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Multi-Payer Alignment on Value-Based Care

BACKGROUND INFORMATION

The Center for Medicare & Medicaid Innovation (CMMI) was established as a key provision of the A ordable Care Act to develop, test, and disseminate care and payment models to enhance health care quality and reduce spending. A decade later, with the combined learnings from more than 50 alternative payment models and the federal government's commitment to expand access to care and lower costs, CMMI is building on and expanding that foundation to catalyze a "stronger and more sustainable path forward" (Brooks-LaSure et al., 2021). To this end, the National Academy of Medicine (NAM) and CMMI have cooperated on a two-phase initiative to engage leading authorities in comprehensive consideration of key learnings and opportunities as CMMI lays the groundwork for a broader transformation of the nation's health and health care system. In Phase 1, a NAM-convened Expert Panel undertook a broad review of priority opportunities for CMMI to catalyze progress toward high-value, high-quality health and health care with enhanced e ectiveness and e ciency in improving individual and population health. The Expert Panel issued a NAM-published Review outlining anchor commitments and action steps in support of CMMI's role as a catalyst for change (NAM, 2021).

In Phase 2, the Expert Panel transitioned to serve as a Steering Committee to guide the NAM in developing and convening a discussion series designed to provide operational and action-oriented steps to help address critical issues and challenges in two areas: *Multi-Payer Alignment on Value-Based Care* and *Collecting Data to Ensure Equity in Payment Policy*. This Discussion Proceedings highlight priority areas and key themes that arose throughout the meeting focused on multi-payer alignment. Through a combination of individual presentations and open discussions, the discussion series engaged a range of field leaders and experts to describe the landscape of challenges and opportunities; highlight multi-stakeholder perspectives and examples of progress; and identify concrete steps to achieve health system preparedness, e-ectiveness, e-ciency, equity, and beneficiary experience. Through this work, six elements were identified as key component processes in CMMI's approach to advancing work on multi-payer alignment and health equity in every activity:

- signaling,
- mapping,
- · measuring,
- modeling,
- · partnering, and
- · demonstrating.

These elements are both aligned with and necessary to the achievement of the five Innovation Center Strategic Objectives outlined in the October 2021 *Innovation Center Strategy Refresh* white paper, namely:

- 1. drive accountable care,
- 2. advance health equity,
- 3. support care innovations,
- 4. improve access by improving a ordability, and
- 5. partner to achieve system transformation (CMMI, 2021).

MEETING SUMMARY

The Landscape of Multi-Payer Alignment and Value-Based Care

David Muhlestein, Leavitt Partners, outlined the various barriers facing e orts to cooperate and align toward value-based care models. Regarding the overall progress of the field toward this goal, Muhlestein noted that despite several promising multi-payer state-led initiatives underway, such as Arkansas's experience with a multi-payer bundled model or Vermont's experience with the Accountable Care Organization model, there is substantial heterogeneity in the payment ecosystem's goals, processes, and progress. As such, there is a significant opportunity for the health and health care systems in both private and public settings to align payment models and mechanisms toward more a ordable and higher quality care.

Muhlestein first outlined the drivers of misalignment within the health care field broadly. Muhlestein ob-

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Tewarson advocated for the federal government to drive value-based care model creation and adoption through the meaningful engagement of employers, health plans, health systems, and states at the regional and state level. This engagement would align with state interest in health equity, the social determinants of health, and behavioral health (NASHP, 2021). Finally, Tewarson opined that CMMI could avoid overly prescriptive approaches experienced in the Integrated Care for Kids Model to build upon the lessons of the Comprehensive Primary Care Plus model. This flexibility, according to Tewarson, would reduce the disculty in implementing models and attract a wider range of providers and payers to adopt CMMI models.

Payers

Mai Pham, Institute for Exceptional Care, noted that significant challenges in transitioning to value-based care are the compelling counterfactual analysis and market dominance of fee-for-service arrangements. Under the current landscape, where providers with advantages in reputation, patient volume, and unit prices reap substantial financial benefits, there is little incentive to transition toward value-based care models. In Pham's experience, previous approaches to value-based care models have failed because of providers renegotiating their business relationship with payers, resulting in unit price increases that outstrip savings generated from decreased care utilization. CMMI has two major leverageable strengths in promoting multi-payer alignment: its position as an authority within the federal government and its ability to identify challenges and provide implementation support for payers outside the federal government.

Pham highlighted that coordinated and decisive action from the federal government in support of value-based care would significantly advance multi-payer alignment. The government's main strength would be to use its full purchasing power to adopt and signal its 1.21A, TDs to value-based rity wignaldepar1.21Alenges PhHral heVive nIndexscapichicolldate-bers, health 's Carsy advdata acrousisitgehpurcvaetricvenges

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sure advanced primary care at the practice level and inform the development of future alternative payment models (PBGH, 2021b, PBGH, 2022).

Mitchell also raised that fee-for-service incentives are impeding health system scaling of evidence-based interventions that drive improvements in beneficiary outcomes. The PBGH Health Value Index has demonstrated concerning decreases in primary care spending and inadequate investments in mental health services (PBGH, 2021c). Mitchell also noted that while other available evidence from model pilots have confirmed the electiveness of intervening in these areas, these interventions have not been scaled. To conclude, Mitchell urged CMMI to move quickly to realize its critical priorities, noting that fee-for-service-dominated care provides high costs with suboptimal value and outcomes (King, 2017).

Open Discussion

Observations by Attendees

Moderator *Mark McClellan, Duke University,* noted that a major complementary e ort, the Health Care Payment Learning & Action Network, is informing CMMI's shift toward advancing future primary care models, aligned economic supports, direct contracting, and the Primary Care First model, as well as regional primary care, population accountability, and health equity goals and actions (HPLAN, 2022). In reaction to the keynote presentations and stakeholder remarks, meeting attendees discussed, underscored, and raised suggestions for CMMI's future approach as it aims to facilitate the further transition of fee-for-service health

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operational clarity on the competencies and requirements to successfully adopt and implement value-based care models. An attendee noted that CMMI guidance on common data elements, operational requirements, and data for community health information exchanges would help clarify regional di erences in cost benchmarking and engagement with commercial payers and employers.

Attendees shifted the conversation to potential areas of cooperation stakeholders could leverage to adopt further APMs using a multi-stakeholder approach. *Elizabeth Mitchell, PBGH,* noted that employers continue to be willing to experiment with value-based care models because of the financial and business pressures and experiences of the COVID-19 pandemic. Additionally, employers demand real-time health care access with digital options and data responsiveness. These services, alongside significant market size, innovative leader-ship, and basic infrastructure, are characteristics of entities and regions that commit to value-based care models. Meanwhile, a participant from Arkansas a rmed Mitchell's point, opining that the experience of the COVID-19 pandemic has led to some political and business leaders in Arkansas recognizing the damaging impact of fee-for-service on the health of rural communities. The same participant highlighted that engaging state-level providers, employees, and providers are critical to ensuring the continued adoption of APMs.

Multi-payer alignment e orts could also be achieved within states. An attendee suggested that states could help achieve this alignment by using their convening and purchasing power to align Medicaid, Medicare, public employees, private payers, and public exchanges. Another attendee suggested that, if applicable, some states could use their oversight power to limit health care costs beyond the state-equivalent gross domestic product. Under this policy, exceeding this limit could result in a public examination of the payer or provider, a substantial reputational penalty. Finally, another attendee contributed that this convening power could rally stakeholders, resources, and the workforce in (1) negotiating more attractive reimbursement rates for value-based care, (2) achieving common performance indicators and benchmarks in terms of provider performance and beneficiary health outcomes, and (3) optimizing resources toward improved care quality and population health outcomes. The ultimate goal, attendees agreed, would be to centering and prioritizing the beneficiary's health through improving health outcomes, promoting equity, and reducing the total cost of care.

AREAS OF FUTURE FOCUS AND PRIORITIES FOR ACTION

Patrick Conway, MD, MSc, Care Solutions, Optum; Peter Long, PhD, Blue Shield of California; Mark McClellan, MD, PhD, MPA, Robert J Margolis Center for Health Policy, Duke University; David Muhlestein, PhD, JD, MHA, MS, Leavitt Partners; and Amol S. Navathe, MD, PhD, Perelman School of Medicine, University of Pennsylvania

Workshop attendees agreed that the largest national priority for CMMI should be breaking up the dominance of fee-for-service payments in favor of value-based care models. While there are significant state and employer e orts to move toward value-based care models, the most transformational e orts will be led by CMS, CMMI, and the federal government (NGA and Duke-Margolis, 2021). However, the authors acknowledge that the road toward a health system dominated by value-based care remains di cult to achieve. At present, the overall incentives for transformation, and the disincentives of operating under fee-for-service arrangements, have not been strong enough for broad, meaningful payment transformation to occur.

To date, progress has mainly been uneven in reducing cost, improving quality, achieving equity, or facilitating widespread model adoption. Therefore, the transition from volume-dependent fee-for-service payments to value-based care models to pay for value and reduce health inequities remains an aspirational goal (Werner et al., 2021). Despite the significant amount of resources and collaboration required to attain this goal, the authors believe that multi-payer alignment on value-based care models will improve the health and well-being of beneficiaries and ultimately lower the total cost of care.

Additionally, the authors believe that CMMI could meaningfully engage relevant stakeholders, including but not limited to CMS, private payers, providers, public exchanges, community-based organizations, and beneficiaries, to develop, implement, and adopt models. This continuous e ort would help build trust, deepen partnerships, and allow for learning from present and future e orts to ensure the di cult transition toward value-based care is informed by the needs, experiences, and aspirations of all stakeholders involved.

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It is also critical that CMMI and the health care financing field continue focusing on ultimately lowering the cost of care and increasing the quality of care received by beneficiaries nationwide. Increasing the number of standardized value-based care models across payers, enhancing incentives, creating more impactful value-based care models, and expanding the array of value-based care model options could make strict fee-for-service payment arrangements unattractive to payers and providers. Additionally, the standardization and scaling of these value-based care models, if achieved with sucient flexibility to meet the needs of health systems in dicent contexts served by dicent payers and their patient populations, would create the environment necessary to facilitate widespread provider adoption and deliver higher quality care at a lower cost.

Finally, discussions at the workshop validated several key areas raised in CMMI's updated strategy, released in October 2021 (CMMI, 2021). First, incentives, technical assistance, and investments in new care delivery techniques are essential to encouraging stakeholders to implement and achieve payment and health system reforms toward value-based care models. Second, outcomes could be broadly defined beyond quality and cost measures. An expanded set of core health measures could capture and account for beneficiary experiences and priorities, outcomes, equity, a ordability, and meaningful engagement. However, CMMI would be best served by ensuring these outcome measures are streamlined and simplified to reduce administrative burden, ease reporting processes, and focus e orts toward collaboration on targeting barriers that impede high-value and quality care (CMMI, 2021). Emphasis on the following priority impact strategies, which are well within CMS and CMMI's toolkit and experience, could foster the environment for change in the next ten years of CMMI progress and innovation:

- 1. Signaling: Leverage the groundwork laid by CMMI and CMS public engagements, statements, and documents to reinforce sector signaling and priorities on multi-payer and value-based care developments. A defined cadence and partnership with stakeholder organizations could help engage the stakeholder community by communicating CMMI's understanding of stakeholder pain points and the importance of achieving consensus, transparency, and solutions to these barriers; providing updates on CMMI multi-payer alignment on value-based-care developments and progress; and announcing model specifics such as risk adjustment, benchmarks, and targets.
- 2. Mapping: Create, through an engaged, multi-stakeholder approach, an implementation roadmap on action steps required to improve care quality and increase the adoption of value-based care models. This roadmap could include CMMI's intended actions to align the economic incentives of providers with value-based care models and increase the adoption of value-based care models. Additionally, the roadmap could signal how CMMI would anticipate engaging with the field or alternate ways of moving the health and health care system toward value-based care beyond their payment model e orts. The roadmap could also include information on priority elements and areas that CMMI would focus on, such as incorporating the social drivers of health, the collection and reporting on standardized core health measures, and care access and a ordability. This clarity would help payers, providers, and health systems allocate investments toward these priorities in anticipation of CMMI's new strategic direction.
- 3. Measuring: Build on CMS's core measurement e orts to simplify measurement, focus on the most important performance elements, and use core measures developed with and informed by beneficiary, payer, and caregiver needs to support and track the alignment required to enable integrated personcentered care (CMS, 2021).
- 4. Modeling: Assess the landscape of current e orts, including stakeholder mix, objectives, level and degree of progress, and alignment with key CMMI goals and models of interest. By deriving learnings and selecting stakeholders through this assessment, CMMI could convene payers and providers to determine and resolve barriers, build trust, and secure commitments from decision makers to work on transitioning toward value-based care models. Using this multi-stakeholder approach, CMMI could then work with these partners to co-develop models that establish a compelling counterfactual case against remaining within a fee-for-service payment system chassis.
- 5. Partnering: Support and facilitate value-based care model adoption and the momentum of emerging and existing multi-payer e orts nationwide. CMMI could prioritize partnering with payers to enable flexibility in model implementation, eligibility, and requirements as a continuous and meaningful engagement e ort. Additionally, this support would leverage individualized partnerships, scaling support, technical assistance, and continuous engagement and progress tracking to further scale the adoption of value-based care models. This engagement would also help CMMI rapidly incorporate learned payment, design, and implementation lessons. CMMI could also support communities, employers, states,

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- groups, and systems currently making advanced progress on implementing aligned value-based care models within its statutory authority through technical assistance, consultations, and other relevant mechanisms
- 6. Demonstrating: As a general operational principle, rapidly pilot new models or improvements to existing models to advance progress on key barriers and strengthen CMMI engagement with field stakeholders. Additionally, as referenced by Frederick Isasi, CMMI could work with ten health systems, communities, or localities where progress has been made on multi-payer alignment toward value-based care to accelerate progress and agree upon bidirectional e orts to address obstacles to success. Through this partnership, CMMI could also reallocate health care investments to the community needs beyond the health care system, such as services to support the social determinants of health.

References

- 1. Berkowitz, S. A., S. Basu, J B. Meigs, and H. K. Seligman. 2018. Food Insecurity and Health Care Expenditures in the United States, 2011-2013. *Health Services Research* 53(3):1600-1620. https://doi.org/10.1111/1475-6773.12730.
- 2. Brooks-LaSure, C., L. Fowler, M. Seshamani, and D. Tsai. 2021. *Innovation at the Centers for Medicare and Medicaid Services: A Vision for The Next 10 Years.* https://doi.org/10.1377/hblog20210812.211558.
- 3. Center for Medicare & Medicaid Innovation (CMMI). 2021. *Innovation Center Strategy Refresh.* Available at: https://innovation.cms.gov/strategic-direction-whitepaper (accessed December 16, 2021).
- 4. Centers for Medicare & Medicaid Services (CMS). 2021. *Core Measures.* Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures (accessed March 23, 2022).
- 5. Frenz, D. A. 2020. What's Your Payer Mix? *Today's Hospitalist*. Available at: https://www.todayshospitalist.com/insurer-payer-mix/ (accessed March 23, 2022).
- 6. Health Care Payment & Learning Action Network (HPLAN). 2022. What is the Health Care Payment Learning & Action Network? Available at: https://hcp-lan.org (accessed March 23, 2022).
- 7. King, M. W. 2017. Health Care E ciencies: Consolidation and Alternative Models vs. Health Care and Antitrust Regulation—Irreconcilable Di erences? *American Journal of Law & Medicine* 43(4):426-467. https://doi.org/10.1177/0098858817753407.
- 8. National Academy of Medicine (NAM). 2021. *Priorities in Advancing High Quality Value-Based Health & Health Care.* Available at: https://nam.edu/wp-content/uploads/2021/07/CMMI_Expert-Panel-Overview_2021_5.19-Final.pdf (accessed December 16, 2021).
- 9. National Academy of State Health Policy (NASHP). 2021. *Championing Health Equity Experiences from State Covid-19 Health Equity Task Forces*. Available at: https://www.nashp.org/wp-content/up-loads/2021/11/NGA_Covid-19-Equity-Taskforce-Summary-11.5.21.pdf (accessed March 23, 2022).
- 10. National Governors Association Center for Best Practices and Duke-Margolis Center for Health Policy (NGA and Duke-Margolis). 2021. *State-Driven Initiatives to Support Moving to Value-Based Care in the Era of COVID-19.* Available at: https://www.nga.org/wp-content/uploads/2021/04/NGA-Duke_Value-Based-Care-Covid-19_final.pdf (accessed December 16, 2021).
- 11. Nuzum, R., C. Lewis, and D. I. Chang. 2021. *Measuring What Matters: Social Drivers of Health.* Available at: https://www.commonwealthfund.org/blog/2021/measuring-what-matters-social-drivers-health (accessed April 21, 2022).
- 12. Onie, R. D., R. Lavizzo-Mourey, T. H. Lee, J S. Marks, and R. J Perla. 2018. Integrating Social Needs into Health Care: A Twenty-Year Case Study of Adaptation and Di usion. *Health A airs* 37(2):240-247 (accessed March 23, 2022).
- 13. Purchaser Business Group on Health (PBGH). 2021a. *PBGH Health Value Index for Successful and Collaborative Health Plan Management*. Available at: https://www.pbgh.org/wp-content/uploads/2021/09/PBGH-Health-Value-Index.pdf (accessed March 23, 2022).
- 14. Purchaser Business Group on Health (PBGH). 2021b. *Quality Improvement Project to Modernize Primary Care Launched*. Available at: https://www.pbgh.org/covered-california-calpers-and-purchaser-business-group-on-health-to-launch-sweeping-quality-improvement-project-to-modernize-primary-care-for-californians/(accessed March 23, 2022).
- 15. Purchaser Business Group on Health (PBGH). 2021C. *PBGH Health Value Index for Successful and Collaborative Health Plan Management Leveraging the Collective Power of PBGH Members to Impact Health Care Delivery: Summary Findings.* Available at: https://www.pbgh.org/wp-content/uploads/2021/09/PBGH-Health-Value-Index-Results-2021.pdf (accessed May 6, 2022).

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- 16. Purchaser Business Group on Health (PBGH). 2022. *CQC Webinar Advanced Primary Care: Piloting Practice Level Measurement*. Available at: https://www.pbgh.org/event/cqc-webinar-advanced-primary-care-piloting-practice-level-measurement/ (accessed May 5, 2022)
- 17. Taylor, D. H., J., M. Danis, S. Y. Zafar, L. J Howie, G. P. Samsa, S. P. Wolf, and A. P. Abernethy. 2014. There Is a Mismatch Between the Medicare Benefit Package and the Preferences of Patients With Cancer and Their Caregivers. *Journal of Clinical Oncology* 32(28):3163-3168. https://doi.org/10.1200/JCO.2013.54.2605.
- 18. The Illinois Health Information Technology Extension Center Collaborative (IL-HITEC). 2019. *Clinician Focused Quality Improvement.*

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