The CMS advisory committee drop: 18 people, one agenda, and a bunch of subtext

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Abstract

March 26, 2026. HHS and CMS dropped the member list for a new federal Healt Advisory Committee. 18 people. Picked from 400+ nominees. Reporting to RFK and Dr. Oz. Non-binding recommendations across Medicare, Medicaid, CHIP, a Marketplace. The five stated priorities: chronic disease, outcomes accountabilit time data, vulnerable populations, and Medicare Advantage sustainability. The r mixes major health system operators (Cleveland Clinic, Sanford, Intermountain), value-based care builders (VillageMD), health IT infrastructure (Availity), comm health (NACHC), and Tony Robbins. Yes that Tony Robbins. This piece covers:

- Who these people are and why the mix is interesting

- The five priority buckets and where the money follows

- Medicare Advantage as the thing everyone should actually be watching

- Real-time data as an infrastructure thesis hiding in plain sight

- MAHA as a policy direction with real market consequences

- Whether any of this matters given it's technically advisory and non-binding

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The Roster and What It Signals

Skip the quotes in the press release. Every federal advisory committee announce produces the same sentences about practical solutions and putting patients first not that anyone is lying, it's just that the quotes are written to be unobjectionabl therefore contain approximately zero information. What contains information is they actually put in the room.

The health system operators are the first thing worth looking at. Bill Gassen run Sanford Health, which is one of the largest rural health systems in the country, operating primarily across the Dakotas and upper Midwest with a footprint that touches communities most coastal health tech companies have never thought ab Dennis Laraway is the CFO of Cleveland Clinic, which runs some of the tightest financial operations of any major academic medical center in the country and ha aggressive about data infrastructure and cost management in ways that a lot of comparable systems haven't matched. Dan Liljenquist is EVP and Chief Strategy Officer at Intermountain Health, former Utah state senator, former Bain consult and the person who quite literally invented Civica Rx, a nonprofit generic drug manufacturer he dreamed up while on a treadmill and then actually built into a company that now has a domestic manufacturing facility coming online in Virgi That particular combination of policy brain, strategy chops, and willingness to b new institutions outside existing incentive structures is pretty unusual and his presence on this committee is not decorative.

Then there is Clive Fields, who co-founded VillageMD and has spent years build out the primary care infrastructure thesis that Walgreens eventually paid several billion dollars for before the whole thing got complicated. His background is squ in value-based primary care at scale and he has thought harder than most people about what physician enablement actually requires operationally. Russ Thomas is CEO of Availity, which is the largest health information network in the country transaction volume and sits in the pipes connecting payers and providers at a level most people in digital health don't fully appreciate. If the committee is serious a real-time data and administrative simplification, having the person who runs that particular piece of infrastructure at the table is not an accident.

Kyu Rhee has one of the more interesting career arcs on the list. Former CMO at former Chief Health Officer at IBM Watson Health during the period when Wat was supposed to transform everything, former SVP and CMO at CVS Health's A business, and now President and CEO of the National Association of Communit Health Centers, which represents 1,512 federally qualified health centers serving roughly 52 million patients. His presence reads as the committee's anchor on the vulnerable populations priority and also brings a track record of having worked intersection of data, AI, and clinical delivery at a point in time when that interse was still being figured out. Jenni Gudapati holds a PhD and has been involved in value-based care and population health in ways that complement the clinical ope voices elsewhere on the list.

The two ex officio members, Kimberly Brandt and Stephanie Carlton, are the government insiders keeping the committee connected to actual CMS operations Brandt in particular has deep background in Medicare oversight and program integrity going back to prior CMS leadership roles, which matters when the agen includes anything touching fraud reduction or quality measurement integrity.

And then there is Tony Robbins. Look, the honest reaction from most people in policy circles was somewhere between confusion and amusement. He is a motiva speaker and self-help figure who recently appeared at a CMS quality conference apparently made enough of an impression on Dr. Oz to land a seat at this table. T charitable read is that he brings a consumer behavior and behavior change lens t

genuinely missing from most policy conversations. The less charitable read is th is an administration that likes names people recognize. Both things can be true. Either way he is one vote among eighteen and the committee's output will be sha by the operators and clinicians, not by the person famous for walking on hot coa

Breaking Down the Five Priorities

The five priority areas CMS listed are worth unpacking individually because the not equally weighted and they do not translate into the same kinds of opportuni for founders and investors.

Chronic disease prevention and management is the most explicitly MAHA-align piece of the agenda. This administration has been consistent about framing the healthcare problem as a sick care problem, meaning the system is optimized to t illness rather than prevent it, and the financial incentives bake in that orientatio every level. That framing is not wrong, honestly. About 90 cents of every dollar Medicare spends goes toward people with multiple chronic conditions. Type 2 diabetes alone accounts for enormous downstream cost across the program. The policy opportunity here is in payment model reform that actually reimburses for prevention activities, which historically CMS has been stingy about because the evidence base for specific interventions has been hard to build and the timefram return are long relative to annual budget cycles. If this committee moves the nee chronic disease payment models at all, the companies in a position to benefit are ones doing remote physiologic monitoring, GLP-1 navigation and adherence too metabolic health platforms with real outcomes data, and behavioral health integ with primary care. The word "prevention" in a federal priority document is usua pretty cheap, but the roster here includes enough people who have actually oper value-based care programs to give this one a bit more credibility than the averag press release.

Outcomes accountability and administrative burden reduction is a pairing that probably sounds contradictory but is actually the core tension the whole system inside. The committee's stated goal is to advance accountability for safety and

outcomes while reducing unnecessary administrative burden. The unnecessary modifier is doing a lot of work in that sentence because most of the administrati burden in healthcare exists because someone at some point decided it was neces for accountability or fraud prevention or quality measurement. Untangling what actually necessary from what is just legacy compliance theater is genuinely hard and there are real economic interests defending the status quo. The prior authorization reform conversation fits squarely here. CMS has been pushing on auth for years and the recent rule phasing out fax machines and paper-based workflows for Medicare Advantage prior auth is a real step, but the implementa where it always gets complicated. For founders, the opportunity is in anything th makes the remaining necessary compliance cheaper to execute. AI-powered prio auth, clinical documentation assistance, automated quality reporting, and coding accuracy tooling are all sitting in this bucket.

The vulnerable populations priority is mostly about Medicaid and community he which together cover a population with genuinely different needs than the commercially insured market most digital health startups default toward buildi Medicaid is a complicated investment thesis because the reimbursement is thin the state-by-state variation in policy and managed care contracting is enormous. Kyu Rhee's presence and his NACHC role make this feel like more than a checkb priority. The FQHC network alone represents a massive underserved infrastruct opportunity. Companies doing remote patient monitoring in Medicaid, social determinants screening and navigation, maternal health, and behavioral health integration in primary care settings are all relevant here. The challenge is always economics and the companies that have figured out how to build sustainable businesses serving this population are relatively rare, which is exactly why they a interesting.

Medicare Advantage Is the Real Story

The Medicare Advantage sustainability priority is the one that should get the mo attention from anyone paying close attention to where CMS policy pressure is ac going to land. MA has been the growth engine of Medicare enrollment for years. half of all Medicare beneficiaries are now enrolled in an MA plan, which is a nu

that would have seemed implausible a decade ago. The program has also been a significant source of revenue for payers who figured out how to work the risk adjustment system in ways that generated margin well above what anyone antici when the program was designed.

CMS has been tightening risk adjustment for several years now. The V28 model transition, which CMS began phasing in for plan year 2024, changed how diagnc codes map to risk scores in ways that materially reduced payments to MA plans had been coding aggressively. The industry fought it hard. Some plans took sign hits. The larger payers with more diversified books managed through it but mid-MA-focused plans felt real pain and that pain is not fully resolved. The committ mandate to modernize risk adjustment and quality measurement sits on top of tl ongoing fight and the direction of the recommendations will matter a lot for pla economics and therefore for the technology companies whose revenue is tied to spending.

Risk adjustment accuracy is an enormous technology market. The companies do retrospective chart review, prospective HCC coding assistance, and AI-powered capture are all exposed to whatever CMS decides to do next with the methodolo the committee recommends further tightening in the name of sustainability and accuracy, plans get squeezed and they look harder at their vendor spend. If the committee recommends a more collaborative approach to risk capture that emphasizes real clinical documentation quality over retrospective coding, that cr opportunity for platforms built around genuine care gap closure rather than cod optimization. The distinction matters and smart founders building in this space should have a clear view on which direction the regulatory wind is blowing, beca the business model implications are pretty different.

The Star Ratings quality measurement system is the other MA piece. Plans live a die on Stars because the performance bonuses attached to four and five star ratir represent meaningful revenue and the gap between a 3.5 star plan and a four sta can be the difference between a viable business and one that is shrinking. The measurement methodology has been criticized for years as rewarding process compliance over actual health outcomes and there is real appetite in some corne

CMS for reform. A committee that includes people like Liljenquist and Laraway have spent careers actually running care delivery organizations rather than just consulting about it might actually produce interesting thinking on this.

The Data Infrastructure Play

The real-time data priority is the one that reads most quietly but probably has tl most durable investment implications. The specific language from CMS talked a expanding real-time data to support higher quality care, speed up claims proces and improve quality measurement. That is a lot of different things packed into o bullet but the common thread is that the current data architecture supporting Medicare and Medicaid program administration is genuinely bad. Claims-based quality measurement runs months to years behind real care delivery. Provider directories are notoriously inaccurate. Prior authorization decisions get made wi access to relevant clinical data. These are not new problems and they are not pri technology problems. They are governance and incentive problems that have per because the incumbent infrastructure is entrenched and the people who benefit the current system have resources to defend it.

Russ Thomas being on this committee is the tell that the administration is at lea nominally serious about this priority. Availity processes an enormous volume of eligibility, claims, and prior authorization transactions across the country and ha ground-level view of where the friction actually lives in payer-provider data exch that most policy people do not have. The administrative simplification rule CMS finalized in March 2026, which phases out fax and paper-based workflows in fav electronic transactions, is a direct predecessor to where this committee is likely on data infrastructure. That rule was projected to save roughly $782 million ann which is real money even in the context of a multi-trillion dollar program.

For founders, the infrastructure opportunity here is in interoperability tooling, r time eligibility and benefits verification, clinical data exchange, and the pipes th connect EHR data to payer systems in ways that support both care quality and administrative efficiency. These are not glamorous categories. Nobody is going t

write a breathless TechCrunch piece about prior authorization API infrastructu
But the market is enormous, the regulatory tailwinds are durable, and the switcl
costs once you are embedded in hospital or payer workflows are real. The compa
that have been grinding in this space for years are sitting in an increasingly favo
policy environment.

MAHA Is a Market Signal Whether You Like It or Not

The Make America Healthy Again framing that RFK Jr. has been deploying
throughout his tenure at HHS is worth taking seriously as a market signal even i
politics around it are complicated or if specific positions within the movement s
you as somewhere between questionable and genuinely alarming. Policy directio
create market conditions regardless of whether you personally agree with them,
this one has a few concrete implications.

The prevention-over-treatment frame has real resonance with value-based care
economics even if it is being packaged in unusual political wrapping. The idea tl
the US is running a sick care system that is optimized for treating illness rather
maintaining health is a critique that has been made by serious health economists
decades. The MAHA version of this argument tends to lean into food quality,
environmental toxins, and pharmaceutical industry criticism in ways that go bey
mainstream health policy. But the underlying payment reform argument, that fe
service creates financial incentives to treat rather than prevent and that capitate
outcomes-based payment models create better incentives, is well-supported and
foundation of most of the value-based care infrastructure that has been built ove
past fifteen years. The committee's chronic disease mandate sits on top of this ar
people on the committee who have actually run value-based care programs have
operational credibility to push for payment model changes that go beyond rheto

The specific MAHA-aligned categories that are worth watching from an investm
standpoint include metabolic health and obesity management, where the GLP-1
revolution has created enormous adjacent infrastructure opportunities in adhere

nutrition support, muscle preservation, and long-term chronic disease managem
Functional medicine and integrative health platforms are getting more policy ta
than they have seen in years. Food as medicine programs, which have been a nic
category in Medicaid managed care for a while, are getting elevated attention.
Environmental health monitoring is early but directionally interesting given the
administration's stated focus on toxin exposure. None of these are sure bets and
several of them have unit economics problems that are real and not solved by po
attention alone. But the direction of regulatory and political energy matters for
category timing.

Non-Binding Doesn't Mean Irrelevant

The committee's recommendations are explicitly non-binding. It is worth being
eyed about what that means and also about what it does not mean.

What it means is that nothing this committee produces automatically becomes p
CMS does not have to implement any of it. Congress does not have to legislate b
on it. The Secretary and the Administrator are free to ignore every recommenda
they choose to, and federal advisory committees throughout history have produc
recommendations that sat in a report somewhere and were never acted on. Anyo
who has watched the Federal Advisory Committee Act process for long enough h
seen this play out many times.

What it does not mean is that the committee is therefore pointless. A few things
this one potentially more influential than the average FACA body. First, the
composition is unusually operational. Most federal advisory committees are hea
academics, former regulators, and policy consultants. This one has people who a
currently running major healthcare organizations and who have direct financial
operational exposure to the policies CMS sets. Those people tend to produce mo
grounded and actionable recommendations than committees that are primarily
theoretical. Second, the mandate aligns with things that the administration has
already shown it will move on. The fax machine rule, the prior auth electronic
transaction requirements, the MA payment tightening, the chronic disease preve

framing in public messaging all of these were happening before this committee existed and the committee is being built on top of an existing policy direction ra than trying to create one from scratch. Third, two-year terms and open public meetings mean the committee's work product will accumulate and become part public record that future rulemaking has to at least acknowledge.

The honest answer for investors and founders is that advisory committee announcements are one data point in a larger picture and the picture is one whe CMS under this administration is moving toward payment model reform, administrative simplification, MA sustainability pressure, and a prevention fram with real policy teeth attached. The committee does not create that picture but i clarifies who has the administration's ear on these issues and what specific exper they are drawing on as they make decisions. For anyone building in MA technol value-based care infrastructure, chronic disease management, or health data exc knowing that the people at the table include Liljenquist, Laraway, Fields, Rhee, Thomas is actually useful information. It tells you something about the analytica frame that recommendations will come from and the political economy of what r be implementable. That is not nothing. It is just not everything either, and treati non-binding advisory committee announcement as a green light for any particul category is the kind of mistake that is easy to make and expensive to fix when th administration arrives and reshuffles the whole deck.

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