit

Patients thrive on continuous support. Your practice earns new recurring revenue with lower operational expense.

### Two Cardiovascular Care Tracks

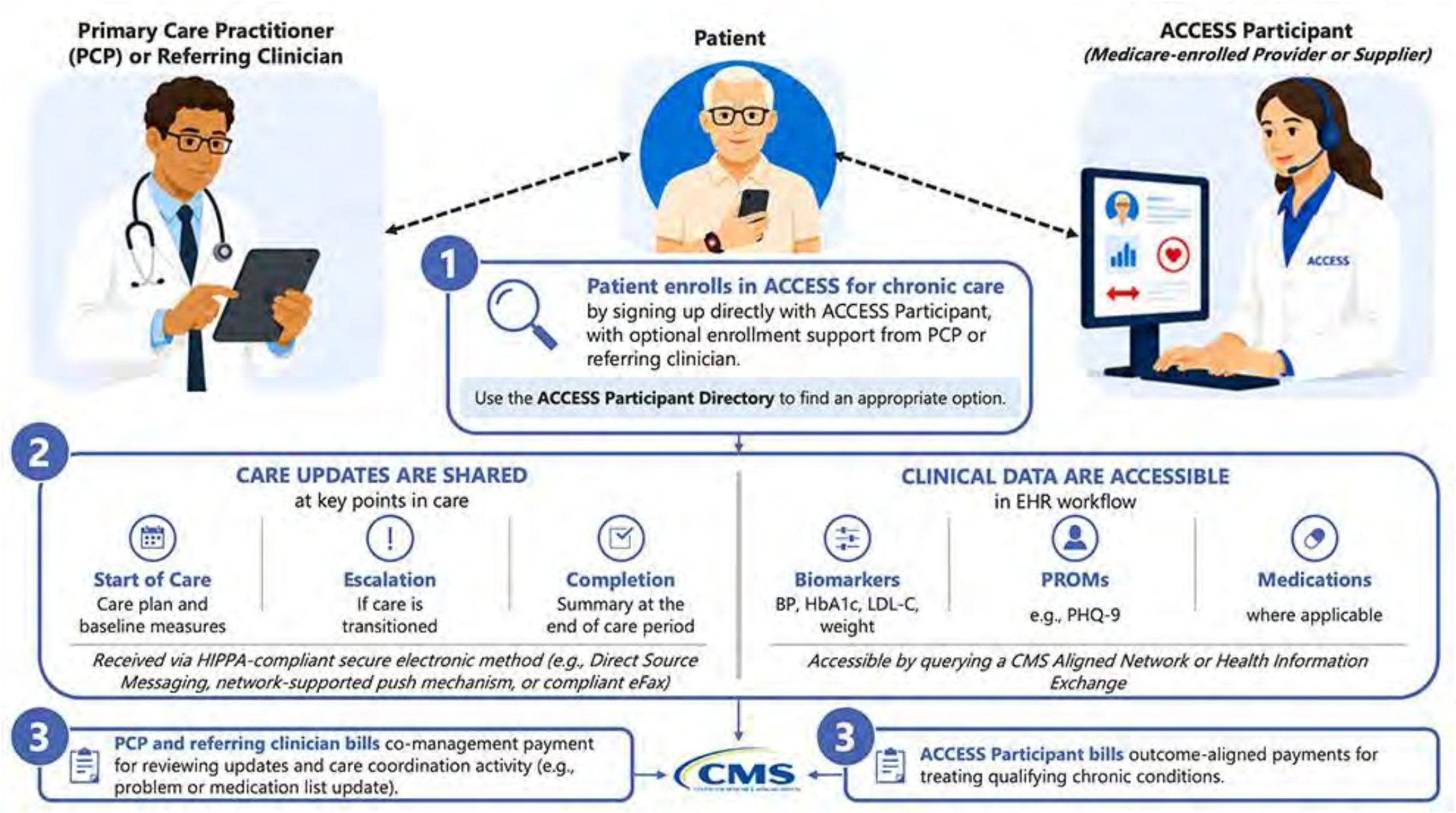
| TRACK | CONDITIONS COVERED | ANNUAL PAYMENT |
|---|---|---|
| **eCKM** | Hypertension, dyslipidemia, overweight, obesity, pre-diabetes | **$360 PMPY** |
| **CKM** | Diabetes, chronic kidney disease, atherosclerotic cardiovascular disease | **$420 PMPY** |

**+ Up to $100 per beneficiary per year for the referring clinician.**

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# ACCESS: Clinician + Patient + Digital Tech



# We Know How To Improve Cardiovascular Health

1. **Continuous Monitoring.** Early detection of deterioration; one study saw a 58% drop in HF hospitalizations vs. usual care
2. **Personalized Education.** Patient-specific guidance that reduces excess testing and boosts satisfaction
3. **Behavioral Change Support.** Evidence-based techniques delivering 3.4x greater improvement in risk factors
4. **Medication Management.** Digital tools that improve adherence by 29% through reminders and streamlined communication
5. **Integration with Clinical Workflows.** Solutions that cut clinician burden by 34% and lift quality performance by 27%

Which of these capabilities is underdeveloped in your current strategy and how do you scale for millions of lives?

**Digital Tech is the engine that powers better outcomes at lower cost**

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# Future: Digital Tech and Value Based Care

- ✓ Integrate EHR, device, and patient-reported data
- ✓ Personalized guidance and education 24/7/365
- ✓ Keep patients engaged in their care plan every day, beyond the exam room
- ✓ Real-time health data with the latest evidence



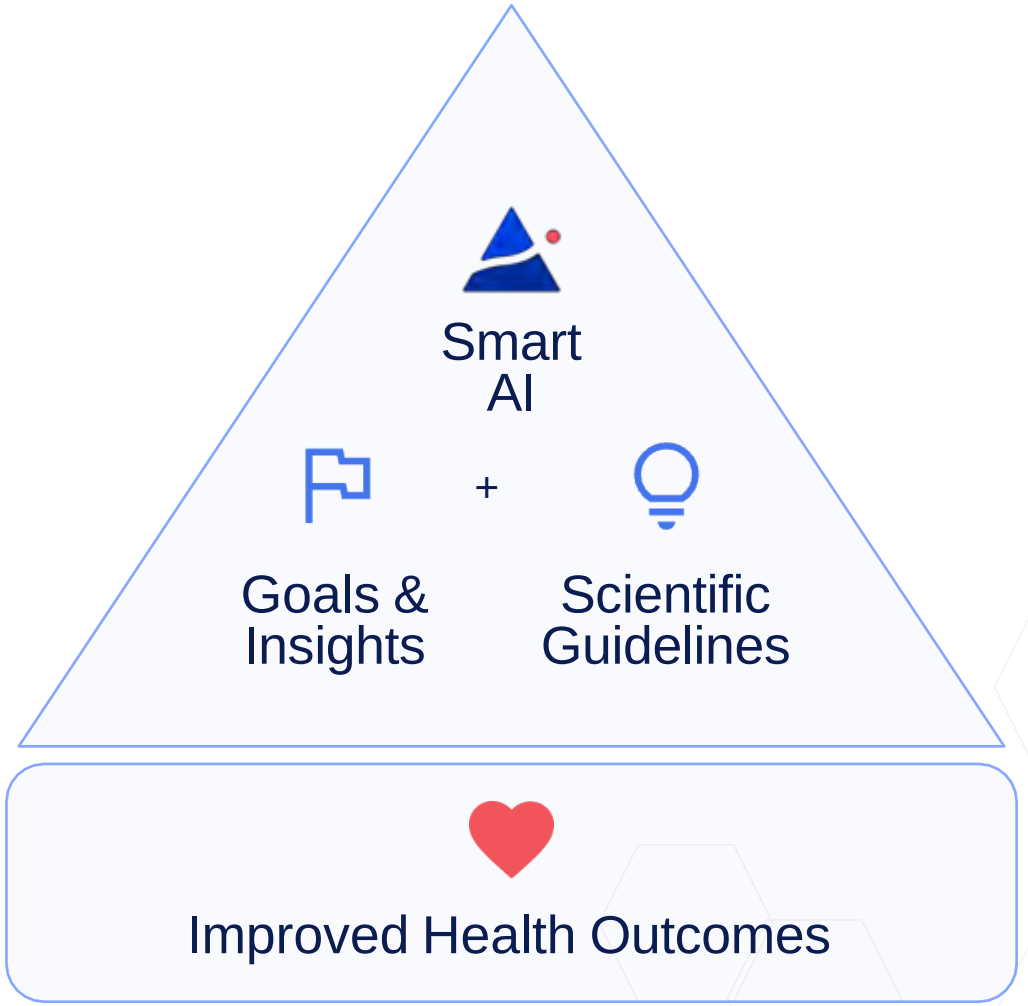

**In healthcare, the winners will be the ones who can scale personalization, coordination, and prevention—all at once**

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# ALYKA: Heart Health Advisor

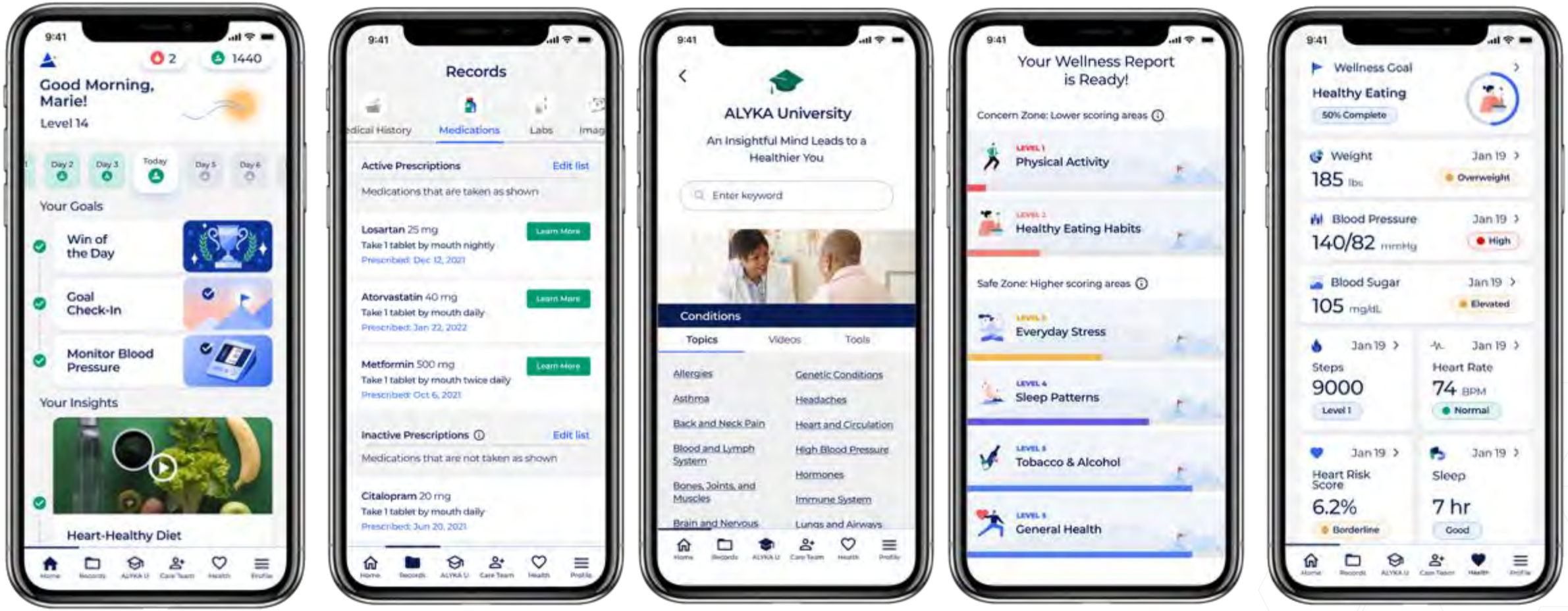



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# Patient-Centered Design and Tested




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# Digital Member Of Your Care Team

## RISK FACTOR MANAGEMENT

### Personalized Goals & Insights:

- Hypertension
- Hyperlipidemia
- Pre-Diabetes and Diabetes
- Overweight and Obesity
- Inactivity
- Stress and Sleep
- Family History

## CHRONIC CARE MANAGEMENT

### Evidence Based Guidance:

- Coronary Artery Disease
- Congestive Heart Failure
- Obstructive Sleep Apnea
- Atrial Fibrillation
- Valvular Heart Disease
- Peripheral Vascular Disease
- Chronic Kidney Disease

## CARE EXPERIENCE & GAP CLOSURE

### Digital Engagement & Check-Ins:

- Annual Wellness Visit
- Rx Adherence
- Visit Follow-ups
- Preventive Screenings
- Imaging Follow-ups
- Medical Surveys
- Vaccinations
- Patient Satisfaction

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ALYKA Health

# Healthcare has a Major Opportunity

## Elevate Engagement and Education

Increase patient activation through goal-setting, self-tracking, and personalized education.

**71% In-App Engagement***

Source: Version 1.0 Daily Goals during 10/12/22 to 12/30/23; Version 2.0 Data Pending

## Support Population Health

Real-time data for deeper insights to stratify risk and identify care gaps across populations.

**8.5 : 1 Return on Investment**

Source: Santa Barbara Actuaries Study for ALYKA Health September 15, 2023

## Improve Quality and Outcome Metrics

Improve key quality measures for value-based care reimbursement models around chronic diseases.

**10% BP, LDL and A1C Reduction***

Source: ALYKA Heart Study (In Process)

## Lower Practice Costs

Digital member of care team to guide patient's care journey for higher satisfaction and lower operating costs.

**20% Reduction in Support Time**

Source: Patient Calls/Emails Pre- and Post- ALYKA Health during 7/1/23 to 6/30/24

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ALYKA Health


ALYKA Health

Jefferson Health

# Value-Based Payment Models: Strategy for Adapting to the Changing Payment Landscape

David B. Burmeister, DO, MBA, FACEP

Associate Chief Physician Executive, Jefferson Health

President, Jefferson Medical Group

# Jefferson Health Footprint

## Serving a rural and urban population across Pennsylvania and New Jersey

**700+**
Total sites of care

**150+**
Primary care sites

**1 of 57**
NCI-designated Sidney Kimmel Comprehensive Cancer Center is one of 57 comprehensive cancer centers nationwide

**Level 1**
Trauma centers



# Jefferson- Value-Based Care Landscape

**2 Billion**
Managed Premium Dollars

**50+**
Value Based Arrangements

**850,000**
Lives in Value Based Arrangements*

## Lines of Business

- Commercial (371K)
- Medicaid (224K)
- Medicare FFS/ACO (87K)
- Medicare Advantage (78K)

**90,000**
Serving our own employees

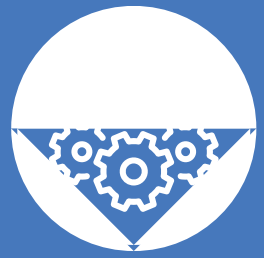
# Population Health Operational Units



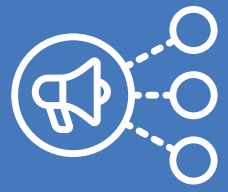
Care Management, Social Needs, Ambulatory Pharmacy



Quality/Wellness



CIN/ACO Operations



Outreach

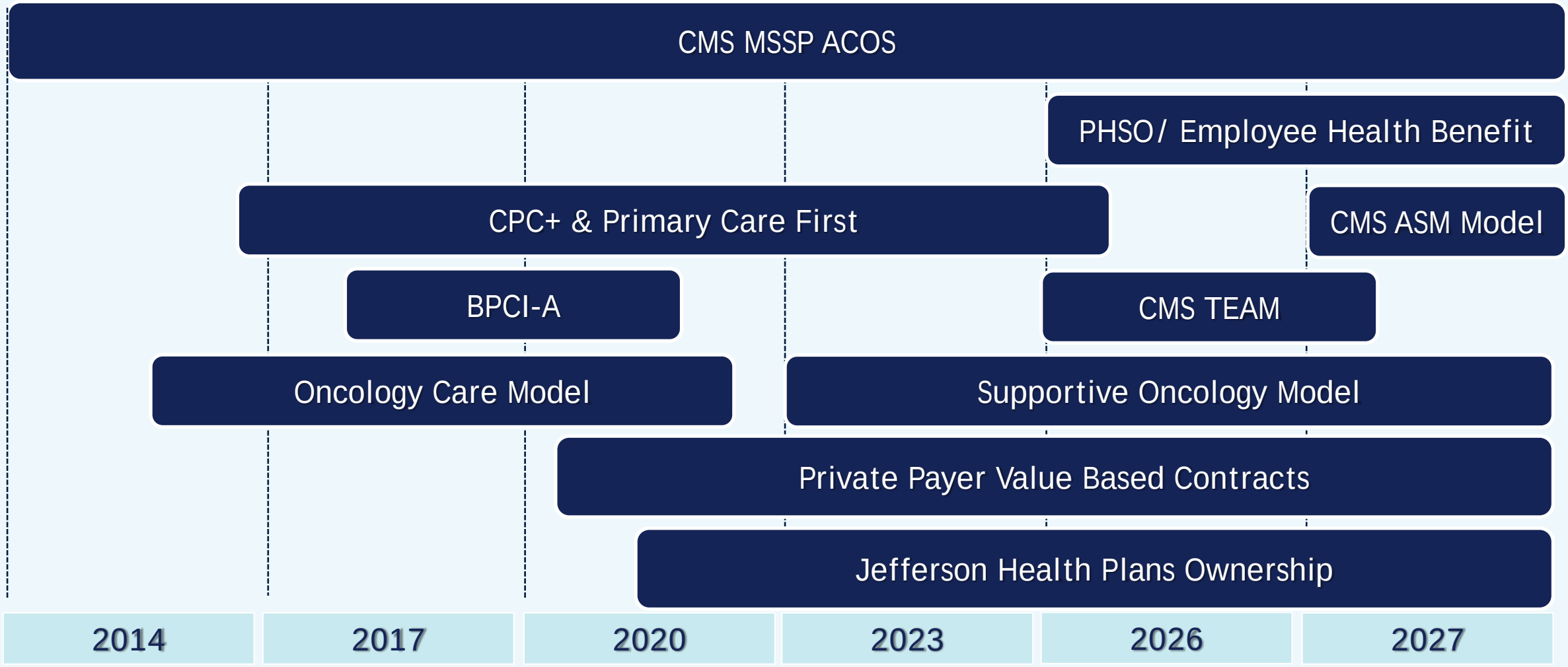


Actuarial Analytics



Practice Transformation

# Resilient Structure Regardless of Program



# CMS Medicare Shared Savings Program Success

## $54 Million+ in Shared Savings (CY 2024)




### Jefferson ACO Quality over Time*

| ACO | 2022 | 2023 | 2024 |
|---|---|---|---|
| DVACO | 78.96% | 84.82% | 83.57% |
| Einstein | 73.25% | 80.24% | 82.96% |
| Lehigh | 80.80% | 85.76% | 90.24% |

### Keys to Success

- Post Acute Management
- Longitudinal Care Management
- Wellness Visit and Care Gap Closure Focus

** 2025 scores have not been released from CMS*

# CMS Mandatory Hospital/ Specialty Programs

## IOTA- Kidney Transplant Model
(Started 2025)

- 6 Year model
- Goal to increase access to kidney transplants for patients with ESRD

## Amb Specialty Value Model
(Starts 2027)

- Mandatory for selected geographic regions and selected specialists
- Goal to improve episode cost and quality for CHF and Low Back Pain.

## CJR-X- Lower joint replacements
(Starts 2028)

- Mandatory for all hospitals not in TEAMS
- Replaces and expands CJR model for Hip, knee, ankle joint replacements

# CJR-X at a Glance

CMS expecting to save $725 Million in penalties and discount factors over 5 years.

**$27M* +/-**
Estimated annual gain or penalty

**13**
Hospitals in scope at FY25 volumes

**Jan 2028**
Performance start, no end date

## The Bundle

- Mandatory nationwide 90-day LEJR episode for hospitals
    - Physicians are not participants
- Inpatient and OPPS procedures. No ASC
- DRG 469/470/521/522; hospitals accountable, not physicians
- Rolling 3-year baseline sets target prices
- No Model End Date
- 31 Episode Minium

## Financial Exposure

- $27M +/- max swing across our hospitals
- Downside risk begins in Year 1
- 20% stop-loss cap; 5% rural and safety net
- 2% discount factor, minimized with higher quality

## Preparation Needed

- Establish Enterprise Governance and management teams
- Standardize LEJR pathway and post-acute network pathways
- Build episode analytics off the CMS claims feed
- Execute collaborator gainsharing agreements
- Stand up notification and quality workflows

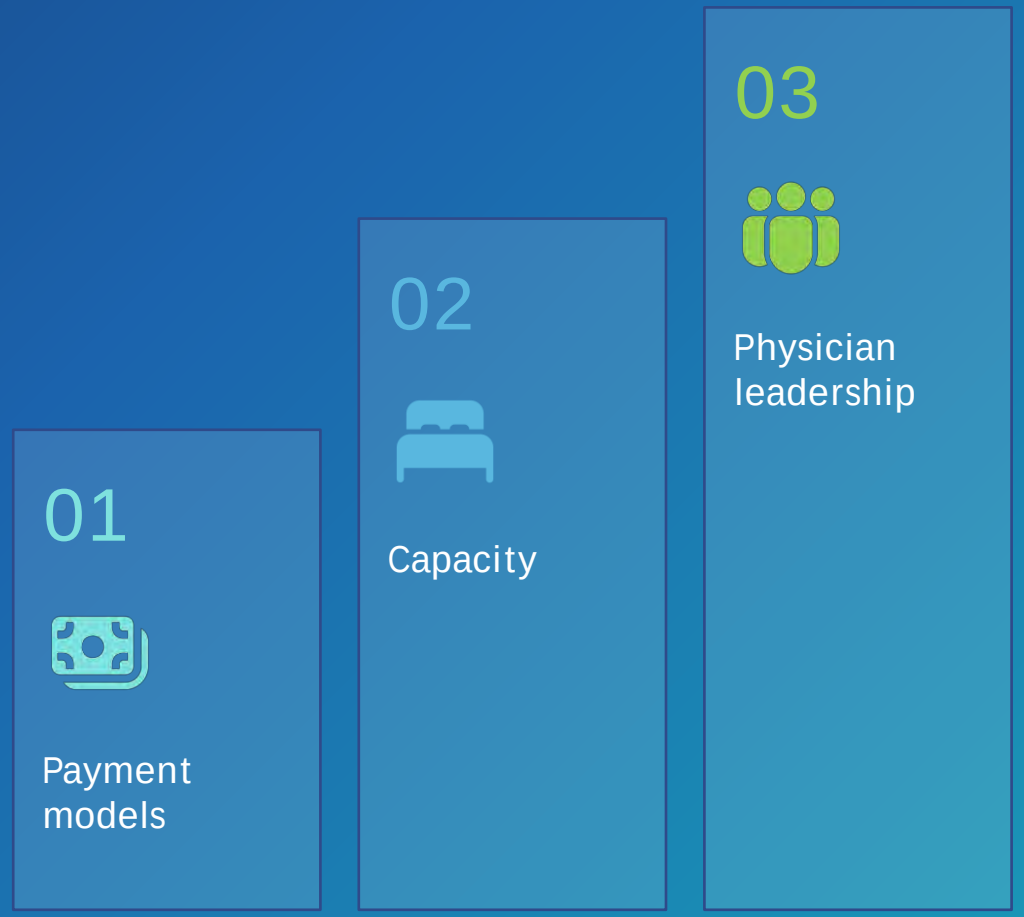
**Includes ROSH and Phycare. $21M at Jefferson 100% owned*

VALUE-BASED PAYMENT

# Value-Based Payment Priorities

Federal and commercial models, capacity management, and physician executive leadership

Perspectives for strategic discussion



# MSSP ACOs Should Remain the Strategic Anchor

The influence extends beyond shared savings into physician payment and primary care funding.

STRATEGIC ANSWER

## MSSP ACOs

The strategic anchor for value-based payment

### Federal policy alignment

They connect directly to broader federal policy direction.

### Physician payment

CMS is increasingly tying physician payment to ACO participation.

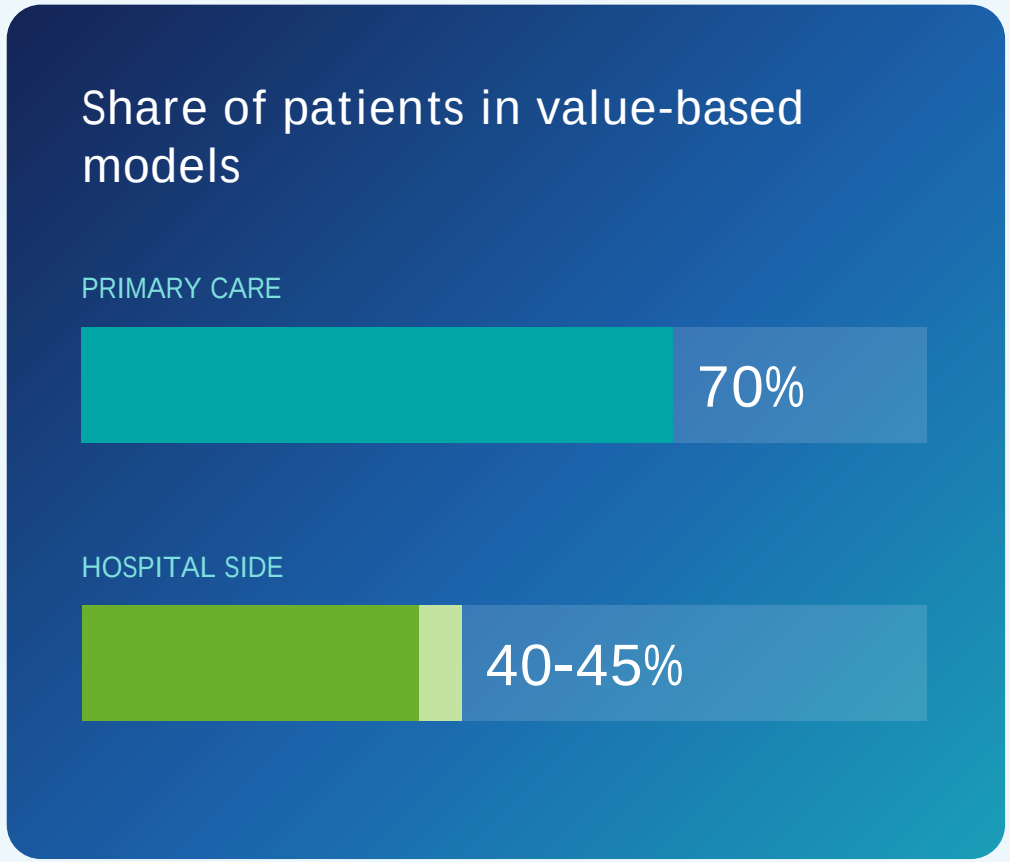
### Primary care funding

Primary care funding is also being linked to ACO participation.

**Implication: ACO strategy becomes enterprise strategy.**

# Quality is converging. Economics are not.

Integrated systems face different scaling realities across physician and hospital operations.




**QUALITY METRICS**

Fairly well aligned across federal and commercial models.

**ECONOMIC MODELS**

Commercial arrangements remain harder to succeed in than a standard MSSP model.

**PATIENT ATTRIBUTION**

Acute care teams may not know when a patient belongs to another organization's ACO.

**JEFFERSON EXAMPLE**

70% of primary care patients are in value models vs. 40-45% on the hospital side

# Use Value-based Care to Unlock Acute Capacity

The strongest expansion opportunity is tighter coordination with the acute side of the system.

1. **Manage ED utilization** — More tightly manage emergency visits within value-based populations.
2. **Create capacity** — Reduce avoidable demand on an acute system that is often stretched.
3. **Fund alternatives** — Support home-based services and palliative care differently under value-based models.

Value-based funding can support care beyond the hospital while helping the entire system run more effectively.



# Physician Executives Should Lead the Strategy

Clinical model redesign requires strong physician leadership at the decision table.

LEAD, NOT ADVISE

## The operating model

Success depends on aligning clinical credibility with administrative execution.

### Dyad leadership

Pair a physician leader with an administrative leader in a population health dyad.

### Service-line engagement

Engage specialty and service-line physician leaders in specific value models.

### Decision-making role

Bring physician executives into financial, risk, and care-delivery decisions.

# Four Moves for Integrated Systems

A practical agenda for the next phase of value-based payment.

## 01 Anchor on MSSP ACOs

Treat participation as a platform for physician payment and primary care strategy.

## 02 Design for Uneven Economics

Do not mistake aligned quality metrics for aligned financial performance. Commercial value-based programs will follow CMS.

## 03 Connect Population Health to Capacity

Use ED management, home-based care, and palliative care to support acute operations.

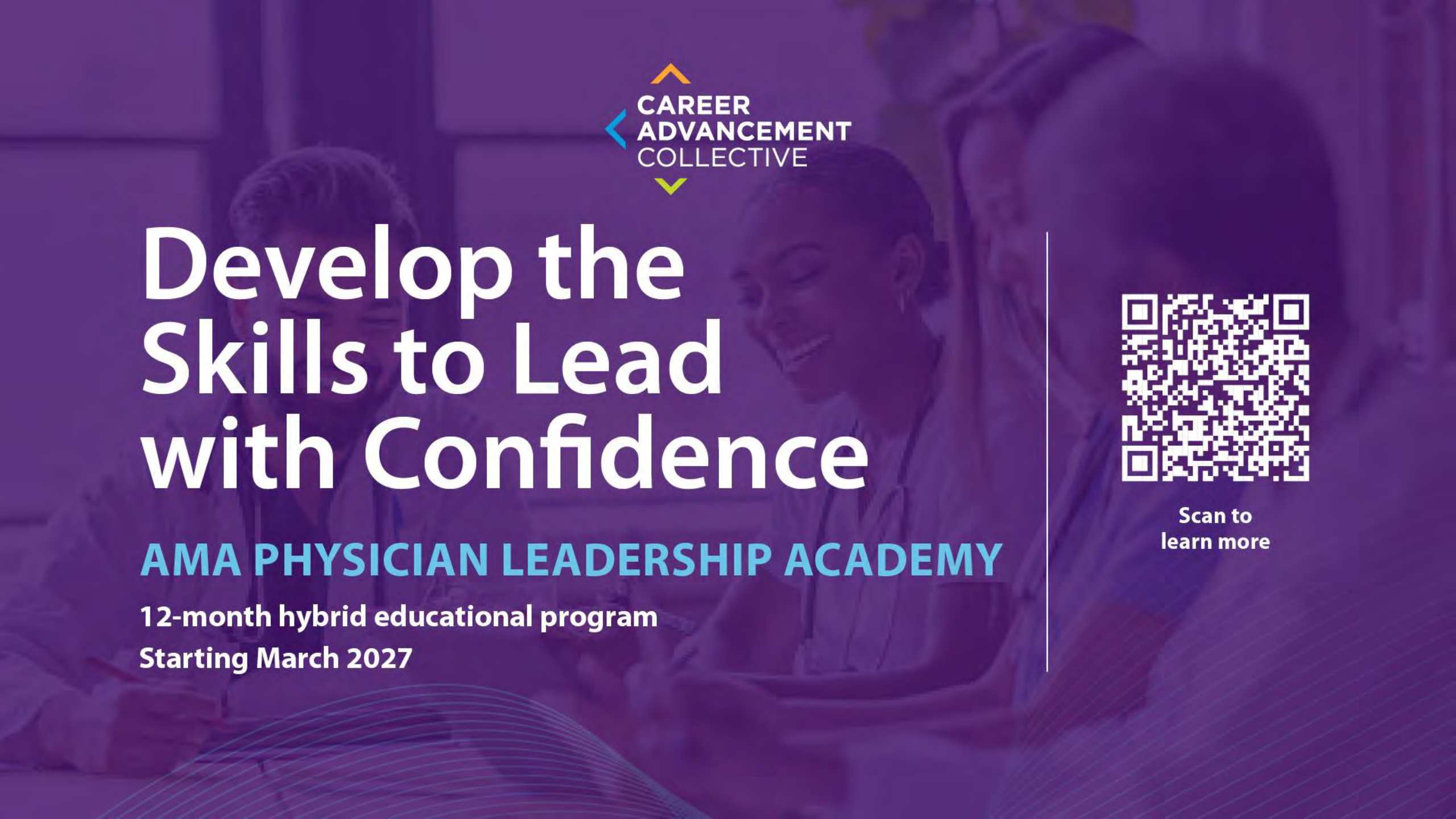
## 04 Put Physician Executives in the Lead

Use dyad leadership and specialty engagement to redesign care models.

**The common thread: align payment strategy, clinical redesign, and enterprise operations.**


Jefferson
Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

# AMA Updates



CAREER ADVANCEMENT COLLECTIVE

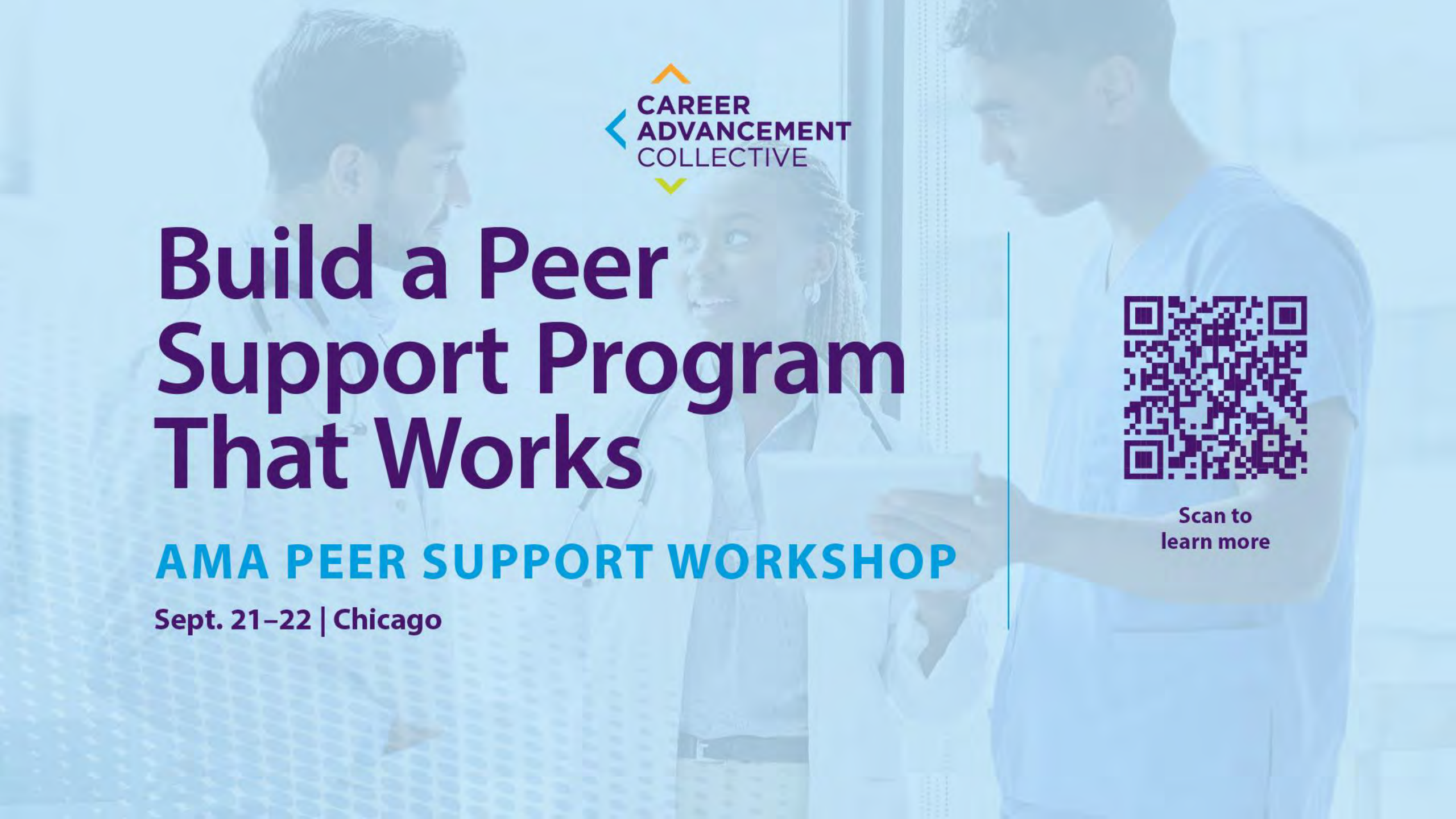
# Develop the Skills to Lead with Confidence

## AMA PHYSICIAN LEADERSHIP ACADEMY

**12-month hybrid educational program**

**Starting March 2027**

**Scan to learn more**



CAREER ADVANCEMENT COLLECTIVE

# Build a Peer Support Program That Works

## AMA PEER SUPPORT WORKSHOP

**Sept. 21–22 | Chicago**

**Scan to learn more**

AMA
AMERICAN MEDICAL ASSOCIATION

# Aligning AI Implementation with Physician Well-being

SANFORD HEALTH

## AMA IPPS I-26

# *AI AND PHYSICIAN WELLBEING: LEADING RESPONSIBLE IMPLEMENTATION*

**HEATHER SPIES, MD, MBA**
CLINICIAN WELL-BEING OFFICER, SANFORD HEALTH

**ROXANA LUPU, MD, MBA**
VP VIRTUAL CARE & CMIO, SANFORD HEALTH

# OBJECTIVES

**Learning Objectives**

- **Analyze** organizational challenges and opportunities associated with AI adoption and physician wellbeing.
- **Evaluate** governance and operational strategies for integrating physician wellbeing into the selection, implementation, and evaluation of AI-enabled tools, including collaboration among health system leaders.
- **Describe** how AMA/Joy in Medicine resources can support physician wellbeing efforts related to AI in clinical practice.

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SANFORD HEALTH

# SESSION PLAN

| | |
|---|---|
| 12:30 – 1:00 pm | How Sanford Health approaches AI adoption with consideration of both the clinician experience and broader organizational priorities |
| 1 – 1:15 | Discussion and Q & A |
| 1:15-1:30 | Table discussions using provided questions |
| 1:30-1:45 | Table report-outs |

S

# SANFORD HEALTH

**60** medical centers*
- *38 owned and leased*
- *22 managed affiliates*

**315** clinic locations*
- *244 owned and leased*
- *71 managed affiliates*

**145** senior living locations*

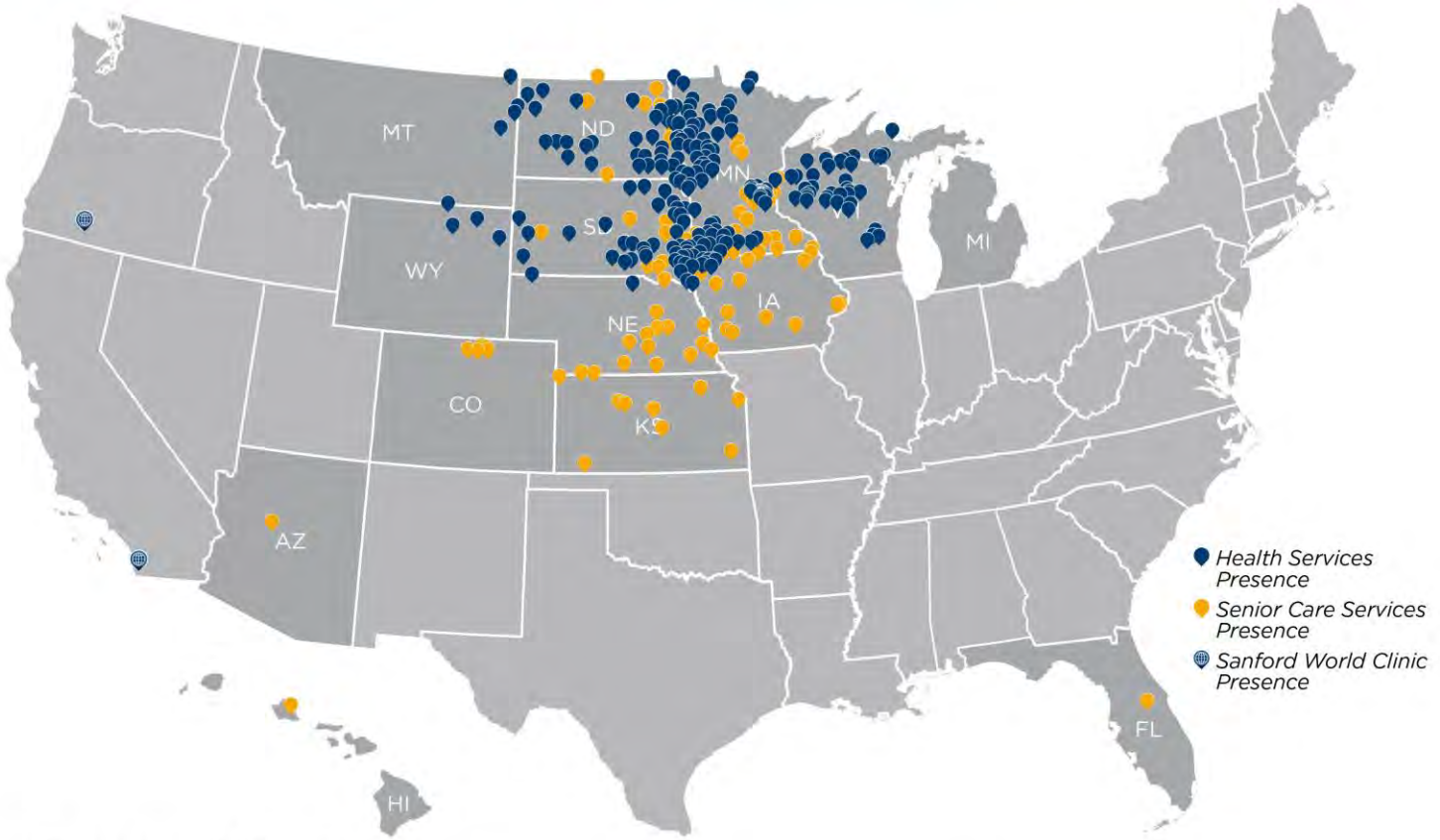
**$13.5 billion** in annual revenue

**415,000** Sanford Health Plan and Security Health Plan members

**2,697** physicians, **2,279** advanced practice providers and **12,780** registered nurses delivering care in more than **80** specialty areas

**500** scientific staff with **1,100** active clinical trials/studies

**60,000** employees







*As of September 1, 2026. Approved by Data Governance Committee.*
**Locations include where Sanford Health offers health care services, management support or partnerships to advance rural care delivery.*

SANFORD HEALTH

**CULTURE**

COMMITMENT
TEAMWORK
SUPPORT
ENVIRONMENT EFFICIENCY
LEADERSHIP






S

# WELLNESS-CENTERED CULTURE

Stanford Model of Occupational Well-being




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SAFE
SANFORD ACCOUNTABILITY FOR EXCELLENCE

SANFORD HEALTH

# CULTURE OF WELLNESS

## COMMUNICATION

- Survey Feedback/Action Plans
- Listening Sessions
- Safety Stories
- Clinician Newsletter
- Clinician Portal

ASSESSMENT
Peakon Engagement
AMA Org Biopsy

JOY IN MEDICINE
Health System Recognition Program

# WORKPLACE EFFICIENCY

THOUGHT LEADERSHIP

RISES
REACH • IMPACT • STRATEGY • EMPOWER • SERVE

Orientation
Onboarding
Mentoring

Clinician Well-being Council (CWC)

Epic / WOW
CBT
CME

**SANFORD CLINICIAN EXPERIENCE & WELL-BEING**

Support

Leadership Development

Personal and Professional Check-In and Growth

## COLLABORATION & TEAMWORK

Recruitment
Sons & Daughters
GME, SME
Sanford Solutions
Medical Informatics
HR & Employee Engagement
Virtual Care
Behavioral Health
AMA & National Thought Leaders

## CLINICIAN RECOGNITION

**Clinician Experience Specialists**

Stanford Model of Occupational Well-being




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# INDIVIDUAL FACTORS

S

HEALTH SYSTEMS ARE RAPIDLY ADOPTING AI-ENABLED TOOLS

WHAT DISTINGUISHES ORGANIZATIONS THAT IMPROVE PHYSICIAN EXPERIENCE FROM THOSE THAT SIMPLY DEPLOY TECHNOLOGY?

LEADERSHIP COLLABORATION AND GOVERNANCE ARE EMERGING AS CRITICAL SUCCESS FACTORS

L

# ALIGNING AI ADOPTION WITH ORGANIZATIONAL PRIORITIES

Patient Care

Physician Experience

- Recruitment & Retention
- Burnout prevention

Organizational Sustainability

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# WHY THIS TOPIC MATTERS NOW

AI and Well-being must be discussed together

AI implementation is not simply a technology strategy

It is a workforce, quality, safety, and clinician experience strategy

S

# WHY THIS TOPIC MATTERS NOW

AI implementation decisions may influence physician well-being as much as the technology itself

L

# OPPORTUNITY AND RISK OF AI ADOPTION

Opportunities

Documentation relief
- Clinical notes
- Back-office (prior auth, coding)

Workflow efficiency

Reduced cognitive load

Risks

Change fatigue

Workflow disruptions

Trust concerns

L

# A PHYSICIAN WELL-BEING LENS FOR AI IMPLEMENTATION

What burden are we reducing?

How will workflows change?

How will physicians be engaged?

How will success be measured?

How are the patients going to be impacted?

L

# GOVERNANCE & COLLABORATION MATTERS: WHO NEEDS A SEAT AT THE TABLE?

CWO
CMIO
CIO
Nurse Informatics
Clinical Operations
Quality & Safety
Frontline Physicians

L

**SHARED GOVERNANCE/COLLABORATION**

**CLINICAL LEADERSHIP ENGAGEMENT**

**FRONTLINE PHYSICIAN FEEDBACK**

**ITERATIVE EVALUATION**

Evaluate → Pilot → Measure → Scale

L

# EMBEDDING WELL-BEING THROUGHOUT THE AI LIFECYCLE

Before Adoption: What burden are we trying to address?

During: What are physicians experiencing?

After: Did the work improve?

L

# MEASURING SUCCESS BEYOND ADOPTION

Physician satisfaction
Workflow efficiency
Time savings
Adoption rates
Burnout drivers
Retention indicators

L

# CASE STUDY – AMBIENT TECHNOLOGY



Responsible rollout and implementation → Data-driven



Collaboration between informatics, physician leadership, and operations



Identify where the highest needs are and expand for highest impact

- Who are the clinicians who would benefit most (Signal data)
- Specialties/roles



Clinician feedback in selecting next vendor/expansion

- What features are important to clinicians



Pilot new technology to understand roll-out needs for an enterprise expansion

- Work with physician champions to design education
- Estimate resources needed to support a successful go-live

# CASE STUDY – AMBIENT TECHNOLOGY

## Measure for impact

- Ambient tech used for more than 70% of the encounters
- All licenses used
- 10% less time spent in notes
- 10% less time spent in chart outside of working hours
- 3% increase in patient experience scores (clinician spent enough time with patient)
- 100% clinicians reported decreased cognitive burden

# CASE STUDY – HOSPITAL COURSE DRAFT

Pilot 30 Physicians

Feedback requested and given on:

- Quality of the draft
- Accuracy of the draft
- Usability of the draft
- Editing efforts
- Workflow integration
- Cognitive burden

Collaboration b/w operations and clinician leadership on expansion plans

# CASE STUDY – HOSPITAL COURSE DRAFT

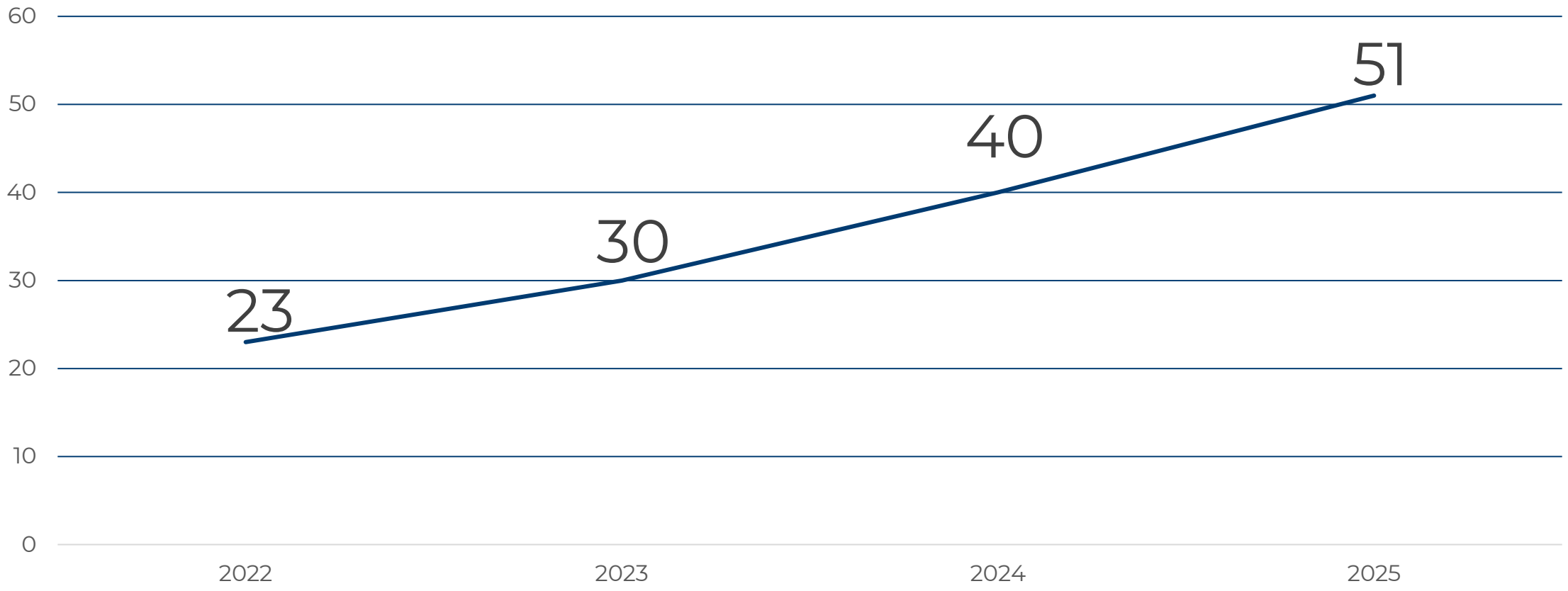
**Measure for impact**



SANFORD HEALTH

# PHYSICIAN ENGAGEMENT

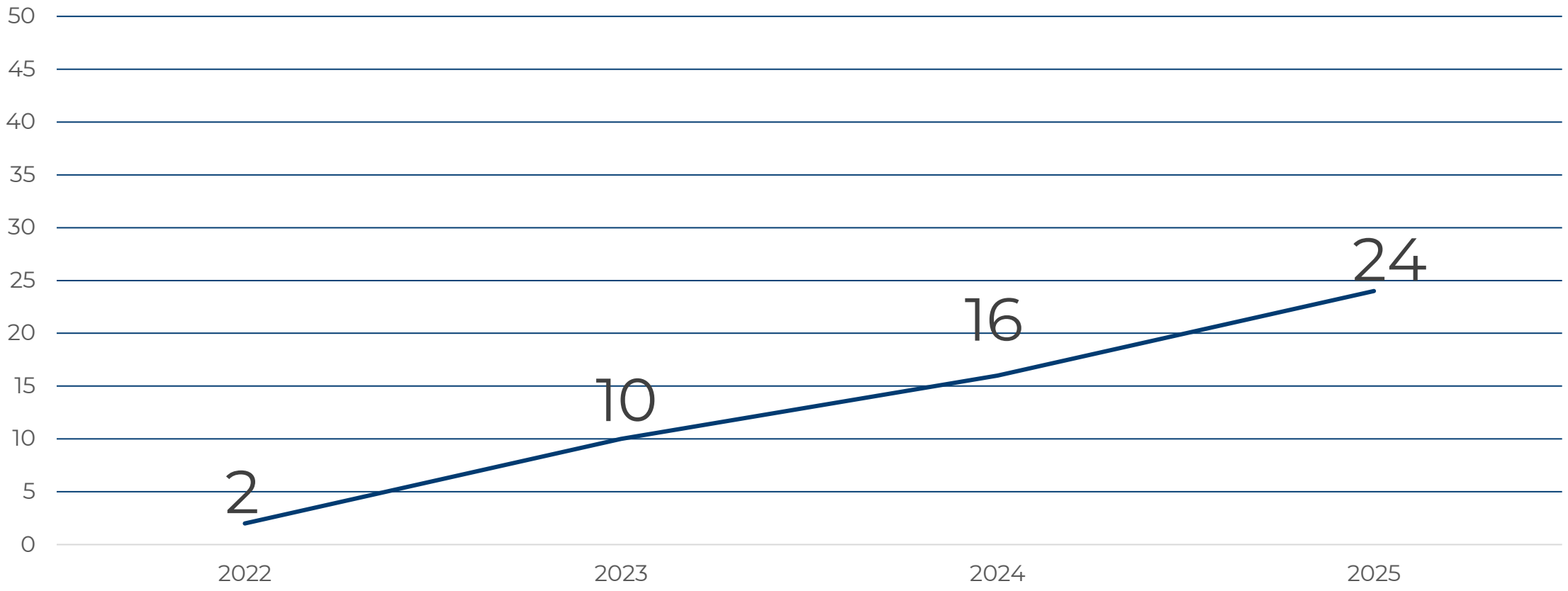
workday.
Peakon Employee Voice




S

# APP ENGAGEMENT

Peakon Employee Voice




S

# CHALLENGES HEALTH SYSTEMS ARE NAVIGATING

Trust and transparency
Governance complexity
Variable adoption
Change fatigue
Demonstrating value

L

# GO SLOW TO GO FAST?
# OR JUST GO?

| | |
|---|---|
| Pilot and change fatigue | Selection process<br>Establish KPIs and measure them<br>Rate of development of AI tools |
| Demonstrate Value | ROI<br>How will it perform at large scale? |
| Trust | Champions leading change<br>Transparency and governance |

L

# THE EMERGING LEADERSHIP IMPERATIVE

?

What should we adopt?
How should we implement it?
How will we know if it helped?
What unintended consequences may emerge?




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# LEVERAGING AMA AND JOY IN MEDICINE RESOURCES

- Well-being strategy
- Assessment
- Efficiency
- Support
- Teamwork
- Leadership engagement
- Burnout reduction
- Advocacy

S

# KEY TAKEAWAYS

1

AI Implementation Is a Well-Being Strategy

2

Collaboration Drives Success

3

Physician Leaders Shape Outcomes

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SANFORD HEALTH

# DISCUSSION

# Q & A

# TABLE DISCUSSIONS

Q1: How is your organization incorporating physician well-being into AI adoption?

Q2: What are the greatest opportunity and greatest risk over the next five years?

# Introducing the Center for Digital Health and AI

**Jennifer Goldsack, MChem, MA, MBA, OLY**

Senior Vice President, Digital Health & AI
American Medical Association

**House of Delegates Interim Meeting**

November 5, 2026
Orlando, FL

STRATEGY OVERVIEW

# AMA Center for Digital Health and AI

Leading the transformation of medicine in the digital era

AMA | Center for Digital Health & AI

## Governance

**What can be trusted?**

Establishing the conditions for appropriate use, oversight and accountability.

## Economic Sustainability

**How can it be sustained?**

Creating viable economic models for technology, clinical work and infrastructure.

## Care Transformation

**How should care change?**

Enabling physicians, care teams and patients to realize the value of new capabilities in practice.

## EVIDENCE

Informs all three pillars — and evolves through real-world implementation.

## CENTER CAPABILITIES

### IMMEDIATE CAPABILITIES

**Convening**

Bring together physicians, patients and stakeholders to solve complex problems.

**Thought Leadership**

Define the questions, frameworks and principles that shape how the field moves forward.

**Policy & Advocacy**

Translate expertise and evidence into the policy conditions for success.

**Evidence Generation**

Identify critical gaps, curate what is known and generate evidence that informs practice, policy and payment.

**Applied Resource Creation**

Translate evidence, policy and leading practices into practical tools for physicians and care teams.

### CAPABILITIES WE WILL BUILD FOR SCALE

**Education**

Translate evidence and leading practices into the competencies physicians and care teams need to succeed.

**Benchmarking**

Define what good looks like, measure progress, identify leading practices and create mechanisms for continuous improvement.

## HOW THEY WORK TOGETHER

Convene → Define → Influence → Generate Evidence → Enable Action

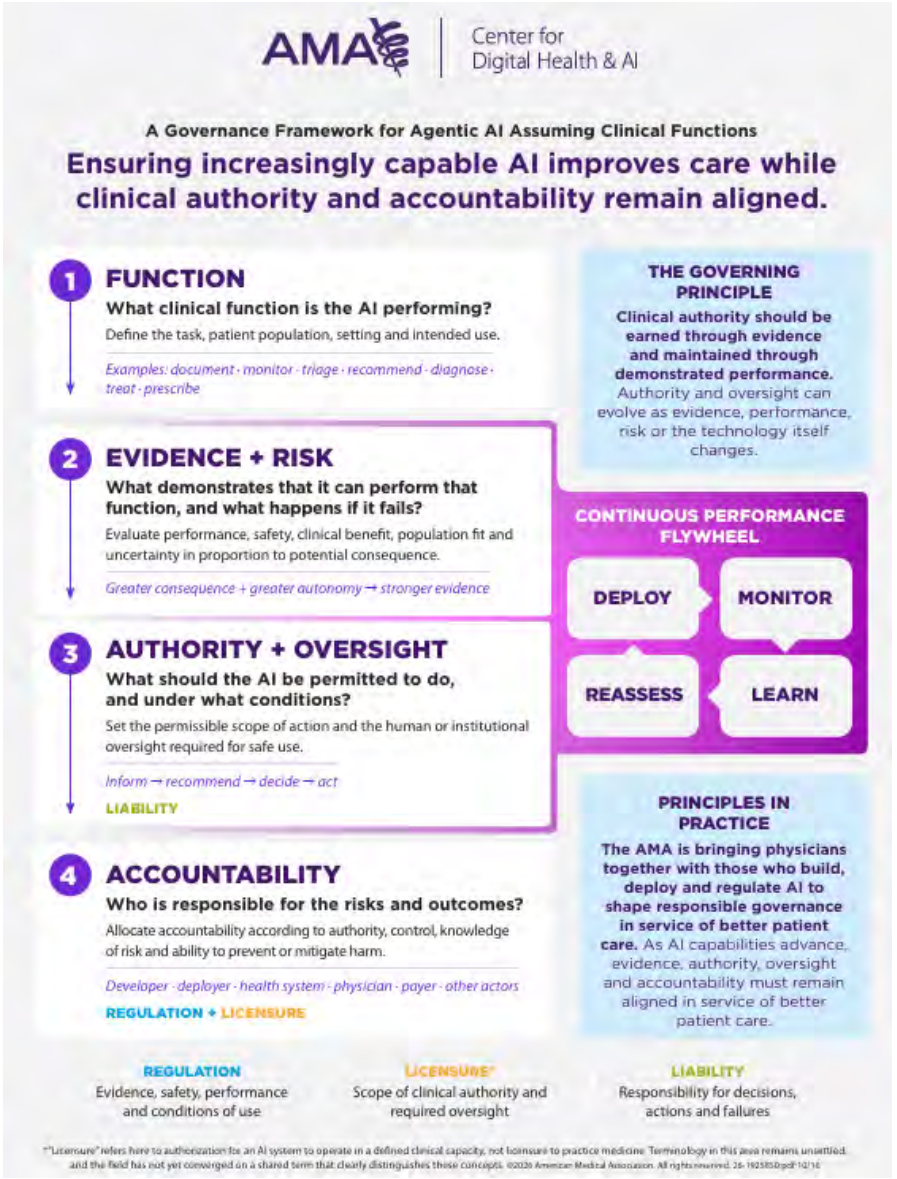
## A technology-agnostic strategy

A consistent framework and set of capabilities that endure as technologies evolve — from today's priorities to those yet to emerge.

# New Resource: A governance framework for agentic AI assuming clinical functions

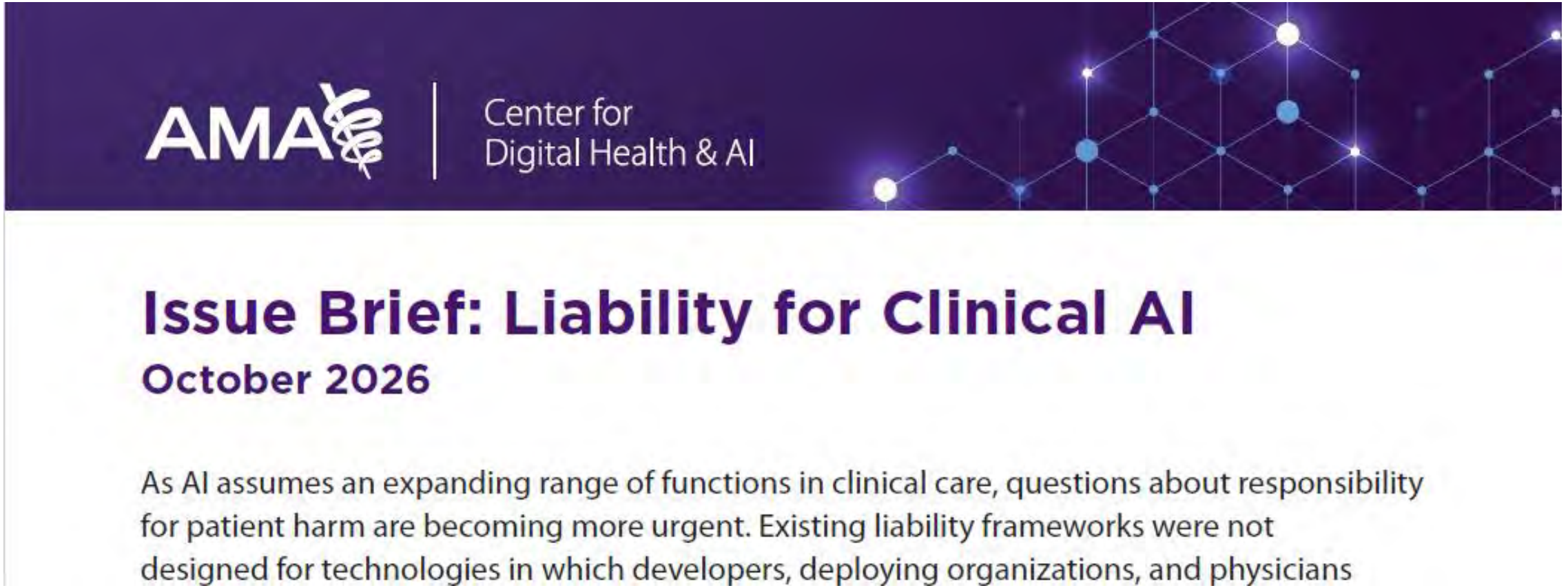
- Clinical authority must be earned through evidence and maintained through demonstrated performance.
- The degree of oversight must reflect the risk, uncertainty, and consequences of the clinical functions AI performs.
- Liability, licensure, regulation, and accountability must evolve together as clinical functions change.

- Released October 13, 2026
- **View here**

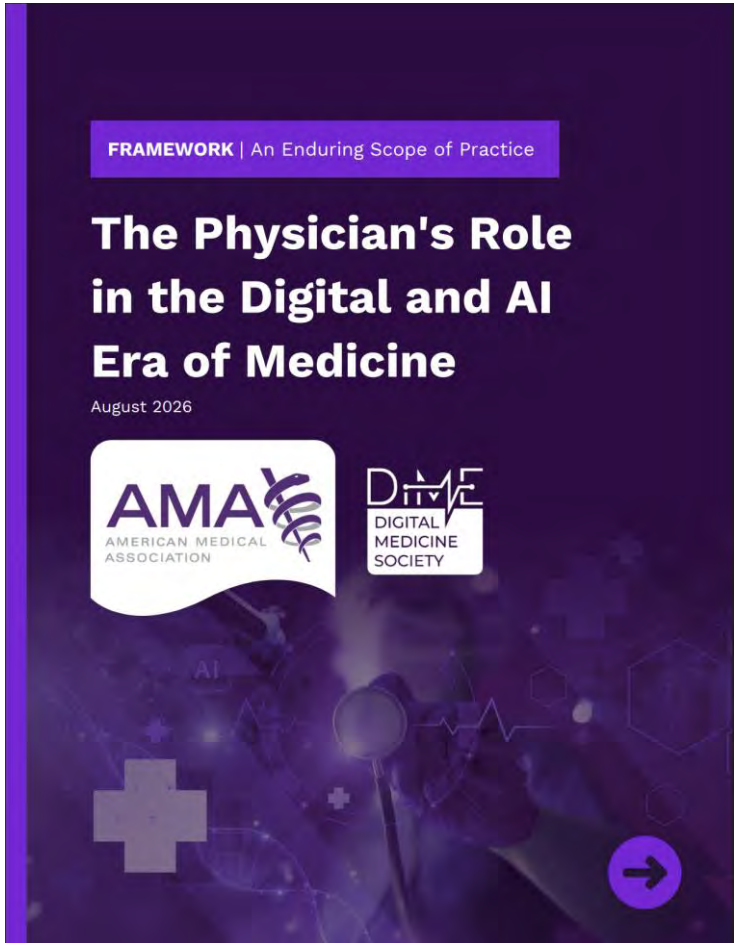


# New resource

Launched October 29, available here



# The physician's role: five key themes




The physician’s role will continue to evolve as technology advances. The framework identifies five responsibilities that remain fundamental to the profession:

**1. Preserve trust through human connection.** Ensure empathy, communication and shared decision-making remain at the heart of medicine.

**2. Demonstrate and promote clinical judgment.** Apply clinical expertise, judgment and accountability where they create the greatest value for patients.

**3. Lead the evolution of medical practice.** Help shape technology-enabled models of care that improve quality, continuity and access while preserving the physician’s highest-value contributions.

**4. Steward the responsible use of technology.** Guide the safe, effective and equitable integration of digital health and AI into clinical practice.

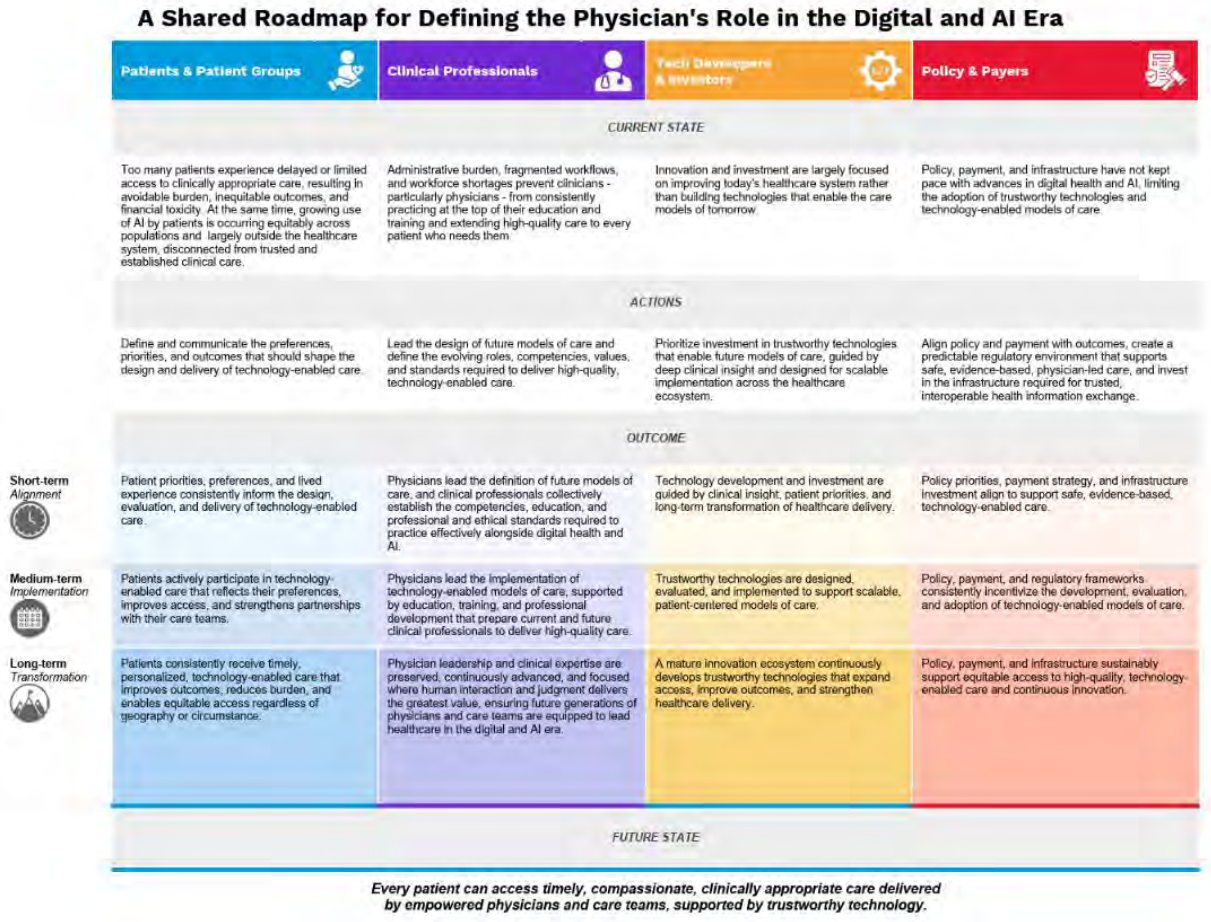
**5. Advance the profession.** Prepare future generations of physicians while preserving and strengthening clinical expertise and ethical decision-making.

View here

# From principles to action: the roadmap

Key themes relevant to the CAP

- **Federal affairs:** Regulatory oversight, evidence expectations, licensure, and accountability.
- **Economic affairs:** Payment for technology, clinical work, and the infrastructure required for safe adoption.
- **Measures and valued programs:** Meaningful evaluation of AI performance, impact on care quality, and the physician and patient experience.




View here

# AMA AI Specialty Collaborative

*Align on and center the physician voice in the design, development, and use of augmented intelligence across health care.*

**Objectives:**

1. Learn from each other through collaborative meetings and communications
2. Align and collaborate on policy efforts
3. Collaborate on the development of education content and resources for society/association membership to increase understanding and use of AI, and advance AI literacy

AMA | Center for Digital Health & AI

# Join the **AMA Digital Health & AI Expert Network** to help shape the future of digital health and AI in medicine!

**Sign up now!**

AMA
AMERICAN MEDICAL ASSOCIATION

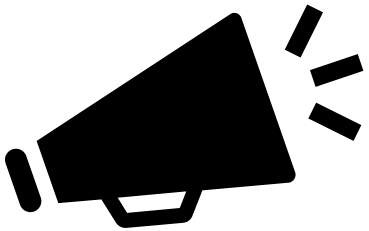
# Thank you!

**jennifer.goldsack@ama-assn.org**

# Upcoming IPPS Meetings

**Annual Meeting 2027 | Jun. 11**
Hyatt Regency Chicago
Chicago, IL

**Interim Meeting 2027 | Nov. 12**
Gaylord National Pacific Resort & Convention Center
Chula Vista, CA



**Stay informed: IPPS monthly newsletter**

Click here to access: AMA IPPS Newsletter


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# Physicians' powerful ally in patient care