Environmental Scan on Improving Multi-Payer Alignment in Value-Based Care

January 30, 2026

This environmental scan was prepared at the request of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) as background information to assist the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in preparing for a theme-based discussion on improving multi-payer alignment in value-based care. This environmental scan provides background on multi-payer alignment, discussion on model alignment areas, factors influencing multi-payer alignment, a summary of multi-payer alignment initiatives, relevant features in previously submitted PTAC proposals, and an appendix table detailing features of select PTAC proposals.[i]

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Exhibits

List of Acronyms

AAFP	American Academy of Family Physicians
ACM	Advanced Care Model
ACO	Accountable Care Organization
ACP	American College of Physicians
ACS	American College of Surgeons
AHEAD	Achieving Healthcare Efficiency through Accountable Design
APC	Ambulatory payment classification
APCD	All-Payer Claims Database
APM	Alternative Payment Model
ASCO	American Society of Clinical Oncology
ASPE	Assistant Secretary for Planning and Evaluation
CAMP	COPD and Asthma Monitoring Project
CMP	Care management payment
CMS	Centers for Medicare & Medicaid Services
COME HOME	Community Oncology Medical Home
CPC	Comprehensive Primary Care
CPC+	Comprehensive Primary Care Plus
CPOC	Consolidated payments for oncology care
CQC	California Quality Collaborative
CQMC	Core Quality Measures Collaborative
CRISP	Chesapeake Regional Information System for Our Patients
CTAC	Coalition to Transform Advanced Care
CTC-RI	Care Transformation Collaborative Rhode Island
DRG	Diagnosis-related group
eCQM	Electronic clinical quality measure
EGM	Episode Grouper for Medicare
EHR	Electronic health record
EOM	Enhancing Oncology Model
ERISA	Employee Retirement Income Security Act of 1974
FFS	Fee-for-service
HaH-Plus	Hospital at Home-Plus
HCPLAN	Health Care Payment Learning & Action Network
HHS	Health and Human Services
HIE	Health information exchange
HIPAA	Health Insurance Portability and Accountability Act
HYH	HowsYourHealth
IGG	Illinois Gastroenterology Group
IHA	Integrated Healthcare Association
IOBS	Innovative Oncology Business Solutions
LUGPA	Large Urology Group Practice Association
MACRA	Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act
MAPCP	Multi-Payer Advanced Primary Care Practice
MASON	Making Accountable Sustainable Oncology Networks

MCP	Making Care Primary
MIPS	Merit-based Incentive Payment System
MOU	Memorandum of Understanding
OPC	Oncology payment category
PCDT	Preliminary Comments Development Team
PCF	Primary Care First
PCMH	Patient-Centered Medical Home
PCOP	Patient-centered oncology payment
PCSP	Patient-Centered Specialty Practice
PFPM	Physician-focused payment model
PIP	Performance incentive payment
PMPM	Per-member-per-month
PRC	Personalized Recovery Care
PRT	Preliminary Review Team
PTAC	Physician-Focused Payment Model Technical Advisory Committee
RFI	Request for Input
RHRCA	Rural Health Redesign Center Authority
RTS	Report to the Secretary
SIM	State Innovation Model
SME	Subject matter expert
STC	State Transformation Collaborative
TCOC	Total cost of care
UNMHSC	University of New Mexico Health Sciences Center
U.S.	United States

I. Introduction and Purpose

Under the bipartisan Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) of 2015, Congress significantly changed Medicare fee-for-service (FFS) physician payment methods. The law also specifically encouraged the development of Alternative Payment Models (APMs) known as physician-focused payment models (PFPMs) and created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review stakeholder-submitted PFPM proposals and make comments and recommendations on them to the Secretary of Health and Human Services (HHS; "the Secretary").

Since its inception, PTAC has received 35 proposals for PFPMs from a diverse set of physician payment stakeholders, including professional associations, health systems, academic groups, public health agencies, and individual providers.[ii] PTAC evaluates the PFPM proposals based on the extent to which they meet the Secretary's 10 regulatory criteria for PFPMs (specified in federal regulations at 42 CFR § 414.1465). Among the 35 proposals that were submitted to PTAC between 2016 and 2020, including 28 proposals that PTAC deliberated on during public meetings, Committee members found that 14 of the 28 proposals included potential approaches to multi-payer alignment.

Given the increased emphasis on developing larger, population-based APMs that encourage accountable care relationships, PTAC conducted several theme-based discussions between 2020 and 2025 that have examined care delivery and payment issues as they relate to value-based care and APMs. A key theme that has emerged during these theme-based discussions is improving multi-payer alignment in value-based care. Relevant topics identified for investigation in this environmental scan include:

- Background on multi-payer alignment;
- Model alignment areas;
- Factors influencing multi-payer alignment; and
- Multi-payer alignment initiatives.

This environmental scan provides Committee members with background information and context reflecting expert perspectives on issues related to improving multi-payer alignment in value-based care. The environmental scan is expected to help Committee members review strategies in proposals previously submitted to the Committee. In addition, the environmental scan can inform the Committee members' review of future proposals and future comments and recommendations that Committee members may submit to the Secretary relating to improving multi-payer alignment in value-based care.

Further, this environmental scan summarizes relevant information from PTAC's review of proposals from previous submitters, as well as selected Centers for Medicare & Medicaid Services (CMS) Innovation Center models and other state model efforts to improve multi-payer alignment.

Section II provides key highlights of the findings from the environmental scan. Section III describes the research questions and methods used in the environmental scan. Subsequent sections provide a

[ii] The 35 proposals submitted to PTAC represent an unduplicated count (i.e., proposals with multiple submissions are counted only once) of the number of proposals that have been voted and deliberated on by the Committee members (28) and the number of proposals that have been withdrawn by stakeholders (seven, including one proposal that was withdrawn prior to any review by the Committee members).

background on multi-payer alignment (Section IV); model alignment areas (Section V); factors influencing multi-payer alignment (Section VI); multi-payer alignment initiatives (Section VII); relevant features in previously submitted proposals (Section VIII); and areas where additional information is needed (Section IX). Additionally, a list of abbreviations can be found at the beginning of the environmental scan, following the Table of Contents.

II. Key Highlights

The following section provides important definitions and highlights key findings from this environmental scan on improving multi-payer alignment in value-based care.

II.A. Definitions

PTAC formed the following working definition for multi-payer alignment:

- Agreement among payer programs and products—including those offered through traditional Medicare, Medicare Advantage, Medicaid fee-for-service, Medicaid Managed Care, commercial insurers, and employers—on model alignment areas necessary to promote value-based care.
- Model alignment areas include but are not limited to goals and strategies, care delivery, financial incentives, quality measures, and data sharing.

II.B. Key Findings

Below are the key findings from the different sections covered in this environmental scan.

Background on Multi-Payer Alignment

In the transition from traditional FFS to value-based care, achieving large-scale change in providers' practice patterns can be difficult because individual payers often represent a small proportion of providers' revenue. The transition to value-based care is further complicated by the lack of standards in key components of value-based models, such as performance measures and reporting, data interoperability and sharing, and methods for attribution, benchmarking, and risk adjustment. Multi-payer alignment on value-based care can help achieve a threshold patient volume and revenue from value-based payments to initiate delivery system investments and care transitions, establish common value-based payment features, and encourage provider participation in value-based care.[1,2] Aligning payers—including Medicare, Medicare Advantage (MA), Medicaid (FFS and managed care), and commercial health plans—around value-based payment models can be beneficial for payers, providers, Accountable Care Organizations (ACOs), purchasers (e.g., employers), and patients. Potential benefits include:

- Improving affordability, access, equity, quality of care, and population health;
- Simplifying care delivery and reducing fragmented care;
- Allowing health care organizations and clinicians to focus on care transformation activities instead of managing different requirements across multiple payment models;
- Reducing administrative burden and costs by promoting consistency in billing and payment systems;
- Reducing the cost of investing in new health system capabilities to improve care; and
- Encouraging the use of patient data to inform clinical decision-making.[3,4,5,6]

Model Alignment Areas

Advancing alignment between public and commercial payers is needed to improve patient outcomes and lower costs through value-based payment models.[7] Payers, particularly payers within the same state or region, may align in the following areas:

- Goals and strategies;
- Care delivery;
- Payment methodology and financial incentives;
- Quality/performance measures and reporting;
- Attribution, benchmarking, and risk-adjustment methods; and
- Data interoperability and sharing.[8]

There is variation in the degree to which payers align in different areas. Payers may implement exact alignment or directional alignment.[9,10] Whereas exact alignment involves alignment on exact program design details and implementation, directional alignment is an iterative approach that involves alignment on program principles and goals while allowing flexibility to tailor design details based on different priorities and needs.

Factors Influencing Multi-Payer Alignment

Different factors can influence the success of achieving multi-payer alignment around a value-based care model, including stakeholder engagement; market circumstances (e.g., patient populations, local insurance market); payer competition and trust; facilitator involvement; antitrust laws and waivers; and use of technical assistance.

Stakeholder involvement and collaboration in the design, implementation, and evaluation of a model are key to the success of an initiative.[11] Stakeholders may include legislators or state agencies, payers, providers, purchasers, and patients. States commonly use one of two approaches to engage providers, patients, and other stakeholders in initiatives.[12] The first approach involves engaging stakeholders at the start of the model design process, where a state may create a work group comprised of stakeholders and hold regular meetings where the work group can discuss and reach consensus on model design decisions. The second stakeholder engagement approach involves designing the model and then engaging stakeholder feedback after model design.

It is important to consider local context when working to achieve consistency across payers.[13] The characteristics and needs of different patient populations and providers can shape a multi-payer alignment initiative, including its goals, quality/performance measures and reporting, and payment methodology.[14] A payer's willingness to participate in multi-payer initiatives may be influenced by its market share within a given region. For example, payers with a dominant presence in the market are more likely to benefit from improvements in the local delivery system and therefore have stronger incentives to engage.[15] The surrounding policy environment can also impact consistency across payers. For example, payer mandates can help achieve a critical mass of payers in multi-payer alignment initiatives. However, self-funded employer plans may be excluded from such mandates, complicating efforts to include the self-insured population in multi-payer initiatives.

Payer competition and trust can influence multi-payer alignment efforts. For example, commercial insurers may not want to share the proprietary nature of their payment design elements. Payers commonly work to distinguish their products from those of their competitors rather than work together to make their plans more similar.[16] This drive for product differentiation can hinder collaboration among payers.[17] Additionally, payer collaboration may be low in regions with competitive market conditions due to a lack of trust among the payers.[18]

Trusted facilitators (i.e., conveners)—such as federal or state entities, public-private partnerships, or private organizations—help to align competing interests, manage expectations, and facilitate collaboration in multi-payer alignment initiatives.[19] These facilitators can increase model acceptance by supporting regular communication and transparency among stakeholders; foster participant trust; build relationships among payers; translate broad goals into smaller, actionable steps; and overcome implementation barriers.[20,21] State entities (e.g., governor's office, insurance commissioner, Medicaid) are often well-positioned to serve as conveners due to their leadership capacity, purchasing power through Medicaid and state employee health plans, and ability to offer antitrust protections. [22]

Collaboration among health care payers to set specific prices and payment levels is restricted by federal antitrust laws.[23] These laws can hinder payer collaboration in multi-payer alignment initiatives. State-led initiatives can help address this challenge. When state entities serve as conveners, they may be eligible for immunity under the state-action doctrine and thus protected from federal antitrust enforcement. Anti-fraud and anti-abuse statutes (e.g., Anti-Kickback Statute, Stark Law) can discourage arrangements between payers and providers. Safe harbor waivers can reduce legal and regulatory barriers that hinder coordinated care and collaboration among payers and other stakeholders in multi-payer alignment initiatives.[24]

CMS has provided technical assistance to states and payers to support engagement in multi-payer alignment efforts and help to establish and meet shared goals.[25] For states, CMS has supported learning collaboratives to share best practices and tools and provided guidance on future Section 1115 waivers, state plan amendments, and directed payments within Medicaid Managed Care.[26] For payers, CMS has offered technical assistance through its innovation models, such as providing financial support to convene payers.[27] By offering these types of supports, CMS can enhance its communication, predictability, and transparency with state and regional multi-payer initiatives and establish a strategic approach to multi-payer alignment efforts.

Multi-Payer Alignment Initiatives

The CMS Innovation Center and several states have undertaken multi-payer alignment initiatives over the course of the last two decades. CMS-led initiatives have evolved over time. For example, the Comprehensive Primary Care (CPC) Initiative started in 2012 and was superseded by the CPC Plus (CPC+) Model. Two primary care-focused models followed the conclusion of CPC Plus: Making Care Primary (MCP) and Primary Care First (PCF). CMS' most recent initiative promoting multi-payer alignment is the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model.

Several states have designed multi-payer initiatives to support their transition to value-based care and transform health care delivery. Most states included Medicare, Medicaid, and commercial payers in their multi-payer alignment efforts. Large and diverse stakeholder participation was critical to success, as well as states that had the support of high-level leadership (e.g., state governor, health insurance commissioner). Several states currently continue their multi-payer efforts, although the names of specific models or initiatives may not be used anymore.

Relevant Features in Previously Submitted Proposals

Among the 35 proposals that were submitted to PTAC between 2016 and 2020, including 28 proposals that PTAC deliberated on during public meetings, Committee members found that 14 of the 28 proposals included potential approaches to multi-payer alignment.

III. Research Approach

This section provides a brief review of the research questions and methods that were used in developing this environmental scan.

III.A. Research Questions

Working closely with the Office of the Assistant Secretary for Planning and Evaluation (ASPE) staff and with input from a subset of Committee members known as a Preliminary Comments Development Team (PCDT),[iii] the following research questions were developed to inform this environmental scan:

- What is the vision and value that multi-payer models bring to value-based care?
- What are the foundational principles and alignment areas for multi-payer alignment?
- What strategies help to align and standardize benchmarking, attribution, and risk-adjustment methods across multiple payers?
- How can differentiation to allow for competition coexist with alignment in patient attribution and risk-adjustment methods?
- What are best practices for sharing data across multiple payers?
- What methods can be used to standardize performance measures and reporting across multiple payers?
- What types of payer incentives should be provided to promote multi-payer alignment?

[iii] The Preliminary Comments Development Team (PCDT) comprised four Committee members: Josh Liao, MD, MSc (Lead); Lindsay Botsford, MD, MBA; Lauran Hardin, MSN, FAAN; and Lee Mills, MD, MMM.

- What types of investments support states with ongoing alignment efforts (e.g., Medicaid waiver programs)?
- What types of technical assistance and supports encourage the transition to value-based payment models in multi-payer alignment initiatives?
- How are antitrust regulations and the use of safe harbor waivers navigated to effectively implement multi-payer alignment?
- How do competitive market dynamics between payers influence collaboration among payers?
- What other factors influence collaboration and engagement among commercial payers in multi-payer alignment initiatives (e.g., a desire for product differentiation from competitors, elements of payment design considered proprietary)?
- What are best practices to ensure consistency in value-based care across payers?
- How is progress toward achieving multi-payer value-based payment model goals monitored?
- Is multi-payer alignment more difficult to achieve for certain APM design components (e.g., benchmarks, risk adjustment) relative to other components?
- How can multi-payer alignment help reduce administrative burden on providers?
- What factors should be considered when implementing multi-payer alignment in primary care versus specialty care practices?
- How do the characteristics and needs of different patient populations and providers influence multi-payer alignment?
- What do we know from current and past multi-payer efforts (e.g., CMS Innovation Center, states)?
- What are approaches to multi-payer alignment that state value-based care models have implemented to date?

These primary research questions, organized by the environmental scan section, are provided in **Appendix A.**

III.B. Research Methods

The environmental scan included information gathered from a targeted review of the literature, an analysis of previous PTAC proposals, and an analysis of select CMS Innovation Center models and other state multi-payer initiatives.

This environmental scan was specifically focused on four pertinent topics (background on multi-payer alignment, model alignment areas, factors influencing multi-payer alignment, and multi-payer alignment initiatives).

The analysis of select PTAC proposals (**Appendix B**) included a review of past proposals, PTAC reports to the Secretary, and content available in other PTAC process documents (e.g., public meeting minutes, Preliminary Review Team [PRT] reports).

IV. Background on Multi-Payer Alignment

Health care financing includes a mix of traditional FFS and value-based care. The shift from FFS toward value-based care aims to improve population health while reducing health care costs. One challenge in the transition to value-based payment is reaching the patient volume and revenue thresholds needed to

change a provider practice's patterns on a large scale. When payments are associated with multiple public and private payers, one individual payer's contribution to a provider's total revenue may be relatively small. As a result, the impact of any single APM may be minimal, and the ability of one payer to drive considerable change is often limited.[28]

In addition to challenges related to scaling, there has been a lack of standards in key components across value-based payment models. Many models have different expectations for performance measurement and reporting, data sharing practices, patient attribution and benchmarking methods, and risk sharing. Given the lack of standards in these model components, participants may be required to invest time and resources into building the infrastructure needed to implement each individual model. Meeting the requirements of multiple models contributes to administrative burden.[29] The fragmentation that exists from the lack of standards in value-based payment models has challenged the transition from FFS to value-based payment, as FFS already has established standards that providers follow.[30]

Multi-payer alignment in value-based care can help achieve a threshold patient volume and revenue from value-based payments to initiate delivery system investments and care transitions, establish common value-based payment features, and motivate provider participation in value-based care.[31,32] PTAC is using the following working definition of multi-payer alignment:

- Agreement among payer programs and products—including those offered through traditional Medicare, Medicare Advantage, Medicaid fee-for-service, Medicaid Managed Care, commercial insurers, and employers—on the goals, strategies, and implementation areas necessary to promote value-based care.
- Implementation areas include but are not limited to financial incentives, care delivery flexibilities, data sharing, outcome measures, and patient engagement.

IV.A. Foundational Principles for Multi-Payer Alignment

Different types of payers, including Medicare, Medicare Advantage, Medicaid (FFS and Managed Care), and commercial health plans, are responsible for paying health care providers across the U.S. health care system. In collaboration with other stakeholders—such as providers, ACOs, purchasers (e.g., employers), and patients—aligning multiple payers around key areas of value-based payment models can promote the models' effectiveness and sustainability. Payers, particularly payers within the same state or region, may align in the following areas:

- Goals and strategies;
- Care delivery;
- Payment methodology and financial incentives;
- Quality/performance measures and reporting;
- Attribution, benchmarking, and risk-adjustment methods; and
- Data interoperability and sharing.[33]

Some areas of alignment may be easier to achieve relative to other areas due to requiring less effort to align and facing fewer regulatory constraints.[34] For example, quality and equity measures linked to incentives may be easier to align than patient attribution methods, risk-adjustment methods, and services that are included versus excluded from models.[35]

Advancing alignment between public and commercial payers is needed to achieve success and scalability in improving patient outcomes and lowering costs through value-based payment models.[36] As the dominant payer in the U.S., CMS' involvement in multi-payer alignment efforts is essential for establishing a unified approach to health care transformation by aligning incentives and requirements across both public and private payers and providing tools and resources for participants. This involvement can help drive progress on a national scale.[37] CMS has played a role as both a payer and facilitator in past multi-payer alignment initiatives and has provided resources and technical assistance to payers and providers to support alignment efforts. For example, CMS' leadership and financial investment in the Comprehensive Primary Care (CPC) Initiative—a CMS-funded multi-payer collaboration between CMS, private payers (commercial, Medicare Advantage, Medicaid Managed Care), and state Medicaid agencies across seven regions—played a pivotal role in securing broad payer participation and fostering active engagement. CMS' involvement encouraged payers to join the initiative by signaling a strong commitment to the initiative and bringing substantial resources to participating regions.[38]

IV.B. Degree of Multi-Payer Alignment

There is variation in the degree to which payers align in different areas, such as goals and strategies or risk-adjustment methods. This variation in the degree of alignment can include exact alignment and directional alignment.[39]

Exact Alignment

Exact alignment involves alignment on exact program design details and implementation with differences only where it is needed (e.g., compliance with local statutes and regulations, population-specific quality measures). For example, in CMS' Primary Care First (PCF) model—a multi-payer model comprised of 17 payer partners across 26 regions—exact alignment on efforts to minimize volume-based incentives involved using either partial primary care capitation or full primary care capitation as opposed to using other forms of payment.[40] Exact or nearly exact alignment ensures that cost-containment and quality goals of an initiative are clear to providers. Exact alignment can also reduce administrative burden on providers by standardizing billing, payment, and quality reporting processes.[41,42]

Despite potential advantages to consistency, exact alignment can be time-consuming and difficult to achieve.[43] Further, exact alignment may not be practical or possible in some cases. For example, although entities across the health care system may share similar goals, they face different legal and regulatory constraints and vary in their infrastructure, making it difficult to align across all areas.[44]

Directional Alignment

Directional alignment is an iterative approach that involves alignment on program principles and goals (e.g., transitioning away from FFS, sharing actionable data with practices) while allowing flexibility to tailor design details based on priorities and needs (e.g., the approach to how payers will minimize volume-based incentives, the type of and frequency in which data are shared with practices). This approach allows alignment to be phased in with more granularity over time by using an iterative approach to incrementally achieve alignment goals.[45] For example, in the PCF model, opportunities for directional alignment to minimize volume-based incentives included primary care episodes, shared

savings and shared losses, and partial primary care capitation.[46] CMS expected participating payers in the PCF model to work toward exact alignment—partial or full primary care capitation—over the course of their participation in the model.

Directional alignment can be relatively easy to achieve and is more commonly implemented relative to exact alignment because the approach offers flexibility.[47] Compared with exact alignment, the approach can potentially be more burdensome for providers as providers are still responsible for managing some variation between payers. Further, cost-containment priorities may not be as clear for providers when directional alignment is implemented compared with exact alignment.[48]

Extent of Alignment

The extent of alignment across payers may depend on a number of factors, including the number of payers involved, the diversity of the payers involved (i.e., the extent to which different lines of business are involved such as Medicare Advantage, Medicaid, and commercial payers), the level of payer involvement (e.g., number of team members engaged, the length of time payers are engaged), and/or the geographic spread (e.g., national versus local alignment) of the payers involved. These factors, coupled with the degree of regulatory intervention required in an initiative, can influence the level of effort needed to achieve the initiative's goals.[49] Alignment within payers (i.e., across programs) is also important to achieve the vision of reducing spending growth and improving population health.

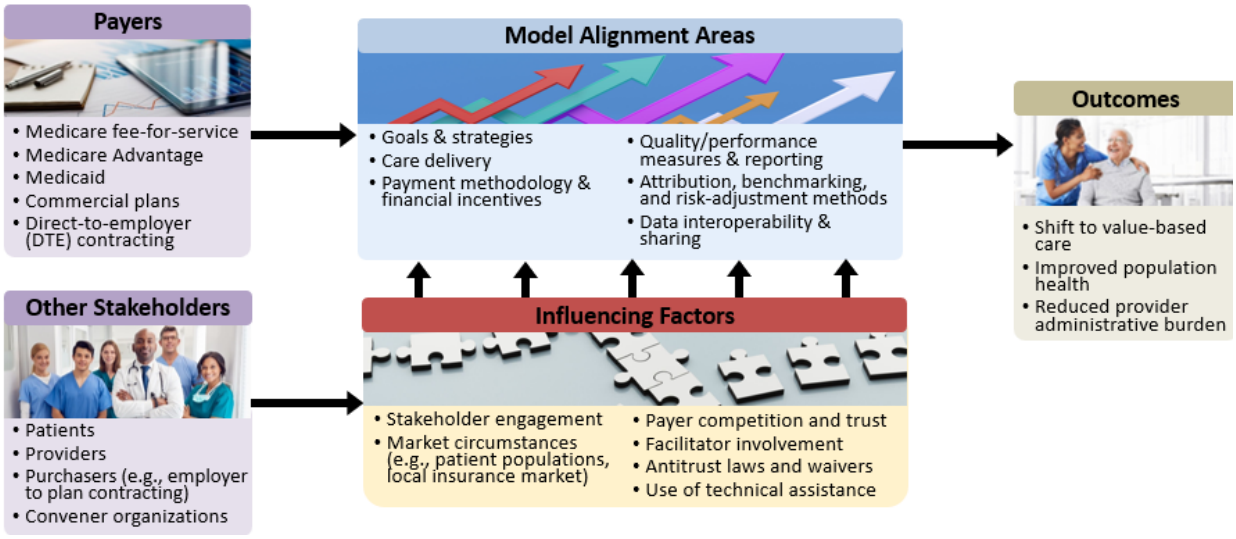
IV.C. The Value of Multi-Payer Alignment

Aligning payers around value-based payment models is associated with multiple potential benefits for payers, providers, patients, and other stakeholders. These benefits include:

- Providing a platform for health care payers and providers to work collaboratively to manage chronic illnesses and prevent diseases, ultimately improving affordability, access, equity, quality of care, and population health;
- Simplifying care delivery and reducing fragmented care by allowing health care provider entities to implement care pathways across a wide range of patients;
- Allowing health care organizations and clinicians to focus their time and effort on care transformation activities instead of managing different payment structures, regulations, and performance metrics across multiple payment models;
- Reducing administrative burden and costs by promoting consistency across billing and payment systems;
- Reducing the cost of investing in new health system capabilities to improve care; and
- Encouraging the use of patient data to inform clinical decision-making by ensuring that providers have access to all claims data.[50],[51],[52],[53]

A conceptual diagram for multi-payer alignment, including payers and other stakeholders, key areas of alignment, factors influencing alignment, and outcomes, is provided in Exhibit 1.

Exhibit 1. Multi-Payer Alignment Conceptual Diagram



Source: ASPE PTAC February Preliminary Comments Development Team Findings Presentation, February 2026

V. Model Alignment Areas

Key areas of alignment with value-based payment models include goals and strategies; care delivery approach and flexibilities; payment methodology and financial incentives; quality/performance measures and reporting; attribution, benchmarking, and risk-adjustment methods; data interoperability and sharing; and provider and patient engagement.

V.A. Goals and Strategies

A shared commitment to change among stakeholders in any multi-payer alignment initiative is a key facilitator in the transition to value-based care.[54] One of the first steps in implementing a multi-payer alignment initiative is to determine the goals for adopting a multi-payer value-based care model and improving care. Clearly defined goals for a multi-payer model or initiative serve as the foundation for developing a plan to implement and update alignment activities. Goals allow stakeholders to understand not only the aims of the initiative but also the benefits that the initiative will provide them.[55] Shared goals can be particularly important as payers may have differing interests and priorities due to serving different patient populations. For example, the characteristics and needs of Medicare's patient population may differ from those of commercial payers, which focus on care for working-age populations, and Medicaid Managed Care plans, which focus on care for low-income populations.[56]

Although the goals for multi-payer initiatives may differ depending on the challenges and opportunities facing a state and its stakeholders, the goals across initiatives are often similar. Many multi-payer alignment efforts include goals focused on improving the affordability and quality of care, reducing health disparities, improving population health, and reducing burden on providers who are working to achieve the goals of the reform. Goals commonly aim to improve specific areas of care, such as behavioral health, certain chronic conditions (e.g., cardiovascular disease), and pregnancy and maternal health. When establishing goals for a multi-payer alignment initiative, states should consider whether there is sufficient leadership available to support and champion a statewide initiative, who the key

stakeholders are that may be willing to collaborate in the initiative, what resources are available to staff to finance the effort, and what relevant lessons can be learned from the state's past value-based care efforts.[57]

Goals must be measurable to monitor progress and ensure sustained engagement from stakeholders.[58] To understand whether goals were met, multi-payer alignment initiatives should include plans for how progress toward achieving the initiative's goals will be monitored. Measures to monitor progress should be selected near the end of the model design process given that the measures will depend on the initiative's design and implementation.[59] To assess adherence to a model, states can review contracts to ensure that plans are aligned to model specifications, evaluate payers' compliance with laws and regulations, or collect progress reports from plans. Measures should also be used to monitor changes in quality of care and identify unintended consequences, such as stinting on care for certain populations with greater health needs. Stakeholders should convene regularly to assess progress toward meeting the initiative's goals, discuss feedback on implementation of the model, and solicit input on potential changes to the model. Information gathered from monitoring progress should be used to inform adjustments to the model design, and progress toward the initiative's goals should be shared via public forums, annual reports, and/or dashboards.[60]

Many stakeholders, including state and federal governments, private payers, and providers, face tension between the need for immediate cost savings versus the reality that achieving measurable savings and improved health outcomes requires time. For instance, Medicare, which typically has high patient retention rates, can benefit from payment models that emphasize long-term improvements in health outcomes because patients tend to receive coverage for long periods of time. In contrast, Medicaid and commercial insurers often face patient churn, potentially making them more likely to favor strategies that achieve relatively quick, short-term improvements.[61] Given that long-term improvements in health and reductions in cost are generally the goals of health care reform efforts, the demand for short-term evidence of success can pose challenges.[62]

Further, as a specific goal or strategy, payers may align on approaches to engage and support providers and patients in multi-payer alignment efforts. To reduce administrative burden for both providers and payers, payers may standardize resources, such as tools for behavioral health screening or for discussing whole-person care with patients, to provide consistent, streamlined processes for engaging patients across payers.[63] For example, in the Washington Multi-payer Primary Care Transformation Model—a statewide multi-payer effort to strengthen primary care—payer collaboration efforts included centralizing resources for providers to reduce the number of individual resources providers had to access for different payers.[64] To directly engage and support patients, payers may align on the types of educational outreach they provide to patients. For example, payers may inform patients about the importance of primary care, how to access primary care, and/or how to select a primary care provider (PCP).[65] Payers may also share information on providers' performance with patients to support their decision-making when selecting a provider. Additional research is needed to identify best practices for aligning payers on goals or strategies for provider and patient engagement approaches.

V.B. Care Delivery

Achieving multi-payer alignment does not require payers to achieve exact alignment. A directional approach to alignment includes efforts to adopt common standards to promote consistency across

payers while allowing flexibility to implement innovative approaches to care delivery based on organizational priorities.[66] These flexibilities in care delivery can allow providers to tailor strategies to fit their local circumstances, including the size and structure of the organization, the organization's readiness for transformation, and the needs of their patient populations. For example, in the Maryland All-Payer Model—where CMS partnered with the state to implement a single set of hospital payment rates for all payers—hospitals operated autonomously within the global budget to select and adapt initiatives (e.g., community health initiatives, transitional case management programs) to improve value-based care on their own organizational priorities, population needs, and local context.[67]

V.C. Payment Methodology and Financial Incentives

Multi-payer alignment initiatives often involve changing financial arrangements to transition from traditional FFS to value-based payment models. Adopting a common payment model with standardized rates can reduce administrative burden for providers and enhance transparency regarding each payer's contribution in the initiative. When developing a multi-payer alignment initiative, stakeholders determine the mechanisms and recipients of payments and the appropriate payment amounts. There are several considerations when determining a payment rate, including the application of payments across entire patient panels, the competencies of the providers (e.g., greater payments for practices that meet higher standards developed by organizations such as the National Committee for Quality Assurance [NCQA]), the complexity of the patient populations, and the inclusion of small practices and rural providers. Payment models can be aligned while allowing flexibility in the payment amount and risk level. Both payers and providers desire flexibility in structuring payments to accommodate differences in needs.[68]

When aligning payers on a value-based payment model, states can select from different types of models to address various drivers of cost. For example, hospital global budgets and episode-based payments may be selected to constrain hospital spending and strengthen quality incentives.[69] In the Maryland All-Payer Model—which informed the Maryland Total Cost of Care (MD TCOC) Model—conversion to a global budget system was considered a first step to aligning hospital priorities around value-based care in the state.[70] To support the transition to a global budget system, hospital revenue was preserved without implementing immediate reductions in the budgets if patient volume decreased. Hospital global budgets may serve as an initial step toward transitioning to accountability for total cost of care, where global capitation and shared risk may be used to reduce total cost of care.[71,72]

Specialty capitation and episode-based payment may be selected to control professional service spending (e.g., specialty physician services, non-physician services provided by behavioral health counselors).[73] For example, the Arkansas Health Care Payment Improvement Initiative—a state initiative that included Medicare, Medicaid, and private payers—used an episode-based payment structure for acute conditions and a Patient-Centered Medical Home (PCMH) payment model (prospective per-member-per-month [PMPM] payment) for chronic conditions.[74]

When selecting a payment model, states should consider how the model will balance cost-control opportunities with political and operational realities, determine which payment models are most likely to gain stakeholder support versus which models may face stakeholder resistance, identify whether the state has had prior success with a model, and determine how a model can incorporate incentives for quality and equity.[75]

One barrier to participation in multi-payer alignment initiatives is the requirement for payers or practices to modify their existing payment methods and billing systems. When only a small portion of a provider's business is associated with an initiative, the cost and complexity of adapting systems can outweigh perceived benefits. To mitigate this potential barrier, multi-payer initiatives can be designed to build upon existing FFS arrangements. PMPM payments may be used to financially support practice transformation and care coordination. These payments are often supplemented with up-front investments, enhanced FFS rates, and performance-based incentives such as pay-for-performance and shared savings models, which together can create a more sustainable and appealing financial structure for participating providers.[76]

V.D. Quality/Performance Measures and Reporting

There has been a proliferation in the number of and variability in existing performance measures. Although offering a menu of measures allows providers and payers to select measures that best reflect their patient populations, the use of different measures can make it difficult to compare outcomes across entities.[77] Aligning performance measures and reporting can help to establish one set of expectations across payers, monitor quality and outcomes, and reduce data collection and the reporting burden for providers.[78,79,80,81] Two key areas for measure alignment include those related to quality and health equity, particularly when the measures are tied to incentives, as aligning these measures can help avoid unintended consequences and create safeguards to ensure a focus on value.[82,83] For example, providing incentives for improving quality of care can prevent providers from eliminating or withholding services to reduce costs.[84]

There are challenges associated with aligning performance measures. Quality measures can be considered proprietary and contribute to an organization's competitive advantage.[85] In these cases, collaboration and alignment around a standard set of shared measures can be difficult to achieve. Additionally, some payers may be resistant to adopting standardized measure sets—such as those developed by state agencies—because they have already invested in their own frameworks and measures for assessing performance.[86]

It is important for payers to align on how measures are aggregated and reported.[87] Many clinicians report multiple quality measures to different entities, and reporting can be challenging when measure requirements are not consistent across payers. The collection of different quality metrics by different payers can limit insights on performance, especially when performance reflects only a small proportion of a provider's patient base. Aggregating data across multiple payers can help generate more accurate estimates of a provider's performance by allowing more stability in the measurements and benchmarks. However, aggregating data across payers can be difficult to do when payers use different quality indicators.[88,89]

One ongoing challenge to reporting clinical quality measures includes variation in data interoperability and the use of health IT across organizations.[90] Assessing performance using clinical quality measures can burden practices, especially those without advanced electronic health record (EHR) systems that are capable of supporting efficient data collection and reporting.[91] Developing All-Payer Claims Databases (APCDs)—databases that collect claims data from both public and private insurers in a state—can help address this challenge by aggregating cost and quality data in one place.[92]

Insights from the CMS Innovation Center's State Innovation Models (SIM) initiative—an initiative involving state-led multi-payer efforts—highlighted several strategies for achieving alignment on quality measures. These strategies included:

- Deciding whether alignment should be mandatory or voluntary;
- Clearly articulating the purpose of alignment and the provider entities to be measured (e.g., individual physicians, ACOs);
- Defining the scope of the effort;
- Convening a workgroup to develop a common set of measures;
- Establishing criteria for selecting measures;
- Inventorying and evaluating existing metrics;
- Selecting appropriate measures; and
- Implementing strategies to sustain alignment over time.[93]

States may also choose to align the performance measures they use in value-based payment models with measures used in CMS programs and initiatives, such as the Medicare Shared Savings Program, the Merit-based Incentive Payment System (MIPS), the Next Generation ACO model, and Medicare Parts C and D Star Ratings.[94]

The Core Quality Measures Collaborative (CQMC)—a multi-stakeholder group composed of representatives from CMS, Medicare and Medicaid Managed Care plans, commercial plans, purchasers, provider organizations, and consumers—has established core sets of quality measures that payers may use for reporting. The goal of establishing core measure sets is to harmonize high-value, evidence-based measures across public and private payers. The core measure sets cover a variety of clinical specialties, such as primary care, behavioral health, cardiology, and gastroenterology. Selected measures must be meaningful to patients, consumers, and providers; reduce variability in measure selection; and reduce measure collection burden and cost for providers.[95,96] Establishing consensus on performance measures can also help build trust among stakeholders involved in multi-payer initiatives.[97]

V.E. Attribution, Benchmarking, and Risk-Adjustment Methods

A lack of alignment across payers in key model design components, including attribution, benchmarking, and risk-adjustment methods, can contribute to administrative burden by making it challenging for providers to know which patients are eligible for payment. A lack of alignment in model components can also reduce the effectiveness of financial incentives.[98,99] For example, a provider's response to performance measures may depend on the methods and quality of data used to determine attribution.[100] However, variation in benchmarking, attribution, and risk adjustment may also be necessary to ensure that models meet the needs of different patient populations and reflect payers' and providers' goals and capabilities in implementing models.[101]

To align model components across payers, broad areas of directional alignment should be identified, and variation in the identified areas can be reduced over time.[102] For example, for the PCF Model, CMS developed a rubric that determined whether payers' attribution methods met CMS' preferred alignment criterion versus acceptable alignment criterion. To meet CMS' preferred alignment criterion, practices had to receive a list of prospectively attributed members on a monthly basis. To meet CMS' acceptable alignment criterion, practices had to receive a list of prospectively attributed members at least

quarterly. Payers that met only CMS' acceptable alignment criterion for attribution were expected to meet CMS' preferred alignment criterion over the course of their participation in the PCF Model.[103] As another example, multi-payer initiatives may use a set of principles to facilitate alignment on risk-adjustment methods across payers. Initiatives may encourage payers and providers to collaborate to identify appropriate risk-adjustment methods for certain models. More work is needed to determine effective approaches to align payers on key model components while also accounting for differences in goals and patient populations.[104]

V.F. Data Interoperability and Sharing

A strong health information infrastructure is necessary for providers to access and share timely data that can inform care. Health information exchanges (HIEs) allow providers to access actionable patient health information and are critical for the implementation and sustainability of multi-payer alignment.[105] One key facilitator in the Maryland All-Payer Model was allowing stakeholders to access hospital-level and patient-level data in one place within the designated HIE in the state: the Chesapeake Regional Information System for Our Patients (CRISP).[106] CRISP supported implementation of the model by allowing stakeholders to track hospital volume in real time and identifying areas to improve value. Additional health information infrastructure supports may include but are not limited to quality reporting systems to collect and exchange quality data, a state APCD to provide access to claims and provider files associated with both public and private payers, state registries to provide payers and providers access to patient information, and a provider directory that includes all in-network providers within a specific region and insurance plan.[107]

Providers often have different IT infrastructures and capacities to collect and analyze data, making it challenging to coordinate patient care effectively across multiple independent payers and provider organizations.[108,109] Multi-payer initiatives have generally placed the responsibility of developing solutions for data sharing on individual health plans and providers. Improving health information infrastructure, such as connecting providers to HIEs, often presents financial barriers because the costs associated with integration can be substantial.[110,111] Additionally, privacy concerns and security laws related to sharing sensitive health information can further complicate efforts to build data sharing networks.[112] However, data sharing capabilities are improving due to recent investments in electronic data standards and advancements in data interoperability. These advancements are helping to streamline and standardize data exchange across settings.[113]

There are several opportunities at the state level to improve data sharing across payers. As a first step, states can enhance data sharing across payers by identifying areas where timely and reliable access to data can most effectively advance care goals.[114] States can also prioritize funding for improving health information infrastructure to enhance providers' capacities for data sharing and analytics.[115] For example, investments in electronic standards and data interoperability may facilitate collaboration between regional and state data exchange infrastructures.[116]

There are also several opportunities at the national level to improve data sharing across payers. CMS can promote data sharing by offering technical assistance and guidance for developing APCDs that capture data on quality, utilization, and cost across all payers in a state. CMS can also consider improving the availability and timeliness of complete Medicare data for states, payers, and providers

and collaborate with states to address state and federal privacy laws, such as the Health Insurance Portability and Accountability Act (HIPAA), that can hinder the sharing of information.[117,118]

VI. Factors Influencing Multi-Payer Alignment

Different factors can influence the success of achieving multi-payer alignment around a value-based care model, including other stakeholder participation, market-specific issues (e.g., patient populations, local insurance market), the extent of payer competition and trust, facilitator involvement, antitrust laws and waivers, and use of technical assistance.

VI.A. Stakeholder Engagement

Insights from multi-payer initiatives have highlighted the importance of bringing together committed stakeholders to achieve multi-payer alignment goals.[119] Stakeholders may include legislators or state agencies, payers, providers, purchasers, and patients. The convener leading an initiative is commonly the entity responsible for engaging different stakeholders to support and participate in the initiative. As participants, providers have a variety of key responsibilities in multi-payer initiatives, such as collecting and reporting clinical data that inform benchmarking and performance measurement.[120]

Stakeholders are not only engaged to participate in multi-payer initiatives but may also be involved in the design and development of multi-payer models. The CMS Innovation Center's central role in developing APMs allows for the engagement of a broad range of stakeholders—including Medicare, Medicaid, private insurers, providers, and other stakeholders—throughout the model development, implementation, and evaluation phases.[121] Close collaboration between CMS and states during model design can promote participant engagement and commitment in the transition to value-based care.[122] For example, CMS worked with Maryland to design the Maryland All-Payer Model. This collaborative approach allowed the state to engage hospitals and payers early in the design process, providing an opportunity for participants to tailor the model to the state's environment and avoid potential barriers to implementation.

Involving providers and patients in model design is key to the success of an initiative. For example, providers can help operationalize care pathways and quality improvement strategies in care models and ensure that approaches to attribution, risk adjustment, and incentive structures appropriately reflect clinical realities. They also serve on advisory boards and working groups to support alignment efforts. Patients and their advocates can ensure that care meets their needs.[123] There is variability in the way and extent to which stakeholders are involved in the design of models, where some initiatives do not engage stakeholders at all while other initiatives include stakeholders throughout the initiative.[124] States typically use one of two approaches to include providers, patients, and other stakeholders in model design.[125] The first approach involves including stakeholders at the start of the model design process. With this approach, a process for making model design decisions with stakeholders should be developed. For example, a state may create a work group comprised of stakeholders and hold regular meetings where the work group can discuss and reach consensus on model design decisions. Although this approach to including stakeholders in model design can be resource- and time-intensive, the approach can foster strong stakeholder buy-in. The second approach to including stakeholders in model design involves designing the model and then requesting stakeholder feedback. Although this approach generally requires few resources because stakeholder consensus on individual model design decisions does not necessarily need to be reached, establishing buy-in from stakeholders using this approach may be difficult.

Establishing a governing body that oversees an initiative's activities can promote transparency and accountability in a multi-payer initiative.[126] For example, established by the Vermont Legislature, Green Mountain Care Board is an independent regulatory board that oversees changes to the state's health care payment and delivery system while ensuring transparency in the health system.[127] The board provides oversight of Vermont's All-Payer Model—a multi-payer effort involving Medicare, Medicaid, and commercial payers. In addition to monitoring and reporting on progress toward achieving the model's goals, Green Mountain Care Board identifies successes and challenges in multi-payer efforts by conducting payer-specific evaluations and collecting stakeholder input on barriers to participation.[128]

VI.B. Market Circumstances

Lessons learned from multi-payer initiatives have underscored the importance of considering local context—including local needs among patient populations and providers, the structure of the local insurance market, and the surrounding policy environment—when working to achieve consistency across payers.[129] The characteristics and needs of different patient populations and providers can shape a multi-payer alignment initiative, including its goals, quality/performance measures and reporting, and payment methodology. For example, in a region with high rates of chronic disease, the payers within the region may align goals and outcome measures focused on improving chronic disease management for patients. The payers may also adopt similar payment methods and reporting requirements to lessen administrative burden on providers in the region so the providers can focus their efforts on caring for patients.[130]

The structure of local insurance markets also influences multi-payer alignment efforts, including payers' willingness to participate. One key factor is a payer's market share within a given region. Payers with a dominant presence in the market are more likely to benefit from improvements in the local delivery system and therefore have stronger incentives to engage.[131] Commercial insurers operating in multiple states may find it impractical to customize a value-based payment model to fit the needs of a single state.[132] State and regional initiatives have demonstrated success with aligning non-Medicare payers by focusing on shared local priorities, addressing the specific needs and abilities of local payers and providers, and scaling the initiative by leveraging Medicaid, state employee health plans, and insurance exchange programs.[133] Opportunities exist for CMS to focus engagement with states that have had limited impact in value-based care models, including states that have large rural communities with low patient volume.[134]

The policy environment can also impact payer engagement and collaboration in multi-payer efforts. Payer mandates can help achieve a critical mass of payers in multi-payer alignment initiatives. However, self-funded employer plans and their administrators are generally excluded from such requirements under the Employee Retirement Income Security Act of 1974 (ERISA).[135] This exemption can complicate efforts to include the self-insured population in multi-payer initiatives. In self-insured arrangements, commercial insurers serve as administrative intermediaries where the sponsoring employer has the ultimate decision-making authority. Obtaining employer approval to participate in new payment models can be a time-consuming and resource-intensive process for commercial payers.[136] Large employers often hesitate to alter their employees' health coverage, particularly when the proposed changes are for programs perceived as experimental or short-term.[137] Additionally, evidence suggests that many large employers prefer to lead rather than follow decision-making about health care payment and delivery.[138]

Although self-funded health plans are generally excluded from state reform policies due to ERISA, self-funded plans can still voluntarily engage in multi-payer initiatives. To encourage engagement of self-insured plans in multi-payer initiatives, states can inform the plans how they might benefit from the initiative.[139] Additionally, states can identify employer champions who are willing to publicly support the initiative to increase the likelihood that other employers will join.

VI.C. Payer Competition and Trust

The adoption of APMs and advanced APMs varies significantly across payer types, with commercial insurers showing the lowest adoption compared with Medicaid, Medicare Advantage, and traditional Medicare.[140,141] The competitive nature of the commercial insurance market may be one reason for lower APM adoption rates among commercial insurers. Some commercial payers may be concerned that investing in payment models that successfully reduce overall health care utilization and costs could inadvertently benefit competitors who do not make equal investments in the development or implementation of such models—essentially subsidizing the care of patients covered by non-participating payers.[142]

Additionally, commercial insurers may be reluctant to share the proprietary nature of their payment design elements and choose not to participate in an APM.[143] Commercial payers often work to distinguish their products from those of their competitors rather than work to make their plans more similar. This drive for product differentiation can hinder collaboration among payers.[144] Solutions that allow for competition through differentiation to coexist with alignment in certain areas, such as risk adjustment, patient attribution methods, and quality measurement, are needed to increase participation in value-based payment models among some types of payers.[145]

Payer collaboration may be low in regions with competitive market conditions due to a lack of trust among the payers and the competing demands that these payers face.[146] This issue was evident in CMS' Comprehensive Primary Care (CPC) Initiative—a collaboration between CMS, commercial insurance plans, and state health insurance plans—where competitive market conditions and high levels of payer consolidation hindered collaboration among non-CMS payers. Further, payers in some regions may enter multi-payer initiatives with already established relationships with the other payers in the region. In these cases, the payers may initially be reluctant to collaborate with new or national payers in an initiative.[147] Creatively identifying ways to enhance communication can help to build trust among payers. For example, in the CPC Initiative, CMS changed which staff attended meetings with payers. Early in the initiative, staff from CMS' national headquarters attended meetings with payers. Later in the initiative, staff from CMS' regional offices began to attend meetings, and these individuals could often attend meetings in person and speak about regional context. Payers found this change to improve communication among stakeholders.[148]

A single payer's dominance in a commercial market can allow that payer to steer decision-making in its region. Smaller payers with less dominance in their regions may perceive having the dominant payer drive decisions in the region as fair. However, this dominance may hinder engagement of smaller payers over time because the uneven distribution of the market among different payers in highly consolidated markets can reduce the perceived value in aligning on similar approaches in a multi-payer initiative. For example, in the CPC Initiative, payers decided to not align on data feedback. Smaller payers in some regions felt that efforts to align on a shared system was not worth the investment, as practices were

already receiving sufficient data from the dominant payer. That is, the smaller payers felt that their data contributions to practices would not add value beyond what the practices were already receiving from the dominant payer in the region.[149]

VI.D. Facilitator Involvement

Trusted facilitators (i.e., conveners) play a crucial role in aligning competing interests, managing expectations, and facilitating collaboration.[150] Facilitators can include federal or state entities, public-private partnerships, or private organizations. These facilitators can increase model acceptance by supporting regular communication and transparency among stakeholders.[151] In the CPC Initiative, payers identified neutral payer conveners as instrumental in fostering participant trust; building relationships among payers; translating broad goals into smaller, actionable steps; and overcoming implementation barriers.[152] Although CMS' leadership was critical for establishing broad payer participation in the CPC Initiative, its dual role as both a convener and payer led to confusion about the degree of influence other payers had in shaping the initiative.[153]

Although different entities can serve as conveners, state entities are often well-positioned to serve as conveners of multi-payer alignment initiatives due to their leadership capacity, purchasing power through Medicaid and state employee health plans, and ability to offer antitrust protections. States that successfully implement multi-payer initiatives have involved sustained leadership. This leadership can come from different stakeholders, such as the governor's office, the insurance commissioner, or Medicaid.[154] For example, the governor of Arkansas played a key role in initiating the Arkansas Health Care Payment Improvement Initiative. The governor identified payment and delivery system transformation as a top priority in the state and provided resources to state offices such as Medicaid, human services, and the independent Arkansas Center for Health Improvement.[155]

VI.E. Antitrust Laws and Waivers

Collaboration among health care payers to set specific prices and payment levels is restricted by federal antitrust laws.[156] These laws tend to support an underlying assumption that payers should compete rather than collaborate and lead to differentiation among products.[157] However, these same laws that promote competition can also impede payers from coordinating and working together in multi-payer alignment in value-based care models.

State-led initiatives can help address challenges related to antitrust laws by facilitating multi-payer collaboration. When state entities act as conveners, they may be eligible for immunity under the state-action doctrine and thus protected from federal antitrust enforcement. This protection provided to state entities allows for greater flexibility in aligning payment methods across multiple payers.[158] To avoid antitrust concerns when multi-payer initiatives are convened by non-state entities, the initiative may focus on aligning payers on key model design features while having each payer negotiate payment amounts with practices independently.[159,160] For example, the Arkansas Health Care Payment Improvement Initiative aligned payers on key model components and quality targets but did not share cost targets among payers to avoid antitrust issues.[161] For the Colorado Multipayer Patient-Centered Medical Home Project—a multi-payer pilot that included Medicaid and five private health plans—antitrust guidelines were developed for stakeholder meetings to ensure that discussion did not cover topics sensitive to antitrust regulations. Stakeholders could discuss payment structures during regular

team meetings but were advised not to discuss specific amounts plans would pay practices or how to set reimbursement for services. Payments and payment contracts were developed between individual practices and plans.[162]

Arrangements between payers and providers can lead to concerns regarding anti-fraud and anti-abuse statutes, including the Anti-Kickback Statute, which prohibits payment for patient referrals, and Physician Self-Referral Law (i.e., Stark Law), which prohibits physicians from referring patients to receive health services from entities with which the physician has a financial relationship.[163] Safe harbor waivers protect some types of payments and practices that would otherwise be considered kickbacks. These waivers can play an important role in enabling multi-payer alignment on value-based care by reducing legal and regulatory barriers that hinder coordinated care and collaboration among payers and other stakeholders.[164] These protections give payers and providers regulatory flexibilities in value-based arrangements by allowing them to collaboratively select payment models and value-based activities, quality measures, patient populations, and referral requirements. CMS issues safe harbor waivers to promote collaboration among payers to develop and test payment models, negotiate rates, and encourage broader payer participation in value-based care.[165]

VI.F. Use of Technical Assistance

Technical assistance for states and payers can support engagement in multi-payer alignment efforts and help to establish and meet shared goals.[166] CMS plays an important role in providing technical assistance to states in multi-payer initiatives. For example, CMS has supported learning collaboratives to share best practices and tools and support states with identifying successful models. To streamline state efforts in initiatives, CMS has provided guidance on future Section 1115 waivers, state plan amendments, and directed payments within Medicaid Managed Care.[167]

CMS also plays an important role in providing technical assistance to payers. For example, CMS has offered technical assistance through its innovation models, such as providing financial support to convene payers.[168] Established by CMS, the Health Care Payment Learning & Action Network (HCPLAN) developed the State Transformation Collaboratives (STCs), comprised of payers in Arkansas, California, Colorado, and North Carolina. Using a community-driven approach that considered the needs of each region, the STCs focused on aligning both public and private payers in the state to improve population health and reduce health care costs.[169] States that hosted an STC provided technical assistance to enhance communication between payers, share evidence-based practices, and ensure that payer relationships remained after models ended.

The Duke-Margolis Center for Health Policy outlined the following steps that CMS can take to enhance participation in multi-payer alignment efforts and achieve standardized approaches:

- Offer a multi-payer alignment calendar to help stakeholders—including states, employers, and payers—plan for upcoming CMS payment reforms and regulatory changes;
- Increase investment in state-level and regional multi-payer initiatives, particularly to enhance data infrastructure and data sharing, and facilitate the approval of Medicaid value-based payment efforts through state plan amendments, 1115 waivers, and managed care organization directed payments;

- Provide technical assistance to states to build competencies on the use of electronic clinical quality measures (eCQMs) and automated strategies for payment reform, such as benchmarking and risk adjustment, to further improve data infrastructure and promote the adoption of electronic data standards;
- Facilitate learning collaboratives to share lessons learned and connect local efforts to national best practices, tools, and resources;
- Establish feedback mechanisms to facilitate clear communication among stakeholders about state and regional multi-payer alignment goals and activities; and
- Continue to participate in multi-payer initiatives to build on previous strategic initiatives and align Medicare accountable care reforms with state and regional efforts.[170]

By offering states and payers these types of supports, CMS can enhance its communication, predictability, and transparency with state and regional multi-payer initiatives and establish a strategic approach to multi-payer alignment efforts.

VII. Multi-Payer Alignment Initiatives

The CMS Innovation Center and several states have undertaken various multi-payer alignment initiatives over the course of the last two decades. To date, there are nine CMS-led initiatives that involve multi-payer alignment efforts. These initiatives have evolved over time. For example, the Comprehensive Primary Care (CPC) Initiative started in 2012 and was superseded by the CPC Plus (CPC+) Model. Two primary care-focused models followed the conclusion of CPC Plus: Making Care Primary (MCP) and Primary Care First (PCF). CMS' most recent initiative promoting multi-payer alignment is the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model. **Exhibit 2** provides information on the approaches to multi-payer alignment, participating states or regions, participating payers, and successes and challenges for the nine CMS-led multi-payer initiatives.

Exhibit 2. CMS-Led Multi-State Multi-Payer Models and Initiatives

CMS Model	Approaches to Multi-Payer Alignment	Participating States/Regions	Participating Payers	Successes and Challenges
Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model[171] 2026–2035	• Builds upon Maryland TCOC and Vermont All-Payer ACO Models • Aligns Medicaid and commercial payers with Medicare • Participation of Medicaid and other payers in hospital global budgets	• Connecticut • Hawaii • Maryland • New York • Rhode Island • Vermont	• Medicare • Medicaid • Commercial	• Performance window for this model does not start until 2026.

CMS Model	Approaches to Multi-Payer Alignment	Participating States/Regions	Participating Payers	Successes and Challenges
Comprehensive Primary Care (CPC)[172,173] 2012–2016	• Population-based care management fees provided by Medicare and other payers • Payers agreed to collaborate on an approach to align goals, financial incentives, and performance measures.	• Arkansas • Colorado • New Jersey • New York (North Hudson-Capital Region) • Ohio & Kentucky (Cincinnati-Dayton Region) • Oklahoma (Greater Tulsa Region) • Oregon	• Medicare • Medicaid (except NJ and NY region) • Commercial	<u>Successes</u> • Payers established valuable relationships with each other in their respective state/region. • Payers in CO and the OH/KY and OK regions were able to create a single tool to aggregate data across payers. • Payers in AR and OR aligned cost and utilization measures in payer feedback reports. <u>Challenges</u> • CMS' dual role as convener and participating payer made collaboration and trust-building difficult. • CPC administrative reporting was burdensome to providers.

CMS Model	Approaches to Multi-Payer Alignment	Participating States/Regions	Participating Payers	Successes and Challenges
Comprehensive Primary Care Plus (CPC+)[174,175,176] 2017–2021	• Population-based care management fees and performance payments provided by Medicare and other payers • Additional payments during COVID-19 • Payers agreed to collaborate on an approach to align goals, financial incentives, and performance measures.	• Arkansas • Colorado • Hawaii • Kansas & Missouri (Greater Kansas City Region) • Louisiana • Michigan • Montana • Nebraska • New Jersey • New York (North Hudson-Capital Region) • New York (Greater Buffalo Region) • North Dakota • Ohio & Kentucky (Cincinnati-Dayton Region) • Oklahoma • Oregon • Pennsylvania (Greater Philadelphia Region) • Rhode Island • Tennessee	• Medicare • Medicaid • Commercial	<u>Successes</u> • Broad participation from public and private payers • Payers in 12 states/regions aggregated data with Medicare FFS data into one single tool. • Having a neutral convener to facilitate data aggregation among payers is important. <u>Challenges</u> • While many large payers participated in CPC+, they did not include all lines of business so multi-payer efforts were not as effective as they could have been. • Inability of many payers to implement population-based payments due to practices' opposition to accepting capitated payments and the investment needed to develop compatible data systems • Need for more transparency in private payers' performance-based payment models
Enhancing Oncology Model (EOM)[177,178] 2023–2030	• Encourages multi-payer participation	• Not a statewide model; participating practices reside across approximately 30 states	• Medicare • Medicaid[iv] • BlueCross BlueShield of South Carolina	<u>Successes</u> • None specifically related to multi-payer alignment to report at this time <u>Challenges</u> • Only one commercial payer is currently participating.

[iv] While EOM is open to state Medicaid agencies to participate, it is not clear if any state Medicaid agencies are currently participating in the model.

CMS Model	Approaches to Multi-Payer Alignment	Participating States/Regions	Participating Payers	Successes and Challenges
Making Care Primary (MCP) Model[179,180] 2024–2025	• Built upon CPC, CPC+, PCF, and Maryland Primary Care Program • Gradual implementation of prospective, population-based payments • Directional alignment on primary care payment, performance measures, financial incentives, data aggregation, and learning systems	• Colorado • Massachusetts • Minnesota • New Jersey • New Mexico • New York • North Carolina • Washington	• Medicare • Medicaid • Commercial	Successes • N/A (no evaluation reports were completed during the 1.5 year run of this model). Challenges • Prematurely ended after less than two years, which did not allow it to progress to its full potential.
Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration[181,182] 2011–2014[v]	• CMS joined state-sponsored multi-payer initiatives involving PCMHs.	• Maine • Michigan • Minnesota • New York • North Carolina • Pennsylvania • Rhode Island • Vermont	• Medicare • Medicaid • Commercial	Successes • Most states had stable payer participation (about 3-7 payers involved, as well as Medicare and Medicaid). Challenges • Practices did not receive data from states and payers in a timely manner. • Multi-payer alignment is complex and takes substantial time to see progress; participants felt that they were just getting started when the demonstration ended.

[v] Five states (Maine, Michigan, New York, Rhode Island, and Vermont) participated through 2016.

CMS Model	Approaches to Multi-Payer Alignment	Participating States/Regions	Participating Payers	Successes and Challenges
Primary Care First (PCF)[183,184,185] 2021–2025	• Aligned payment methodology, performance measurements, and data sharing approach • Flat primary care visit fee, a population-based payment, and performance-based adjustment	• Alaska • Arkansas • California • Colorado • Delaware • Florida • Hawaii • Kansas & Missouri (Greater Kansas City Region) • Kentucky (Northern Region) • Louisiana • Maine • Massachusetts • Michigan • Montana • Nebraska • New Hampshire • New Jersey • New York (Greater Buffalo Region) • New York (North Hudson-Capital Region) • North Dakota • Ohio • Oklahoma • Oregon • Pennsylvania (Greater Philadelphia Region) • Rhode Island • Tennessee • Virginia	• Medicare • Medicaid[vi] • Commercial	Successes • Private payer collaboration with CMS and CMS Innovation Center Models Challenges • Limited payer participation and alignment; only three state Medicaid agencies and 17 commercial payers participated across 26 states/regions. • About one-quarter of payers withdrew from the model citing: 1) PCF was not a priority compared with their own initiatives; 2) low practice participation as many practices opted to join ACO REACH (Realizing Equity, Access, and Community Health); and 3) issues paying capitated payments for PCF using their own billing systems.

[vi] State Medicaid agencies that participated in PCF were Louisiana, Maine, and Ohio.

CMS Model	Approaches to Multi-Payer Alignment	Participating States/Regions	Participating Payers	Successes and Challenges
State Innovation Models (SIM) Initiative[186,187,188] 2013–2020	• Three types of awards: model testing, model pre-testing, model design[vii] • Engaged public and commercial payers, providers, and patients to develop or implement a state innovation plan • States were provided flexibility to use CMS funds to build their state innovation plan to meet the needs of their states. • States needed to submit a Medicare alignment proposal to gain the ability to align with Medicare.	• Arizona • Arkansas • California • Colorado • Connecticut • Delaware • District of Columbia • Hawaii • Idaho • Illinois • Iowa • Kentucky • Maine • Maryland • Massachusetts • Michigan • Minnesota • Montana • Nevada • New Hampshire • New Jersey • New Mexico • New York • Ohio • Oklahoma • Oregon • Pennsylvania • Rhode Island • Tennessee • Texas • Utah • Vermont • Virginia • Washington • West Virginia • Wisconsin	• Medicare • Medicaid • Commercial	<u>Successes</u> • States' planning and implementation efforts resulted in the development of relationships that would serve as a starting point for future state multi-payer initiatives. <u>Challenges</u> • Only three states (AR, OR, and VT) aligned payment models across multiple payers.

[vii] Model test awards gave funds for states to implement and test health system transformation strategies; model pre-test and design awards gave funds for states to plan and design health system transformation strategies.

CMS Model	Approaches to Multi-Payer Alignment	Participating States/Regions	Participating Payers	Successes and Challenges
State Transformation Collaboratives (STCs)[189,190] (Joint effort between CMS and HCPLAN) 2023–present	• Collaboratives within each state to test approaches to multi-payer alignment focused on specific needs of each state • Stakeholder convenings and work groups that connect large groups of stakeholders for each state (e.g., payers, providers, purchasers, patient advocates, and community-based organizations)	• Arkansas • California • Colorado • North Carolina	• Medicare • Medicaid • Commercial	<u>Successes</u> • HCPLAN was able to compile a multi-payer alignment blueprint based on approaches taken by the STC states. • The Arkansas STC built on CPC+ and PCF efforts to develop aligned performance measures. • The California STC engaged new commercial payers to join STC alignment efforts. • The Colorado STC facilitated sessions to receive feedback on legislation that would set standards to align primary care APM model design components, including aligned performance measures. • The North Carolina STC focused on aligning performance measures and standardizing health equity data collection efforts.

Several states have designed multi-payer initiatives to support their transition to value-based care and transform health care delivery. Nine states have undertaken substantial work implementing a multi-payer model or initiative. These nine state-led initiatives are highlighted in **Exhibit 3**, detailing the approaches to multi-payer alignment, participating payers, and successes and challenges of the initiative. Most states included Medicare, Medicaid, and commercial payers in their multi-payer alignment efforts. Large and diverse stakeholder participation was critical to success, as well as states that had the support of high-level leadership (e.g., state governor, health insurance commissioner). Several states currently continue their multi-payer efforts although the names of specific models or initiatives may not be used anymore.

It should be noted that several states have established multi-payer task forces, stakeholder groups, and/or collaboratives; however, states were included in this table only if they have implemented a specific model or initiative.

Exhibit 3. Single State Multi-Payer Models and Initiatives

State Model/Initiative	Approaches to Multi-Payer Alignment	Participating Payers	Successes and Challenges
Arkansas Health Care Payment Improvement Initiative[191,192,193,194] 2012–present	• Aligned on design elements and implementation strategy • Standardized reporting tools and targets for quality outcomes • Episode-based payment structure for acute conditions and PCMH payment model (prospective per-member-per-month payment) for chronic conditions • Mandatory participation for episode payments system • Does not align/share cost targets among payers to avoid antitrust issues	• Medicare FFS • Medicaid FFS • Medicaid Managed Care • Arkansas Blue Cross Blue Shield • QualChoice • Ambetter • Humana	Successes • CPC participant, which was critical in AR's development of this initiative • Leadership stemming from the AR governor • Buy-in from AR's largest private employer (Walmart) • Stakeholder consensus on key model design components • AR's commercial insurance market is consolidated to a few carriers, which helped simplify design process. • Episode-based payments improved quality and contained costs. Challenges • Private payers do not participate in every care episode.
California Advanced Primary Care Initiative (The Payment Model Demonstration Project)[195,196,197,198] 2022–present	• Involvement of Purchaser Business Group on Health's California Quality Collaborative (CQC), Integrated Healthcare Association (IHA), and health plans in designing payment model(s), developing performance metrics, and developing/executing implementation strategy • Shared platform/reporting system across payers so practices have a complete view of patient information • Walmart, Covered California (marketplace), CA Public Employees' Retirement System, and CA Department of Health Care Services (Medicaid) will monitor demonstration progress. • Builds upon the Advanced Primary Care Measurement Pilot, which began in January 2022	• Medicare FFS • Medicare Advantage • Medicaid FFS • Medicaid Managed Care • Aetna • Blue Shield of California • Centene Health Net • Covered California (marketplace) • CA Public Employees' Retirement System (CalPERS)	Successes • Including independent practices in the model, which constitute a substantial portion of PCPs in California Challenges • TBD; evaluations to commence in 2026

State Model/Initiative	Approaches to Multi-Payer Alignment	Participating Payers	Successes and Challenges
Colorado APM Alignment Initiative[199] 2021–present	• Flexibility to providers and payers to implement any APM on the HCPLAN APM continuum • Prospective payment methodology is encouraged. • Standardized quality measures across payers • Attribution by patient attestation; when not available, payers should use claims. • Risk-adjust by health conditions, age, and gender • Medicare was included as a payer when the state participated in the CMS Making Care Primary Model.	• Medicare FFS • Medicare Advantage • Medicaid FFS • Medicaid Managed Care • Anthem • CVS/Aetna • Denver Health • Kaiser Permanente • Rocky Mountain Health Plans • ERISA & state employee self-funded plans	Successes • Formed an APM alignment advisory group and two sub-groups (focused on primary and maternity care) representing a broad range of stakeholders to develop consensus-based recommendations Challenges • Stakeholders recognized that it is hard to align across national health plans that want consistency across their markets.
Maryland Total Cost of Care (TCOC) Model[200,201,202,203,204,205] 2019–2026	• All-payer global budget pays hospitals annual fixed amount. • Used a waiver to establish shared hospital payment rates where all payers in Maryland pay hospitals based on same/similar rates • Standardized billing and reporting requirements across payers • Standardized quality measures across payers • Payer alignment on bundles and primary care • Convened a payer alignment work group to propose recommendations, such as communication of model to other stakeholders in MD	• Medicare FFS • Medicaid FFS • Medicaid Managed Care • CareFirst • UnitedHealthcare • Wellpoint	Successes • Set the groundwork for health care delivery system transformation • Established community partnerships Challenges • Initially, the all-payer rate system created the perverse incentive to increase volume of services. Maryland introduced global budgets to negate this incentive. • Budgets should be determined locally and consider local cost of living (e.g., urban vs. rural vs. in-between areas). • Improving population health requires the need to identify the 5% of the population that is accountable for almost half of health care spending.

State Model/Initiative	Approaches to Multi-Payer Alignment	Participating Payers	Successes and Challenges
Minnesota Accountable Health Model[206,207,208] 2013–2017	• Aligned risk adjustment, attribution, financial incentives, and ACO contract requirements • Standardized performance measures across payers • Standardized data analytics content and format	• Medicare FFS • Medicaid FFS • Medicaid Managed Care	Successes • Engaged a broad stakeholder group • Several state efforts took place around a similar timeframe, such as the Multi-Payer Alignment Task Force (mostly focused on improving exchange of data) and the Health Care Homes (HCH) Program, which also participated in the CMS MAPCP demonstration from 2011-2014; it is still active and focuses on primary care clinics that involve Medicaid and commercial payers (and Medicare during the CMS MAPCP timeframe). Challenges • Lack of clear goals and competitive nature of plans stalled progress to align payment methodologies and performance measures.
Pennsylvania Rural Health Model[209,210,211,212,213] 2017–2024	• All-payer global budget payments for rural hospitals • Independent entity (PA Rural Health Redesign Center Authority [RHRCA]) to administer the model	• Medicare FFS • Medicare Advantage • Medicaid FFS • Medicaid Managed Care • Highmark • Highmark Wholecare • Geisinger Health Plan • UPMC Health Plan • Aetna	Successes • Provided technical assistance to rural hospital participants • Improved quality outcomes Challenges • Commercial payers expressed concerns about the sustainability and administrative burden of the model. • Difficulty with predicting global budgets due to factors such as unexpected changes in market competition and clinician turnover, as well as complex reconciliation methodology that resulted in hospitals and payers having to repay Medicare at end-of-year reconciliation

State Model/Initiative	Approaches to Multi-Payer Alignment	Participating Payers	Successes and Challenges
Rhode Island Chronic Care Sustainability Initiative (CSI-RI)[214,215,216,217] 2008–2014	• PCMH model • Medicaid and commercial payers used a common contract that listed standard practice requirements and performance measures. • Commercial payers required to invest increasingly more of their total spend on primary care and non-FFS payments as years progress • Medicare was a payer when the model participated in the CMS MAPCP demonstration from 2011-2014. • Aligned on goals, performance measures, practice transformation resources, and incentives	• Medicare FFS • Medicare Advantage • Medicaid FFS • Medicaid Managed Care • Neighborhood Health Plan • Blue Cross Blue Shield RI • Tufts Health Plan • United Health Plan	<u>Successes</u> • Engaged leadership of key stakeholders and the RI health insurance commissioner • Participation by all commercial plans in the state because participation was mandated • Substantial investment in health information technology to support health care transformation • Efforts were continued after model end through the Care Transformation Collaborative Rhode Island (CTC-RI). <u>Challenges</u> • No documentation of challenges/lessons learned could be located.
Vermont All-Payer Accountable Care Organization (ACO) Model[218,219,220,221] 2017–2025	• Prospective value-based reimbursement system • Aligned incentives across payers • Standardized quality measures across payers • Creation of an independent regulatory board (Green Mountain Care Board) to develop the model framework and targets	• Medicare FFS • Medicare Advantage • Medicaid FFS • Medicaid Managed Care • BlueCross BlueShield of VT • MVP Health Care	<u>Successes</u> • Collaboration among stakeholders • Improved population health and quality outcomes <u>Challenges</u> • The majority of payers and providers need to participate for the model to succeed. • Key health reform activities, such as integration of clinical and claims data, need an overarching agency/ organization to lead efforts.

State Model/Initiative	Approaches to Multi-Payer Alignment	Participating Payers	Successes and Challenges
Washington Multi-Payer Collaborative Primary Care Transformation Initiative[222,223,224225] 2019–present	• Aligned payment methodologies • Standardized performance measures across payers • Expectation to gradually transition from FFS to prospective payments	• Medicare FFS • Medicaid FFS • Medicaid Managed Care • Community Health Plan • Coordinated Care • Kaiser Permanente • Molina • Regency BlueShield • UnitedHealthcare Premera Blue Cross • Wellpoint	<u>Successes</u> • Formation of multi-payer collaborative learning cohort involving primary care practices and payers • Developed Memorandum of Understanding (MOU) for participating payers <u>Challenges</u> • Collaboration among agencies and different stakeholders can be time- and resource-intensive. • Operation of initiative without federal or external funding • Clear and attainable goals should be made.

VIII. Relevant Features in Previously Submitted Proposals

This section summarizes findings from an analysis of components in previously submitted PTAC proposals that are relevant to multi-payer alignment. Among the 35 proposals that were submitted to PTAC between 2016 and 2020, including 28 proposals that PTAC deliberated on during public meetings, Committee members found that 14 of the 28 proposals included potential approaches to multi-payer alignment **(Exhibit 4).**

Exhibit 4. PTAC Proposals that Describe Multi-Payer Alignment Approaches

Model Name	Clinical Focus	Value-Based Care Components
American Academy of Family Physicians (AAFP) *(Provider association and specialty society)* Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care Recommended for limited-scale testing, 12/19/2017	Primary Care	**Overall Model Design Features**: APC-APM builds on concepts tested through CPC and CPC+ models. Primary care medical homes work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange. **Approaches to Incorporate Multi-Payer Alignment**: APC-APM is intended to be a multi-payer model that adds to the design of the multi-payer CPC and CPC+ models, which promote longitudinal, comprehensive, and coordinated care with primary care teams.
American College of Physicians-National Committee for Quality Assurance (ACP-NCQA) *(Provider association and specialty society/other)* The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version) Recommended for testing to inform payment model development, 9/15/2020	Improved coordination in primary and specialty care practices	**Overall Model Design Features**: The model builds on the CPC+, PCMHs, and Patient-Centered Specialty Practice (PCSP) concepts. **Approaches to Incorporate Multi-Payer Alignment**: Medical Neighborhood is a multi-payer initiative that aims to achieve better coordination between primary and specialty care practices. The model intends to align performance measures, payment criteria, and incentives across payers.
The American College of Surgeons (ACS) *(Provider association/specialty society)* The ACS–Brandeis Advanced Alternative Payment Model Recommended for limited-scale testing, 4/11/2017	Cross-clinical focus with sets of procedural episodes of care	**Overall Model Design Features**: Focused on procedural episodes, leveraging the Episode Grouper for Medicare (EGM) software developed by CMS and Brandeis University, the model is based on shared accountability, integration, and care coordination. **Approaches to Incorporate Multi-Payer Alignment**: This advanced APM is a multi-payer model that nests acute condition episodes within chronic condition episodes and clusters episodes in an advanced APM (rather than a single episode comprising the APM) to facilitate business efficiencies in a multi-payer system.

Model Name	Clinical Focus	Value-Based Care Components
American Society of Clinical Oncology (ASCO) *(Provider association/specialty society)* Patient-Centered Oncology Payment Model (PCOP) Recommended for testing to inform payment model development, 9/15/2020	Oncology	**Overall Model Design Features**: The model proposes to create PCOP communities that include several providers, payers, and other entities to provide high-quality, coordinated care. **Approaches to Incorporate Multi-Payer Alignment**: PCOP is a multi-payer model that aims to align on payment incentives, performance measures, and clinical treatment pathways. The model proposes the formation of a group of stakeholders that would include all payers, providers, and employers to collaborate on the development and implementation of methodologies.
Coalition to Transform Advanced Care (C-TAC) (*Coalition*) Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model Recommended for limited-scale testing, 3/26/2018	Advanced illness, palliative care, end-of-life care	**Overall Model Design Features**: An interdisciplinary care team implements the ACM care delivery services. **Approaches to Incorporate Multi-Payer Alignment**: The ACM proposes multiple payers to participate and align on payment model design.
Dr. Jean Antonucci, MD *(Independent individual)* An Innovative Model for Primary Care Office Payment Recommended for limited-scale testing, 9/6/2018	Primary care	**Overall Model Design Features**: The model aims to provide office-based primary care with a capitated payment structure and proposes to use a HowsYourHealth (HYH) tool to ascertain risk and quality. **Approaches to Incorporate Multi-Payer Alignment:** The model includes all payers who choose to participate.
Illinois Gastroenterology Group and SonarMD, LLC (IGG/SonarMD) *(Regional/local single specialty practice; Device/technology company)* Project Sonar Recommended for limited-scale testing, 4/10/2017	Chronic disease (Crohn's disease)	**Overall Model Design Features**: The model integrates evidence-based medicine with proactive patient engagement. It allows physicians to participate in chronic disease management that is not triggered by a surgical procedure or on an inpatient or outpatient basis. **Approaches to Incorporate Multi-Payer Alignment**: Blue Cross Blue Shield (BCBS) of Illinois is already using the model.

Model Name	Clinical Focus	Value-Based Care Components
Innovative Oncology Business Solutions, Inc. (IOBS) *(For-profit corporation)* Making Accountable Sustainable Oncology Networks (MASON) Referred for further development and implementation, 12/10/2018	Oncology	**Overall Model Design Features**: Builds off the Community Oncology Medical Home (COME HOME) CMS Innovation Center project. **Approaches to Incorporate Multi-Payer Alignment**: This model could be adopted by other payers without requiring substantial process changes.
Icahn School of Medicine at Mount Sinai (Mount Sinai) (*Academic institution*) "HaH-Plus" (Hospital at Home-Plus): Provider-Focused Payment Model Recommended for implementation, 9/17/2017	Inpatient services in the home setting	**Overall Model Design Features**: Multidisciplinary care around an acute care event to reduce complications and readmissions. **Approaches to Incorporate Multi-Payer Alignment**: Submitters worked to adapt the payment model to other payers. Medicare Advantage and Medicaid Managed Care plans expressed interest, and the model was implemented at the VA.
Large Urology Group Practice Association (LUGPA) *(Provider association and specialty society)* LUGPA APM for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer Not recommended, 2/28/18	Urology/Oncology (treatment of prostate cancer)	**Overall Model Design Features**: The model aims to identify those newly diagnosed prostate cancer patients with low-risk localized disease to receive active surveillance rather than active intervention. **Approaches to Incorporate Multi-Payer Alignment:** Submitters worked with other payers to implement the model beyond the Medicare population.
Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group Inc. (PMA) (*Regional/local single specialty practice*) The COPD and Asthma Monitoring Project (CAMP) Not recommended, 4/11/2017	Chronic obstructive pulmonary disease (COPD) and/or asthma	**Overall Model Design Features**: The model proposes remote interactive monitoring for patients with COPD, asthma, and other chronic lung diseases. **Approaches to Incorporate Multi-Payer Alignment:** The model involved other payers beyond Medicare and looked to align payers on goals and performance measures.

Model Name	Clinical Focus	Value-Based Care Components
Personalized Recovery Care (PRC) (*Regional/local single specialty practice*) Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home Recommended for implementation, 3/26/2018	Inpatient services in the home setting or skilled nursing facility	**Overall Model Design Features**: This is a home hospitalization care model that proposes to provide inpatient hospitalization-level care and personalized recovery care (PRC) at home or a skilled nursing facility for patients with certain conditions through an episodic payment arrangement. **Approaches to Incorporate Multi-Payer Alignment**: PRC is currently available in commercial and Medicare Advantage plans, and submitters considered including other payers, such as Medicaid Managed Care.
The University of Massachusetts Medical School (UMass) (*Academic institution)* Eye Care Emergency Department Avoidance Not recommended, 11/8/2019	Eye care	**Overall Model Design Features**: The model aims to reduce emergency department (ED) utilization for ED-avoidable eye conditions and provide incentives for optometrists and ophthalmologists to increase urgent care access for these conditions. **Approaches to Incorporate Multi-Payer Alignment:** The model is open to Medicare, Medicaid, and private payers. Payers would work to establish goals for participating providers.
The University of New Mexico Health Sciences Center (UNMHSC) (*Academic institution*) ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Emergencies Recommended for implementation, 9/16/2019	Cerebral emergency care; telemedicine	**Overall Model Design Features**: Rural EDs can consult neurologists via teleconsultation and assess patients' condition when they present at the hospital ED. The model aims to reduce costs in hospital transfers and ambulatory medicine. **Approaches to Incorporate Multi-Payer Alignment**: The model is available for Medicare and other payers to use a new bundled code for telemedicine consultations. Performance measures are shared between payers to provide transparency.

Appendix B includes additional information about the relevant components of the 14 proposals.

IX. Areas Where Additional Information is Needed

This section identifies three areas where additional information may be needed to guide future research on improving multi-payer alignment in value-based care. **Appendix C** further describes areas that may be better addressed outside of the literature (e.g., through external stakeholder or subject matter expert input).

- More work is needed to determine effective approaches for attribution, benchmarking, and risk adjustment to align payers on key model components while also accounting for differences in goals and patient populations.
- Additional information is needed to establish best practices for aligning payers on their outreach and engagement strategies to providers and patients.
- More work is needed to determine the appropriate degree of multi-payer alignment that is necessary to promote value-based care.

Appendix A. Research Questions by Environmental Scan Section

Section	Research Questions
Section IV. Background on Multi-Payer Alignment	• What is the vision and value that multi-payer models bring to value-based care? • What are the foundational principles and alignment areas for multi-payer alignment?
Section V. Alignment Areas	• What strategies help to align and standardize benchmarking, attribution, and risk-adjustment methods across multiple payers? • How can differentiation to allow for competition coexist with alignment in patient attribution and risk-adjustment methods? • What are best practices for sharing data across multiple payers? • What methods can be used to standardize performance measures and reporting across multiple payers? • What types of payer incentives should be provided to promote multi-payer alignment?
Section VI. Factors Influencing Multi-Payer Alignment	• What types of investments support states with ongoing alignment efforts (e.g., Medicaid waiver programs)? • What types of technical assistance and supports encourage the transition to value-based payment models in multi-payer alignment initiatives? • How are antitrust regulations and the use of safe harbor waivers navigated to effectively implement multi-payer alignment? • How do competitive market dynamics between payers influence collaboration among payers? • What other factors influence collaboration and engagement among commercial payers in multi-payer alignment initiatives (e.g., a desire for product differentiation from competitors, elements of payment design considered proprietary)? • What are best practices to ensure consistency in value-based care across payers? • How is progress toward achieving multi-payer value-based payment model goals monitored? • Is multi-payer alignment more difficult to achieve for certain APM design components (e.g., benchmarks, risk adjustment) relative to other components? • How can multi-payer alignment help reduce administrative burden on providers? • What factors should be considered when implementing multi-payer alignment in primary care versus specialty care practices? • How do the characteristics and needs of different patient populations and providers influence multi-payer alignment?

Section	Research Questions

Section VII. Multi-Payer Alignment Initiatives	• What do we know from current and past multi-payer efforts (e.g., CMS Innovation Center, states)?
	• What are approaches to multi-payer alignment that state value-based care models have implemented to date?
	  ○ What successes have states had in implementing multi-payer alignment?
	  ○ What continue to be challenges to implementing multi-payer alignment, and what are the opportunities to mitigate these challenges?

Appendix B. Summary of Relevant Components for Selected Proposals Reviewed by PTAC that Focus on Improving Multi-Payer Alignment in Value-Based Care

Overview of Methodology Used to Review the Proposals

The following information was reviewed for each submitter's proposal, where available: proposal and related documents, Preliminary Review Team (PRT) Report, and Report to the Secretary (RTS). Information found in these materials was used to summarize the proposals' main design features, including payment methodology, how payment is adjusted for performance, and approaches to incorporate multi-payer alignment.

Among the 35 proposals that were submitted to PTAC between 2016 and 2020, including 28 proposals that PTAC deliberated on during public meetings, Committee members found that 14 of the 28 proposals included potential approaches to multi-payer alignment.

Findings from the review of these 14 proposals are summarized in the following table.

Exhibit B1. Characteristics of PTAC PFPM Proposals that Focus on Improving Multi-Payer Alignment in Value-Based Care

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-Based Care Components
American Academy of Family Physicians (AAFP) *(Provider association and specialty society)* Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care Recommended for limited-scale testing, 12/19/2017	**Clinical Focus**: Primary Care **Providers**: Physicians with a primary specialty in family medicine, general practice, geriatric medicine, pediatric medicine, or internal medicine **Setting**: Primary care practices **Patient Population**: Medicare FFS beneficiaries	**Overall Model Design Features**: APC-APM builds on concepts tested through CPC and CPC+ models. Primary care medical homes work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange. **Financial Methodology**: Capitated per-beneficiary-per-month (PBPM) with shared risk options for accountability **How Payment is Adjusted for Performance**: Participants assume performance risk. APMs that meet or exceed agreed-upon benchmarks retain incentive payment. Failure to meet benchmarks would involve repaying all or part of the incentive payment. **Approaches to Incorporate Multi-Payer Alignment**: APC-APM is intended to be a multi-payer model that adds to the design of the multi-payer CPC and CPC+ models, which promote longitudinal, comprehensive, and coordinated care with primary care teams.
American College of Physicians-National Committee for Quality Assurance (ACP-NCQA) *(Provider association and specialty society/other)* The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version) Recommended for testing to inform payment model development, 9/15/2020	**Clinical Focus**: Improved coordination in primary and specialty care practices **Providers**: Primary and specialty care practitioners **Setting**: Primary and specialty care practices **Patient Population**: Medicare FFS beneficiaries with multiple chronic conditions	**Overall Model Design Features**: The model builds on the CPC+, PCMHs, and PCSP concepts. **Financial Methodology**: Participants receive a monthly PBPM care coordination fee and a retrospective positive or negative payment adjustment. Track 1 includes fee-for-service payments, while Track 2 has a reduced fee-for-service payment and a comprehensive specialty care payment (CSCP). **How Payment is Adjusted for Performance**: Performance-based payment adjustment is based on spending relative to a financial benchmark, adjusted for performance on quality and utilization metrics. **Approaches to Incorporate Multi-Payer Alignment**: Medical Neighborhood is a multi-payer initiative that aims to achieve better coordination between primary and specialty care practices. The model intends to align performance measures, payment criteria, and incentives across payers.

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-Based Care Components
The American College of Surgeons (ACS) *(Provider association/specialty society)* The ACS–Brandeis Advanced Alternative Payment Model Recommended for limited-scale testing, 4/11/2017	**Clinical Focus**: Cross-clinical focus with sets of procedural episodes of care **Providers**: Single or multispecialty practices and groups of small provider practices **Setting**: Inpatient, outpatient, ambulatory **Patient Population**: Medicare FFS beneficiaries from over 100+ conditions or procedures	**Overall Model Design Features**: Focused on procedural episodes, leveraging the EGM software developed by CMS and Brandeis University, the model is based on shared accountability, integration, and care coordination. **Financial Methodology**: Retrospective payment that compares episode target prices to the actual cost of the care provided **How Payment is Adjusted for Performance**: Performance (e.g., unacceptable, acceptable, good, excellent) determines the shared savings retained by the APM entity or the amount to repay CMS for losses. **Approaches to Incorporate Multi-Payer Alignment**: This advanced APM is a multi-payer model that nests acute condition episodes within chronic condition episodes and clusters episodes in an advanced APM (rather than a single episode comprising the APM) to facilitate business efficiencies in a multi-payer system.

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-Based Care Components
American Society of Clinical Oncology (ASCO) *(Provider association/specialty society)* Patient-Centered Oncology Payment Model (PCOP) Recommended for testing to inform payment model development, 9/15/2020	**Clinical Focus:** Oncology **Providers:** Clinicians, including hematologists and oncologists **Setting:** Oncology specialty practices **Patient Population:** Oncology practice patients	**Overall Model Design Features**: The model proposes to create PCOP communities that include several providers, payers, and other entities to provide high-quality, coordinated care. **Financial Methodology**: Providers receive three payments: monthly care management payments (CMP), performance incentive payments (PIP), and adjustments to FFS reimbursement. A portion of the CMP will be allocated to a PIP. PIPs will be positively or negatively adjusted based on provider success in adherence to clinical treatment pathways, quality metrics, and cost reduction. There are two tracks: Track 1 participants continue to receive FFS reimbursement in addition to the CMPs; Track 2 participants participate in the Consolidated Payments for Oncology Care (CPOC) where practices can bundle 50% or 100% of the value of specified services. 10% of the amount bundled will be subject to the same performance adjustment as PIPs times a 1.4 multiplier. **How Payment is Adjusted for Performance**: If providers do not meet minimum expectations, CMP and PIP amounts may be suspended, and providers will need to develop an improvement plan. **Approaches to Incorporate Multi-Payer Alignment**: PCOP is a multi-payer model that aims to align on payment incentives, performance measures, and clinical treatment pathways. The model proposes the formation of a group of stakeholders that would include all payers, providers, and employers to collaborate on the development and implementation of methodologies.

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-Based Care Components
Coalition to Transform Advanced Care (C-TAC) (*Coalition*) Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model Recommended for limited-scale testing, 3/26/2018	**Clinical Focus**: Advanced illness, palliative care, end-of-life care **Providers**: PCPs, specialists **Setting**: Hospitals, health systems, hospices, home health **Patient Population**: Medicare FFS beneficiaries with advanced illness in the last year of life	**Overall Model Design Features**: An interdisciplinary care team implements the ACM care delivery services. **Financial Methodology**: A non-tiered PMPM payment with downside risk for TCOC and an upside bonus for quality, subject to maximum payment and loss amounts **How Payment is Adjusted for Performance**: Pay-for-quality structure, where participants are eligible for a quality-based bonus funded by shared savings and determined by performance measure performance **Approaches to Incorporate Multi-Payer Alignment**: The ACM proposes multiple payers to participate and align on payment model design.
Dr. Jean Antonucci, MD *(Independent individual)* An Innovative Model for Primary Care Office Payment Recommended for limited-scale testing, 9/6/2018	**Clinical Focus:** Primary care **Providers:** Primary care providers, nurse practitioners **Setting:** Primary care practices **Patient Population:** Medicare beneficiaries	**Overall Model Design Features**: The model aims to provide office-based primary care with a capitated payment structure and proposes to use a HowsYourHealth (HYH) tool to ascertain risk and quality. **Financial Methodology**: $60 PMPM for low- and medium-risk patients, and $90 PMPM for high-risk patients **How Payment is Adjusted for Performance**: 15% of annual income will be withheld; if participants do not meet quality and cost benchmarks, they may lose this income. **Approaches to Incorporate Multi-Payer Alignment:** The model includes all payers who choose to participate.

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-Based Care Components
Illinois Gastroenterology Group and SonarMD, LLC (IGG/SonarMD) *(Regional/local single specialty practice; Device/technology company)* Project Sonar Recommended for limited-scale testing, 4/10/2017	**Clinical Focus**: Chronic disease (Crohn's disease) **Providers**: Specialty physicians **Setting**: Outpatient settings and specialty care practices **Patient Population**: Medicare FFS beneficiaries	**Overall Model Design Features**: The model integrates evidence-based medicine with proactive patient engagement. It allows physicians to participate in chronic disease management that is not triggered by a surgical procedure or on an inpatient or outpatient basis. **Financial Methodology**: Add-on PBPM payment with two-sided risk, plus a payment to support remote monitoring **How Payment is Adjusted for Performance**: Payments would be adjusted based on quality and financial performance. **Approaches to Incorporate Multi-Payer Alignment**: BCBS of Illinois is already using the model.
Innovative Oncology Business Solutions, Inc. (IOBS) *(For-profit corporation)* Making Accountable Sustainable Oncology Networks (MASON) Referred for further development and Implementation, 12/10/2018	**Clinical Focus**: Oncology **Providers**: Oncologists, surgeons, PCPs, pathologists, radiologists **Setting**: Oncology practices **Patient Population**: Medicare FFS beneficiaries	**Overall Model Design Features**: Builds off the Community Oncology Medical Home (COME HOME) CMS Innovation Center project **Financial Methodology**: Determined by the oncology payment category (OPC), consisting of FFS payments for physician visits, imaging, lab, radiation therapy, surgery; infusion with a facility fee; ambulatory payment classifications (APCs) for hospital outpatient care; diagnosis-related groups (DRGs) for inpatient care; and the PCOP for medical home infrastructure **How Payment is Adjusted for Performance**: 2% of the OPC, which includes all expenses related to cancer care except drugs, is reserved for a quality pool. If quality measures are not met, the 2% is not rewarded. **Approaches to Incorporate Multi-Payer Alignment**: This model could be adopted by other payers without requiring substantial process changes.

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-Based Care Components
Icahn School of Medicine at Mount Sinai (Mount Sinai) (*Academic institution*) "HaH-Plus" (Hospital at Home-Plus): Provider-Focused Payment Model Recommended for implementation, 9/17/2017	**Clinical Focus**: Inpatient services in the home setting **Providers**: Physicians and HaH-Plus providers, including nurse practitioners, registered nurses, social workers, and physical, occupational, and speech therapists **Setting**: Patient homes **Patient Population**: Medicare FFS beneficiaries who have one of the 44 acute conditions	**Overall Model Design Features**: Multidisciplinary care around an acute care event to reduce complications and readmissions **Financial Methodology**: Bundle payment covering the acute episode and an additional 30 days of transition services. Two components are in the payment model: 1) a new DRG-like HaH-Plus payment to substitute for the acute inpatient payment to the hospital and attending physician; and 2) the potential for a performance-based payment linked to the total Medicare spend for the entire HaH-Plus episode and the APM performance on quality metrics. **How Payment is Adjusted for Performance**: The APM entity's performance on quality metrics influences payment. **Approaches to Incorporate Multi-Payer Alignment**: Submitters worked to adapt the payment model to other payers. Medicare Advantage and Medicaid Managed Care plans expressed interest, and the model was implemented at the VA.
Large Urology Group Practice Association (LUGPA) *(Provider association and specialty society)* LUGPA APM for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer Not recommended, 2/28/18	**Clinical Focus:** Urology/Oncology (treatment of prostate cancer) **Providers:** Eligible professionals (including urologists) at large and small urology and multispecialty practices **Setting:** Large and small urology and multispecialty practices **Patient population:** Newly diagnosed prostate cancer patients with localized disease	**Overall Model Design Features**: The model aims to identify those newly diagnosed prostate cancer patients with low-risk localized disease to receive active surveillance rather than active intervention. **Financial Methodology**: An episode-based payment that would retrospectively compare actual initial episode spending against a target amount **How Payment is Adjusted for Performance**: Participants earn performance-based payments or owe performance-based repayments based on the number of quality performance targets achieved/exceeded. **Approaches to Incorporate Multi-Payer Alignment:** Submitters worked with other payers to implement the model beyond the Medicare population.

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-Based Care Components
Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group Inc. (PMA) (*Regional/local single specialty practice*) The COPD and Asthma Monitoring Project (CAMP) Not recommended, 4/11/2017	**Clinical Focus:** COPD and/or asthma **Providers:** Pulmonary physicians **Setting:** Patient home **Patient Population:** COPD and asthma patients	**Overall Model Design Features**: The model proposes remote interactive monitoring for patients with COPD, asthma, and other chronic lung diseases. **Financial Methodology**: Two-sided risk arrangement that would permit CMS to recoup up-front costs first and then allow participants to share in remaining savings or losses up to a stop loss percentage amount **How Payment is Adjusted for Performance**: The proposal does not specify how quality measures would affect payment. **Approaches to Incorporate Multi-Payer Alignment:** The model involved other payers beyond Medicare and looked to align payers on goals and performance measures.
Personalized Recovery Care (PRC) (*Regional/local single specialty practice*) Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home Recommended for implementation, 3/26/2018	**Clinical Focus**: Inpatient services in the home setting or skilled nursing facility **Providers**: Admitting physicians at facilities receiving personalized recovery care (PRC) payments; on-call physicians; recovery care coordinators **Setting**: Patient home or skilled nursing facility **Patient Population**: Commercial and Medicare Advantage patients with one of 150 acute conditions	**Overall Model Design Features**: This is a home hospitalization care model that proposes to provide inpatient hospitalization-level care and PRC at home or a skilled nursing facility for patients with certain conditions through an episodic payment arrangement. **Financial Methodology**: Bundled episode-based payment not tied to an anchor admission, replacing FFS with shared risk. Bundled payment has two components: 1) risk payment for delivering care compared to the targeted cost of care; and 2) a per-episode payment made for care provided instead of an acute care hospitalization. **How Payment is Adjusted for Performance**: A portion of physician compensation is tied to quality metrics and outcomes. **Approaches to Incorporate Multi-Payer Alignment**: PRC is currently available in commercial and Medicare Advantage plans, and submitters considered including other payers, such as Medicaid Managed Care.

Model Name	Clinical Focus, Providers, Setting, Patient Population	Value-Based Care Components
The University of Massachusetts Medical School (UMass) (*Academic institution)* Eye Care Emergency Department Avoidance Not recommended, 11/8/2019	**Clinical Focus:** Eye care **Providers:** Optometrists and ophthalmologists **Setting:** Practices and other entities employing eye care professionals **Patient Population:** Patients with non-emergent eye conditions	**Overall Model Design Features**: The model aims to reduce ED utilization for ED-avoidable eye conditions and provide incentives for optometrists and ophthalmologists to increase urgent care access for these conditions. **Financial Methodology**: Providers who meet or exceed the target number of qualifying ED-avoidable visits and upheld or improved quality performance will receive shared savings payments. **How Payment is Adjusted for Performance**: Providers must meet quality performance thresholds; if providers do not meet these thresholds, their financial loss will equal the minimum of 8% of payments for qualifying visits during the performance year. **Approaches to Incorporate Multi-Payer Alignment:** The model is open to Medicare, Medicaid, and private payers. Payers would work to establish goals for participating providers.
The University of New Mexico Health Sciences Center (UNMHSC) (*Academic institution*) ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Emergencies Recommended for implementation, 9/16/2019	**Clinical Focus**: Cerebral emergency care; telemedicine **Providers**: Neurologists, neurosurgeons, and providers in rural and community systems **Setting**: Inpatient, outpatient, or emergency department **Patient Population**: Patients with neurological emergencies	**Overall Model Design Features**: Rural EDs can consult neurologists via teleconsultation and assess patients' condition when they present at the hospital ED. The model aims to reduce costs in hospital transfers and ambulatory medicine. **Financial Methodology**: Additional one-time payment without shared risk **How Payment is Adjusted for Performance**: Performance is monitored but does not impact payment. **Approaches to Incorporate Multi-Payer Alignment**: The model is available for Medicare and other payers to use a new bundled code for telemedicine consultations. Performance measures are shared between payers to provide transparency.

Appendix C. Areas for Future Exploration and Research

Please note that the items listed below may be better addressed outside of the literature (e.g., through external stakeholder or subject matter expert input). They are captured here for further exploration.

- Perspectives on multi-payer alignment (e.g., payer, Medicare FFS, Medicare Advantage, Medicaid, provider, enablement organization, purchaser)
- Experiences and lessons learned from the implementation of multi-payer alignment in various CMS Innovation Center models
- Concrete actions and steps from state value-based care models that have implemented multi-payer alignment
- Approaches to multi-payer alignment that CMS and other parties could use to test and implement multi-payer models in value-based care
- Effective strategies to align Medicare APMs/ACOs with Medicare Advantage plans
- Degree of multi-payer alignment needed to promote value-based care
- The role of antitrust regulations and the use of safe harbor waivers to effectively implement multi-payer alignment
- Factors, outside of competitive market dynamics, that influence collaboration and engagement among commercial payers in multi-payer alignment initiatives
- Payer experience working between books of business (e.g., Medicare, Medicaid, commercial)
- Factors to consider when implementing multi-payer alignment in primary care versus specialty care practices
- Solutions that have been used to overcome barriers to implementing multi-payer alignment
- Short-run steps toward achieving multi-payer alignment
- Long-term aspirational goals for multi-payer alignment and how these could be accomplished

Appendix D. Annotated Bibliography

Anglin G, Tu HA, Liao K, Sessums L, Taylor EF. Strengthening multipayer collaboration: lessons from the comprehensive primary care initiative. *The Milbank Quarterly*. 2017;95(3):602-633. https://doi.org/10.1111/1468-0009.12280

Subtopic: Key Highlights; Background on Multi-Payer Alignment; Model Alignment Areas; Factors Influencing Multi-Payer Alignment
Type of Source: Journal Article
Objective: To describe lessons learned from the Comprehensive Primary Care (CPC) initiative.
Main Findings: To overcome barriers (e.g., competing institutional priorities) and increase the likelihood of successful payer collaborations, multi-payer initiatives should consider contracting with neutral payer conveners, engaging other stakeholders in addition to payers, engaging payer champions, and gathering feedback from practice representatives. In addition, the Centers for Medicare & Medicaid Services (CMS) can consider continuing to build trust with payers early in initiatives, clarifying its responsibilities if it will have a dual role as a convener and participating payer in initiatives, and, whenever possible, coordinating with other regional initiatives.
Strengths/Limitations: One strength of this study was its focus on identifying challenges and opportunities related to CMS' dual role as an initiative convener and participating payer.
Generalizability to the Medicare Population: Moderate; this article discussed lessons learned from a large multi-payer initiative in which CMS played a role as a convener and a payer.
Methods: Between 2013 and 2016, semi-structured interviews were conducted with participating payers and payer conveners, including CMS staff, CPC participating payers, and payer conveners. Payer engagement and participation were tracked during CPC multi-payer meetings between 2012 and 2016. Qualitative data were coded to identify factors that facilitate and hinder successful payer collaboration.

Arkansas Center for Health Improvement. *Arkansas Health Care Payment Improvement Initiative: 4th Annual Statewide Tracking Report.* August 2019. https://achi.net/publications/2019-ahcpii-tracking-report/

Subtopic: Multi-Payer Alignment Initiatives
Type of Source: Report
Objective: To report on the progress made by the Arkansas Health Care Payment Improvement Initiative (AHCPII), which aimed to improve health system payments through interventions such as the episode of care model and patient-centered medical homes (PCMHs).
Main Findings: In the fourth annual report on AHCPII, the program reported that a majority of Arkansas' primary care providers are now participating in a value-based care model (e.g. PCHM, Comprehensive Primary Care Plus [CPC+]). A review of PCMH quality metrics showed that 75 percent were improved or maintained over prior year levels for Medicaid. PCMH providers also improved access, care management, and overall quality and efficiency through practice transformation activities. Key to Arkansas' efforts was strong multi-payer alignment from both public and private sectors on quality measurement and supporting enhanced provider reporting tools.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Strong; this report highlighted Arkansas' participation in the original Comprehensive Primary Care (PCP) initiative starting in 2012. The success of CPC and Arkansas's PCMH program prepared the state's providers to participate in the CPC+ model. Lessons learned can provide models of successful strategies for future programs focusing on Medicare populations.
Methods: An analysis of provider and payer reported data was conducted.

Bachrach D, du Pont L, Lipson Manatt M, Phelps & Phillips, LLP. Arkansas: a leading laboratory for health care payment and delivery system reform. *The Commonwealth Fund*. August 2014. https://www.commonwealthfund.org/publications/issue-briefs/2014/aug/arkansas-leading-laboratory-health-care-payment-and-delivery

Subtopic: Factors Influencing Multi-Payer Alignment; Multi-Payer Alignment Initiatives
Type of Source: Issue Brief
Objective: To discuss how the Arkansas Health Care Payment Improvement Initiative (AHCPII) has supported the evolution from fee-for-service models to value-based health care delivery.
Main Findings: The state of Arkansas was an early innovator in developing a systemwide multi-payer approach to meet the triple aim of improved patient care, improved health of populations, and reduced costs. AHCPII consisted of three components: patient-centered medical homes (PCMHs); Health Homes for chronically ill and other individuals with complex health care needs; and payment and delivery models based on episodes of care. Although these three components were a best fit for Arkansas, other states can draw on the lessons learned from this program implementation to design their own strategies. Importantly, to successfully implement reform strategies, states must have the support of state leadership and funding and benefit from increased availability of federal funding for multistakeholder strategies.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Moderate; this issue brief specifically addresses innovation in Arkansas' state Medicaid programs. Similar strategies to improve health care delivery can be employed by stakeholders interested in improving Medicare. There may be dually enrolled beneficiaries who benefited from AHCPII's implementation.
Methods: Document review and key informant interviews were conducted.

Backus E, Gobielle A, Hogan C, Holmes J, Rambur B. The All-Payer Accountable Care Organization Model: an opportunity for Vermont and an exemplar for the nation. *Health Affairs Blog*. November 22, 2016. doi:10.1377/hblog20161122.057616

Subtopic: Multi-Payer Alignment Initiatives
Type of Source: Blog Post
Objective: To provide an overview and endorsement of the Vermont All-Payer Accountable Care Organization (ACO) Model.
Main Findings: The Vermont All-Payer ACO Model (agreement performance period 2017-2022) aimed to move all payers (Medicare, Medicaid, and commercial) towards a prospective, value-based reimbursement system where providers would be held accountable for population health outcomes. The Green Mountain Care Board, Vermont's independent board established by the state's health care reform law in 2011, endorsed this model due to its inclusion of specific components, including provider-led reform, patient choice, changing provider incentives to reward quality over quantity, enhancing more integrated and coordinated care, cost containment protections, incentives to improve care delivery and health outcomes, local control of measurement design, and no financial penalties for the state if financial target or population health goals are not met.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Strong; the Vermont All-Payer ACO Model included Medicare as a payer. Outcomes from this model would be broadly applicable to the Medicare population.
Methods: N/A

Bailit MH, Flahert G, Hwang A. Adopting multipayer value-based payment models. *The Commonwealth Fund*. January 2023. https://www.commonwealthfund.org/sites/default/files/2023-01/Bailit_implementation_guide_multipayer_VBP.pdf

Subtopic: Key Highlights; Background on Multi-Payer Alignment; Model Alignment Areas; Factors Influencing Multi-Payer Alignment
Type of Source: Report
Objective: To provide a guide for states who are interested in implementing multi-payer value-based payment (VBP) models to limit cost growth while incentivizing higher-quality and better-coordinated patient care.
Main Findings: To implement a multi-payer VBP model successfully, the state must work through several key decisions and be prepared for an iterative and dynamic process. States should consider what their goals are, who will provide leadership for the model, who their stakeholders are and how to engage them, and create a plan for how the state will support providers to succeed and monitor progress towards the model's goals. Additional considerations and detailed guidance is provided throughout the guide.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Moderate; this guide is not specific to Medicare beneficiaries but is applicable to many multi-payer VBP models.
Methods: N/A

Centers for Medicare & Medicaid Services. Comprehensive Primary Care Plus (CPC+) Model: Evaluation of the Fifth Year (2021). Findings at a Glance. https://www.cms.gov/priorities/innovation/data-and-reports/2023/cpc-plus-fg-fifth-annual-eval-report

Subtopic: Multi-Payer Alignment Initiatives
Type of Source: Report
Objective: To provide key takeaways of an evaluation of the fifth year of the Comprehensive Primary Care Plus (CPC+) model.
Main Findings: Despite reducing emergency department visits, acute inpatient hospitalizations, and acute inpatient expenditures in the fifth year of the model, total Medicare expenditures were not reduced and net savings were not achieved. There were also limited improvements in quality of care in Medicare claims. The results of this evaluation indicated that improvement in primary care may not be enough to reduce total Medicare expenditures. The report suggested that more support is needed to right-size payments for low-value services, specialists, and hospitals. The report also highlighted a need for increased incentives for care coordination.
Strengths/Limitations: This was a large model implemented across 18 regions nationwide for five years, allowing for a robust evaluation of the outcomes.
Generalizability to the Medicare Population: Strong; the Findings at a Glance summarize the evaluation report for the CMS Innovation Center model.
Methods: N/A

Cherian LT, Scott GT. Value-based safe harbors and exceptions to the anti-kickback statue and stark law. *K&L Gates Hub*. February 24, 2021. https://www.klgates.com/White-Paper-Value-Based-Safe-Harbors-and-Exceptions-to-the-Anti-Kickback-Statute-and-Stark-Law-2-24-2021

Subtopic: Key Highlights; Factors Influencing Multi-Payer Alignment
Type of Source: White Paper
Objective: To review the 2020 U.S. Department of Health and Human Services' Final Rules and assess how they will impact the future of care coordination and health care payment models.

Main Findings: The 2020 Final Rules present new opportunities for payers and providers participating in payment models, including the ability to "design their own model," and utilize safe-harbor exceptions to fraud and abuse laws (i.e., Stark Law, Anti-Kickback Statutes) within value-based arrangements to improve care coordination. The new rules offer short-term opportunities (e.g., coordinate and provide in-kind assistance) and long-term opportunities (e.g., downside risk protections) for stakeholders in value-based arrangements.
Strengths/Limitations: At the date of publication, the Final Rules were still novel, and applications of the new rules were not yet evaluated.
Generalizability to the Medicare Population: Strong; the white paper reviewed two Final Rules that directly impact Medicare providers.
Methods: N/A

Colorado Alternative Payment Model (APM) Alignment Initiative. *Bailit Health*. June 2022. https://doi.colorado.gov/sites/doi/files/documents/Colorado-Alternative-Payment-Model-Alignment-Initiative-Final-Report-June-2022.pdf

Subtopic: Multi-Payer Alignment Initiatives
Type of Source: Report
Objective: To discuss recommendations and findings from Colorado maternity and primary care stakeholders to understand the interest in and barriers to pursuing a statewide Alternative Payer Model (APM).
Main Findings: Overall, stakeholders across the state were interested in aligning APMs to encourage greater adoption of the models statewide. A governance mechanism was needed to ensure APM implementation and compliance requirements were followed. Health equity needed to be considered in the broader context of care delivery and reimbursement. APMs should be flexible in their design to consider the differing needs in care of adults versus children. Navigating federal requirements from public payers requires consideration for any statewide APM initiative.
Strengths/Limitations: Direct patient perspectives were not represented in the stakeholder conversations.
Generalizability to the Medicare Population: Moderate; the stakeholder interviews did not focus on the Medicare population, but APMs included public payers. Lessons learned may be applicable for future Medicare models.
Methods: Twenty-four stakeholder interviews were conducted over two months, after which the conversations were analyzed and grouped by theme for reporting purposes.

Conrad DA, Grembowski D, Hernandez SE, Lau B, Marcus-Smith M. Emerging lessons from regional and state innovation in value-based payment reform: balancing collaboration and disruptive innovation. *The Milbank Quarterly*. 2014;92(3):568-623. https://doi.org/10.1111/1468-0009.12078

Subtopic: Key Highlights; Model Alignment Areas; Factors Influencing Multi-Payer Alignment
Type of Source: Journal Article
Objective: To provide an overview of the challenges, opportunities, and lessons of multistakeholder, value-based payment reform based on a case study of several programs conducted across the United States.
Main Findings: The form and method of implementation of different initiatives was highly dependent on where the programs were located (e.g. state, regional, local context, regulations and requirements). It was important to have a neutral convening organization that could help competitors and stakeholders find common ground and manage expectations. Information and data-related barriers needed to be considered when designing value-based payment models to

ensure the successful implementation of new modes of payment and accurate patient attribution. Provider experience and favorable views of risk-bearing models is necessary for successful implementation.
Strengths/Limitations: Some of the barriers, such as provider experience and data-related concerns, may have evolved since this report was published in 2014.
Generalizability to the Medicare Population: Strong; this case study examined programs that were supported by Medicare funding.
Methods: A comparative case study was conducted using document review, key stakeholder interviews and qualitative analysis to identify lessons learned and implications for policy and practice.

Eisenstein J, Chang D. Case study: improving population and individual health through health system transformation in Washington State. *National Academy of Medicine*. April 24, 2017. https://nam.edu/perspectives/case-study-improving-population-and-individual-health-through-health-system-transformation-in-washington-state/

Subtopic: Multi-Payer Alignment Initiatives
Type of Source: Journal Article
Objective: To demonstrate the ways Washington State has been working to transform their health care delivery system to improve the population-level health of its residents.
Main Findings: Among the lessons learned from Washington was the importance of having state leadership supporting population health improvement goals. This leadership enabled two bipartisan bills to be passed, supporting health system transformation across the state, including the development of accountable communities of health (ACHs), a state level performance measurement committee, restructuring Medicaid procurement mechanisms, establishing an all-payer claims database, and setting health services goals. Additional lessons learned included the importance of interagency collaboration, the role of managed care organizations in addressing upstream drivers of health, the power of Washington's ACHs in coordinating regional care, the power of peer learning among clinical providers, the importance of having a robust data system, and having an evidence base for the system transformation.
Strengths/Limitations: Although this case study is focused on one state's experience, it provides valuable lessons for other states to consider.
Generalizability to the Medicare Population: Moderate; although the case study examined the state Medicaid system transformation, it leveraged federal funding and lessons learned can be applied to the Medicare population.
Methods: N/A

Evaluating Accountability for Statewide Health Cost and Quality Outcomes: The Maryland Total Cost of Care Model. *Mathematica*. December 20, 2022. https://www.mathematica.org/publications/evaluation-of-the-maryland-total-cost-of-care-model-quantitative-only-report-for-the-models-first

Subtopic: Multi-Payer Alignment Initiatives
Type of Source: Report
Objective: To report on the impacts of the Maryland Total Cost of Care (MD TCOC) Model implementation from 2019 to 2021.
Main Findings: In its first three years of performance, the MD TCOC Model reduced rates of all-cause acute care hospital admissions by 16.1 percent, moderately reduced Medicare fee-for-service spending by 2.5 percent, increased non-hospital spending by 2.7 percent, and reduced hospital spending by 6.6 percent. Additionally, the model improved several quality of care measures, including reducing potentially preventable admissions, reducing the likelihood of an

unplanned readmission to the hospital, and increasing timely follow-up after hospital discharge. The MD TCOC Model was built onto the existing Maryland Alternative Payment Model (MDAPM) and had overall larger impacts on outcomes during its performance period, which could be attributed to the influence of global budgets beginning in 2014, broader accountability, incentives, and supports starting in 2019, and how these two influences might work together to produce optimal results.
Strengths/Limitations: The COVID-19 pandemic overlapped with the period evaluated in the report, which may have influenced the estimates.
Generalizability to the Medicare Population: Strong; the MD TCOC Model focused on the Medicare population.
Methods: A difference-in-differences design was implemented using a matched comparison group to estimate the impacts of the model. Regression models controlled for beneficiary-level demographic characteristics.

Evaluation of Primary Care First: Third Annual Report. *Mathematica Policy Research*. May 2025. https://www.cms.gov/priorities/innovation/data-and-reports/2025/pcf-third-eval-rpt

Subtopic: Multi-Payer Alignment Initiatives
Type of Source: Report
Objective: To evaluate the progress of the Primary Care First (PCF) Model in relation to the model's goals, including better care for Medicare fee-for-service (FFS) beneficiaries and lower costs for the Centers for Medicare & Medicaid Services (CMS).
Main Findings: Substantial practice attrition from the model was observed through 2023 due to concerns related to financial aspects of the model. The small number of participating national and regional payers led to limited payer alignment and fewer resources and supports for implementation. Practices' care delivery activities were motivated by involvement in multiple value-based contracting arrangements. The PCF payments did not have a major impact on practices' decisions. Acute hospitalization rates were not reduced among Medicare FFS beneficiaries and PCF increased Medicare expenditures by one percent.
Strengths/Limitations: The evaluation was conducted at the mid-point of the performance period and impacts will continue to be evaluated in future years to identify overall patterns.
Generalizability to the Medicare Population: Strong; the PCF Model focused on the Medicare population and aimed to lower Medicare FFS expenditures.
Methods: A mixed methods analysis of primary and secondary data was conducted. A comparison was made between the outcomes of primary care practices that participated in the PCF Model versus primary care practices in PCF regions with similar characteristics but did not participate in the model.

Evaluation of the Comprehensive Primary Care Initiative. Fourth Annual Report. *Mathematica Policy Research*. May 2018. https://downloads.cms.gov/files/cmmi/CPC-initiative-fourth-annual-report.pdf

Subtopic: Multi-Payer Alignment Initiatives
Type of Source: Report
Objective: To evaluate the impact of the Comprehensive Primary Care (CPC) initiative over the full intervention period in relation to the model's goals, including improving primary care delivery, health care quality, patient experience, and lower costs.
Main Findings: Over the course of the model, CPC reduced hospitalizations and emergency department visits for attributed Medicare fee-for-service (FFS) beneficiaries. Expenditures for these beneficiaries grew less for CPC practices than for comparison practices, but not enough to cover Medicare's CPC care management fees. Minimal effects were observed for claims-based

quality of care measures and beneficiaries' experience of care. Practices engaged in significant care delivery transformation activities and felt that supports provided from the Centers for Medicare & Medicaid Services (CMS) were helpful for accomplishing the work required for the model.

Strengths/Limitations: CPC did not have strong incentives for individual practices to transform in ways that would result in substantially fewer hospitalizations and expenditures. Therefore, it was difficult to determine a causal relationship between better care delivery approaches and improvements in key outcomes.

Generalizability to the Medicare Population: Strong; the CPC initiative focused on the Medicare population and aimed to lower Medicare FFS expenditures.

Methods: A mixed methods, rapid cycle evaluation and analysis of primary and secondary data was conducted. A comparison was made between the outcomes of practices that participated in the CPC initiative versus practices with similar characteristics but did not participate in the model to assess CPC's impacts on cost and quality for Medicare FFS beneficiaries.

Evaluation of the Minnesota Accountable Health Model. *State Health Access Data Assistance Center (SHADAC)*. September 2017. https://www.leg.mn.gov/docs/2018/other/180336.pdf

Subtopic: Multi-Payer Alignment Initiatives

Type of Source: Report

Objective: To evaluate the impact of the Minnesota Accountable Health Model at the end of its performance period in relation to the model's goals, including improving patient experience and population health and reducing health care costs.

Main Findings: The overall impact of the model resulted in significant investments in key areas such as health IT, health information exchange, improved person-centered, coordinated care, and an improved understanding of the multi-payer Accountable Care Organization (ACO) landscape in the state. In the future, the state will need to continue engaging hard to reach organizations, provide support for practice transformation efforts, and further study the impact of state models on quality and cost.

Strengths/Limitations: The timing of the evaluation and the development of the model design were not aligned to allow for ideal development of evaluation tools.

Generalizability to the Medicare Population: Moderate; the model focused on a broad range of beneficiaries, including the Medicare population.

Methods: A mixed methods analysis of primary and secondary data was conducted. Data included semi-structured interviews, web-based surveys, data from the Minnesota All Payer Claims Database and the Minnesota Statewide Quality Reporting and Measurement System, and document review of state, grant, and contract materials.

Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration Final Report. *RTI International*. June 2017. https://downloads.cms.gov/files/cmmi/mapcp-finalevalrpt.pdf

Subtopic: Multi-Payer Alignment Initiatives

Type of Source: Report

Objective: To evaluate the impacts of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration and determine how local contextual factors influence the impact of the demonstration in different states.

Main Findings: The impacts of the MAPCP Demonstration varied between implementation states but was overall budget neutral. MAPCP Demonstration practices felt that they were fully able to operate as Patient-Centered Medical Homes by the end of the model and expected

favorable impacts on quality of care, access to care, utilization, and expenditures in the future if they could maintain their patient-centered features in a collaborative all-payer environment.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Moderate; the MAPCP Demonstration focused on a broad range of beneficiaries, including the Medicare population.
Methods: A mixed methods analysis of primary and secondary data was conducted.

Evaluation of the Vermont All-Payer Accountable Care Organization Model. *NORC at the University of Chicago*. December 2022. https://www.norc.org/content/dam/norc-org/pdf2024/VermontAllPayerModel-SecondEvalReportv2_1_4_23.pdf

Subtopic: Multi-Payer Alignment Initiatives
Type of Source: Report
Objective: To assess the implementation and impact of the Vermont All-Payer Accountable Care Organization Model (VTAPM) and its ability to incentivize care delivery transformation, reduce spending, and improve population health outcomes.
Main Findings: In the first three performance years, VTAPM achieved statistically significant reductions in gross Medicare spending. Despite the impacts of the COVID-19 pandemic in 2020, decreases in acute care and specialist evaluation and management visits were observed. There was continued progress in performance year three towards meeting performance targets for population health and quality of care outcomes.
Strengths/Limitations: The University of Vermont Health Network was subject to a cyberattack in October 2020 that disrupted access to care. This cyberattack was accounted for in the evaluation by using a sensitivity analysis that excluded the fourth quarter of 2020 from impact estimates.
Generalizability to the Medicare Population: Strong; the evaluation focused on Accountable Care Organization (ACO)-attributed Medicare beneficiaries.
Methods: Thematic analysis of semi-structured interviews and a web-based survey was conducted. A quasi-experimental difference-in-differences design was used to estimate effects at the Medicare ACO level and state level.

Golden W, Thompson J, Olsen S, Hill R, Fendrick A, Mathis C, Chernew, M. Patient centered medical home in Arkansas. *Health Affairs Blog*. May 20, 2014. doi:10.1377/hblog20140520.039098

Subtopic: Model Alignment Areas; Factors Influencing Multi-Payer Alignment; Multi-Payer Alignment Initiatives
Type of Source: Blog Post
Objective: To provide an overview of Arkansas' approach to Patient Centered Medical Homes (PCMH).
Main Findings: The PCMH payment model was developed to support Arkansas' primary care transformation and its goal to focus on team-based strategies, chronic care coordination, and healthier patient outcomes. PCMHs were designed in collaboration with primary care practitioners. The incentive system was developed to meet the diversity of practices that treat Medicaid patients. Model design elements included a per-member per-month medical home support payment and two shared savings methods.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Moderate; elements of Arkansas' PCMH design aligned with Arkansas' 2012 implementation of Medicare's Comprehensive Primary Care (CPC) initiative.
Methods: N/A

Haran C, Gilburg ML. Eight Washington Health Plans Align to Transform Primary Care. *Milbank Memorial Fund*. July 30, 2024. https://www.milbank.org/news/eight-washington-health-plans-align-to-transform-primary-care/

Subtopic: Multi-Payer Alignment Initiatives
Type of Source: Web Page
Objective: To announce the commitment of eight Washington state health plans to support the state's Primary Care Transformation Initiative through multi-payer primary care transformation.
Main Findings: The Primary Care Transformation Initiative aims to improve primary care in Washington state by aligning plan offerings and design as well as to implement advanced provider payment models. The goal of the initiative is to decrease practices' administrative burden and increase financial support to achieve Washington's goal of spending 12 percent of total health care spending on primary care.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Moderate; the memorandum of understanding was signed by private payers but commits to an initiative that is building on the previous implementation of the Primary Care Transformation Model, which was supported by the CMS Innovation Center.
Methods: N/A

Hospital Rate Setting: Successful in Maryland, but Challenging to Replicate. *Altarum Healthcare Value Hub*. May 2020. https://healthcarevaluehub.org/wp-content/uploads/2020_Update_Altarum-Hub_RB_1_-_Hospital_Rate_Setting_Final.pdf

Subtopic: Multi-Payer Alignment Initiatives
Type of Source: Research Brief
Objective: To compare Maryland's success in hospital rate setting to other states who were unable to achieve the same success.
Main Findings: Rate setting can be successful in controlling the rate of hospital cost increases subject to implementation methods, enforcement mechanisms, noncompliance penalties. Maryland's system worked due to stakeholder support of legislation, flexibility for the Health Services Cost Review Commission to develop methods to support the system with meetings its goals, and political and budgetary independence as an agency.
Strengths/Limitations: There was not enough research to measure the impact of an all-payer hospital rate setting model on administrative costs.
Generalizability to the Medicare Population: Moderate; although Medicare was a part of the rate setting model, Maryland was the only place rate setting has been successful. Generalizability to other states may be limited.
Methods: N/A

Howard SW, Bradford N, Belue R, Henning M, Qian Z, Ahaus K, Reindersma T. Building alternative payment models in health care. *Frontiers in Health Services*. 2024;4:1235913. http://doi.org/10.3389/frhs.2024.1235913

Subtopic: Model Alignment Areas
Type of Source: Journal Article
Objective: To update the literature on the design and implementation of alternative payment models (APMs) to understand the current landscape of successful models in use.
Main Findings: There are five overarching themes of design considerations for implementation of APMs: population and scope of care and services; benchmarking, metrics, data, and technology; finance, APM type, risk adjustment, incentives, and provider behavior; provider

partnerships and the role of physicians; and leadership and regulatory issues. Providers are an integral part of any APM and attention should be given to how they are trained and the resources they are provided by payers during implementation. Governments are important partners that can facilitate health care transformation efforts by establishing waiver processes for regulations that may impede these efforts.
Strengths/Limitations: The participant sample was small and was comprised of a small number of health care organizations across three countries, limiting generalizability.
Generalizability to the Medicare Population: Moderate; although the article was not focused on the Medicare population, lessons learned could be applicable to Medicare beneficiaries.
Methods: A literature review was conducted using snowball sampling to identify subject matter experts for semi-structured interviews. Thematic analysis was used to code participant responses related to APM design and implementation.

Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Final Report. *Mathematica Policy Research*. December 2023. https://www.cms.gov/priorities/innovation/data-and-reports/2023/cpc-plus-fifth-annual-eval-report

Subtopic: Multi-Payer Alignment Initiatives
Type of Source: Report
Objective: To evaluate the progress of the Comprehensive Primary Care Plus (CPC+) model over the course of its implementation.
Main Findings: Stakeholder participation remained stable across the five years of CPC+. The most helpful supports for practices were the care management fees, small group coaching, and peer-to-peer learning. Observed improvements to care delivery included timely primary care access, enhanced behavioral health integration, and increased documentation of advance care plans. CPC+ reduced outpatient emergency department visits, acute inpatient hospitalizations, and acute inpatient expenditures. However, these reductions were not enough to reduce total Medicare expenditures or achieve net savings.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Strong; CPC+ included Medicare beneficiaries.
Methods: A mixed methods analysis of primary and secondary data was conducted.

Japinga M, Pokam Tchuisseu Y, Saunders R, McClellan M. A path forward for multipayer alignment to achieve comprehensive, equitable, and affordable care. *Duke-Margolis Center for Health Policy*. 2022. https://healthpolicy.duke.edu/sites/default/files/2022-12/A%20Path%20Forward%20for%20Multipayer%20Alignment%202.pdf

Subtopic: Key Highlights; Background on Multi-Payer Alignment; Model Alignment Areas; Factors Influencing Multi-Payer Alignment
Type of Source: Report
Objective: To provide a framework for states and regions to establish and implement multi-payer initiatives.
Main Findings: Previous national approaches to payment reform models have sought to align payers with Medicare payment reform models, which has had a variety of drawbacks and has resulted in limited multi-payer participation. To address this challenge, the authors sought to develop a new framework for future payment reform models that aim to achieve national alignment of payers. The framework includes three primary components: identify and leverage shared goals for actionable alignment; create a pathway to help achieve these goals; provide input on how the Centers for Medicare & Medicaid Services (CMS) can facilitate more meaningful Medicare participation with current resources and authorities. The framework is an

expansion on the foundational elements of multi-payer alignment, which included performance measurement and reporting, measures and initiatives related to health equity, other key payment model components, timely and consistent data sharing, and technical assistance.
Strengths/Limitations: The framework was developed considering perspectives from a wide range of stakeholders.
Generalizability to the Medicare Population: Strong; the report sought to improve nationwide alignment of payers with CMS models.
Methods: An environmental scan of previous and ongoing multi-payer initiatives was conducted. A stakeholder workshop series was held with participants representing state Medicaid agencies, commercial payer organizations, employers, data organizations, and other key stakeholders.

Kilaru AS, Crider CR, Chiang J, Fassas E, Sapra KJ. Health care leaders' perspectives on the Maryland All-Payer Model. *JAMA Health Forum*. 2022;3(2):e214920. doi:10.1001/jamahealthforum.2021.4920
Subtopic: Key Highlights; Model Alignment Areas; Factors Influencing Multi-Payer Alignment
Type of Source: Journal Article
Objective: To examine perspectives of Maryland health care leaders on the implementation of the Maryland All-Payer Model (MDAPM) and identify lessons learned on hospital global budgets for adoption in other settings.
Main Findings: Maryland's transition to hospital global budgets was viewed as a process requiring clear expectations, hospital autonomy, strong stakeholder communication, and shared commitment to change. Participants emphasized the importance of having actionable data and calibration of budgets to address technical challenges and maintain fairness. A shared commitment to change, driven by external pressures and collaborative design, was critical for successful implementation.
Strengths/Limitations: A strength of the study was its inclusion of diverse stakeholder perspectives. A limitation of the study was that all participants were invested in the MDAPM, which may introduce a positive bias for the model.
Generalizability to the Medicare Population: Moderate; the MDAPM was designed in partnership with the Centers for Medicare & Medicaid Services (CMS) but implemented in Maryland's unique regulatory environment, potentially limiting the generalizability of findings for some states and settings.
Methods: This qualitative study analyzed semi-structured interview data from 20 health care stakeholders from hospitals, state and federal agencies, and payers. Interviews were conducted between 2019 and 2020.

Kissam SM, Beil H, Cousart C, Greenwald LM, Lloyd JT. States encouraging value-based payment: lessons from CMS's State Innovation Models Initiative. *The Milbank Quarterly*. 2019;97(2):506-542. https://doi.org/10.1111/1468-0009.12380
Subtopic: Key Highlights; Model Alignment Areas; Factors Influencing Multi-Payer Alignment
Type of Source: Journal Article
Objective: To identify strategies, challenges, and lessons learned among six states implementing value-based payment models under the Centers for Medicare & Medicaid Services' (CMS') State Innovation Models (SIM) Initiative Round 1.
Main Findings: States used SIM funds to expand value-based payment (VBP) models in Medicaid, invest in health IT infrastructure, and enhance care coordination. One challenge to health system transformation was reluctance among commercial payers to coordinate on models. Multi-payer alignment was achieved in states with few commercial payers or with strong regulatory levers to encourage commercial payer participation. Infrastructure investments such

as electronic health information exchange and workforce development were effective in driving health care delivery system change.
Strengths/Limitations: One limitation was potential limited generalizability of results as participants reflected the stakeholders with the greatest involvement in SIM activities.
Generalizability to the Medicare Population: Moderate; although Medicare did not participate in SIM Round 1, lessons learned on multi-payer alignment and infrastructure investment could inform future Medicare initiatives.
Methods: The evaluation leveraged qualitative data from document review, monthly calls with state officials, site visits, and focus groups with providers and consumers between 2014 and 2018. Analysis focused on identifying patterns in topics such as policy strategies to support payment models, stakeholder engagement, health IT, and workforce development.

Mantel J. An overlooked argument for a single-payer healthcare system: eliminating misalignment among payment models. *Annals Health L. & Life Scis*. 2023;32:101.

Subtopic: Key Highlights; Factors Influencing Multi-Payer Alignment
Type of Source: Journal Article
Objective: To explain the potential advantages of adopting a single-payer health care system for promoting care delivery transformation, including addressing challenges in the current multi-payer system.
Main Findings: Under multi-payer systems, providers face diluted financial incentives and conflicting payment rules. Alternative Payment Models (APMs) could have greater impact under a single-payer system compared with a multi-payer system. The adoption of a single-payer system, where a single government insurer applies a common set of payment rules and incentives, could promote meaningful care delivery transformation.
Strengths/Limitations: This article provides a comprehensive review of structural barriers within the multi-payer system and how they hinder payment reform efforts.
Generalizability to the Medicare Population: Strong; findings suggest that alignment under a single-payer approach could enhance Medicare's ability to promote care transformation.
Methods: A review of existing literature, including prior APM evaluations, was conducted to identify barriers in the current payer system.

McGinnis T, Newman J. Advances in multi-payer alignment: state approaches to aligning performance metrics across public and private payers. *Milbank Memorial Fund*. 2014.
https://www.chcs.org/media/MultiPayerHealthCare_WhitePaper_071014.pdf

Subtopic: Background on Multi-Payer Alignment; Model Alignment Areas
Type of Source: Issue Brief
Objective: To explore how three states—Wisconsin, Vermont, and Maine—aligned provider performance measures across payers.
Main Findings: Key elements to successfully achieve alignment on a performance measure strategy across payers included having state leadership; developing a multi-stakeholder governance structure; using a neutral convener and trusted facilitator; and having access to technical information. Additional lessons learned from the three state innovators included ensuring a diverse set of stakeholders are engaged throughout the multi-payer alignment process; developing consensus among stakeholders early in the process; determining the relationship between measurement alignment and payment reform efforts; and understanding that alignment efforts take time.
Strengths/Limitations: Lessons learned can inform Medicaid and private purchasers in aligning provider performance measures across payers.

Generalizability to the Medicare Population: Strong; the issue brief recommended that states consider identifying ways to encourage national stakeholders, including Medicare, to participate in a standardized way.
Methods: Qualitative case studies from Wisconsin, Vermont, and Maine were conducted to understand public-private collaborations, processes for consensus-building, and factors influencing success in achieving multi-payer alignment on performance measures.

Multi-Payer Alignment Blueprint. Health Care Payment Learning & Action Network. July 2023. https://hcai.ca.gov/wp-content/uploads/2023/08/HCP-LAN-Multi-Payer-Alignment-Blueprint-Executive-Summary.pdf

Subtopic: Key Highlights; Background on Multi-Payer Alignment; Factors Influencing Multi-Payer Alignment; Multi-Payer Alignment Initiatives
Type of Source: Report
Objective: To summarize lessons learned from the Health Care Payment Learning & Action Network's (HCP-LAN's) State Transformation Collaboratives (STCs).
Main Findings: Foundational elements on which states may align include performance measurement and reporting; health equity; key payment model components; timely and consistent data sharing; and technical assistance. To promote meaningful progress on multi-payer alignment, local and regional initiatives should consider national priorities. The Centers for Medicare & Medicaid Services (CMS) can play a key role in promoting participation in multi-payer alignment initiatives.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Strong; the blueprint considers how different state multi-payer alignment strategies could inform future CMS Innovation Center models and work toward national alignment.
Methods: N/A

Multi-Payer Investments in Primary Care: Policy and Measurement Strategies*. Center for Health Care Strategies & State Health Access Data Assistance Center*. July 2014. https://www.chcs.org/media/Primary-Care-Infrastructure-Investment-SIM-TA-Paper-7-1-14.pdf

Subtopic: Factors Influencing Multi-Payer Alignment; Multi-Payer Alignment Initiatives
Type of Source: Report
Objective: To provide states with guidance on how to develop a multi-payer primary care investment strategy.
Main Findings: There are different levers to increase multi-payer primary care infrastructure investment, including paying providers through non-fee-for-service arrangements. Strategies to increase the amount of health care funding in primary care services include increasing the percentage of health payments spent on primary care; using a more comprehensive capitation rate that covers practice expenses, infrastructure and systems, and salaries; using new billing codes for primary care, such as care coordination or telemedicine; using higher primary care rates; paying for performance incentives; and implementing shared savings within a medical home model. Providing financial and non-financial supports can help primary care practices with transforming into medical homes. The impacts of policies to enhance primary care infrastructure should be monitored.
Strengths/Limitations: N/A

Generalizability to the Medicare Population: Strong; the report considered how health care is paid for by Medicare as well as other payers including Medicaid, commercial health plans, and employer plans.
Methods: N/A

Paradise J, Gold M, Wang W. Leveraging Medicaid in a multi-payer medical home program: spotlight on Rhode Island's Chronic Care Sustainability Initiative. *Kaiser Family Foundation*. November 21, 2013. https://www.kff.org/medicaid/leveraging-medicaid-in-a-multi-payer-medical-home-program-spotlight-on-rhode-islands-chronic-care-sustainability-initiative/

Subtopic: Multi-Payer Alignment Initiatives
Type of Source: Issue Brief
Objective: To examine lessons learned from Rhode Island's Chronic Care Sustainability Initiative, a multi-payer, statewide patient-centered medical home (PCMH) initiative that included commercial health plans and the state's Medicaid health plan.
Main Findings: Medicaid's participation in the PCMH initiative was important given Medicaid is a large purchaser. It is important to develop a common contract for multiple payers by using a consensus process that engages participating stakeholders. Collaboration among plans, practices, and purchasers takes time, effort, and leadership. Implementing multi-payer initiatives and practice transformation requires overhead and infrastructure costs. Sustained payer support may require evidence that investing in primary care improves care while generating savings.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Moderate; the issue brief was focused on leveraging Medicaid in multi-payer, PCMH initiatives. Lessons learned may be applicable to the Medicare population.
Methods: Program documents and telephone interviews with program managers, health plans, and practices with Medicaid patients were reviewed to identify key perspectives and lessons learned.

Silow-Carroll S, Edwards JN, Rodin D. How Colorado, Minnesota, and Vermont are reforming care delivery and payment to improve health and lower costs. *The Commonwealth Fund*. 2013;10:1-9.

Subtopic: Model Alignment Areas
Type of Source: Issue Brief
Objective: To identify factors that influence the alignment of incentives between payers and providers in Colorado, Minnesota, and Vermont.
Main Findings: Colorado and Minnesota implemented accountable care models for Medicaid beneficiaries. Vermont worked toward a unified health care budget. Drivers of reform across the three states included having a history and culture of reform efforts; economic necessity; multi-stakeholder agreement on priorities; and strong health care leadership. Lessons learned included allowing regional or local flexibility in reform design; standardizing measures; leveraging resources across departments and agencies; convening and educating stakeholder leaders; building on what already exists; broadening service integration; acknowledging the long-term nature of savings; and integrating reform across state programs and Medicare and commercial insurers. Medicare's participation in multi-payer programs was critical given Medicare is a dominant payer.
Strengths/Limitations: The study had a small sample size, limiting the generalizability of results.
Generalizability to the Medicare Population: Moderate; the study included interviews with 10 officials from the Centers for Medicare & Medicaid Services (CMS) to understand the types of information that is useful to shape federal programs and supports.

Methods: Case studies on Colorado, Minnesota, and Vermont were conducted. Case studies included literature reviews and in-depth interviews with a broad range of stakeholders, such as Medicaid officials, administrators of regional health networks, hospital leadership, and insurers.

State Innovation Models (SIM) Initiative Evaluation Model Test Year Five Annual Report. *RTI International*. December 2018. https://downloads.cms.gov/files/cmmi/sim-rd1-mt-fifthannrpt.pdf

Subtopic: Multi-Payer Alignment Initiatives
Type of Source: Report
Objective: To report on Year 5 of the State Innovation Models (SIM) Initiative, a state-level effort to achieve health system transformation.
Main Findings: Six states—Arkansas, Maine, Massachusetts, Minnesota, Oregon, and Vermont—tested nine Alternative Payment Models (APMs). Vermont's Accountable Care Organization (ACO) Shared Savings Program, which aligned Medicare, Medicaid, and a large commercial insurer, had a slow increase in total Medicaid expenditures. All ACOs showed lower rates of emergency department visits. Common implementation strategies to support the state's health care transformation efforts included having providers report the use of admission, discharge, and transfer notifications; improving quality of care measures; improving alignment of quality measures collected across payers; developing systems to analyze Medicaid claims to support new APMs; supplying providers with performance feedback reports on cost and quality of care; integrating new workforce roles such as community health workers; and providing one-on-one and peer-to-peer technical assistance for providers.
Strengths/Limitations: All models were implemented in similarly motivated states that the CMS Innovation Center determined ready for a model test award.
Generalizability to the Medicare Population: Strong; the model was developed by the CMS Innovation Center.
Methods: Model-specific analyses used a difference-in-differences design to compare populations impacted by the models relative to within-state populations cared for by non-participating providers. Qualitative data included site visit interviews with key informants, focus groups, evaluation calls with state officials, and review of documents such as operational plans and news articles.

Stremikis S. All aboard: engaging self-insured employers in multi-payer reform. *Milbank Memorial Fund*. February 17, 2015. https://www.pbgh.org/wp-content/uploads/2021/01/Milbank_-_PBGH_Report_FINAL_2_17_15.pdf

Subtopic: Key Highlights; Background on Multi-Payer Alignment; Model Alignment Areas; Factors Influencing Multi-Payer Alignment
Type of Source: Report
Objective: To understand the extent to which self-insured employers participate in state-level, multi-payer delivery system and provider payment reform projects in Arkansas, Minnesota, Oregon, and Vermont.
Main Findings: Each state had success with improving coordination among payers. However, recruitment of employers with self-insured plans was an ongoing challenge for states. Many employers were not familiar with multi-payer efforts in their state and some were reluctant to change their employees' coverage. Additionally, outreach to employers by state officials or insurance executives was commonly limited.
Strengths/Limitations: The report included case studies for all four states, which summarized each state's multi-payer efforts and lessons learned, including successes, challenges, and advice.

Generalizability to the Medicare Population: Strong; the report focused on multi-payer participation of self-insured employers in the CMS Innovation Center's State Innovation Models (SIM) Initiative.
Methods: Structured interviews were conducted with state officials, insurance executives, and business leaders in 2014.

Takach M, Townley C, Yalowich R, Kinsler S. Making multipayer reform work: what can be learned from medical home initiatives. *Health Affairs*. 2015;34(4):662-672. https://doi.org/10.1377/hlthaff.2014.1083
Subtopic: Key Highlights; Background on Multi-Payer Alignment; Model Alignment Areas; Factors Influencing Multi-Payer Alignment
Type of Source: Journal Article
Objective: To report on lessons learned from 17 multi-payer medical home initiatives launched between 2008 and 2014.
Main Findings: There are four main decision points in multi-payer initiatives, including selecting a convener; establishing criteria for provider participation; determining payment methods and amounts; and measuring performance. Multi-payer initiatives varied as each initiative was influenced by its insurance market and policy environment. One key factor influencing success included having stakeholders negotiate strategies that consider local context. Partnering with Medicare was critical for multi-payer reforms.
Strengths/Limitations: One limitation includes the use of public information on websites in the analysis. Public websites may not reflect the latest information and/or may offer a one-sided perspective of an initiative. Formal evaluations of some initiatives included in the analysis were incomplete. Clinical quality measures were included for only a subset of the initiatives.
Generalizability to the Medicare Population: Strong; lessons learned may be useful for the development of future multi-payer initiatives by the CMS Innovation Center.
Methods: Primary and secondary data were analyzed to understand lessons learned from 17 multi-payer initiatives. Primary data included consultations with stakeholder participants, surveys administered before the start of the initiative, and email communications. Secondary data sources included initiative websites, evaluation reports, and reports to legislatures.

The Enhancing Oncology Model First Annual Evaluation Report. *The Lewin Group*. August 2025. https://www.cms.gov/priorities/innovation/data-and-reports/2025/eom-1st-eval-report
Subtopic: Multi-Payer Alignment Initiatives
Type of Source: Report
Objective: To report on Year 1 of the Enhancing Oncology Model (EOM).
Main Findings: Compared with non-EOM practices, EOM practices had higher episode volume in EOM cancers and lower episode costs at baseline. There was a reduction in total spending in the first six months of the model, which translated to a total gross savings of $13.1 million across episodes. The reduction in total episode spending was driven by decreased spending on Part B systemic cancer therapy. EOM had a net loss of $13.2 million in the first performance period. EOM practices reported that value-based pharmacy interventions contributed to success. There was no evidence that EOM impacted hospice use for end-of-life care in the first six months of the model.
Strengths/Limitations: One limitation of using claims data to compare episodes between EOM practices and a comparison group is that claims data are limited in capturing unmeasured differences.
Generalizability to the Medicare Population: Strong; this evaluation was focused on a model developed by the CMS Innovation Center.

Methods: The first evaluation included findings from claims-based impact analyses for the first performance period. The evaluation also included practices' experiences at the start of the model, which were captured through document review, site visits at EOM practices, and interviews with patients.

The Pennsylvania Rural Health Model (PARHM) Fourth Evaluation Report. *NORC at the University of Chicago*. December 2024. https://www.norc.org/content/dam/norc-org/pdf2024/parhm-fourthannualreport_12_19_24.pdf

Subtopic: Multi-Payer Alignment Initiatives
Type of Source: Report
Objective: To report on experiences and outcomes of the Pennsylvania Rural Health Model (PARHM) through Performance Year 4.
Main Findings: The report focused on the model's global budget and reconciliation experience, behavioral health care transformation activities, and concurrent participation in other value-based care models. Global budgets provided rural hospitals with stability, allowing the hospitals to maintain service lines and access to care for rural communities. End-of-year reconciliation was difficult for rural hospitals to predict and, for many hospitals, led to repayments to Medicare. The model supported hospitals with addressing their communities' behavioral health needs. Similarities between the model and other value-based care models facilitated transformation efforts. However, a lack of alignment across value-based care models created challenges for some participants. One key lesson learned was that multi-payer engagement is the model supported participants' transition to value-based care within states that had a growing percentage of Medicare Advantage and Medicaid managed care patients.
Strengths/Limitations: One limitation was the small number of participants in the model (18 rural hospitals). The small sample size hindered comparisons between participating hospitals and non-participating hospitals as well as comparisons with statewide and national benchmarks.
Generalizability to the Medicare Population: Strong; the evaluation was focused on a model developed by the Centers for Medicare & Medicaid Services (CMS) and the CMS Innovation Center.
Methods: A mixed methods approach was used to analyze model documents, interviews with model participants and partners, and quantitative data sources. Case studies were conducted to understand themes that emerged in prior data collection efforts and document review.

The Pennsylvania Rural Health Model (PARHM) Second Annual Evaluation Report. *NORC at the University of Chicago*. June 2022. https://www.norc.org/content/dam/norc-org/pdf2024/PARHM-SecondAnnualReport.pdf

Subtopic: Multi-Payer Alignment Initiatives
Type of Source: Report
Objective: To report on Year 2 of the Pennsylvania Rural Health Model (PARHM).
Main Findings: Global budgets helped stabilize rural hospitals' finances. Commercial payers were considered central to the model's success, as these payers have a large share of covered lives from private commercial, Medicare Advantage, and Medicaid managed care plans. Commercial payers reported skepticism of the sustainability of the model and concerns about the model's administrative burden. The financial viability of the hospitals decreased during the baseline period.
Strengths/Limitations: Given a descriptive analysis was conducted rather than an impact analysis, one limitation was that results of the analysis could not be attributed solely to the

model. Another limitation was the small number of hospital types and cohorts in the model. Given the small sample size, trends in outcomes could be influenced by outliers.
Generalizability to the Medicare Population: Strong; the evaluation was focused on a model developed by the Centers for Medicare & Medicaid Services (CMS) and the CMS Innovation Center.
Methods: Qualitative analyses were conducted to understand the implementation experiences of participating hospitals and payers. Qualitative data included information from model reports and interviews with hospitals, payers, and other implementation partners. Quantitative analyses were conducted to understand financial performance, access to care, and quality of care outcomes during the second performance period.

Thompson J, Golden W, Motley M, Fendrick A, Mathis C, Chernew, M. Arkansas Payment Improvement Initiative: private carriers participation in design and implementation. *Health Affairs Blog*. October 15, 2014. doi:10.1377/hblog20141015.041812

Subtopic: Factors Influencing Multi-Payer Alignment; Multi-Payer Alignment Initiatives
Type of Source: Blog Post
Objective: To describe private insurers' participation and collaboration with the state's Medicaid program in the Arkansas Payment Improvement Initiative.
Main Findings: Arkansas' Medicaid program and some of its largest private insurers collaborated to create a critical mass toward health care transformation. Private payers met regularly with an executive committee led by Medicaid to discuss progress and alignment strategies. Private payers did not participate in every launched Medicaid episode.
Strengths/Limitations: N/A
Generalizability to the Medicare Population: Moderate; the initiative focused on participation of private insurers and their collaboration with the state's Medicaid program. Findings on private insurers' participation in the initiative may be applicable to future initiatives.
Methods: N/A

Watkins LD. Aligning payers and practices to transform primary care. *Milbank Memorial Fund*. 2014. http://www.statecoverage.org/files/Milbank_-_Aligning_Payers_and_Practices.pdf

Subtopic: Factors Influencing Multi-Payer Alignment
Type of Source: Report
Objective: To understand how states transformed primary care and the factors that influenced their transformation efforts.
Main Findings: Because no single payer has enough of a practice's patient share or revenue to impact how the practice delivers care, efforts must be coordinated across payers. A multi-payer alignment approach is critical for engaging both clinicians and payers. Reliable data and measurement and transparency in experiences and information positively impact success in multi-payer alignment initiatives. State leadership is also necessary for the success of multi-payer primary care initiatives. Transformation efforts take time.
Strengths/Limitations: Findings have implications for future payment reforms. The report identified best practices for states participating in primary care transformation.
Generalizability to the Medicare Population: Strong; findings are relevant to multi-payer initiatives led by the Centers for Medicare & Medicaid Services (CMS) and may inform future primary care transformation efforts.
Methods: In 2013, a survey was administered to members of the Multi-State Collaborative, comprised of representatives from state-based primary care initiatives. Structured interviews were conducted with leaders and implementation directors of the initiatives.

Wirth B, Takach M. State strategies to avoid antitrust concerns in multipayer medical home initiatives. *The Commonwealth Fund*. July 2013.
https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2013_jul_1694_wirth_state_strategies_avoid_antitrust_ib.pdf

Subtopic: Factors Influencing Multi-Payer Alignment
Type of Source: Issue Brief
Objective: To summarize states' strategies for addressing antitrust concerns in multi-payer medical home initiatives.
Main Findings: Concerns about antitrust liability must be considered in multi-payer medical home initiatives. States can use legislative, executive, or regulatory policies to provide protection from antitrust laws. Of 14 select states that have implemented at least one multi-payer medical home initiative, nine states had policies to provide some legal protection for their efforts; one state conducted oversight activities to reduce the risk of antitrust liability; and six states engaged in multi-payer initiatives without formal antitrust protection. States that do not have policies in place to provide protection from antitrust laws can still proceed in their multi-payer initiatives by avoiding discussions of payment amounts among the stakeholders in the initiative.
Strengths/Limitations: A survey was administered to only a subset of states that have implemented at least one multi-payer alignment initiative. Five states were not surveyed because their initiatives were developed under the Comprehensive Primary Care (CPC) initiative, where meetings were conducted without antitrust protection.
Generalizability to the Medicare Population: Strong; findings are applicable to states implementing multi-payer alignment initiatives.
Methods: A survey was administered to 14 states that have implemented at least one multi-payer alignment initiative. A review of state websites was also conducted.

Appendix E. References

[1] Japinga M, Pokam Tchuisseu Y, Saunders R, & McClellan M. A Path Forward for Multipayer Alignment to Achieve Comprehensive, Equitable, and Affordable Care. Duke-Margolis Center for Health Policy. 2022. https://healthpolicy.duke.edu/sites/default/files/2022-12/A%20Path%20Forward%20for%20Multipayer%20Alignment%202.pdf

[2] Physician-Focused Payment Model Technical Advisory Committee (PTAC). Report to the Secretary: optimizing population-based total cost of care (PB-TCOC) models in the context of alternative payment models (APMs) and physician-focused payment models (PFPMs). Published 2023. Accessed October 13, 2025. https://www.aspe.hhs.gov/sites/default/files/documents/4b65476c58e363735aa9065a82a35df4/PTAC-TCOC-RTS.pdf

[3] Centers for Medicare & Medicaid Services. Multi-Payer Alignment. October 18, 2024. https://www.cms.gov/priorities/innovation/key-concepts/multi-payer-alignment

[4] Japinga M, Pokam Tchuisseu Y, Saunders R, & McClellan M. A Path Forward for Multipayer Alignment to Achieve Comprehensive, Equitable, and Affordable Care. Duke-Margolis Center for Health Policy. 2022. https://healthpolicy.duke.edu/sites/default/files/2022-12/A%20Path%20Forward%20for%20Multipayer%20Alignment%202.pdf

[5] Physician-Focused Payment Model Technical Advisory Committee (PTAC). Report to the Secretary: optimizing population-based total cost of care (PB-TCOC) models in the context of alternative payment models (APMs) and physician-focused payment models (PFPMs). Published 2023. Accessed October 13, 2025. https://www.aspe.hhs.gov/sites/default/files/documents/4b65476c58e363735aa9065a82a35df4/PTAC-TCOC-RTS.pdf

[6] Bailit MH, Flahert G, Hwang A. Adopting Multipayer Value-Based Payment Models. The Commonwealth Fund. January 2023. https://www.commonwealthfund.org/sites/default/files/2023-01/Bailit_implementation_guide_multipayer_VBP.pdf

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