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# Multi-Payer Alignment on Value-Based Care

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## BACKGROUND INFORMATION

The Center for Medicare & Medicaid Innovation (CMMI) was established as a key provision of the Affordable 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 effectiveness and efficiency 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, effectiveness, efficiency, 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 affordability, 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 efforts 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 affordable and higher quality care.

Muhlestein first outlined the drivers of misalignment within the health care field broadly. Muhlestein observed that the present health care ecosystem consists of an interconnected web of relationships that make it difficult to achieve consensus or, absent a central coordinator, for one entity to implement a coherent set of solutions to transform the health care payment landscape toward value (King, 2017). The relationship between patients, providers, purchasers, and payers was originally linear and, therefore, relatively simpler to navigate. However, as the health care sector has grown to almost a fifth of the U.S. economy, these stakeholders now partner and transact through multiple layers and channels of negotiation through mechanisms such as direct contracting, public and private exchanges, quality reporting, defined benefits, and contributions (King, 2017). In the present ecosystem, stakeholders seek to pursue their interests individually without accounting for unintended consequences, such as higher care costs or the continued dominance of fee-for-service health care. As such, Muhlestein noted, without a central coordinator of these relationships and interests, a suboptimal system of collective misalignment is created. CMMI could potentially function as this central coordinator to ensure the federal government, private payers, and providers can agree upon efforts that address stakeholder needs and prioritize the need to achieve high-value care for patients and beneficiaries.

Muhlestein then outlined the misalignment between CMMI payment and model approaches and the needs of payers and providers. First, Muhlestein noted that health care payment regulations and structures are misaligned between public and private stakeholders. In particular, Muhlestein raised the example that outcomes, quality measures, benchmarking, payments, reporting, and transparency are misaligned between Medicare and private payers. According to Muhlestein, under Medicare's parts A, B, C, and D benefit design, payers struggle to reimburse providers accurately and adequately for complex multidimensional medical and pharmaceutical interventions used to treat diseases such as cancer (Taylor et al., 2014).

Second, Muhlestein raised that the adoption of CMMI's alternative payment models (APMs) has also been limited due to a lack of co-development of these models. According to Muhlestein, while CMMI conducts public consultations and listening sessions under its present approach to model development, models are developed solely by the agency. After a model is developed, CMMI attempts to attract payers and providers to provide commitments and resources to pilot and adopt models. While some payers and providers may benefit from certain models, the lack of co-development means that CMMI cannot anticipate, ameliorate, and address feedback that would ensure their models apply to a wider mix of payers and providers in multiple contexts. As such, to ensure more seamless communication of needs, challenges, and opportunities, Muhlestein suggested CMMI adopt a more comprehensive engagement strategy that involves Medicare, Medicaid, private payers, and other relevant stakeholders from listening sessions and consultations toward model development, demonstrations, evaluation, and adoption.

In addition to conflicting stakeholder interests, the threat of antitrust litigation is a key barrier to achieving alignment through partnerships, ventures, and other cooperative configurations (King, 2017). CMMI could clarify its statutory authority and collaborate with other federal agencies by issuing safe harbor waivers as part of the federal government. These waivers could permit CMMI to convene payers to co-develop models, discuss negotiated rates, and build broad commitments to drive increased uptake and participation of APMs.

Across the health and health care ecosystem, the Centers for Medicare and Medicaid Services (CMS) and CMMI could work with stakeholders to select a shared goal relevant to achieving greater care value and

multi-payer alignment. By choosing and aligning around a common obstacle, stakeholders could collaborate on breaking down the process and structural barriers that need to be overcome to enhance health care system performance, optimize beneficiary health, and increase the adoption of value-based care models. Finally, Muhlestein suggested that these stakeholders use CMS's newly released Core Quality Measures to track field progress, build stakeholder accountability, and ensure public reporting and transparency (CMS, 2021).

## Multi-Stakeholder Perspectives on Multi-Payer Alignment on Value-Based Care

### *Patients, Families, and Communities*

*Frederick Isasi, Families USA*, argued that fee-for-service payment arrangements incentivize the provision of high-cost, low-value care that neglects beneficiary interests. Because of the economic dominance of fee-for-service payments in provider and payer market share, Isasi advocated for CMMI to intervene in ten selected markets to increase the competitiveness of value-based care models (King, 2017). CMMI could first require providers to submit payer mix information across multiple payers over a five-year time horizon. The payment mix refers to the percentage of patients with Medicare and Medicaid payments relative to commercial payment models (Frenz, 2020). During the succeeding five years, providers would be assisted and encouraged by CMMI to move toward serving 60%–80% of patients through value-based care models. The success of this intervention could demonstrate the ability of providers to deliver higher quality care while profiting from CMMI's value-based care.

Isasi noted the critical importance of meaningfully engaging stakeholders to codesign, disseminate, and implement value-based care models. CMMI could use a readiness assessment to effect payment transformation in ten communities nationwide to enhance CMMI stakeholder engagement efforts. CMMI would convene and support a multi-stakeholder community table using evidence-based and data-driven approaches in these communities. These groups would have the authority to invest in evidence-based and health-related investments and resources such as behavioral health services, affordable housing, social services, and criminal justice reform.

The tables could also allocate resources to address the impact of major crises, including the COVID-19 pandemic, structural racism, adverse childhood experiences, and the opioid crisis on their respective communities. This intervention could demonstrate that multi-payer alignment reform could occur through well-designed community interventions while realizing the potential impact of addressing community and social drivers of health.

### *States*

*Jessica Altman, Commonwealth of Pennsylvania*, outlined how Pennsylvania used its convening and purchasing power to increase the adoption of value-based care models in Medicaid; state employee plans; public sector purchasing collaborative for unions, teachers, and local governments; and certifying Qualified Health Plans in the state marketplace. Through a rate review, Pennsylvania is also considering enhancing payment value and tightening cost controls by redefining the right value of services and procedures. Additionally, Altman noted that in her experience, the COVID-19 pandemic pushed providers to innovate and navigate a challenging environment. In her view, the pandemic demonstrated the resilience and effectiveness of providers in value-based care arrangements. CMMI could help states by providing greater clarity around metrics and data collection and an implementation roadmap to achieve patient-centered equitable care.

*Hemi Tewarson, National Academy for State Health Policy (NASHP)*, discussed her observations from a NASHP-convened focus group of 400 state leaders. According to Tewarson, the group concluded that while states are major purchasers, they need employers and CMS to drive markets toward value-based care models. Additionally, Tewarson noted that successes in Vermont, Maryland, and Pennsylvania could not be directly replicated due to the misalignment and variation of payers, providers, beneficiary populations, state governments, and CMS efforts in other states. Therefore, states need support and guidance on collaborating with payers and employers to achieve multi-payer alignment. Additionally, the focus group suggested that CMS consider continuing some of the workforce-related COVID-19 regulatory flexibilities to maintain the workforce resilience necessary to sustain a transition toward a value-based care system.

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 difficulty 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 commitment to value-based care within its departments and agencies. To accomplish this goal, the federal government could amend regulations and policies in Medicare Advantage plans, in the Department of Defense's TRICARE, in the Affordable Care Act's exchanges, and throughout the Veteran's Health Administration to shift purchasing of health care for federal employees toward value-based care models. Finally, Pham added that CMMI could also support health equity by reallocating capital toward investments supporting health systems serving underserved communities and providers with a higher proportion of beneficiaries covered by value-based care models.

### *Purchasers*

*Elizabeth Mitchell, Purchaser Business Group on Health (PBGH)*, emphasized the irrationality of asking any organization to work voluntarily against their financial interests. Mitchell noted that progress on payment reforms would require drastic actions such as mandates, credible business threats, and contract changes that require value-based care. To test and implement models rapidly, CMMI could fund external entities that can operate outside the constraints of a government agency. CMMI could also collaborate with purchasers, groups, and community organizations that have achieved progress in aligning incentives and payment systems.

Mitchell also emphasized the need for CMMI to provide personalized technical and financial assistance to field stakeholders. CMMI could first assess markets by readiness for value-based care model implementation and then require matching funds from markets to share commitment and risk to transitioning to a value-based care model. Finally, they could support providers with funding for direct technical assistance from regional experts. Mitchell also suggested that CMMI set health outcome targets; utilize patient-reported outcome measures; require data stratification by race and ethnicity; and reauthorize the Network of Quality Improvement and Innovation Contractors, networks tasked with large-scale quality improvement efforts with an updated Clinician Quality Improvement Contractor Clinician-Focused Task Order (IL-HITEC, 2019). This updated task order would add a focus on using a concise measure set focused on primary care in addition to the ongoing goals of chronic disease management and prevention; improving behavioral health outcomes, including a focus on decreased opioid misuse; focusing on patient safety; and improving community-based care transitions to reduce hospital admission (IL-HITEC, 2019).

Mitchell also urged CMMI to define, track, and report value-based care performance metrics. CMMI could refer to PBGH's Health Value Index, which collected health plan performance data across nine basic metrics and 29 large purchaser groups (PBGH, 2021a). Mitchell also highlighted that four major employers: California Public Employees' Retirement System, Covered California, the County of San Francisco, and eBay, are collaborating to pilot PBGH's Advanced Primary Care measure set in 2022 health plan contracts. According to Mitchell, this pilot exemplifies the potential of large employers and public health care purchasers to mea-

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 effectiveness 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 effort, 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 care toward value-based care.

An attendee first noted that current CMMI model incentives are weak. CMS could design value-based care models to reward behavioral change or form a coalition of employers, communities, providers, and states to prioritize value. To strengthen this transition to value and encourage more investments in health, attendees suggested the social drivers of health as a critical priority and gap that CMMI could urgently pursue in its future payment models. For example, according to *Rocco Perla, The Health Initiative*, an individual with diabetes who is food insecure costs on average \$4,413 more per member per year than a person with diabetes who is not food insecure (Berkowitz et al., 2018), and that 38% of the geographic variation in Medicare spending is attributed to social drivers in unadjusted models (Zhang, 2021). Perla added that these and similar findings indicate that CMMI should further emphasize the social drivers of health, including access to healthy food, stable and affordable housing, transportation, and safety (Nuzum et al., 2021). According to Perla, CMMI's APMs are currently insufficient in addressing the social drivers of health, because they do not incentivize, reimburse or support providers and practices to address these drivers by screening for social needs, navigating patients to services, or reimbursing community organizations that could meet these needs. Referencing previous work on this subject with *Rebecca Onie, The Health Initiative*, Perla emphasized that these efforts ultimately depend on the availability of resources in communities. Therefore, Perla noted that CMMI and health and health care systems could explore ways to incentivize and leverage additional investments in community assets and social infrastructure to close resource gaps that impact health outcomes such as low food access areas (Onie et al., 2018).

In response to Perla and Onie, an attendee highlighted that more evidence and case studies, particularly on successes from the CMMI State Innovation Model grants, are needed to inform social risk adjustment and new value-based care models. CMMI could collaborate with the CMS Office of the Actuary to collect the data needed to clarify financial modeling methodologies. CMMI could also study the experience and lessons of North Carolina's multi-stakeholder social drivers of health infrastructure, navigation, and payment pilot.

However, one attendee noted the characteristics, realities, and infrastructure of states like Oregon, Vermont, and Massachusetts are not directly translatable to other states because of the significant variation in health systems that Muhlestein and Tewarson discussed. The attendee suggested that CMMI work with the 30 states where value-based care models have limited impact due to their largely rural areas, lower patient volume, and, therefore, noncompetitive marketplaces.

Ultimately, attendees noted that despite the importance of CMMI's goals for health system transformation and defining core health measures, it could not resolve every issue. Instead, CMMI's focus could be on defining a core set of parameters, reducing the total cost of care, improving outcomes, and enhancing patient health and health care experiences. Attendees also raised a compelling need for CMMI to provide

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 differences 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 leadership, and basic infrastructure, are characteristics of entities and regions that commit to value-based care models. Meanwhile, a participant from Arkansas affirmed 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 efforts 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 efforts to move toward value-based care models, the most transformational efforts 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 difficult 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 effort would help build trust, deepen partnerships, and allow for learning from present and future efforts to ensure the difficult transition toward value-based care is informed by the needs, experiences, and aspirations of all stakeholders involved.

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 sufficient flexibility to meet the needs of health systems in different contexts served by different 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, affordability, 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 efforts 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 efforts. 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 affordability. 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 efforts 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 person-centered care (CMS, 2021).
4. **Modeling:** Assess the landscape of current efforts, 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 efforts nationwide. CMMI could prioritize partnering with payers to enable flexibility in model implementation, eligibility, and requirements as a continuous and meaningful engagement effort. 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,

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 efforts 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.

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