HCP**LAN**
Health Care Payment Learning & Action Network

Multi-Payer Alignment Blueprint

A guide for applying engagement strategies to achieve multi-payer alignment

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Executive Summary

Health care payment reform depends on participation from multiple payers to achieve sustainable system-wide transformation. Directional alignment of public and private payers across foundational areas—performance measurement and reporting, health equity, key payment model components, timely and consistent data sharing, and technical assistance—has the power to accelerate the realization of nationwide, value-based care that reduces burden and improves quality of care.

The Health Care Payment Learning and Action Network (HCP-LAN or LAN) created the State Transformation Collaboratives (STC) to take a locally-focused approach to address the needs of state populations through alternative health care payment. The STCs—Arkansas, California, Colorado, and North Carolina—are comprised of payers, with input from providers, health systems, purchasers, patient advocates, and community organizations. They are dedicated to transforming health care in their state by shifting economic drivers away from fee-for-service and toward high-value care.

Purpose of the Multi-Payer Alignment Blueprint

The STCs provide a mechanism to foster and test approaches to multi-payer alignment that have potential for regional or national application, with local priorities at top of mind. The HCP-LAN Multi-Payer Alignment Blueprint compiles successful multi-payer alignment initiatives from STC states along with national efforts and contributions from the LAN. The initiatives vary in scale and complexity and provide examples that other states can adapt and incorporate into their own multi-payer alignment strategy. The shared goals and approaches across these initiatives also provide a basis for generating cross-state alignment and building a foundation for national alignment.

Emerging Themes from Multi-Payer Alignment Initiatives

Over the course of developing the Blueprint, the LAN identified key themes consistently present in multi-payer alignment initiatives across the five foundational elements.

Performance Measurement and Reporting: Performance measurement makes it possible to accurately monitor quality and outcomes, create a single set of expectations across payers, and reduce provider burden. STC state approaches focus on the following themes:

- Developing and utilizing nationally stewarded approaches
- Improving the effectiveness and use of outcome measures
- Standardizing measurement and reporting approaches
- Integrating principles of equity and disparity reduction
- Improving accountability

Executive Summary

Advancing Health Equity: Value-based care incentivizes changes to health care delivery, making it more accessible, drive better patient outcomes, and reduce inequities in both care and outcomes. Aligning multiple payers in their design and implementation of Alternative Payment Models (APM) will ensure equitable benefits to the patients served and improve overall population health. STC state approaches focus on the following themes:

- Defining what health equity means to stakeholders
- Establishing standards to collect health equity data
- Delivering more equitable and culturally and linguistically appropriate services
- Partnering with community-based organizations (CBO) to address unmet social needs
- Increasing accountability on addressing disparities and improving outcomes

Aligning Key Payment Model Components: Achieving multi-payer alignment on APM design requires decisions about what structural features to include in a payment model design, including risk adjustment, benchmarking, attribution, quality performance measurement systems, high-value networks and partnerships, APM infrastructure investments, and payer-provider contracting. Alignment does not require payers to build identical arrangements or programs; however, for APMs to be successful and scalable in improving outcomes and reducing costs, greater alignment is needed between commercial and public payers. STC state approaches focus on the following themes:

- Identifying model goals and shared values
- Taking a cascading and iterative approach to aligning model components
- Providing model design flexibility
- Adopting core concepts in payment methodology
- Creating transparency in payment model parameters
- Incorporating patient-centered care in model design

Timely and Consistent Data Sharing: Increased data sharing can enable improved benchmarking capabilities, care coordination between providers, and up-to-date quality reporting. Streamlining data reporting from multiple payers enhances the efficiency and effectiveness of data-driven interventions, leading to improvements in health care outcomes. STC state approaches focus on the following themes:

- Standardizing data, including how it's stored and shared
- Improving interoperability of electronic health record (EHR) data
- Increasing use of regional health information exchanges (HIE)
- Integrating social needs data and referrals into HIE platforms
- Reducing provider burden
- Exchanging data in real time
- Improving data quality and completeness

Executive Summary

Providing and Leveraging Technical Assistance: Technical assistance—which for the STC states covers everything from research, outreach/convening support, training and education, and workgroup development—enables successful participation value-based care arrangements. STC state approaches focus on the following themes:

- Building off existing national-level support
- Maintaining payer connections after models end
- Developing and sharing evidence-based best practices
- Including a variety of modalities
- Improving communication between payers

Building Momentum to National Multi-Payer Alignment

Health care payment and delivery reforms that do not include perspectives from stakeholders across the industry and encourage alignment run the risk of perpetuating a system with disparate attempts at improving patient outcomes and high administrative burden. Initiatives that reflect national priorities are positioned to move toward shared goals, elements, and approaches that foster cross-state alignment and build a more efficient, high-performing health care system.

The examples of multi-payer alignment initiatives featured in this Blueprint, while not exhaustive, provide a picture of success factors that can be applied in other states' alignment efforts. They demonstrate that alignment happens in stages, with states starting small and utilizing continued and committed partnerships to build momentum toward sustainable impact on health system transformation.

The LAN encourages stakeholders to use the Blueprint to learn from states' initiatives in addressing alignment challenges and further grow efforts for cross-state alignment. The LAN thanks the many participants contributing to this work, especially STC members from Arkansas, California, Colorado, and North Carolina for their continued engagement in the efforts towards advancing multi-payer alignment in value-based care arrangements:

- Arkansas Blue Cross and Blue Shield
- Arkansas Department of Human Services (Arkansas Medicaid)
- Arkansas State Health Alliance for Records Exchange (SHARE)
- Blue Shield of California
- California Public Employees' Retirement System (CalPERS)
- Covered California
- Medi-Cal (California Medicaid)
- Colorado Department of Health Care Policy and Financing (Colorado Medicaid)
- Colorado Division of Insurance
- North Carolina Medicaid

Introduction

Building strong partnerships across payers, purchasers, providers, states, and beneficiaries is essential to achieving system-wide transformation. The Centers for Medicare & Medicaid Services (CMS) has made multi-payer alignment a key priority in their strategic plan for the next decade and recognizes that successful payment reforms depend on participation from multiple payers earlier in the design process.[1] The LAN seeks to use its strategic initiatives to promote this priority and develop resources that support industry action toward this goal.

The STCs were created to support state-level partnerships across the health care industry, with the aim of establishing multi-partner initiatives aligning on components of a value-based, person-centered approach to health. Through the STCs, state, federal, and commercial payers, and providers, health systems, purchasers, patient advocates, and community organizations all have a seat at the table to advance APM adoption.

Four diverse states were selected to host an STC: **Arkansas**, **California**, **Colorado**, and **North Carolina**. Each state is pursuing different multi-payer alignment strategies, which provides an opportunity to test approaches and how they impact system transformation to inform future CMS Innovation Center (Innovation Center) models.

The Multi-Payer Alignment Blueprint features examples of initiatives from the four STC states, as well as from the national level, which can be used to inform alignment efforts in other states. Each initiative reflects the STC's local and regional priorities and varies in scale and complexity, offering examples of different stages in multi-payer alignment. This Blueprint, which also features national level efforts, serves as a resource for organizations that are developing or refining their strategy for proliferation of accountable care.

The Duke-Margolis Center for Health Policy's (Duke-Margolis) proposes a framework for multipayer alignment, which serves as the foundation for the STC Blueprint.[2] These foundational elements are part of a flexible approach toward achieving multi-payer alignment that can be adapted based on state and regional priorities and environments.

✓ **Performance Measurement and Reporting**
✓ **Advancing Health Equity**
✓ **Aligning Key Payment Model Components**

✓ **Timely and Consistent Data Sharing**
✓ **Providing and Leveraging Technical Assistance**

Alignment is a gradual process; the Duke-Margolis framework recommends concurrent action across these elements to encourage partner buy-in and build a critical mass to support more impactful initiatives in the future. Commonalities across approaches, such as aligned quality measure sets or standards for equity data collection, present an opportunity to generate cross-state alignment and build a foundation for national alignment.

Advancing and Sustaining Multi-Payer Alignment

Multi-payer alignment can help accelerate participation in new payment and delivery models, create a single set of expectations and goals, and improve provider capabilities, satisfaction, and overall infrastructure. However, exact alignment may not always be feasible or desirable. Partners across the health care ecosystem often have directionally aligned priorities, but have different contracting systems, capabilities, constraints, and infrastructure.

A **directional approach** to alignment can be built on common drivers of success, focusing on developing similar components and guardrails across the five foundational elements, but allowing for some innovation and flexibility based on organizational priorities. For example, a state could develop technical standards for measures or define a set of best practices to support the collection and use of health equity data.

Examples in the Blueprint show commonalities in shared goals and cross-cutting themes that can help shape cohesive multi-payer approaches at the state and national level. Successful initiatives include many of the following core tenets:

✓ **Adopting shared goals:** Partners experiencing similar challenges benefit from aligning on efforts that more effectively achieve health care transformation objectives, such as improving affordability, quality, and equity.

✓ **Identifying a central coordinator or convener:** A convener builds consensus and drives collective alignment across shared priorities and can handle the logistical hurdles, direction, governance, and transparency needed to bring together participants.

✓ **Developing a partner engagement strategy:** Discussions that include broad payer representation across lines of business, with provider, community, and patient voices, amplifies the reach and impact of alignment efforts.

✓ **Monitoring progress and challenges:** Leveraging best practices and participant experience to refine the multi-payer alignment approach over time builds momentum for more complex initiatives at a larger scale in the future.

✓ **Leveraging technical assistance, including local and national resources:** Technical assistance from public and private efforts can support investment and action in ongoing alignment efforts. Payers can leverage previous multi-payer initiatives and Innovation Center models and guidance on section 1115 waivers, state plan amendments, or Medicaid managed care directed payments to sustain momentum after an initiative or model ends.

STC State Profiles

Assessing Alternative Payment Model progress, multi-payer activity, health outcomes, and the recent progress and planned activities for the STC

Arkansas

Arkansas began its multi-payer effort in 2011 with the AR Health Care Payment Improvement Initiative (AHCPII) and is continuing to expand its accountable care organization (ACO) market. Regional payers have convened under the Center for Medicare and Medicaid Innovation (Innovation Center) Comprehensive Primary Care Plus (CPC+) Model across several states in the region through a value-based care steering committee lead by payers, where a significant state market share is represented.

Separately, through the SHARE, different alignment strategies have enabled providers to have a comprehensive view of patient care encounters and patterns, and payers receive comprehensive performance data more quickly rather than having to reconcile data from different practices. Additionally, the Multi-State Multi-payer Collaborative is now focusing efforts on multi-payer reporting of an aligned primary care quality measure set and standardizing social determinant of health (SDOH) screening and billing.

2023 Engagement: The Arkansas STC will build on CPC+ and Primary Care First (PCF) Model alignment efforts to form an aligned quality measure set. Their immediate focus is to increase payer representation in quality measure discussions.

Arkansas Fast Facts

29.7%
MEDICAID COVERAGE[3]*

36.4%
RURAL POPULATION[4]

20
MSSP ACOs[5]

✓ NATIONAL VALUE-BASED CARE ARRANGEMENT **

* Includes those covered by Medicaid, Medical Assistance, Children's Health Insurance Plan (CHIP) or any kind of government-assistance plan for those with low incomes or a disability, as well as those who have both Medicaid and another type of coverage, such as dual eligibles who are also covered by Medicare.
** Participant in at least one Innovation Center value-based care model.

STC State Profiles

Assessing Alternative Payment Model progress, multi-payer activity, health outcomes, and the recent progress and planned activities for the STC

California

Many payers are engaged statewide, although some convening and data interoperability efforts are limited by regional differences. California has undertaken multiple efforts to drive APM adoption. Covered California, the state's health insurance marketplace, and CalPERS, the state public employee retirement and health benefits program. Both Covered California and CalPERS require plans to report data about their adoption of APMs. The California Department of Health Care Services (DHCS) administers the state's Medicaid program (Medi-Cal). Under its previous "Medi-Cal 2020" waiver, DHCS required that 60% of managed care enrollees assigned to public hospitals receive care under an APM.

DHCS has furthered these efforts by requiring all Medi-Cal-managed care plans to report on APM payment arrangements to their providers and the proportion of their spend on primary care. DHCS will also be launching a new APM program for Federally Qualified Health Centers (FQHC), effective January 1, 2024, that will support care transformation and improved quality and health equity outcomes.

2023 Engagement: The LAN will continue to engage new commercial payers to participate in STC alignment efforts. It will also increase visibility into primary care transformation lessons learned for the broader California payer community through greater access to and connection with the PCF Model.

California Fast Facts

27.7%
MEDICAID COVERAGE[3]*

2.2%
RURAL POPULATION[4]

32
MSSP ACOs[5]

✓ **NATIONAL VALUE-BASED CARE ARRANGEMENT ****

* Includes those covered by Medicaid, Medical Assistance, Children's Health Insurance Plan (CHIP) or any kind of government-assistance plan for those with low incomes or a disability, as well as those who have both Medicaid and another type of coverage, such as dual eligibles who are also covered by Medicare.

** Participant in at least one Innovation Center value-based care model.

STC State Profiles

Assessing Alternative Payment Model progress, multi-payer activity, health outcomes, and the recent progress and planned activities for the STC

Colorado

Much of Colorado's recent push has become from a partnership with the Colorado Department of Health Care Policy and Financing (HCPC), which provides oversite for the Medicaid program, and the Colorado Division of Insurance (DOI) to develop a multipayer APM. Convening efforts occur both formally and informally through the Colorado Primary Care Payment Reform Collaborative as Colorado looks to drive APM adoption and measure alignment through legislation.

These efforts led to legislation, House Bill 22-1325, directing DOI to establish aligned parameters for all primary care APMs in Colorado, including an aligned quality measure set. The legislation also requires parameters for different model components—patient attribution, risk adjustment, and core competencies for primary care providers—and partner engagement is currently underway. Colorado is also working to advance an interoperable social-health information exchange (S-HIE) ecosystem. In Fall 2023, Colorado will announce a contract to fund regional infrastructure and partnership building for priority use cases that are customizable to the priorities of the region.

2023 Engagement: The LAN will support DOI with facilitating engagement sessions on core competencies for primary care providers to deliver whole-person care. When engagement sessions for HB 22-1325 are complete, the LAN will provide guidance on incorporating feedback for DOI's consideration before a final rule is promulgated.

Colorado Fast Facts

19.8%
MEDICAID COVERAGE[3*]

12.3%
RURAL POPULATION[4]

14
MSSP ACOs[5]

✓ **NATIONAL VALUE-BASED CARE ARRANGEMENT** **

* Includes those covered by Medicaid, Medical Assistance, Children's Health Insurance Plan (CHIP) or any kind of government-assistance plan for those with low incomes or a disability, as well as those who have both Medicaid and another type of coverage, such as dual eligibles who are also covered by Medicare.
** Participant in at least one Innovation Center value-based care model.

STC State Profiles

Assessing Alternative Payment Model progress, multi-payer activity, health outcomes, and the recent progress and planned activities for the STC

North Carolina

North Carolina has focused on growing accountable care across the health care market, including Medicaid's role in expanding Managed Care Organization (MCO) contracts and building on provider-based models to grow APMs. The state recently passed legislation to expand Medicaid to an estimated 600,000 additional people.

For 2023, the STC set priorities to focus on aligning quality measure concepts and technical specifications and standardize health equity data collection. The North Carolina Transformation Workgroup is conducting multi-partner discussions to build consensus on quality measure alignment. The state has also partnered with non-profit organizations to develop NCCARE360, which is the first statewide network that unites health care and human services organizations with a shared technology that enables a coordinated, community-oriented, person-centered approach for delivering care in North Carolina.

2023 Engagement: The North Carolina STC will continue to advance primary care quality measure alignment and consistency in the collection and use of health equity data. The STC will also explore opportunities to use the recent Medicaid expansion to focus on primary care transformation for low-income adults.

North Carolina Fast Facts

20.0%
MEDICAID COVERAGE[3*]

20.4%
RURAL POPULATION[4]

35
MSSP ACOs[5]

✓ **NATIONAL VALUE-BASED CARE ARRANGEMENT** **

* Includes those covered by Medicaid, Medical Assistance, Children's Health Insurance Plan (CHIP) or any kind of government-assistance plan for those with low incomes or a disability, as well as those who have both Medicaid and another type of coverage, such as dual eligibles who are also covered by Medicare.
** Participant in at least one Innovation Center value-based care model.

Resources

#	REFERENCE
1	Centers for Medicare & Medicaid Services. (2022). Innovation Center Strategy Refresh: Driving Health System Transformation – A Strategy for the CMS Innovation Center's Second Decade. https://innovation.cms.gov/strategic-direction-whitepaper
2	Japinga M, Pokam Tchuisseu Y, Saunders R, & McClellan M. (2022). A Path Forward for Multipayer Alignment to Achieve Comprehensive, Equitable, and Affordable Care. Duke-Margolis Center for Health Policy. https://healthpolicy.duke.edu/sites/default/files/2022-12/A%20Path%20Forward%20for%20Multipayer%20Alignment%202.pdf
3	Kaiser Family Foundation. (2021). Medicaid Coverage: Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity. https://www.kff.org/medicaid/state-indicator/nonelderly-medicaid-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
4	United States Department of Agriculture. (2023). Rural Population Percentages: Data for Nonmetro and Metro Area. https://www.ers.usda.gov/data-products/state-fact-sheets/
5	Centers for Medicare & Medicaid Services Data. (January 2023). MSSP ACOs: ACOs participating in the Medicare Shared Savings Program. https://data.cms.gov/medicare-shared-savings-program

How to Read the Multi-Payer Alignment Blueprint

Navigation Guide for Foundational Elements of Multi-Payer Alignment

Throughout the Multi-Payer Alignment Blueprint, content relates to five key foundational elements and includes information on strategies deployed in the four STC states. To help guide the reader through the content, icons indicate when information specifically relates to one foundational element and can be used to navigate in between sections of the document.

Performance Measurement and Reporting

Identifying strategies to establish directional alignment in the use of quality measures to identify gaps, compare performance, and monitor progress toward shared multi-payer alignment goals.

Advancing Health Equity

Identifying strategies to establish directional alignment in health equity to define, understand, measure, and address health disparities in a sustainable way.

Aligning Key Payment Model Components

Identifying strategies to establish directional alignment on key payment model components, such as attribution, benchmarking, and risk adjustment to reduce administrative burden and create shared value-based design principles.

Timely and Consistent Data Sharing

Identifying strategies to establish directional alignment on data sharing enable data-driven clinical decisions, support whole-person care, and increase interoperability for more uniform data access.

Providing and Leveraging Technical Assistance

Identifying strategies to establish directional alignment on technical assistance to establish shared goals and the learning and support opportunities needed to meet those goals.

HCP LAN

How to Navigate the Interactive Multi-Payer Alignment Blueprint

The Multi-Payer Alignment Blueprint includes interactive features in various forms, such as navigation buttons to assist the reader in jumping throughout the document's content and clickable hyperlinks to view additional information online.

Most interactive features will have some form of signifier, whether that's a hover effect, an icon that highlights, or other effects. Be on the lookout for elements and links like these shown with which to interact with throughout the document.

Throughout the Multi-Payer Alignment Blueprint, you will see five icons on the bottom of the page that relate to the five main topics covered: Performance Measurement and Reporting, Advancing Health Equity, Aligning Key Payment Model Components, Timely and Consistent Data Sharing, and Providing and Leveraging Technical Assistance. Click on any of the five icons to jump to the beginning of the related section.

Navigation Guide for Foundational Elements of Multi-Payer Alignment

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Performance Measurement and Reporting
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These icons in the Navigation Guide will take you to the main sections of the document.

This will take you back to the Table of Contents.

These buttons will take you to the main sections of the document.

Multi-Payer Alignment Dimensions

The Multi-Payer Alignment Blueprint is intended to be used as a starting point for states looking to replicate outputs of collaborative initiatives or strategies, allowing them to more easily overcome similar challenges other states faced in pursuit of their own multi-payer alignment initiatives. To help apply examples to a broader audience, each state example is categorized across four dimensions that may exist, in different combinations, in a variety of circumstances.

Level of Payer Engagement

Indicates how deeply involved payers are committed to the effort as measured by time and resources required (e.g., frequent meetings, engagement over a long period of time, number of staff engaged)
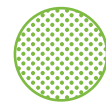
LOW   MODERATE   HIGH

Diversity of Payer Engagement

Indicates the range of payers involved as measured by number of different entities and/or lines of business
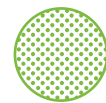
LOW
(e.g., only Medicaid; or 1 commercial payer)
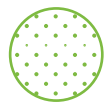
MODERATE
(e.g., Medicaid and 1 commercial payers; or 2+ commercial payers)

HIGH
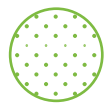(e.g., Medicaid and 2+ commercial payers; or 4+ commercial payers)

Scale

Indicates geographic spread of payer involvement based on level of population coverage
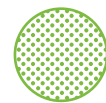
LOW
(e.g., Multiple counties)

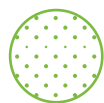MODERATE
(e.g., State-wide)

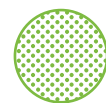HIGH
(e.g., Multi-state)

Complexity

Indicates level of effort most likely required to achieve similar outputs and/or outcomes, as measured by a combination of the above factors and level of regulatory intervention required

LOW   MODERATE   HIGH

Performance Measurement and Reporting

HCP-LAN Perspective

Performance measurement makes it possible to monitor, in a transparent and quantifiable manner, how well payers and providers achieve the Quadruple Aim of enhanced patient experience, better health outcomes, improved clinician experiences, and lower costs.

Performance measurement also provides information on the health outcomes achieved by payers and providers, which can inform purchaser and consumer choices in the market, impact payment initiatives and incentives, and motivate ongoing improvement. Performance measurement enables continuous quality improvement by highlighting aspects of care delivery that require optimization, establishing common performance targets or goals for specific dimensions of care, and providing a mechanism to consistently measure disparity reduction. Finally, performance measurement provides a framework that patients, payers, purchasers, providers, and other key partners can use to collaborate productively toward the achievement of their collective goals for patients and the health care system as a whole.[1]

The LAN aims to understand the performance measures that are evaluated across states by comparing state measures to national measure sets, such as the Universal Foundation, in order to identify priority areas for all states and payers, including prevention measures, controlling chronic conditions, and child/pediatric measures. The LAN encourages cross-state alignment on high priority measure sets to improve the coordination of clinical quality and performance metrics across governmental and commercial health plans for synergistic improvements in health outcomes.

Approaches to Performance Measurement and Reporting

Payers, providers, and other organizations in health care may address alignment on performance measurement and reporting using a variety of approaches, ranging from initiating quality measure collection to creating downside risk adjustments based on provider performance. Regardless of the approach, instituting consistent performance measures allows payers and providers to track changes in patient outcomes, a critical element of advancing alignment and addressing shared quality goals across payers, providers, and patients. These performance measurement efforts should also be considered opportunities for cross-state alignment, so 50 different quality measure alignment efforts do not lead to 50 different aligned measure sets. The CMS Universal Foundation preliminary measures set, which was partially informed by an analysis of common measures in the STC states, provides a baseline to promote cross-state alignment.[1]

Examples of state approaches include:

Using nationally stewarded measures: For partners initiating discussions around measure alignment, beginning with a list of commonly reported measures (e.g., National Quality Forum (NQF) endorsed measures) acts as a strong starting point for discussion. Colorado approached engagement discussions on quality measure alignment by starting with a list of commonly used measures that have already been established. Using this approach, participants can better contribute to measure discussion, and eventually transition to performance measurement and reporting without contributing to increased provider burden.

Pursuing alignment in initiative design: As demonstrated by Covered California's accountability efforts, working across payers on contract requirements, such as measure reporting requirements for providers or data collection standards, is an important approach to encourage performance measurement consistency. When approaching alignment, conversations facilitated by a neutral convener are helpful to reach a common goal across all participants and decrease the chances of misalignment of priorities and varied requirements across payers. Improved alignment also reduces the administrative burden placed on providers by limiting the number of unique requirements by individual payers.

Creating opportunities for performance improvement: Established incentives for measure collection, reporting, and performance can support quality improvement goals. Organizations just beginning to initiate payment incentives may start with payment for reporting, while other organizations may focus on payment for performance, including both upside and downside risk. Payment incentives for reporting or performance likewise benefit from alignment to establish consistent standards for value-based performance.

The Universal Foundation

Challenge: CMS operates more than 20 quality programs focused on individual clinicians; health care settings, including hospitals or skilled nursing facilities; health insurers; and value-based entities, such as accountable care organizations (ACO). Each of these programs has its own set of quality measures to assess performance on the specific goals or individual setting of that program. While there is some overlap of measures across programs, many programs have unique measures or utilize modified measures, creating inconsistencies. This leads to an increased reporting burden, misalignment of clinical best practices, and increased confusion across programs, practices, and providers.

Approach: CMS created the Universal Foundation measure set (Appendix A-1) as part of its effort to implement its National Quality Strategy.[1] The Universal Foundation measure set seeks to focus on measures that:

- Apply and are meaningful to broad segments of the population
- Reduce provider burden through greater quality measure alignment
- Advance health equity through tracking of disparities
- Shift reporting from a manual process to one utilizing electronic and automatic processes

CMS sought to prioritize measures that aligned with these goals and had minimal unintended consequences. In addition, CMS created a cross-center working group focused on development and implementation of aligned measures.

Initiative: CMS selected preliminary measures for the Universal Foundation that focus on physical and behavioral health of both adult and child populations, and address diseases and conditions that have high morbidity and mortality in the United States.

Identified measures for the adult population include prevention measures, such as breast cancer and colon cancer screening, as well as immunizations. Measures focusing on chronic conditions include controlling high blood pressure and managing diabetes via Hemoglobin A1c. Behavioral health measures include screenings for depression and treating substance use disorder. There are also specific measures for pediatric patients, such as measures for wellness and immunization visits.

The Universal Foundation will eventually include measures that are necessary to specific populations, such as pregnant women or those nearing end of life, as well as those receiving care in a specific setting, like a hospital.

Impact: CMS believes that focusing attention on a foundational set of measures will lead to higher quality care for the more than 150 million Americans covered by CMS programs, and eventually, the Universal Foundation will set the stage for alignment and improved outcomes throughout health care. The agency intends to move forward aligning measures and providing opportunities for feedback via listening sessions, requests for information, and proposed rulemaking.

National Quality Forum Innovator Coalition

Challenge: Many metrics exist to measure health care quality and are used in reimbursement equations, but not all capture outcomes that matter most to patients and clinicians, whose feedback is critical to supporting value-based payment models that focus on population health. This feedback, however, is generally gathered at the end of the measurement development process, rather than on the front end, which leaves little room for improvement based upon patient and clinician input.

Approach: Aligned Innovation is a multi-payer initiative pioneered by NQF to advance Next Generation Quality Measures to support the Universal Foundation.[2] NQF convenes an Innovator Coalition, which includes public and private sector organizations that are the principal customers and drivers of Aligned Innovation. For each topic the Coalition selects for new measure development, different partners are engaged to provide expertise and support.

1. **Specialty Societies** provide relevant expertise from participating clinical experts.
2. **Patients and clinicians** with experience in the relevant clinical area are engaged to elicit the outcomes that matter most, which then become the "outcome measure concepts" for Aligned Innovation measure development.
3. **A Multistakeholder Advisory Council (MAC)**, which consists of a broad and diverse set of organizations that represent important end-users and enablers of measures, are involved throughout the process to provide input and advice.
4. **Provider partners** from a nationally representative set of provider organizations ensure upfront identification of clinical and operational factors critical to the measures' ultimate acceptance and feasibility and participate in scaled implementation and testing.

Payer Engagement: Arkansas Blue Cross and Blue Shield, and ten other national payers/organizations across multiple states

Initiative: The Aligned Innovation, an initiative embraced by the LAN as a critical enabler to multi-payer alignment, aims to accelerate the development of outcome measures by engaging multiple partner groups throughout the measure development process, prioritizing patients and clinicians. This unique multi-partner approach completes the end-to-end process of measure development, testing, and validation in roughly two years. The Coalition, including Arkansas Blue Cross and Blue Shield, prioritized quality measures for behavioral health and maternal health outcomes, which includes outcomes for mild to moderate behavioral health conditions (e.g., depression, anxiety), and reducing severe maternal morbidity (SMM). SMM refers to severe complications of labor and delivery that can have long-lasting and even fatal consequences.[2] The work will also include developing and applying a health disparity assessment to be applied across both behavioral and maternal health outcome measures.

National Quality Forum Innovator Coalition (continued)

Measures that have come to the forefront for development are:

1. A comprehensive measure assessing a combination of symptoms and functioning for depression and anxiety;

2. Risk appropriate care to reduce SMM; and

3. Hypertension control throughout pregnancy to reduce maternal and neonatal adverse outcomes. The Coalition is working to define measure specifications with input from partners before beginning to implement and test the measures at a large scale.

Impact: Aligned Innovation leverages human-centered design to fill high priority gaps in our nation's portfolio of quality measures based on outcomes that matter most to patients and clinicians. For every new measure introduced, partners seek to retire two or more measures from their performance accountability measure sets to optimize measure sets that support value-based payment, population health, and advancing health equity, while decreasing provider burden and advancing interoperability. When the measure development process is completed at the end of 2024, Arkansas Blue Cross and Blue Shield and other Coalition participants will determine if these measures will be included in future value-based care arrangements.

The National Quality Forum (NQF) is a not-for-profit, nonpartisan, membership-based organization that works to catalyze improvements in health care. We do this by leveraging our unique position, bringing all voices to our table and forging multistakeholder consensus on measurement standards and practices that improve outcomes, affordability, safety, and equity. NQF is focused on impact, advancing priorities shared across stakeholders, and addressing structural challenges that transcend effective quality measurement and improvement based on science and evidence. Learn more at www.qualityforum.org. If you have any questions or would like to set up a call to obtain more information, please reach out to the project team at alignedinnovation@qualityforum.org.

NATIONAL QUALITY FORUM
Driving measurable health improvements together

Level of Payer Engagement	Diversity of Payer Engagement	Scale	Complexity

Covered California Contracting and Accountability Strategies

Challenge: While the nation has made great strides in expanding coverage to millions of Americans, health care outcomes have not improved and there has not been substantial change in disparities.[3] Prior to a piece of 2022 legislation, Covered California did not have a mechanism to hold health plans accountable for improving care; furthermore, and the volume of measures and individualized approaches to address quality and equity has created administrative burden for plans.[3]

Approach: Covered California initially considered several proposals for Qualified Health Plan contracting for 2023-2025. These proposals were initially aligned with major purchasers like CMS, Medi-Cal, and CalPERS. The options were then refined through market analysis, literature reviews, legal and regulatory assessments, and partner engagement. Covered California collected written comments from experts and health plans and conducted interviews with federal and state policy leaders, advocates, and associations.

Payer Engagement: Anthem, Blue Shield of California, Bright Healthcare, Centene/HealthNet, Kaiser Permanente, LA Care, Molina Healthcare, Oscar Health, Sharp Health Plan, Valley Health Plan, and Western Health Advantage. *Note: Covered California also received written feedback from national and regional plans that had expressed interest in entering the Covered California market in 2023 or 2024.*

Initiative: Covered California pursued two interrelated strategies:

1. **Selective Contracting for Quality:** Covered California pursued a new contracting and accountability effort that sets a minimum level of quality performance for participating qualified health plan issuers (QHP) on the state-based Marketplace.[4] Health plan products that perform below the 25th percentile of national performance on the Quality Rating System (QRS) clinical measure set for an extended period will be removed from the Marketplace.

2. **Quality Transformation Initiative:** Covered California set direct and substantial incentives for QHP issuers to improve health care quality and reduce health disparities.[5] QHP issuers failing to meet measure benchmarks for four measures (Appendix A-2) must make payments to the Quality Transformation Fund, which will be used to advance Covered California's quality-related operations and activities. With broad partner engagement and transparency in their approach, Covered California was able to achieve a consensus from the payer community in support of the new quality initiative.

Impact: By aligning a small set of clinically impactful, disparity-sensitive quality measures, purchasers can contribute to measurable population health improvements, reduce administrative burden on plans and providers, and prevent misalignment of priorities and requirements. CalPERS and Medi-Cal also aligned their accountability set and methodology for repayment with Covered California for greater state alignment.[6]

Level of Payer Engagement	Diversity of Payer Engagement	Scale	Complexity

Colorado Alternative Payment Model Alignment Initiative

Challenge: Colorado has long focused on improving its health care by ensuring access to high-quality, affordable health care for Coloradans. In the spring of 2021, Colorado initiated a process to develop a multi-payer statewide APM, with the goal of aligning payers' efforts to shift away from fee-for-service (FFS) payments to value-based payments.[7]

Approach: The Office of Saving People Money on Health Care in the Lieutenant Governor's Office partnered with the Colorado Department of Health Care Policy & Financing (HCPF), DOI, and the Department of Personnel and Administration (DPA) to develop a process to align APMs. An independent facilitator conducted 24 partner interviews with HCPF, DOI and DPA, providers, health plans with lines of business in Colorado, Colorado purchasing alliances, and consumer advocates. Following the interviews, Colorado formed an overarching APM Alignment Advisory Group, and two sub-groups focused on primary care and maternity care to develop recommendations on consensus-based APMs to advance alignment of value-based payment approaches within public and commercial markets.[7]

Payer Engagement: Anthem, Inc., CVS/Aetna, Denver Health Medical Plan, Colorado Access, HCPF, Kaiser Permanente, and Rocky Mountain Health were invited to participate in the APM Alignment Initiative workgroups.

Initiative: The sub-groups discussed quality measure alignment and the use of standardized measures derived from national quality measure sets, particularly CMS core quality measures, as Medicaid is required to report on these measures.[7] The group recommended eight adult primary care measures and eight pediatric primary care measures (Appendix A-2). The sub-group did not mandate which measures should be reported but is committed to an ongoing discussion in the future.

In May 2022, Colorado passed legislation directing DOI to establish aligned parameters for primary care APMs. DOI is currently in the process of engaging feedback from payers, providers, and consumers to develop a set of measures that will be adopted as regulation by December 1, 2023.[8]

Impact: With a legislatively mandated set of aligned quality measures for primary care APMs, Colorado will be able to measure population health improvements and reduce administrative burden for both providers and payers. The voluntary sub-group discussion on measure alignment paved the way for the measures that will be considered as part of legislation under the DOI.

Level of Payer Engagement   **Diversity of Payer Engagement**   **Scale**   **Complexity**

Quality Measure Alignment for Advanced Medical Homes

Challenge: North Carolina passed Medicaid reform legislation in 2015 that was intended to control cost increases in Medicaid over time, share the risk of Medicaid costs with providers and insurers, and maintain or improve the health of Medicaid beneficiaries. The legislation requires a new delivery system and managed care contracts to be built on defined measures and goals for risk-adjusted health outcomes, quality of care, patient satisfaction, access, and cost.[9] The North Carolina Department of Health and Human Services (DHHS) developed the Medicaid Advanced Medical Home (AMH) program as a vehicle for delivering care management while North Carolina underwent the transition to Medicaid managed care in 2021.

Approach: In December 2016, the North Carolina Institute of Medicine (NCIOM) Task Force on Health Care Analytics convened to develop a set of quality metrics to be used to drive improvement in population health under North Carolina's Medicaid reform plan. The Task Force was made up of members who represented diversity in expertise, experience, and geographic regions, including physicians; nurses; and other health care providers; experts; Medicaid beneficiaries and patient/family representatives; private payers; and care managers. The Task Force developed guiding principles to help direct its work, including broad participation; transparency; emphasis on clinical and public health impact, centering on primary care; alignment with nationally-vetted measures, as much as possible; adaptability on ongoing evaluation of measure sets; and reaching consensus.[10] This work led to a set of 10 core recommended measures for North Carolina Medicaid to include in their Primary Care Case Management Entity Contracts and to use to inform the development of quality improvement strategies.

Payer Engagement: United HealthCare, Blue Cross Blue Shield North Carolina, and North Carolina Medicaid participated in the Task Force. The quality measure set applies to Medicaid Prepaid Health Plans (AmeriHealth Caritas North Carolina, Healthy Blue of North Carolina, UnitedHealthcare of North Carolina, WellCare of North Carolina, and Carolina Complete Health).

Initiative: For alignment across payers, DHHS developed a Medicaid Managed Care Quality Strategy,[11] containing a subset of measures specific to the AMH program (Appendix A-2). The measures and associated technical specification calculations are used to monitor performance and calculate performance incentive payments. DHHS also recently added requirements for gap reporting, which are intended to identify plans and providers that aren't meeting quality guidelines, to provide practices with actionable information about which members have gaps in care.[12]

Impact: The AMH Measure Set has promoted, and will continue to promote, health plan accountability in a new managed care environment. Based on 2021 measure rates, the state set 2023 benchmark goals is continuing to monitor measure performance statewide, by line of business, and at the plan-level.[13] These measures are also monitored across demographic strata such as age, gender, disability status, geography, race, and ethnicity. North Carolina will soon begin evaluating the qualitative outcome of quality measurement alignment on the provider experience and its impact on reducing administrative burden.

Level of Payer Engagement   **Diversity of Payer Engagement**   **Scale**   **Complexity**

Resources

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Advancing Health Equity

HCP-LAN Perspective

APMs present a significant opportunity to incentivize changes in delivery to help make care more accessible, drive better patient outcomes, and reduce inequities in both care and outcomes. Collaboration with partners across the health care ecosystem is necessary to align the design and implementation of APMs that advance health equity. Payers, purchasers, providers, community-based organizations, and other partners must come together with individuals, families, and their communities to address health inequities.

The LAN established the Health Equity Advisory Team (HEAT) to identify and prioritize opportunities to advance health equity through APMs, influence design principles, and inform LAN priorities and initiatives. The LAN believes that our approach to health equity must be person-centered if we wish to effectively use value-based care and APMs to meet an individual's health care and health-related social needs.

The APMs that Advance Health Equity Theory of Change and accompanying guidance document outline the LAN's perspective on how APMs could be designed to advance health equity.[1] The Theory of Change illustrates how APMs can be structured to advance health equity along three primary drivers: care delivery redesign, payment incentives and structures, and performance measurement. Within these primary drivers, the Theory of Change outlines 14 specific design elements, or secondary drivers, that HCP-LAN partners can incorporate into APMs.

In 2023, the HEAT has made an intentional choice to focus its activities, dialogue, and materials on community engagement. CBOs play an important role in addressing health disparities and inequities within and beyond the health care system, providing much-needed local services and care coordination to help families and individuals thrive in their lived environments and attain their highest level of health. In the coming months, please look out for HEAT events and publications that will amplify and disseminate the existing work being done by CBOs in value-based care and bridge notable gaps in knowledge and understanding of CBOs and CBO partners.

The LAN recognizes that guidance adoption requires time and effort and depends on a variety of important factors, including payer and provider capacity, the availability of complete and accurate demographic data, and access to health and social services. Over time, these approaches will evolve to reflect implementation lessons, such as the examples provided in this Blueprint, and additional evidence-based methodologies.

Approaches to Addressing Health Equity

States are undertaking different strategies to address health equity, from legislative mandates and specific contracting provisions, to partnerships with CBOs, states, payers, and providers. Each aims to achieve similar shared goals, but employs an approach tailored to its unique landscape and needs with differing degrees of involvement to advance health equity. After establishing progress in health equity approaches, accountability for health equity related outcomes can be incorporated into initiative design.

Examples of state approaches include:

Creating shared definitions of health equity: People and organizations across the health care ecosystem may define health equity differently depending on their background and positionality within health care. Establishing an understanding of what health equity means provides direction and a shared purpose to initiatives. Once established, specific initiatives may focus on one or multiple approaches to addressing health inequities, including but not limited to expanding culturally appropriate care, improving access to care, and/or identifying opportunities for disparities reduction.

Creating consistent methods to collect equity-related data: In order to address disparities, many initiatives involve establishing data collection standards to identify where disparities exist. Payers, providers, and CBOs are grappling with differing screening and data collection approaches, leading to calls for increased alignment in approaches and data consistency. Once collected, payers can establish benchmarks to measure improvement, equitable performance, and reduced disparities.

Establishing partnerships with CBOs: States, payers, and providers can establish multi-payer partnerships with CBOs and create a database that connects members with organizations that provide appropriate services. This approach can operate as a pilot in a few counties or can be spread across the state. Linking members to organizations to support their non-medical needs (e.g., transportation, shelter, or food insecurity) can accelerate population health improvement.

Including health equity language in contract provisions: Adding health equity provisions in RFPs and contract language addresses health equity on a larger scale. States are increasingly using their Medicaid programs to transform health care delivery and improve individual and population health with a focus on promoting equity. Evaluating potential payers on their individual health equity approaches emphasizes the importance of the issue, advances the goal of the state and the payer, and helps foster a shared commitment to addressing health equity.

Embedding Health Equity in Innovation Center Models

Challenge: Innovation Center value-based care models have not historically covered the full diversity of Medicare and Medicaid beneficiaries. Beneficiaries in advanced primary care models tend to be white and less likely to be dually eligible or live in rural areas, limiting the usefulness and reach of models.[2] Contributing to the gap in coverage, safety net providers who serve a high proportion of underserved and rural beneficiaries often face barriers to participation in Innovation Center models, including limited upfront investments and increased financial risk from participation. Additionally, models aiming to advance health equity have faced challenges related to collecting consistent and standardized data to address disparities.[3]

Approach: In their 2021 Strategy Refresh, the Innovation Center outlined a series of commitments to advance health equity and the inclusion of historically underserved beneficiaries in Medicare, Medicaid, and the marketplace as a whole.[2] These commitments include testing new models and modifying existing models to include health equity and SDOH considerations, increasing the number and diversity of beneficiaries represented in value-based payment models, recruiting and supporting safety net providers and providers new to value-based arrangements through progressive participation tracks, evaluating models for health equity impact, and strengthening the collection and analyses of population demographic data to better identify gaps in care.

Initiative: The Innovation Center has begun to incorporate these health equity commitments across all stages of the model life cycle, from recruitment to implementation to evaluation. Efforts are being applied to both new and existing models, including ACO Realizing Equity, Access, and Community Health (ACO REACH),[4] Enhancing Oncology Model (EOM),[5] Medicare Advantage Value-Based Insurance Design (VBID) Model,[6] and Making Care Primary (MCP).[7]

Across the industry, payers are identifying strategies to improve the collection of complete and standardized data related to race, ethnicity, and language (REL) and SDOH data. Innovation Center models are also incorporating data collection standards and are requiring providers to conduct screenings to strengthen their understanding of patients' health-related social needs and efforts to address them. Given the collective efforts towards data standardization, significant alignment opportunities across payers exist.

In addition, many models are requiring participants to create health equity plans, where participants must identify their underserved patient populations and create strategies to reduce any disparities in these populations. For some models, like ACO REACH, equity plans are required across an ACO's entire patient populations, while other models, such as VBID, require health equity plans for specific patient populations prior to expanding. Participants are encouraged, and in some models are required, to monitor and update their plans for continuous quality improvement.[8] With the Innovation Center's 2030 goal to incorporate multi-payer alignment in all new models, the Innovation Center will continue to seek opportunities for directional alignment with payer partners across these design features.

Embedding Health Equity in Innovation Center Models (continued)

The Innovation Center is also improving model design to include more safety net provider participation. ACO REACH, EOM, and MCP are instituting health equity related benchmark adjustments based on beneficiary demographics, such as dual eligibility status. These efforts incentivize providers that have been historically underrepresented to participate in models. Recruitment of more safety net providers and FQHCs are coupled with a more comprehensive analysis of provider applications to continually assess provider network composition and adequacy. The Innovation Center is working across payers and community partners to develop a definition for Medicaid safety net providers to consistently measure participation in models. These cross-industry and cross-payer partnerships are critical to build infrastructure for referral services.

Impact: As additional models are announced in the coming years, the Innovation Center will continue to advance health equity and expand provider representation in models. To monitor progress towards expanding access to accountable, high-quality, and person-centered care, the Innovation Center has outlined metrics with 2025 and 2030 targets:[8]

1. Percent of all models that will collect and report demographic and, where feasible, social needs data and health equity plans to CMS
2. Percent of facilities participating in Innovation Center models identified as safety net facilities
3. Percent of primary care providers participating in Innovation Center models identified as safety net providers
4. Rate of potentially preventable admissions for overall conditions per 100,000 Medicare beneficiaries served by an Innovation Center model
5. Disparity in the rate of potentially preventable admissions for overall conditions per 100,000 Medicare beneficiaries served by Innovation Center models across race and ethnicity groups

The impact of the new models and updates to existing models will be assessed for continual improvement under these metrics and additional factors including the proportion of Innovation Center participants serving historically underserved communities and resolution of health-related social needs. With the release of the Universal Foundation, there is additional opportunity and urgency for payers to align across health equity and patient reported outcome measures, standards for data collection, and shared care goals.

Hark at Excellerate Foundation

Challenge: Born out of the desire to identify the cause of poor school attendance in Northwest Arkansas, it became apparent the region is resource rich and connection poor, and while there are often services available to help individuals, accessing those services is difficult. Identifying and accessing available resources was not a problem unique to students in the Northwest Arkansas region, but was a problem across the state.[9,10]

Approach: The community identified the need for a "platform" organization to collaboration between health and human services professionals, help individuals navigate the health and human services system, and provide technology solutions to facilitate connecting resources to the people who need them most.[9,10]

Payer Engagement: Arkansas Blue Cross, Blue Shield, and the Arkansas Department of Human Services (Arkansas Medicaid).

Payers also engaged closely with Arkansas Behavioral Health Integration Network, Arkansas Children's Hospital, Arkansas Crisis Center, Bella Vista Fire and EMS, Blue & You Foundation, City of Fayetteville, Community Clinic NWA, Community Quality Alliance, Fayetteville Police Department, HARK, Mercy, Northwest Arkansas Council, NW Health Systems, Rogers Fire Department, SHARE, Springwoods Behavioral Health, The Joshua Center, University of Arkansas, UAMS Community Health and Research, UAMS NWA, United Way of NWA, Veteran's Health Council Systems of Ozarks, Washington County, Washington Regional Medical Center, and Whole Health Institute.

Initiative: Hark began by creating extensive map of regional resources that could connect people to services related 10 different domains (education, food, goods, health, housing, legal, money, social support, transit, and work). In collaboration with United Way, Hark receives information on 2-1-1 callers who are in need of social services. Once connected, Community Liaisons create customized assistance plans for each individual who indicates a need, which is tailored to their specific needs and links individuals to a few of the hundreds of organizations in the Hark database, ensuring that those needs were met.[9]

To better understand the lives and health of the people of Northwest Arkansas and to help guide them to community services, Hark and SHARE, the statewide HIE, worked together to build an interface linking the SDOH data from 2-1-1 to the HIE that makes the information available to providers when serving their patients' health care needs.[10] Now, providers and community liaisons are aware of the social needs impacting their populations.

Hark at Excellerate Foundation (continued)

Impact: Hark has helped thousands of people across Northwest Arkansas become connected to resources through the region's most comprehensive and real time updating resource map, updating in near real time via the Hark system. Since March 2020, more than 14,000 people across the region have been connected to help and service through Hark's extensive mapping of regional resources, covering 10 social determinants of health (e.g., housing, food, education, social support, and transit) and 50 individual areas of need.[9,10]

Level of Payer Engagement

Diversity of Payer Engagement

Scale

Complexity

California Medi-Cal MCO Requirements to Advance Health Equity

Challenge: The California Department of Health Care Services sought to redefine how care is delivered to more than 12 million low-income Californians who are enrolled in Medi-Cal managed care. DHCS wanted to transform the health care system to advance equity, quality, access, accountability, and transparency to reduce health disparities and improve health outcomes for Californians.[11]

Approach: In 2022, California underwent a process to update the Medi-Cal managed care plan model contract, under which all Medi-Cal managed care plan partners operate. Starting on January 1, 2024, all managed care plans, including those with direct contracts and those operating in all plan model types in all counties, will work under the new, rigorous managed care plan contract to provide high-quality, equitable, and comprehensive coverage for Medi-Cal managed care members.[11] The new contracts are a key lever to driving improvements in how health care is delivered to Medi-Cal members and implementing a new standard for person-centered and equity-focused care. California's contracting goal is to engage with payers that demonstrate commitment and a clear strategy to drive quality of care and health equity improvements, enhance transparency and accountability, and work locally with partners and community-based providers to address SDOH.[12] In addition, Medi-Cal leadership meets regularly with plan executive leadership to specifically discuss and further advance shared goals on quality and health equity targets.

Payer Engagement: California has provided conditional approval to 17 counties to change the type of managed care model in which they participate to County Organized Health System or Single Plan model. DHCS has also directly contracted with five managed care plans—Blue Cross of California Partnership Plan (Anthem), Blue Shield of California Promise Health Plan, Community Health Group Partnership Plan, Health Net Community Solutions, Inc., and Molina Healthcare of California—to operate within Two Plan or Geographic Managed Care model counties.[12] State legislation authorizes DHCS to contract with Kaiser Foundation Health Plan to serve as a primary Medi-Cal managed care plan for members in geographic regions in which Kaiser is a Knox-Keene Licensed health care service plan.[13] Where possible, DHCS has also aligned these efforts with other payers including CalPERS and Covered California.

Initiative: California used the opportunity to reimagine its managed care model landscape to implement new requirements related to reducing health disparities among specific populations. Managed care plans will be required to identify health disparities and inequities in access, utilization, and outcomes by race, ethnicity, language (including limited English proficiency), sexual orientation, and gender identity. Based on these disparities, Managed care plans are required have focused efforts to improve health outcomes within the most impacted groups and communities. For the first time, plans will be required to have a Chief Health Equity Officer. Both the managed care plans and their subcontracted health plans will be mandated to achieve National Committee for Quality Assurance (NCQA) Health Equity Accreditation, a new standards program focused on advancing the delivery of more equitable and culturally and linguistically appropriate services across member populations.[11]

California Medi-Cal MCO Requirements to Advance Health Equity
(continued)

In addition, managed care plans are expected to implement new population health management and care management strategies to address the unmet social needs of members and document members' SDOH needs and services. The plans must partner with local agencies (e.g., local health departments, county behavioral health plans, continuums of care, or community-based organizations) to ensure that they understand and meet community needs.[11]

DHCS is adjusting the rates it pays plans based on quality and equity. Since January 1, 2023, DHCS has incorporated performance on ten key quality measures, including chronic disease management, children's preventive care, maternity care, and member experience, to adjust base capitation payments for select health plans. The adjustments are based on both absolute performance on these measures against national benchmarks, as well as degree of improvement compared to prior years. For 2024, DHCS is refining this approach and will also incorporate degrees of health disparities in its adjustments. Plans are now required to report on primary care expenditures, with strengthened requirements related to how much plans spend on medical care and quality improvement activities. Managed care plans and their fully delegated subcontractors with positive net income will also be required to allocate 5 to 7.5 percent of these profits (depending on the level of their profit) to local community activities that develop community infrastructure to support Medi-Cal members.[13] Additionally, if managed care plans and their fully delegated subcontractors do not meet quality outcome metrics, an additional 7.5 percent of these profits must be allocated to these activities.

Impact: California's efforts illustrate one of the most comprehensive approaches to driving health equity improvements, enhancing transparency and accountability, and working locally with partners and community-based providers to address SDOH by using procurement and contracting strategies. These efforts are in the early stages and additional evidence is needed to determine the impact and how these approaches can best be used to improve equity.

Level of Payer Engagement

Diversity of Payer Engagement

Scale

Complexity

North Carolina Healthy Opportunities Pilots

Challenge: While high-quality medical care is crucial, up to 80 percent of a person's health is determined by social and environmental factors.[14] There are some standing authorities to use Medicaid Managed Care funds to pay for non-medical interventions that target social determinants of health (SDOH), but this is optional and occurs at a limited scale. North Carolina needed a mechanism to address social needs across the state.

Approach: North Carolina's Department of Health and Human Services submitted a Section 1115 Medicaid Demonstration waiver to CMS in 2018 that included the Healthy Opportunities Pilots. The Pilots are part of the state's broader transition to NC Medicaid managed care and are testing and evaluating the impact of offering non-medical services on health outcomes and costs in three parts of the state. Medicaid Prepaid Health Plans (PHP) are responsible for managing Pilot enrollees' care management infrastructure, with some care management functions delegated to advanced medical homes and local health departments. Three Network Lead organizations (Access East, Inc., Community Care of the Lower Cape Fear, and Impact Heath), one in each Pilot region, contract with CBOs to cover all domains of services for eligible enrolled members in their region with at least one qualifying physical or behavioral health condition and one qualifying social risk factor. Funding for the Pilots is not part of the PHPs' capitated rates, but rather is paid through a separate Demonstration waiver budget of mostly federal dollars.[14]

To structure the Pilots, DHHS solicited input during a yearlong process to build a fee schedule for non-medical services, including feedback from a technical advisory group and national experts, with support from the Commonwealth Fund.[15] The state held public meetings, solicited written public comments, and facilitated focus groups to obtain feedback on priority SDOH domains, proposed service definitions, pricing methodology, and standardized SDOH screening questions. DHHS engaged PHPs throughout the process to provide input on the pilot components, including the development of the SDOH screening questions, which the state field-tested at 18 clinical sites.[14]

Payer Engagement: Medicaid Prepaid Health Plans (AmeriHealth Caritas North Carolina, Healthy Blue of North Carolina, UnitedHealthcare of North Carolina, WellCare of North Carolina, and Carolina Complete Health). In October 2023, additional specialty managed care plans are expected to launch, including Alliance Health, Eastpointe, Partners Health Management, Sandhills Center, Trillium Health Resources, and Vaya Health.[16]

Initiative: The Pilots cover the cost of the 29 interventions defined and priced in the Department's Pilot Service Fee Schedule, which were selected based on their potential to improve health, lower health care costs, and address four SDOH domains (food, housing, transportation, interpersonal violence or toxic stress).[17]

North Carolina Healthy Opportunities Pilots (continued)

There are several components of the program with standardized multipayer structures or processes, including standardized screening and enrollment tools to support alignment and data consistency. One tool is a short screening with questions about social needs, which plans are required to use to make their "best efforts" to screen all Medicaid managed care standard plan members.[18] If the screening shows a social need and the member has a physical or behavioral health condition, there is then a standard enrollment process to connect members to services.

There is also a standardized technology platform, NCCARE360, to facilitate all referrals and invoicing related to the Pilots. While DHHS does not administer NCCARE360, it was developed through a public-private partnership and is the first statewide resource and referral platform to bridge health care and social services and "closed the loop" to ensure service delivery. Any entity involved in administering the Pilots must use NCCARE360 to make referrals for Medicaid members to encourage a consistent multi-faceted feedback loop. Commercial payers, health providers, and other non-Pilot participants can optionally use NCCARE360, and it is widely used across the state.

Impact: As of April 30, 2023, there are 8,572 people enrolled in the Pilots and more than 61,000 services have been delivered, with anecdotal evidence showing how the Pilots have impacted Pilot enrollees.[19] A key component of these Pilots, and a regulatory requirement of 1115 waivers, is an evaluation design. The University of North Carolina Cecil G. Sheps Center for Health Services Research, in partnership with NC DHHS, is conducting the evaluation including rapid cycle assessments and a robust evaluation at the end of the Pilots. Rapid-cycle assessments will track enrollees' health outcomes and costs to determine which interventions are most and least effective as part of the CMS evaluation. The final evaluation will determine if there is evidence to support systematically integrating Pilot services statewide through NC Medicaid Managed Care.[19] Additionally, Duke-Margolis is conducting an ongoing qualitative evaluation in coordination with NC DHHS and the Sheps Center focused on generating timely guidance on the Pilots' policy design and implementation.[20]

Level of Payer Engagement

Diversity of Payer Engagement

Scale

Complexity

Resources

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Aligning Key Payment Model Components

HCP-LAN Perspective

Multi-payer initiatives benefit from streamlined model components, reducing variation between payer approaches and provider burden from participating in multiple models with different designs. Key model components may span measurement approaches, care coordination approaches, interventions and techniques, technology usage, patient attribution, benchmarking, and risk adjustment. The level of alignment across different components may vary, with some warranting the need for closer alignment than others.

In support of model component alignment, the LAN has established multiple reports, including a synthesis of common design features of successful APMs[1] and recommendations on benchmarking[2] and patient attribution[3] alignment strategies. Across the reports, the LAN outlines how success alignment components can reduce provider burden, promote a culture of collaboration, align quality measurement, and establish common data infrastructure.

For any component, the LAN believes it's important to incorporate clear and actionable information in design to enhance trust and transparency shared between partners across the health care ecosystem. While it may not be feasible for approaches across model components to be identical, directional alignment introduces a balance between multi-payer goals with APM/accountable care goals and payer flexibility. Directional alignment does not require that payers build identical arrangement but emphasizes that alignment is phasic. Alignment over time on design principles can lead to improved accountability and quality in APMs and lower costs in health care.

Approaches to Aligning Key Payment Model Components

Achieving multi-payer alignment on APM design requires decisions about what structural features, or "building blocks," to include in a payment model design. These building blocks include risk adjustment, benchmarking, attribution, quality performance measurement systems, high-value networks and partnerships, APM infrastructure investments, and payer-provider contracting. Alignment does not require payers to build identical arrangements or programs, but they can achieve directional alignment on core concepts. For example, payers can adopt core processes, inputs, and coding that are used in each payer's risk adjustment methodology. The LAN has a series of white papers that provide guidance on these structural features, with the goal of creating consensus on a set of recommendations for use nationally.[1,2,3]

Examples of state approaches include:

Identifying model values for voluntary alignment: Initiative design may start by articulating model goals and the shared values to be included in model components (e.g., defining successful primary care attributes). These model design components may include performance measures, attribution methodologies, or benchmarking standards to create a clear idea of quality care and improvement. Over time, iteratively defining model values can create a shared vision around model design, leading to alignment among participants. For example, a decade-long effort in California led to the development of a collaborative value-based primary care model and a voluntary coalition of large commercial payers committing to primary care alignment through 2025.

Driving alignment across key payment model components through legislative mandate: Mandating alignment through legislation is direct and must be balanced against legal barriers, such as prohibiting payer collusion. States can move toward multi-payer alignment by requiring more transparency in risk adjustment parameters and patient attribution methodologies, without explicitly requiring all payers to adopt an identical model. For instance, Colorado legislation required the development of parameters for all APMs in the state, and the state is currently engaging partners to explore and garner buy-in on alignment provisions.

Incremental reforms through model design flexibility: Not all payers are identical, and Medicaid programs and populations are unique state-to-state. Certain alignment goals are more easily accomplished through legislation, whereas models that require providers to take on substantial risk need to maintain flexibility to incentivize participation. Arkansas used a multi-payer model with three components, including an Episodes of Care model that was constructed to help standardize implementation of episodes across payers. Despite similarities across the implementation of episodes, the model still offers the flexibility to choose which types of episodes to implement and the thresholds for shared savings and payments.

Arkansas Health Care Payment Improvement Initiative

Challenge: In 2010, Arkansas was facing complex fiscal, population, and provider system challenges. Meanwhile, Arkansas's population suffered from pervasive chronic disease and the provider community was fragmented with few formal structural connections between providers and health systems. The state sought to achieve health system transformation built on three underlying assumptions: (1) the trajectory of health care costs was unsustainable, (2) correcting inefficiencies in the system could result in shared savings, and (3) a value-based system needed to replace the traditional fee-for-service model that perpetuated misaligned financial incentives.[4]

Approach: With fewer payers across the state compared to the rest of the nation, and dominated by local plans, Arkansas could more easily achieve alignment across insurers' initiatives and overall health care delivery reform. Arkansas used money through the CMS State Innovation Models (SIM) Initiative to develop the Arkansas Health Care Payment Improvement Initiative.[4] Arkansas engaged a variety of payers through a combination of legislative action and model design flexibility. The SIM funding was integral to creating relationships across the state and establishing the state's ability to convene multi-payer meetings, which facilitated meaningful cooperation and goal alignment between partners across the health care ecosystem.[5]

Payer Engagement: Arkansas Department of Human Services (Arkansas Medicaid), Arkansas Blue Cross Blue Shield, QualChoice, Centene/Ambetter, HealthSCOPE, and United Healthcare. Self-insured payers include Walmart, Arkansas State Employees and Public-School Employees, and Federal Employees Plan.

Initiative: The state set a goal to move most public and private health care expenditures to a value-based system in four years through incremental reform, focusing on priorities in primary and acute care first and addressing Medicaid's antiquated per diem payment methodology and hospital supplemental payments in later stages.[4] AHCPII is a multipayer model with three components:[6]

1. **Multi-payer total cost of care (TCOC) patient centered medical home (PCMH):** Arkansas promulgated a rule that required QHPs participating in the Arkansas Health Insurance Marketplace to enroll members (including the Medicaid expansion population) in PCMHs on or after January 1, 2015, and pay a per member per month (PMPM) fee.

2. **Retrospective episodes of care model:** The state utilized fourteen types of episodes (e.g., surgical intervention and hospitalization management), giving payers flexibility to select which episode worked best for them. For each episode, work groups analyzed Arkansas-specific data, created quality metrics and diagnosis exclusion criteria, determined risk adjustment, defined outliers, and identified potential adjustments based on severity, transfer cases, clinical factors, and facility per diem normalization. The construction and implementation of episodes were largely the same across payers; slight variation occurred in the thresholds for shared savings and payment amounts.

Arkansas Health Care Payment Improvement Initiative (continued)

3. **Medicaid-only health home model:** Designed to provide additional support for some of the most vulnerable populations in the state through independent assessment, tiered provider payments, and accountability for quality targets. The model was met with challenges and Arkansas has since implemented the Provider-led Arkansas Shared Savings Entity (PASSE) Program to better serve these individuals.

Impact: While national and state level PCMH efforts have returned mixed results, Arkansas's multi-payer TCOC approach has experienced marked success.[6] The state succeeded in having both Medicaid and commercial insurers align around VBP models in their provider contracts. Arkansas built sustainability into its SIM model through multi-payer collaboration, full integration of the episodes of care and PCMH models into the state's Department of Human Services, and automation of data efforts.[5] AHCPII's greatest impact, however, may come from the foundation it laid for broader value-based care strategy, and future value-based care initiatives. AHCPII demonstrated that, not only can value-based care be used as a tool to align commercial and Medicaid insurers, but it could serve as a starting point for any future Arkansas initiatives.

Level of Payer Engagement   **Diversity of Payer Engagement**   **Scale**   **Complexity**

Expansion of Value-Based Care Across Arkansas

Challenge: On the heels of the success of the AHCPII, and with the desire to continue to expand value-based care across the state and to address population health disparities, Arkansas enacted legislation paving the way for improved patient care and outcomes.[6]

Approach: In 2013, the Arkansas legislature enacted the Health Care Independence Program (HCIP), which mandated that all QHPs that provide insurance in the Health Insurance Marketplace participate in the state PCMH model and provided specific criteria defining the model.[7] In 2021, additional legislation was passed, under a Section 1115 waiver, requiring QHPs to participate in the Arkansas Health and Opportunity for Me (ARHOME) program, which went into effect in 2023.[8]

Payer Engagement: Arkansas Blue Cross and Blue Shield, Arkansas Department of Human Services (Arkansas Medicaid), and Centene / Ambetter

Initiative: The requirements enacted in the HCIP require QHPs to support population health in Arkansas by:

1. Attributing enrollees to a primary care provider;
2. Providing financial support to patient-centered medical homes to achieve practice transformation milestones; and
3. Supplying clinical performance data to patient-centered medical homes to enable them to address quality and cost of care across the patient's care continuum.

The ARHOME program introduced a new focus on specific patient populations at greater risk for poor health outcomes, including high-risk pregnant women and individuals with mental illness, substance use disorder, or two or more chronic conditions. Under ARHOME, QHPs offer incentives to members or providers to encourage the use of preventive care and improvement in health outcomes as well as incentives to members that encourage advances in economic or employment status for the member.

Additionally, the innovative Life360 HOME program, part of ARHOME, includes an important focus on social determinants of health. In Life360 HOME, the Arkansas Department of Human Services will partner with local hospitals to provide additional support for at-risk populations including women with high-risk pregnancies (Maternal Life360), individuals in rural areas with behavioral health needs (Rural Life360), and young adults at risk for long-term poverty and poor health outcomes (Success Life360).

Expansion of Value-Based Care Across Arkansas

Impact: Arkansas primary care providers joined the PCMH program in strong numbers. With eligible providers currently participating, Arkansas primary care providers (PCP) continue to provide high-value care. Over the years, PCMH providers have continued to outperform their non-value-based peers on key quality metrics, like cancer screenings and chronic condition management (e.g., diabetes, asthma),[9] showing that value-based care has been a critical driver for positive health outcomes in Arkansas. The ARHOME program, new to the state but already having served hundreds of thousands of citizens, has built on the successes of its predecessor, the AHCPII, and is making a positive difference in the lives and health of Arkansans.[6]

Level of Payer Engagement

Diversity of Payer Engagement

Scale

Complexity

The California Advanced Primary Care Initiative

Challenge: Primary care is essential to supporting healthy communities. Studies show that robust systems of primary care can lower the rates of overall health care utilization, disease, and death, and increase the use of preventive services.[10] Across the country, partners across the health care ecosystem are looking towards increased investment and alignment in primary care approaches for improved care and outcomes.

Approach: The California Advanced Primary Care Initiative was formed from a series of combined and cascading efforts in California to support multi-payer alignment in primary care. Between 2016 and 2019, the Purchaser Business Group on Health's (PBGH) California Quality Collaborative (CQC) and the Integrated Healthcare Association (IHA) implemented a statewide technical assistance program (see Providing and Leveraging Technical Assistance for more information) that prompted further collaborative efforts to identify and reward primary care practices that provide advanced primary care.

In 2019, the CQC developed a shared standard for advanced primary care by defining primary care practice attributes and benchmarks.[11] Soon after, IHA partnered with Covered California, RAND, and the California Health Care Foundation (CHCF) to assess primary care spending and health outcomes.[12] These efforts to define high quality primary care attributes and assess primary care spending led to a partnership among CQC, IHA, and payer and provider organizations to form foundational work around shared standards for advanced primary care attributes, measures, and common payment models. A combined, voluntary, and purposeful effort among purchasers and payers from this work culminated in the development of an Advanced Primary Care Measure Set[13] and multiple payers voluntarily committing to the California Advanced Primary Care Initiative through 2025 via a Memorandum of Understanding (MOU).[14]

Payer Engagement: Aetna, Anthem Blue Cross, Blue Shield of California, Health Net, Oscar, and UnitedHealthcare

Initiative: The Advanced Primary Care Measure Set includes 13 measures across five domains—health outcomes and prevention, patient reported outcomes, patient safety, patient experience, and high value care. In addition to the adoption of the measure set, the Memorandum of Understanding outlines four commitments for scaling advanced primary care and a roadmap to achieving progress through 2025. Select features include:

- **Transparency:** Report data for overall primary care investment, measures in the Advanced Primary Care Measure Set, and visibility into performance variation and progress toward value-based care arrangements;

- **Primary Care Payment:** Adopt a common value-based payment model and process to match patients to a primary care provider for comprehensive primary care arrangements;

The California Advanced Primary Care Initiative (continued)

- **Investment:** Collaboratively set a target for the percent of total health care spend dedicated to primary care without increasing total cost; and

- **Practice Transformation:** Explore shared opportunities for improvement across all lines of business along three dimensions of health care transformation: behavioral health integration, Race, Ethnicity, and language data, and technical assistance for expanded access to health care services and data-driven care.

The Initiative and adoption of the measure set has been supported through the neutral convening of CQC and IHA. The payers and conveners entered into the MOU committing to activities to implement the advanced primary care roadmap and to meeting regularly to share progress.[15] The collective understanding created through the MOU provides accountability and shared success among participants. While not part of the MOU, California's largest public purchasers—Covered California, Medi-Cal, and CalPERS—have complimented the efforts with voluntary alignment in select contract provisions, including reporting on primary care spending, consideration of a target floor for primary care spending, reporting on primary care payment models, increasing adoption of value-based models for primary care, and reporting on the payment model for primary care in each health plan's five largest contracted physician organizations.[16]

Impact: The California Advanced Primary Care Initiative illustrates the power and possibility of a voluntary commitment established by a shared vision. The efforts leading towards the MOU formed from many years of overlapping work for collective action and impact to improve the health of Californians. Pilot results from the Primary Care Measure Set are anticipated in Fall 2023.

Level of Payer Engagement

Diversity of Payer Engagement

Scale

Complexity

Colorado House Bill (HB) 22-1325: Primary Care Alternative Payment Models

Challenge: While Colorado has a strong history of multi-payer alignment in support of primary care, as evidenced by participation in several Center for Medicare & Medicaid Innovation demonstration models and the formation of the Colorado Multi-payer Collaborative, by 2021 the path for continued alignment of commercial and public health plans was less clear. As payers increasingly utilized their own APMs, each with its own requirements and attributes, guardrails were needed to promote alignment and ensure health equity was incorporated into APM design for primary care.[17]

In 2019, Colorado enacted legislation (HB 19-1233) creating a Primary Care Payment Reform Collaborative that is tasked with making recommendations on how to increase the state's investment in its primary care infrastructure.[18] Based on recommendations from the Collaborative, in 2021 DOI promulgated Regulation 4-2-72,[19] which requires a one percent increase in primary care investment in Calendar Years (CY) 2022 and 2023 and sets targets for total medical expenditures in APMs. However, the Collaborative and the Division jointly recognized that for APMs to be successful and scalable in improving outcomes and reducing costs, greater alignment is needed between commercial and public payers.

Approach: During the 2022 regular session, Governor Polis signed HB 22-1325, which requires the DOI to collaborate with fellow states agencies, the Collaborative, health insurance carriers, and providers participating in APMs to develop and promulgate rules establishing aligned APM parameters for primary care services offered through health benefit plans.[20] By December 1, 2023, the commissioner of insurance must promulgate rules detailing the requirements for APM parameter alignment.

Payer Engagement: For all healthcare plans that are issued or renewed on or after January 1, 2025, each carrier's alternative payment models for primary care must incorporate the aligned alternative payment model parameters created by DOI.

Initiative: As outlined in the bill, the alternative payment model parameters must:[19]

- Include transparent risk adjustment parameters that ensure that primary care providers are not penalized for or disincentivized from accepting vulnerable, high-risk patients and are rewarded for caring for patients with more severe or complex health conditions and patients who have inadequate access to affordable housing, healthy food, or other social determinants of health;

- Utilize patient attribution methodologies that are transparent and reattribute patients on a regular basis, which must ensure that population-based payments are made to a patient's primary care provider rather than other providers who may only offer sporadic primary care services and include a process for correcting misattribution;

Colorado House Bill (HB) 22-1325: Primary Care Alternative Payment Models (continued)

- Include a set of core competencies around whole-person care delivery that primary care providers should incorporate in practice transformation efforts; and

- Require an aligned quality measure set that considers the quality measures and the types of quality reporting that carriers and providers are engaging in under current state and federal law and includes quality measures that are patient-centered and patient-informed and address: Pediatric, perinatal, and other critical populations; the prevention, treatment, and management of chronic diseases; and the screening for and treatment of behavioral health conditions.

Impact: Per the legislation, once DOI has five years of data, they are required to analyze the data, produce a report on the data, and present the findings to the general assembly during the department of regulatory agencies' presentation to legislative committees at hearings. Colorado will also conduct an evaluation at the end of CY 2023 that measures the change in proportion of expenditures on primary care. The rules and regulations enacting aligned APM parameters which were established by HB 22-1325 puts the Colorado health care system in a position to more easily achieve multi-payer alignment.

Level of Payer Engagement

Diversity of Payer Engagement

Scale

Complexity

North Carolina Medicaid Enrollment Process: Patient Choice

Challenge: As North Carolina transitioned to a Medicaid managed care model, the state needed a process to enroll beneficiaries in participating plans. Because most Medicaid primary care providers receive prospective PMPM payments for medical home infrastructure and care management and many are held responsible for health quality measures in accountable care arrangements, it's critical that beneficiaries are accurately assigned (used for coordinating care delivery) and attributed (used to calculate quality and performance) to a primary care provider.

Approach: With the transition to Medicaid managed care starting in North Carolina on July 1, 2021, the state needed an aligned assignment process, with the goal to prioritize personal choice. To meet their goal, North Carolina instituted a methodology allowing beneficiaries to choose their plan. Health plans were made aware of the enrollment process and, once a plan was selected or assigned, were responsible for the assignment process of beneficiaries to providers.

Payer Engagement: Medicaid Prepaid Health Plans (AmeriHealth Caritas North Carolina, Healthy Blue of North Carolina, UnitedHealthcare of North Carolina, WellCare of North Carolina, and Carolina Complete Health). In October 2023, additional specialty managed care plans are expected to launch, including Alliance Health, Eastpointe, Partners Health Management, Sandhills Center, Trillium Health Resources, and Vaya Health.

Initiative: If health plan selection is not made by a beneficiary, then a series of criteria are considered to enroll Medicaid beneficiaries in a health plan, including geographic location, special population, historical physician, family health plan assignment, previous health plan enrollment, and, if none of those criteria lead to an assignment, then the patient is assigned to a health plan based on a rotating selection process.[21] When selecting a plan, beneficiaries may also start by identifying a preferred primary care provider, and subsequently determining a health plan based on which health plans the provider accepts (a process often supported by the NC Medicaid Enrollment Broker). Once selected or assigned, information is shared with the plan, which then does the provider assignment and shares with the providers. During the initial process of determining patient assignment, plans were given the opportunity to provide feedback to Medicaid, in compliance with departmental and federal regulations.

Impact: Since Medicaid managed care launched in July 2021, North Carolina has enrolled over 1.8 million patients in managed care plans using the patient choice assignment process.[22] Data from May 2021 indicated that 97% of patients were enrolled in a plan that included their current provider in network.[23] The process has illustrated the importance of having accurate underlying data on both members and providers so that Medicaid agency and members have clear processes for implementing assignment changes or corrections.

Level of Payer Engagement	Diversity of Payer Engagement	Scale	Complexity

Resources

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Timely and Consistent Data Sharing

HCP-LAN Perspective

Increased data sharing and interoperability can improve health outcomes by improving benchmarking capabilities, care coordination between providers, and up-to-date quality reporting. As the adoption of APMs increases, increasing data sharing infrastructure is equally as important.

Building successful data sharing infrastructure requires coordination between partners across the health care ecosystem, including patients, providers, payers, and data aggregators. In order to gather information about building data sharing capacity, the LAN convened the Value-Based Data Sharing Requirements Initiative (DSRI) to compile best practices and recommendations.[1] The report emphasizes the importance of building data governance, articulating data sharing barriers, and emphasizing data sharing sustainability. It also suggests strategies for effectively collaborating with external partners.

To build momentum towards data capabilities, the LAN considers two primary areas of focus in the Accountable Care Curve: data capture and analysis, including utilizing of multiple data sources (i.e., clinical, claims, and SDOH) for population health improvement, and improving data infrastructure, including sending, receiving, and reconciling data from multiple/aggregated sources through interoperable data exchanges.[2] Each organization faces unique technical and operational challenges to building data sharing capacity. Addressing these issues collectively can increase the availability of patient information, reduce redundancies in care, facilitate smooth hand-offs between providers, and enable providers to work with patients on care management, even when they are away from care facilities.

The LAN believes that by collecting data from across different systems and making it accessible, health care providers can gain a more comprehensive view of each patient's medical history, current condition, and treatment plan in real-time. The ability to access, match, reconcile, and use patient data generated by different systems enables better patient care and engagement.

Approaches to Timely and Consistent Data Sharing

Streamlining data reporting from multiple payers allows providers to more easily assess next steps and determine priority actions. ACOs and providers can deliver more efficient, higher quality, safer, and more personalized care and care coordination when they have access to up-to-date health data, including information on admissions, discharges, and care transitions for their attributed beneficiaries. Receiving the information electronically allows for portability into office workflows to further enhance the efficiency and effectiveness of data-driven interventions, leading to improvements in health care outcomes.

Examples of state approaches include:

Use of a health information exchange (HIE): The purpose of HIEs is to improve the quality, coordination, and cost effectiveness of health care in their communities. Despite that simple concept, HIEs vary greatly in their organization, geographic coverage, and services. Due to the administrative challenges posed by gaining buy-in from providers and payers, mandating or incentivizing use is one way to increase participation in and utility of HIEs.

Implementation of a data exchange framework: Coordinated data sharing frameworks help organize and centralize the exchange of data in cases where it may otherwise be siloed. The exchange of data can sometimes remain stagnant because it is often voluntary, and without guidance and entities' commitment, there is little incentive to exchange data. By providing standards and policies for the mass-exchange of health data, payers, hospitals, providers, and public health systems can overcome this collective action problem in coordination with relevant HIEs to meet performance goals and improve population health. Stratifying this data also provides the opportunity to better understand existing health disparities on a system-wide level.

Incorporation of social service providers into the health information exchange or equivalent data-sharing mechanism: State and regional HIEs tend to provide tools and services to traditional health care institutions like hospitals, practices, payers, long-term and post-acute care providers, and public health organizations. However, HIEs and other data-sharing mechanisms are evolving to incorporate local social service or CBOs like those that address food, housing, and other environmental issues.

Bulk Fast Healthcare Interoperability Resources (FHIR) API

Challenge: The amount of data exchanged throughout the health care industry and the availability of new data has grown rapidly. As a result, there has been a major gap in providers' ability to quickly share data in real time, and consumers' ability to have easy access to their health data. Of particular concern was the large-scale transfer of health data between systems, which the recently developed Health Level Seven (HL7) FHIR standard did not solve. As a result, the Bulk FHIR Application Programming Interface (API) was designed specifically to handle and transfer large data sets, allowing clinician to easily access and analyze data on groups, cohorts, and populations.[3]

Approach: When FHIR started development in 2012, it sought to standardize the storage and sharing processes of health data. Once these practices were put into place, it become clear that there was still a need for development of a bulk data API to ease the process of exchanging larger datasets. Five years later, the HL7 community began to explore the feasibility of such an API, and by the end of the year, they concluded that Bulk FHIR was both achievable and worth the research and development costs. The first version of Bulk FHIR was published two years later. This first version included operations for querying data from all or select groups of patients, creating a more efficient file format for streaming data, and building capabilities for asynchronous requests to kick-off a bulk data export. Since then, the API has undergone multiple rounds of testing and feedback, and second version was released in 2021.[4]

Initiative: At its core, FHIR is a standardization of health records and information which allows for greater and faster exchange of data between health care providers. Bulk FHIR allows not only for this information to be sent in batches at a population level, but to be queried as well, providing health care professionals not just with raw data, but the ability to manipulate and analyze the data to draw powerful conclusions about their patients. Bulk FHIR's advancement of value-based care is centered around its role in optimizing the transfer of patient data between health care providers and being able to process EHR from a multitude of sources in a standardized and secure manner. Bulk FHIR also provides quick, automated updates to data sets, so providers can pull data daily and have the most up-to-date records.[3]

Impact: In the four years since the first version was released, Bulk FHIR has already had an impact on the health care industry. CMS is using Bulk FHIR to send beneficiaries' claims data to health care providers and ACOs to help improve health outcomes and lower costs. Specifically, CMS has been delivering large datasets of Medicare fee-for-service claims under the Data at the Point of Care pilot and Beneficiary Claims Data API.[3] The Bulk Data IG has also been implemented in several commercial products in the Office of the National Coordinator for Health Information Technology (ONC) Certification Program. With ONC continuing to fund the development of open-source tools like a library for bulk data tools and a bulk data testing suite, Bulk FHIR is set continue to address the industry's ability to access, transfer, and analyze large-scale datasets.[3]

The State Health Alliance for Records Exchange

Challenge: As the adoption of APMs grow, providers need to track patient and measure outcomes. With the breadth of electronic data available, it is difficult for providers to monitor outcomes. Data is often received in various formats and cadences across payer lines, contributing to administrative burden among providers. In Arkansas, payers have convened around the statewide HIE to address this challenge.

Approach: The Arkansas Office of Health Information Technology (OHIT) established the State Health Alliance for Records Exchange (SHARE), a statewide health information exchange (HIE), in 2018.[5] As the state-run HIE, SHARE became an organization for payers to come together to understand how data could support their population health management. The focus on data needs began with the Comprehensive Primary Care (CPC) Initiative and a workgroup of various payers. This multi-payer group met regularly and started to assess technologies readily available to address some of the data challenges. Options included forming new partnerships with data vendors or creating new databases. Ultimately, the multi-payer group decided to focus efforts on SHARE, Arkansas's existing HIE, and determined it was a viable option that could support the existing needs. Now, most payers participate with SHARE, which offers both payers and providers access to patient encounter data.

Payer Engagement: Most Arkansas payers have existing relationships with SHARE, which vary from suppliers of data to suppliers and users of aggregated data. Payers also convened with Medicare under Comprehensive Primary Care Plus (CPC+) and Primary Care First (PCF) Models around data sharing.

Initiative: Arkansas payers enabled easier data review by submitting attribution files to SHARE for provider routing. SHARE began using these rosters to map provider-patient relationships and send encounter data to providers at a uniform cadence and format that worked best for each provider. Through this alignment, providers attain a comprehensive view of patient care encounters and patterns. Providers can now track performance outcomes in real time to understand anticipated measure performance, rather than waiting months for claims data. In turn, payers also receive the data back to track performance measurement, rather than reconciling data from different practices.

Impact: Because SHARE receives and reconciles widespread payer data, providers do not have to go through the effort of submitting their own rosters to receive data or reconciling multiple payer reports. Together, these alignment strategies significantly reduce administrative burden for providers, enhance the focus on utilization of data for action, and enable APM expansion. There are currently 116 hospitals connected to SHARE, 2,941 facilities contributing data to SHARE, and 763 facilities retrieving data from SHARE. Hospitals, providers, nurses, care coordinators, behavioral health workers, and other health care professionals are using SHARE to provide their patients with the best possible care.[5]

Level of Payer Engagement

Diversity of Payer Engagement

Scale

Complexity

California's Health and Human Services Data Exchange Framework

Challenge: While parts of California's health care system rely on coordinated, interoperable electronic systems, other parts still operate in decentralized, manual, and siloed systems of clinical and administrative data exchange that are voluntary in many situations. The voluntary patchwork makes it difficult to provide whole-person care, address rising homelessness, addiction, and mental health issues, and provide consumers with full access to their own medical records. In addition, a lack of clear policies and requirements to share data between payers, providers, hospitals, and public health systems is a significant hindrance to addressing public health crises.[6]

Approach: In July 2021, California Governor Gavin Newsome signed Assembly Bill (AB) 133, which directed the California Health and Human Services Agency (CalHHS) to develop a Data Exchange Framework (DxF) by July 1, 2022.[6] CalHHS convened a series of focus groups to capture diverse perspectives, ultimately engaging over 50 strategic, technical, and operational experts inside and outside of California representing HIE organizations, consumer privacy advocates, health care providers, health plans, human service organizations, and California state agencies and departments. CalHHS also reviewed and considered comments received during and outside of the formal public comment periods.[6]

Payer Engagement: An advisory group and other subcommittees/focus groups included representatives from Kaiser Permanente, Partnership HealthPlan of California, Blue Shield of California, Local Health Plans of California, Health Net, Contra Costa Health Services, and Health Plan of San Mateo.

Initiative: The Governor and Legislature established several phases for implementing these new data exchange rules, starting with the adoption by CalHHS of the Data Sharing Agreement (DSA) and Policies and Procedures by July 1, 2022. AB 133 requires certain health care entities to execute the final agreement by January 31, 2023, including general acute care hospitals, physician organizations and medical groups, skilled nursing facilities, health service plans and disability insurers, Medi-Cal managed care plans, clinical laboratories, and acute psychiatric hospitals. By January 2024, health care entities will be required to begin exchanging health information in real time—with each other and with public health and social services—for treatment, payment, and/or health care operations.[6]

Impact: Over 1,400 organizations signed the CalHHS DxF Data Sharing Agreement by the January 31, 2023, deadline. The guiding principles for the DxF include advancing health equity, making data available to drive decisions and outcomes, supporting whole-person care, promoting individual data access, and reinforcing individual data privacy and security.[7]

Level of Payer Engagement   **Diversity of Payer Engagement**   **Scale**   **Complexity**

Increasing Statewide Interoperability: Colorado HIE Partnership and Evolution

Challenge: As electronic data systems grow, interoperability—the exchange of data between systems—is an important piece of improving the effectiveness of data. The Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted as part of the American Recovery and Reinvestment Act of 2009, creating an unprecedented opportunity to enable interoperability. The initial goal of focusing on interoperability was to develop HIE networks that connect historically disjointed EHR systems to one another. Under HITECH, Colorado improved the interoperability of EHR data, especially hospital data, which lead to improvements in hospital-centered performance measurement and enabled providers to gain a more comprehensive view of their patients' medical history. In recent years, an increasing focus on holistic client health, including the integration of social care into the delivery model, has increased the need to integrate non-clinical data sources into the data sharing landscape.

Approach: The social care landscape is much less standardized than the current health care landscape. Many types of organizations participate in the social care system, all of which have varying levels of technical expertise and different suites of available tools. The Metro Denver Partnership for Health (MDPH) is one of these regional organizations, many of which share the same goal: to better coordinate local services to support individuals and families and work to advance an interoperable S-HIE ecosystem across the state.[8]

In April 2021, the Colorado Health Institute (CHI) convened and facilitated focus groups and key informant interviews with public health agencies, health systems and hospitals, CBOs, community members, human service agencies, Regional Accountable Entities, and technical organizations. The focus groups and interviews provided insights that shaped a value proposition[7] for an S-HIE and established an integrative governance structure where all partners share in decision-making, responsibilities, and activities to advance the development, implementation, and sustainability of an interoperable S-HIE.[9]

Payer Engagement: Kaiser Permanente, Colorado Access, Colorado Community Health Alliance, Rocky Mountain Health Plans, Northeast Health Partners, and HCPF

Initiative: Current interoperability efforts in Colorado are focused on the S-HIE. Colorado aims to increase interoperability and data sharing without forcing significant changes to health care or social care provider experience. Instead, the goal is to let providers stay in their preferred system of record, reduce administrative burden on providers and patients, and make it easier to deliver social care.

Increasing Statewide Interoperability: Colorado HIE Partnership and Evolution (continued)

As a result, the S-HIE interoperability approach must be highly flexible, vendor agnostic, and adaptable as this landscape emerges and evolves. In recognition of this need, the State of Colorado, led by the Office of eHealth Innovation, is taking a two-pronged approach. The statewide unifying architecture will connect disparate data sources, and focus on interoperability, flexibility, and data governance. The second prong strategy is to fund regional infrastructure and partnership building for priority use cases that are customizable to the priorities of the region. This contract will be announced by Fall of 2023.

Impact: Improved interoperability can reduce provider burden, improve data sharing, and grow success in accountable care arrangements. Improved tracking of patients relieves burden for practices, while also enabling greater success in accountable care programs by giving providers the opportunity to better track patient outcomes. Additionally, better engagement and traction with payers, practices, and aggregators improves collaboration and involvement in data initiatives.

Level of Payer Engagement

Diversity of Payer Engagement

Scale

Complexity

NCCARE360

Challenge: SDOH play a substantial role in people's health and the medical care they receive. Health care providers often do not have the resources to connect their patients to the social and human services, or the CBOs that could assist them.[10]

Approach: NCCARE360 is the result of a strong public-private partnership between the DHHS and the Foundation for Health Leadership & Innovation (FHLI).[11] NCCARE360 is an important component in DHHS' Healthy Opportunities strategy and integral to DHHS' mission is to improve the health, safety, and well-being of all North Carolinians. The NCCARE360 implementation team includes United Way of North Carolina/NC 211, Unite Us, and Expound Decision Systems.

United Way of NC/NC 2-1-1 connects individuals and families across North Carolina to free and confidential information on local health and human services resources, through a simple dialing code 2-1-1, and a statewide resource database and call center. Unite Us provides the care coordination and outcomes platform for NCCARE360 that allows health care providers, CBOs, and others to work together securely in real time. Expound Decision Systems has created a data repository model, which is being used to manage resources specific to addressing the SDOH in North Carolina.

Payer Engagement: All payers can use NCCARE360, with PHPs required to use it for the Healthy Opportunities Pilots (plans include AmeriHealth Caritas North Carolina, Healthy Blue of North Carolina, UnitedHealthcare of North Carolina, WellCare of North Carolina, and Carolina Complete Health). In October 2023, additional specialty managed care plans are expected to launch, including Alliance Health, Eastpointe, Partners Health Management, Sandhills Center, Trillium Health Resources, and Vaya Health.

Initiative: While other states have negotiated cross-sectoral referral technology platforms on a regional scale, North Carolina was the first to create a statewide network that unites health care and human services organizations with a shared technology, enabling a coordinated, community-oriented, person-centered approach for delivering care in North Carolina. NCCARE360 helps providers electronically connect those with identified needs to community resources and allows for feedback and follow up. This solution provides accountability for services delivered, allows for a "no wrong door" approach, closes the loop on every referral to confirm patients are receiving the support they need, and reports outcomes of that referral connection.

Impact: As of January 11, 2023, more than 100,000 North Carolinians have been referred to services through the NCCARE360 platform. More than 3,000 organizations have been onboarded onto the platform and there are 7,500 active programs to which referrals can be made. Platform trends show that the top five service needs by volume statewide are food assistance, housing and shelter support, individual and family support (e.g., childcare assistance), income support (e.g., emergency/one-time financial assistance), and utility bill payment assistance.[10]

Level of Payer Engagement   **Diversity of Payer Engagement**   **Scale**   **Complexity**

NC Medicaid's Partnership with NC HealthConnex: Improving Quality Measurement

Challenge: Under North Carolina Medicaid's current structure, some key data elements used for Medicaid programs are incomplete, non-standardized, and duplicative across multiple sources. Providers must send and report data in multiple formats and interface with each Medicaid PHP and receive plan-specific extracts in return. This lack of standardization leads to increased administrative burden and siloed data use by both providers and plans.

Approach: NC Medicaid has partnered with NC HealthConnex, North Carolina's statewide HIE, to undertake efforts to increase interoperability and improve data quality for Medicaid quality measurement. North Carolina is developing a data strategy to improve the quality measurement of the data being exchanged while focusing on reducing burden, aligning with CMS objectives, and supporting North Carolina priorities. These priorities include improving data collection and use for behavioral health (e.g., depression screening data), child and family well-being (e.g., addressing health-related social needs), and health equity (e.g., addressing disparities). Through this proposed process, North Carolina aims to reduce data sharing burden and increase access to near-real-time, actionable data.[12]

Payer Engagement: NC HealthConnex has partnered with NC Medicaid to provide clinical data extracts to PHPs (plans include AmeriHealth Caritas North Carolina, Healthy Blue of North Carolina, UnitedHealthcare of North Carolina, WellCare of North Carolina, and Carolina Complete Health). In October 2023, more PHPs will launch, including Alliance Health, Eastpointe, Partners Health Management, Sandhills Center, Trillium Health Resources, and Vaya Health. North Carolina will continue to engage its PHPs throughout the development of the proposal described below.

Initiative: NC Medicaid is interested in improving the quality of key data elements from NC HealthConnex in order to support quality measurement and eventually move toward greater interoperability. In the initial pilot, North Carolina is focusing on improving data collection, quality, and monitoring for three measures: Controlling High Blood Pressure (CBP), Hemoglobin A1c Control for Patients with Diabetes (HBD), and Screening for Depression and Follow-Up Plan (CDF).[13] North Carolina hopes that this pilot effort can lay the groundwork for digital quality measurement and increased data exchange.

To achieve improvement in reporting and measure results, North Carolina is launching an effort to increase the completeness and standardization of data submitted by providers. As a first step, North Carolina is conducting exploratory work, such as engaging external quality reviewers, to better understand current gaps in the data. Moving forward, North Carolina hopes to engage providers and PHPs to identify solutions and develop new policies as needed. NC Medicaid is also considering implementing provider coaching, provider incentives, and technical assistance to support improved data quality and required technology updates. When providers meet data completeness and quality benchmarks that enable interpretation and analysis by other providers, payers, and Medicaid, NC Medicaid envisions that PHPs will access clinical data for quality measure reporting via NC HealthConnex rather than collecting data directly from providers.[13]

NC Medicaid's Partnership with NC HealthConnex: Improving Quality Measurement (continued)

Impact: In 2020, North Carolina started increasing the measure data available for CBP, an NCQA Healthcare Effectiveness Data and Information Set (HEDIS) measure that assesses adults 18 and older with a diagnosis of hypertension whose blood pressure was adequately controlled at less than 140/90. Prior to the use of NC HealthConnex data, under a process that only reported annually using claims and encounter data, the CBP rate of Medicaid adult members was 4.6%. After launching a hybrid method (claims/encounter data combined with electronic clinical data via NC HealthConnex), rates improved to 20%. NC Medicaid attributes this increase to the improved data accuracy and expects that this rate will continue to increase as a result of its data quality improvement initiatives. Eventually, NC Medicaid hopes to move toward digital quality measurement, in which data is compiled from multiple sources for real time, actionable use. Providers will be better enabled to improve CBP performance by using the most up-to-date data in patient care, instead of waiting on annual results based off claims data. Today, NC HealthConnex hosts more than 9 million unique patient records, with over 90% of Medicaid beneficiaries represented in HIE data.[14]

Looking forward, there are substantial additional opportunities to improve data quality and grow the use of NC HealthConnex for NC Medicaid use cases. North Carolina will begin some of its exploratory work with external quality review organizations in Summer 2023, the results of which will drive future efforts to develop standards and solutions. Impact analyses will be conducted as additional data is incorporated into the NC HealthConnex platform.

Level of Payer Engagement

Diversity of Payer Engagement

Scale

Complexity

Resources

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Providing and Leveraging Technical Assistance

HCP-LAN Perspective

Technical assistance helps to advance multi-payer alignment by providing partners with the support needed to advance their alignment or payment reform goals. Technical assistance approaches, which include but are not limited to activities such as research, outreach/convening support, training and education, peer-to-peer learning collaboratives, subject matter expertise provision, one-on-one support, and/or workgroup development, facilitate the dissemination of best practices and evidence-based steps and resources needed to accelerate progress, particularly for smaller organizations and local communities with limited resources.

Since its launch, the LAN has provided technical assistance support, starting with the establishment of the Primary Care Payer Action Collaborative (PAC)[1] as a forum for public and private payers in CPC+[2] to accelerate the adoption and sustainability of APMs in primary care. The PAC convened national payers and identified common challenges to primary care APM implementation across regions in key technical domains, which included data sharing systems, quality measurement implementation, and benchmarking and patient attribution strategies. The LAN developed a series of events and collaborative learning agendas to address the priority topic areas and support payers' implementation efforts.

The LAN believes that multi-payer initiatives are most successful with complimented with forums that convene organizations across the health care ecosystem, including providers, health plans, CBOs, state/local governments, and employers, to come together to collectively address health care challenges. These forums can inform approaches by identifying the highest priority topics and challenges for specific payers or regions and building them into larger, national goals over time.

Approaches to Providing and Leveraging Technical Assistance

Technical assistance can advance the impact of multi-payer efforts by circulating promising practices within the community of participants as well as using the collective learning to build tools and resources that accelerate multi-payer alignment more broadly. Support tied to a pilot or program can be more formal, through structured learning, resource repositories, or a data results dashboard; however, states have demonstrated that forming informal multi-payer collaboratives can also effectively provide knowledge sharing and technical assistance.

Examples of state approaches include:

Build upon national-level support tied to a pilot or program: As Duke-Margolis notes in their Multi-payer Alignment Framework, leveraging national resources makes it easier for states to develop their own approaches to multi-payer alignment. Innovation Center model participation accelerates the sharing and learning from promising practices by creating a three-way channel of learning and engagement—from CMS to model participants, from model participants back to CMS, and among model participants. Technical assistance such as research, quality improvement toolkits, and evidence-based practices can also be more easily disseminated when supported by CMS investments.

Organize informal collaboratives with payer communities outside Innovation Center models: Payers that have previously been supported through Innovation Center model investments, resources, and technical assistance can maintain connections by forming independent multi-payer and provider collaboratives. Informal learning systems allow payers to candidly share challenges as well as success stories. It offers more flexibility to choose topics of interest, pose questions more directly, and circulate helpful resources. When driven by a commitment to advancing value-based care, voluntary engagement in regional alignment efforts can sustain the value of cross-state learning and drive toward national alignment.

Use Medicaid waiver programs to develop evidence-based best practices: Medicaid waiver programs support multi-payer alignment at a smaller scale and provide tailored resources for specific conditions or patient populations. Regional payers, who have a robust understanding of the nuances of the local health care market, can engage more deeply with providers, consumers, human service organizations, schools, and other community resources but have the flexibility to make iterative improvements to pilot services. Sharing best practices through multi-payer initiatives accelerates the distribution of new knowledge for a greater impact on population health and reducing health disparities. Successful waiver programs can also signal areas of focus for future Innovation Center models so states can be prepared to respond to shifts in CMS strategic directions in the future.

CMS Innovation Model Learning Systems

Challenge: CMS Innovation Center models test new health care payment and service models to improve patient care, lower costs, and better align payment systems to promote patient-centered practices. Participation in CMS Innovation models requires that providers, payers, and/or community partners ("participants") sign a Participation Agreement (PA) or equivalent agreement to be eligible for related support and payment. The PA or equivalent commits model participants to a set of requirements to maintain compliance with these requirements in order to remain in the model and receive related payments. The Innovation Center continually evaluates quality of care and changes in spending in each model, for which Innovation Center gathers and reports on lessons learned and best practices.

Approach: Across models, the Innovation Center invests in the provision of education, outreach, and technical assistance through the design, implementation, and monitoring of model learning systems. Learning systems are a structured approach to sharing, integrating, and actively applying quality improvement concepts and tactics along with new information and new knowledge on what works, and what doesn't work, to support achieving the model aim. An effective learning system creates a three-way channel of learning and engagement: from the Innovation Center to model participants, from model participants back to the Innovation Center, and among model participants. The Innovation Center's approach to model learning systems is operationalized through seven core functions: drivers of model success; technical assistance; use of data for improvement; assessment and feedback; model performance measurement; tools to capture and support performance; and learning communities.

Initiative: The Innovation Center's learning systems and related technical assistance are currently available to model participants. Model learning systems offer a variety of modalities through which participants can learn and share promising practices, including but not limited to:

- Virtual events: Webinars/virtual classes, office hours/open forums, technical expert panels;
- Print materials: Factsheet/flyer, infographic/print material, Frequently Asked Questions (FAQ) document, quick reference guide;
- Multimedia products: Videos/vignettes, podcasts, eLearning modules;
- Evidence-based resources: Change packages, case studies; and
- Collaboration opportunities: Platform to house related resources and host dialogue, affinity groups, action groups, huddles, annual meetings.

Impact: Learning systems engage participants in peer-to-peer dialogue and shared learning, and as a result increase participant understanding of model requirements (including care delivery requirements) and payment structures, increase participant compliance, mitigate model retention, and support achievement of model outcomes. Target model outcomes include beneficiary and population health improvement, cost reduction or maintenance, and continuous quality improvement.

Arkansas Multi-state Multi-Payer Collaborative

Challenge: Since 2011, Arkansas Blue Cross and Blue Shield, Blue Cross and Blue Shield of Kansas City, and Blue Cross and Blue Shield of Oklahoma (hereon referred to as BCBS plans) have engaged in a regional, multi-payer learning and technical assistance effort. The effort started as an initiative to stay connected, share lessons learned, and demonstrate best practices related to the CPC Initiative, but now the Collaborative has spanned two additional Innovation Center models (CPC+ and PCF) and expanded to include Centene as a participant. What began as a multi-state effort specific to BCBS plans and a single Innovation Center model has since grown organically and is continuing to expand.

Approach: The agenda for the monthly and often virtual convening of payers is driven by the payers themselves and includes both PCF and non-PCF-related topics. Payers candidly share challenges as well as success stories, pose questions to one another, and circulate helpful resources. The meetings are coordinated and led by Arkansas. The initiative is an example of how effective learning and technical assistance can occur even in the absence of sustained funding or infrastructure, if leadership across payers realize sustained value and remain committed to the cause.

Payer Engagement: Arkansas Blue Cross and Blue Shield, Blue Cross and Blue Shield of Kansas City, and Blue Cross and Blue Shield of Oklahoma, Centene, and Arkansas Department of Human Services (Arkansas Medicaid)

Initiative: Recent meetings have explored the following topics:

• Effective techniques for increasing participation of providers in APMs and patient centered medical home (PCMH) programs;
• Approaches to primary care spending legislation;
• Multi-payer participation in health information exchanges and related efforts to improve data quality and reduce provider burden;
• Sustainability of data aggregation and feedback for providers; and
• Reducing provider burden through a multi state quality and utilization measure collaboration.

Impact: The group's effectiveness as a source of learning and technical assistance across payers has increased interest in participation from additional payers outside of the region. Together, the group has benefited from the expertise of each participating organization in the areas of value-based care, practice transformation coach skill development, HIE support, and multi-payer alignment.

Level of Payer Engagement	Diversity of Payer Engagement	Scale	Complexity

California Quality Collaborative: Practice Transformation Initiative

Challenge: CMS launched the Transforming Clinical Practice Initiative (TCPI) in 2015 to provide technical assistance to more than 140,000 clinicians (both primary and specialty care) over a four-year period in sharing, adapting, and further developing their comprehensive quality improvement strategies. TCPI created a nationwide, collaborative, and peer-based learning network designed to prepare practices to successfully participate in value-based payment arrangements. The California Quality Collaborative (CQC) was selected as one of 41 organizations nationally.[3]

Approach: The CQC, a program of the Purchaser Business Group on Health (PBGH) partnered with the Center for Care Innovations (CCI) and the Integrated Healthcare Association (IHA) to execute the Practice Transformation Initiative (PTI). They sought to include a diversity of provider organizations that included organizations at all phases of learning and capacity building. Inclusion of independent physician associations (IPA) with limited infrastructure and capacity offered the opportunity to fill a gap in knowledge about how practice transformation happens in these settings, and which change elements are most impactful.[4]

Payer Engagement: All health plan sponsors of the CQC, and Molina Health Care of California directly participating in the technical assistance

Initiative: The PTI offered four key components of technical assistance – training and seed funding, in-person convenings, virtual learning, and data systems support. CQC trained practice facilitation coaches hired by participating organizations—medical groups, IPAs, community health centers and health plans—to redesign care at 2,000 clinician practices based on the 10 Building Blocks of High-Performing Primary Care. Quarterly meetings with organization leaders fostered peer-to-peer learning to accelerate progress. PTI also offered individualized coaching for each organization, virtual learning sessions, a data results portal and an online community. At the end of the program, CQC created an online library sourced with tools, resources, and content from the four-year program.[4]

Impact: The PTI fundamentally changed the approach to providing technical assistance and support at a broad scale in California. The project established key components that are necessary to drive change and demonstrated that this type of work is more than worth the up-front investment of resources. This work led to shared standards of Advanced Primary Care (both attributes and quality measures) that have manifested in the multi-payer alignment effort, CA Advanced Primary Care Initiative. Notably, 40,000 patients in California had improved HbA1c, a measure that is central to improved outcomes for patients with diabetes. PTI yielded a total cost savings of $186 million, equivalent to $42,000 saved per PTI-enrolled clinician, most of which was related to avoided inpatient bed days and emergency department visits.[4]

Level of Payer Engagement   **Diversity of Payer Engagement**   **Scale**   **Complexity**

Colorado State Innovation Model Technical Assistance[5]

Challenge: State Innovation Models (SIMs) aim to address multi-payer health care payment and delivery system reform for the population of the participating states or territories. Colorado was awarded SIM funding from 2015 to 2019 to improve the integration of physician and behavioral health services in coordinated community systems, with value-based payment structures, for 80% of state residents by 2019.

Approach: Colorado prioritized their SIM goals along four key areas: payment reform, practice transformation, population health, and health information technology. Across these dimensions, Colorado incorporated participant engagement and technical assistance approaches to support practices in building their behavioral health integration and transformation towards value-based payment structures.

Payer Engagement: Anthem Blue Cross Blue Shield, Cigna, Colorado Choice Health Plans, Kaiser Permanente, Rocky Mountain Health Plans, UnitedHealthcare, and Health First Colorado (Colorado Medicaid)

Initiative: The SIM provided technical assistance to 344 primary care practices. Technical assistance primarily focused on practice transformation efforts. Services provided included:

- **Collaborative Learning Sessions:** In-person convenings of practices, bi-directional health homes, and other key participants. Events helped practices identify and disseminate best practices.
- **Training & Webinars:** 100+ in-person trainings and webinars were developed and facilitated on a variety of topics, including the Collaborative Care Model for primary care working with psychiatry, the Merit-based Incentive Payment System (MIPS) and the Quality Payment Program, and specific training for behavioral health professionals working in primary care settings with an explanation of the SIM CQMs.
- **e-Learning:** e-Learning modules targeted patient-care team members to facilitate an understanding of whole-patient health needs, and how to work in an integrated care setting. Trainings were funded by a collaborative of the the Office of Behavioral Health (OBH), the Colorado Department of Public Health and Environment (CDPHE), and the Practice Innovation Program.
- **SIM Implementation Guide:** The guide provided a description of the SIM milestones and recommendations on how to meet objectives described in the milestones.
- **PIP Website and Resource Hub:** The website held a collection of tools and resources to support practices, as well as information about the SIM process and key documents.
- **Maintenance of Certification (MOC) and Continuing Medical Education (CME):** Training credits towards Board recertification were available to providers based on participation in project activities and the quality improvement process.

Colorado State Innovation Model Technical Assistance[5] (continued)

Challenge: The Colorado SIM program achieved its aims while reducing per-capita health care spending, with projected health care cost savings of $125.9 million (resulting in a return on investment of 2.00).[6] Practices also voiced ongoing value from SIM, including continued improvements in data cleansing and practice assessment data (captured through technical assistance). Technical assistance approaches were likewise successful, although some practices new to behavioral health integration voiced a desire for more active, intentional technical assistance and better communication with other SIM grantees. Colorado is using the lessons learned from their SIM initiative to improve future reform efforts.

Level of Payer Engagement

Diversity of Payer Engagement

Scale

Complexity

North Carolina Integrated Care for Kids

Challenge: The needs of children at greatest risk for physical and behavioral health issues, including mental health and substance abuse challenges, are often overlooked due to a disconnect between the health care system, schools, foster care, child welfare, and community resources and organizations.[7]

Approach: In 2019, CMS announced the Integrated Care for Kids (InCK) model, a child-centered local service delivery and state payment model that aims to reduce expenditures and improve the quality of care for children under 21 years of age covered by Medicaid. The North Carolina Department of Health and Human Services (NC DHHS), in partnership with Duke Health System and UNC Health System, launched the North Carolina InCK model that serves children and families in five counties.[8] The group built a coalition of child health leaders across the state, including health care providers, insurance companies, schools, and childcare programs for infants and toddlers.

Payer Engagement: Medicaid Prepaid Health Plans (AmeriHealth Caritas North Carolina, Healthy Blue of North Carolina, UnitedHealthcare of North Carolina, WellCare of North Carolina, Carolina Complete Health), and Medicaid Direct (Fee for Service), and NC Health Choice (CHIP). In October 2023, additional specialty managed care plans are expected to launch, including Alliance Health, Eastpointe, Partners Health Management, Sandhills Center, Trillium Health Resources, and Vaya Health.

Initiative: The NC InCK Model uses child-focused risk stratification to assign children to Service Integration Levels (SILs) based on holistic cross-sector data indicators. Children in SIL 2 and 3 receive enhanced care management from a Family Navigator, who coordinates services and supports the family's needs across physical and behavioral health, early care and education, schools, housing, food, public health services, child welfare, mobile crisis response, juvenile justice, and legal aid.

InCK also uses an APM that rewards participating clinical practices using a tiered performance benchmark structure, with incrementally increasing incentive payments for higher performance. The APM is based on six child-centered performance measures: Kindergarten Readiness Promotion Bundle, Screening for Food Insecurity and Housing Instability, Shared Action Plan, Screening for Clinical Depression & Follow-Up, Rate of Emergency Department Visits, and Equity: Reduction in Racial and Ethnic Disparities with Well Child Visits.[9]

All InCK Model lead organizations receive technical assistance and participate in a model-wide learning system. The technical assistance support helps InCK Model participants in advancing the success and goals of the model through development and distribution of strategic topics (e.g., addressing social determinants of health, beneficiary and participant journey mapping) through webinars, affinity groups, and resources. Technical assistance efforts also develop resources and communications and provide trainings and convenings for providers on topics such as capacity building on core child service areas, assessing and addressing non-clinical needs, and best practices across practices and sectors.

North Carolina Integrated Care for Kids (continued)

Impact: The goals of the model are to systematically identify the children with the greatest needs to better target interventions, strengthen integration and information sharing between medical and Core Child Services (CCS) providers, improve health and social outcomes, and reduce out-of-home placements for high-risk children. The learning and technical assistance events garner high attendance and participants report that content is helpful, particularly when there is sufficient opportunity to share lessons learned across participants. The model will operate through December 31, 2026, and the results will be used to evaluate care quality, utilization, and costs.

Level of Payer Engagement **Diversity of Payer Engagement** **Scale** **Complexity**

Resources

#	REFERENCE
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Conclusion

Multi-payer alignment is critical to executing health care payment reform strategies that advance value-based, accountable care and support shared goals such as improving population health and affordability and reducing administrative burden. The examples featured in this Blueprint show that states can implement multi-payer initiatives across five foundational elements by starting small and utilizing continued and committed partnerships to build momentum toward sustainable impact. Moreover, they can do so regardless of region, resources, and infrastructure, and with or without legislative and regulatory action.

As more states implement multi-payer initiatives, it will become increasingly important to ensure such initiatives work as part of a national strategy. CMS can play a key role in driving this and ensuring more meaningful participation from Medicare. The Innovation Center's new **Making Care Primary (MCP)** Innovation Model will support eight states—including Colorado and North Carolina—in primary care transformation efforts, particularly in its support of FQHCs and other smaller, independent health care organizations. The multi-payer component of the model features the same goals, principles, and priorities as the Blueprint, with the goal of improving communication, clarity and predictability across state and federal initiatives.

The LAN will also continue to promote efforts that advance multi-payer alignment and develop resources that share best practices, provide cross-state learning, and support industry action. As states develop new multi-payer approaches, or refine current strategies, the LAN will document their progression and impact to streamline directional alignment and scale to a national level, as opposed to a potentially disparate collection of alignment efforts.

Harnessing both state and national energy, through local and regional initiatives reflecting national priorities is ultimately what will support meaningful multi-payer progress and engage a broad range of stakeholders. In time, the infrastructure and components developed through these collective efforts can outlast anything CMS or individual states can do alone, creating a more sustainable and effective health care system.

Appendix A-1:
CMS Preliminary Adult and Pediatric Universal Foundation Measures

CMS Preliminary Adult and Pediatric Universal Foundation Measures

Domains are from Meaningful Measures 2.0. Identification numbers are CMS Measures Inventory Tool measure family identification numbers; names reflect the descriptions associated with those numbers.

1. Adult: Wellness and Prevention
   - 139: Colorectal cancer screening
   - 93: Breast cancer screening
   - 26: Adult immunization status

2. Adult: Chronic Conditions
   - 167: Controlling high blood pressure
   - 204: Hemoglobin A1c poor control (>9%)

3. Adult: Behavioral Health
   - 672: Screening for depression and follow-up plan
   - 394: Initiation and engagement of substance use disorder treatment

4. Adult: Seamless Care Coordination
   - 561 or 44: Plan all-cause readmissions or all-cause hospital readmissions

5. Adult: Person-Centered Care
   - 158 (varies by program): Consumer Assessment of Healthcare Providers and Systems overall rating measures

6. Adult: Equity
   - Identification number undetermined: Screening for social drivers of health

7. Pediatric: Wellness and Prevention
   - 761 and 123: Well-child visits (well-child visits in the first 30 months of life; child and adolescent well-care visits)
   - 124 and 363: Immunization (childhood immunization status; immunizations for adolescents)
   - 760: Weight assessment and counseling for nutrition and physical activity for children and adolescents
   - 897: Oral evaluation, dental services

CMS Preliminary Adult and Pediatric Universal Foundation Measures (continued)

8. Pediatric: Chronic Conditions
   - 80: Asthma medication ratio (reflects appropriate medication management of asthma)

9. Pediatric Behavioral Health
   - 672: Screening for depression and follow-up plan
   - 268: Follow-up after hospitalization for mental illness
   - 264: Follow-up after emergency department visit for substance use
   - 743: Use of first-line psychosocial care for children and adolescents on antipsychotics
   - 271: Follow-up care for children prescribed attention deficit–hyperactivity disorder medication

10. Pediatric: Person-Centered Care
    - 158 (varies by program): Consumer Assessment of Healthcare Providers and Systems overall rating measures

Appendix A-2:
STC State Measure Sets

Covered California Contracting and Accountability Strategies

Note: CalPERS has also aligned its accountability set and methodology for repayment for 2024-2028 contracts with their health plans. For measure specifications, please refer to the NQF measure database.

1. Controlling High Blood Pressure (NQF# 0018)
2. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) (NQF# 0575)
3. Colorectal Cancer Screening (NQF# 0034)
4. Childhood Immunization Status (Combo 10) (NQF# 0038)

The following NQCA and HEDIS measures to be included in QTI core measure set after benchmarks have been established.

1. Depression Screening and Follow-Up for Adolescents and Adults
2. Pharmacotherapy for Opioid Use Disorder (POD)

Colorado Alternative Payment Model (APM) Alignment Initiative

For measure specifications, please refer to the NQF measure database.

Adult Primary Care Measures

1. Breast Cancer Screening in Women (NQF# 2372)
2. Cervical Cancer Screening (NQF# 0032)
3. Colorectal Cancer Screening (NQF# 0034)
4. Screening for Depression and Follow-Up Plan (NQF# 0418)
5. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) (NQF# 0575)
6. Controlling High Blood Pressure (NQF# 0018)
7. Initiation and Engagement of Substance Abuse Treatment (NQF# 0004)
8. CAHPS Health Plan Adult Survey (NQF# 0006)

For measure specifications, please refer to the NQF measure database.

Pediatric Primary Care Measures

1. Child and Adolescent Well Visits (NQF# 1516)
2. Developmental Screening in the First Three Years of Life (NQF# 1448)
3. Well-Child Visits in the First 30 Months of Life (NQF# 1392)
4. Screening for Depression and Follow-Up Plan (NQF# 0418)
5. Childhood Immunization Status: Combination 10 (NQF# 0038)
6. Immunizations for Adolescents: Combination 2 (NQF# 1407)
7. Lead Screening in Children (NQCA and HEDIS measure)
8. CAHPS Health Plan Child Survey

North Carolina: Quality Measure Alignment for Advanced Medical Homes

For measure specifications, please refer to the NQF measure database.

1. Well Child Visits: 0-30 Months of Life (NQF# 1392)
2. Child and Adolescent Well Visits (NQF# 1516)
3. Childhood Immunization Status: Combination 10 (NQF# 0038)
4. Immunizations for Adolescents: Combination 2 (NQF# 1407)
5. Screening for Depression and Follow-Up Plan – Ages 12 to 17 (NQF# 0418/0418e)
6. Screening for Depression and Follow-Up Plan – Ages 18 and older) (NQF# 0418/0418e)
7. Cervical Cancer Screening – Ages 21 to 64 (NQF# 0032)
8. Chlamydia Screening in Women – Ages 16 to 20 (NQF# 0033)
9. Chlamydia Screening in Women – Ages 21 to 24 (NQF# 0033)
10. Controlling High Blood Pressure (NQF# 0018)
11. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) (NQF# 0575)
12. Plan All Cause Readmissions (PCR) [Observed versus expected ratio] (NQF# 1768)
13. Total Cost of Care
14. Prenatal and Postpartum Care (NQF# 1517)

Appendix B:
Acronym Guide

Acronym	Definition
AB	Assembly Bill
ACO	Accountable Care Organization
ACO REACH	ACO Realizing Equity, Access, and Community Health
AHCPII	Arkansas Health Care Payment Improvement Initiative
AMH	Advanced Medical Home
API	Application Programming Interface
APM	Alternative Payment Model
ARHOME	Arkansas Health and Opportunity for Me
CalHHS	California Health and Human Services Agency
CalPERS	California Public Employees' Retirement System
CBO	Community-Based Organization
CBP	Controlling High Blood Pressure
CCI	Center for Care Innovations
CCS	Core Child Services
CDF	Screening for Depression and Follow-Up Plan
CDPHE	Colorado Department of Public Health and Environment
CHCF	California Health Care Foundation
CHI	Colorado Health Institute
CME	Continuing Medical Education
CMS	Centers for Medicare & Medicaid Services
CPC	Comprehensive Primary Care
CPC+	Comprehensive Primary Care Plus
CQC	California Quality Collaborative
CY	Calendar Year
DHCS	California Department of Health Care Services
DHHS	North Carolina Department of Health and Human Services
DOI	Colorado Department of Insurance
DPA	Department of Personnel and Administration
DSA	Data Sharing Agreement
DSRI	Data Sharing Requirements Initiative

Appendix B: Acronym Guide

Acronym	Definition
Duke-Margolis	Duke-Margolis Center for Health Policy
DxF	Data Exchange Framework
EOM	Enhancing Oncology Model
FAQ	Frequently Asked Questions
FFS	Fee-for-Service
FHIR	Fast Healthcare Interoperability Resources
FHLI	Foundation for Health Leadership & Innovation
FQHC	Federally Qualified Health Center
HB	House Bill
HBD	Hemoglobin A1c Control for Patients with Diabetes
HCIP	Health Care Independence Program
HCPF	Colorado Department of Health Care Policy and Financing
HCP-LAN or LAN	Health Care Payment Learning and Action Network
HEAT	Health Equity Advisory Team
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HITECH	Health Information Technology for Economic and Clinical Health
HL7	Health Level 7
IHA	Integrated Healthcare Association
InCK	Integrated Care for Kids
IPA	Independent Physician Associations
MAC	Multistakeholder Advisory Council
MCO	Managed Care Organization
MCP	Making Care Primary
MDPH	Metro Denver Partnership for Health
MIPS	Merit-Based Incentive Payment System
MOC	Maintenance of Certification
MOU	Memorandum of Understanding
NCIOM	North Carolina Institute of Medicine
NCQA	National Committee for Quality Assurance

Acronym	Definition
NQF	National Quality Forum
OBH	Office of Behavioral Health
OHIT	Arkansas Office of Health Information Technology
ONC	Office of the National Coordinator for Health Information Technology
PA	Participation Agreement
PAC	Primary Care Payer Action Collaborative
PASSE	Provider-led Arkansas Shared Savings Entity
PBGH	Purchaser Business Group on Health
PCF	Primary Care First
PCMH	Patient Centered Medical Home
PCP	Primary Care Provider
PHP	Prepaid Health Plan
PMPM	Per Member Per Month
PTI	Practice Transformation Initiative
QHP	Qualified Health Plan
QRS	Quality Rating System
REACH	Realizing Equity, Access, and Community Health
REL	Race, Ethnicity, and Language
SDOH	Social Determinant of Health
SHARE	State Health Alliance for Records Exchange
S-HIE	Social-Health Information Exchange
SIL	Service Integration Level
SIM	State Innovation Model
SMM	Severe Maternal Morbidity
STC	State Transformation Collaborative
TCOC	Total Cost of Care
TCPI	Transforming Clinical Practice Initiative
VBID	Value-Based Insurance Design