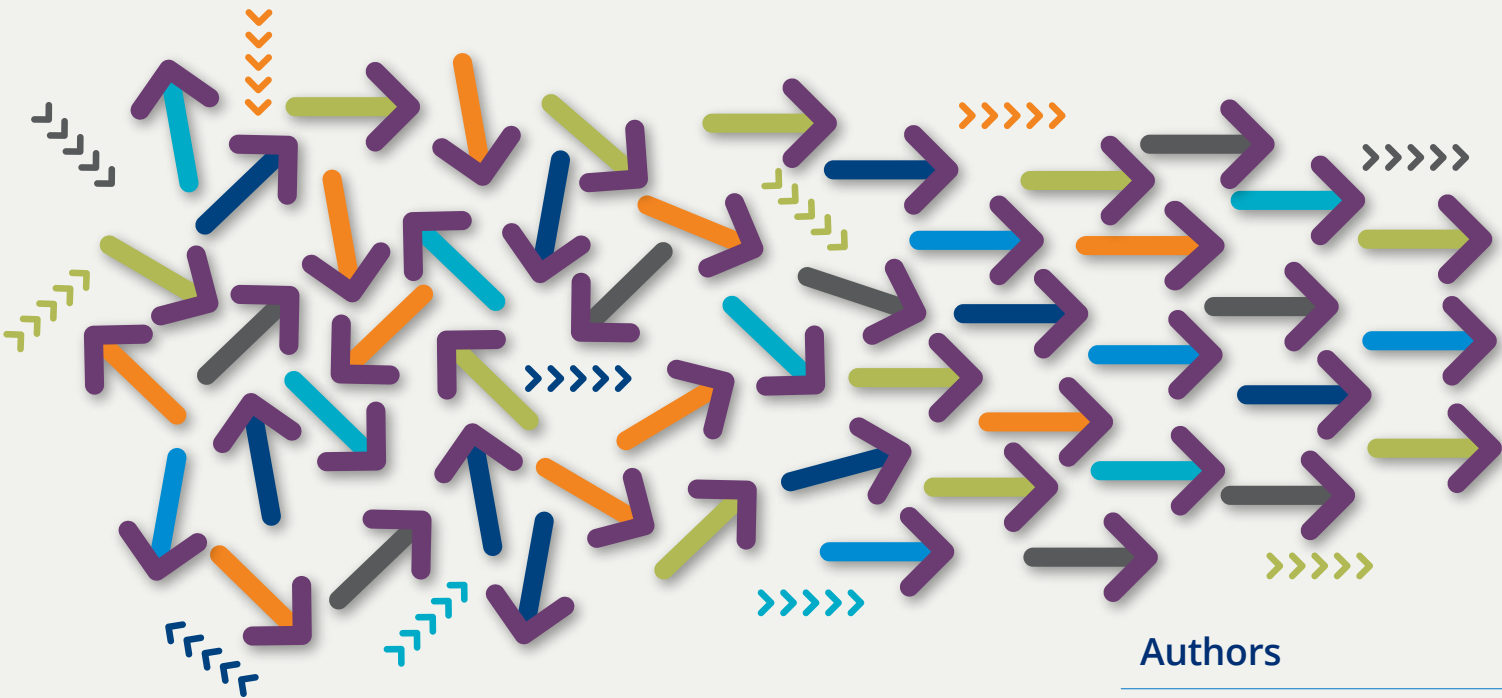# A Path Forward for Multipayer Alignment to Achieve Comprehensive, Equitable, and Affordable Care

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KEY TAKEAWAYS

- Improving multipayer alignment across key features of value-based payment models is widely recognized as critical for reducing administrative burden and achieving common goals, such as improving population health and affordability. The Center for Medicare and Medicaid Services (CMS) has made multipayer alignment a strategic pillar, and it is a growing part of state and employer efforts.

- However, differences in priorities, capabilities, and contracting processes have limited progress on comprehensive multipayer alignment around quality measures and other key payment reform elements and supports. At the same time, high-level conceptual alignment approaches that recognize these differences and allow for flexibility have often lacked clear and measurable steps to accelerate and sustain progress across these approaches.

- Informed by a series of stakeholder workshops and an evidence review, we propose a pragmatic, iterative multipayer alignment framework to achieve increasingly substantial alignment, with three components:

  - Identifying and leveraging shared goals that motivate shared, ongoing action for alignment;

  - Creating an alignment pathway to help achieve these shared goals through short-term actionable steps on five foundational elements of alignment: performance measurement and reporting, measures and initiatives related to health equity, other key payment model components (such as attribution, benchmarking and risk adjustment), timely and consistent data sharing, and technical assistance; and

  - Reimagining how CMS, with current resources and authorities, can facilitate more meaningful Medicare participation in multipayer initiatives and provide other supports for state and employer alignment efforts nationwide.

- This framework can help states and regions to establish and implement multipayer initiatives, make meaningful and measurable progress in these initiatives, align more effectively with Medicare reforms, and build out the critical mass necessary to achieve value-based care transformation.

BACKGROUND

Stakeholders across the health care system continue to implement and refine value-based payment (VBP) models as a critical part of providing more affordable, high-quality, and whole-person care. Many states and the Center for Medicare and Medicaid Services (CMS) have highlighted system-wide, multipayer alignment in key administrative details and technical supports for these directionally similar efforts as a strategic priority, including in the recent CMS [Innovation Center Strategy Refresh](#). The Health Care Payment Learning & Action Network (LAN) recently initiated the [State Transformation Collaboratives](#) to promote state-level and multipayer collaboration in four states, building on a range of existing state, regional, and national care improvement initiatives.

However, in the absence of well-established standards, different payers and providers have developed contracts and VBP supports that are conceptually similar but differ in terms of specific performance measures, attribution and benchmarking methods, data sharing approaches, and other foundational elements. This fragmentation results in two problems that complicate the shift from fee-for-service (FFS) to value-based payment. The first is higher transition costs: without standard and well-understood approaches, it takes more time and effort in each case to invest in and build the infrastructure to support the implementation for each different model, with different performance measures, attribution, data, risk-sharing, and other components. Second, too many different model components can create substantial ongoing administrative burden for health care organizations, contributing to [clinician burnout](#) and diminishing the impact of each initiative.

These burdens make staying in FFS more attractive, despite its well-documented inefficiencies. In contrast to VBP models, which often lack standard or common components, FFS has well-established standards supported by CMS. There is one standard set of ICD-10 codes for diabetes used by providers to support FFS billing; in contrast, a single provider may have to construct different performance measures for diabetes control for each of its VBP contracts. Remaining in FFS carries significant administrative burdens, but the established contracting and data sharing standards means that the administrative details of renewing these payment models is easier, creating a significant ongoing barrier to value-based health care transformation.

Of course, some variation in the "componentware" of value-based care contracts—specifically attribution, benchmarking, and risk adjustment—is appropriate. Different providers, payers, and purchasers serve patient populations with different needs, and with different capabilities and priorities in terms of implementing value-based payment reforms. VBP reform is a dynamic and evolving process, and too-rigid standards can become outdated, and obstacles to needed further innovation. [The increasing prevalence of payment reform across all major US payers](#) has helped build consensus on the basic conceptual structure of payment models. However, differences in their technical components have become a major concern.

For example, some providers trying to expand their VBP contracts must construct many different measures for common outcomes, such as effective control of diabetes or prevention of avoidable admissions or technical differences in attribution or risk adjustment formulas, that add significant burden while bringing few benefits (such as recognizing differences in local context or priorities). The absence of a common approach makes reaching a "critical mass" of reasonably aligned value-based contracts more challenging for any provider that is committed to value-based care reform, slowing uptake and expansion of non-FFS payments.

To overcome these challenges, there is growing support for and implementation of multipayer initiatives that facilitate alignment on key features of value-based payment and care reforms. Multipayer initiatives can help simplify and streamline care delivery within VBP models and across the health care system. They provide a mechanism for achieving common measures and other VBP features where improvement is needed, which helps providers pursue shared outcome, equity, and affordability goals for most (or all) of their patients. Multipayer initiatives can also reduce the cost and uncertainty of impact of investments in new health system capabilities to improve care, including more reliable and actionable steps to improve provider performance, including better data and technical supports.
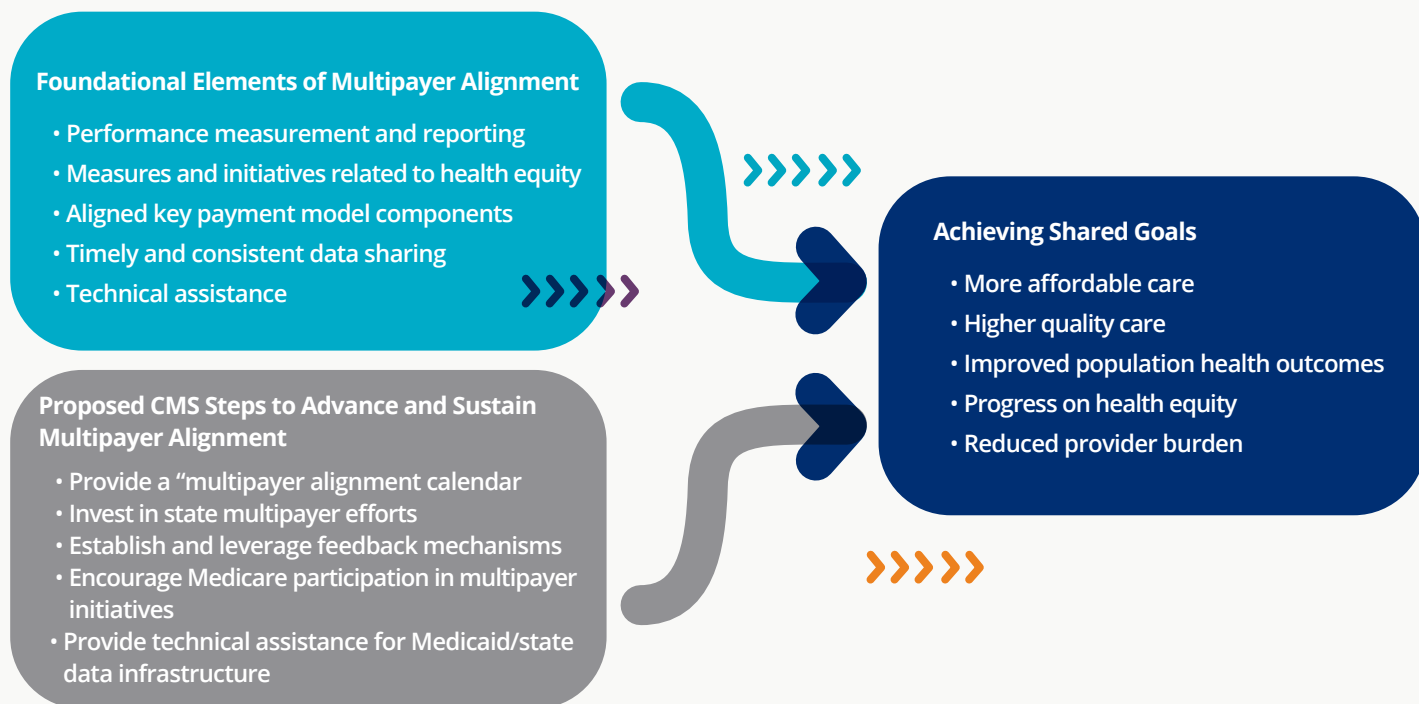
In this report, we lay out a framework that aims to overcome the current challenges by supporting actions that can help state and local multipayer initiatives make progress in the short-term across measurable goals while building a longer-term pathway for national alignment on foundational elements supporting payment and care reform. These foundational elements include: performance measurement and reporting, measures and initiatives related to health equity, other key payment model components (such as attribution, benchmarking and risk adjustment), timely and consistent data sharing, and technical assistance. As **Figure 1** summarizes, this approach recognizes that the goals motivating each state and regional effort differ, but often overlap, and that alignment across a common set of foundational elements supporting payment reform elements could help advance shared goals.

Reflecting current CMS strategic priorities, CMS could provide more support for aligning these efforts. This could include an ongoing, intentional process to share relevant information with state or regional initiatives, identifying best practices and priority areas for alignment support, tied to opportunities across Medicare's payment reform activities. CMS could also develop processes around relevant upcoming regulations, administrative actions, and developing guidance that affects Medicare and Medicaid. Such an intentional, bidirectional process between CMS and regional alignment initiatives could increase awareness and input, supporting increased alignment and support over time. CMS and states could work more closely by empowering joint leadership and iterative feedback, creating a more sustainable infrastructure, facilitating adoption of national standards, and building the critical mass for substantive and transformative payment and care reform.

The framework and recommendations included in this report are based on an environmental scan and a series of three stakeholder workshops hosted by the Duke-Margolis Center for Health Policy, with support from Arnold Ventures. Our environmental scan synthesized information on lessons learned from previous multipayer initiatives and ongoing efforts to promote alignment using grey literature and peer-reviewed literature. The stakeholder workshops were held from May to August 2022 and included over 50 total attendees representing state Medicaid agencies, commercial payer organizations, employers, data organizations, and other key stakeholders.

Figure 1 | **A Path Forward to Advance Multipayer Alignment**

Foundational Elements of Multipayer Alignment

- Performance measurement and reporting
- Measures and initiatives related to health equity
- Aligned key payment model components
- Timely and consistent data sharing
- Technical assistance

Proposed CMS Steps to Advance and Sustain Multipayer Alignment

- Provide a "multipayer alignment calendar
- Invest in state multipayer efforts
- Establish and leverage feedback mechanisms
- Encourage Medicare participation in multipayer initiatives
- Provide technical assistance for Medicaid/state data infrastructure

Achieving Shared Goals

- More affordable care
- Higher quality care
- Improved population health outcomes
- Progress on health equity
- Reduced provider burden

Current Challenges in Encouraging Multipayer Alignment

CMS has played a critical role through Medicare in the systemwide adoption of FFS standards, and can advance the adoption of more consistent approaches and standards where appropriate for value-based payment arrangements. Since its early payment reform models in the Center for Medicare and Medicaid Innovation, CMS has sought to align other payers with Medicare payment reform models. However, in these efforts, such as the Comprehensive Primary Care (CPC) model and CPC Plus models, these multipayer alignment efforts largely involved CMS providing transparency and technical support for other payers to adopt CMS-developed pilot contract terms. These models helped some markets make progress in aligning primary care payment reforms, but multipayer participation was limited for a variety of reasons, many stemming from the focus on building infrastructure for a particular pilot, without providing substantial advance notice on these payment details or clarifying what would likely happen when the pilot ended. Since other payers had their own established timelines and methods for contracting, it was difficult for them to shift measures or take on other substantive steps on the timeframe of a particular Medicare pilot.

An array of state and regional multipayer initiatives have had some success in aligning non-Medicare payers. These initiatives are often better able to identify common local priorities for reform, as well as address local payer and provider needs and capabilities. They can potentially leverage Medicaid, state employee health plans, and exchange programs to reach a critical mass. Successful examples include Massachusetts' effort to align on quality measures; the Vermont's All-Payer ACO Model; and Washington State's multipayer model for transforming primary care and Civitas Networks for Health's efforts to facilitate alignment across practices engaged in the Transforming Clinical Practice Initiative (TCPI). However, these initiatives have each required substantial investment by states and participating payers, employers, and organizations, and have not been duplicated in many parts of the United States. Fifty different quality initiatives in 50 different states will likely result in differing sets of standards and duplicative investments made without a meaningful path to national action. Moreover, significant state-to-state differences in aligned standards complicates the ability of Medicare or national commercial payers to participate in each state effort.

Joint public-private sector initiatives focusing on specific areas of standards—most notably quality measures—has offered another mechanism for advancing national alignment. The Clinical Quality Measures Collaborative (CQMC) has endorsed standard sets of quality measures in a range of important areas of care. CMS supports a process through the National Quality Foundation (NQF) for "endorsing" quality measures for broad adoption, and leverages a program called the Measure Applications Partnership (MAP) for gathering stakeholder feedback on which measures are best to use for different federal programs. There are over 400 NQF-endorsed measures (as of this writing), with NQF reporting that over 300 have been adopted across various programs. However, it is unclear how many measures have been adopted widely. Different measures are adopted in different places or models without subsequent alignment, leaving gaps in what we can measure and limiting initiatives that aim to move beyond claims data and capture more meaningful outcomes.

The result is two unsatisfactory approaches for national multipayer alignment. National approaches often amount to aligning with Medicare, or seeking Medicare alignment with an existing state multipayer approach, and often amount to a "take it or leave it" choice for regional or state collaborators that may have different priorities, standards, and capabilities. Alignment centered around state and local initiatives can better reflect local circumstances and goals, but it does not have a clear path to national alignment or a path to consistent participation from national payers like Medicare that may have less flexibility to implement local standards.

Overcoming Current Multipayer Alignment Challenges: Pragmatic, Iterative Alignment

Our framework to address these challenges – pragmatic, iterative multipayer alignment (PIMA) – is informed by the experiences of multipayer initiatives across the country and recent CMS and national payer steps to facilitate alignment. The PIMA framework begins with identifying shared goals; participants in successful multipayer alignment initiatives highlighted the importance of defining, updating, and making measurable progress on shared goals as a core driver of engagement and sustainability. To facilitate progress on the goals, we found that many initiatives devoted considerable effort to a specific set of alignment activities. In the sections below, we describe how national supports and coordination, particularly involving CMS, can support these foundational elements of multipayer alignment.

Shared Goals to Drive Multipayer Alignment

Alignment on a manageable number of meaningful and potentially feasible shared goals for improving care generates the momentum needed for multipayer alignment efforts to have impact. Shared goal setting is an important first step. The highest-priority goals for each multipayer initiative vary, depending on the circumstances, opportunities, and challenges facing the state or region and its stakeholders. However, multipayer initiatives tend to focus on qualitatively similar goals, which include:

- **Improving affordability of high-quality care –** e.g., by reducing total cost of care growth, and/or out-of-pocket spending, in conjunction with goals related to improving health system performance;

- **Improving quality of care –** e.g., by improving key dimensions of quality or access to care for preventive services and common conditions or health problems, and/or by improving access to comprehensive, coordinated care by expanding access to accountable health care organizations;

- **Improving population health –** e.g., by improving clinical and patient-reported outcomes for common conditions and health problems where there is clear evidence of significant opportunity for improvement;

- **Advancing health equity –** e.g., by undertaking intentional efforts to address root causes of inequities that lead to disparities by race, ethnicity, socioeconomic status, and urban/rural status in affordability, quality, and health outcomes;

- **Reducing provider burden –** e.g., by implementing approaches to make it easier and less costly for providers to take steps to advance shared care reform goals

These goals often involve some common priority areas of care, including pregnancy and maternal health, behavioral health and substance abuse, common chronic conditions like cardiovascular disease and diabetes, and infectious diseases with public health implications (e.g., childhood vaccination). To sustain engagement and momentum from stakeholders, the shared goals need to be measurable and linked to an actionable path for the initiative to make progress, enabling increasingly aligned and meaningful measures over time.

Translating Shared Goals into Action

Achieving progress on multipayer alignment requires translating overarching goals into a clear plan for implementing and updating specific alignment activities. We focus here on common activities frequently undertaken in multipayer initiatives. These foundational elements, combined with an iterative pathway, allow for short-term incremental progress and ongoing improvements (reflected in such areas as reduced clinician administrative burden), thus reinforcing trust, support, and engagement. The momentum from these short-term gains can facilitate further, more substantive alignment and impactful steps leading to a "virtuous cycle" of multipayer progress.

The left side of Figure 2 highlights the five foundational elements of alignment commonly incorporated into the multipayer initiatives that we reviewed:

- **Performance measurement and reporting** to measure progress toward the initiative's goals and to provide a foundation for supporting quality improvement, transparency, and payment initiatives. This in turn helps focus and refine activities and maintain engagement to improve affordability, quality, and outcomes, while reducing provider burden.

- **Measures and initiatives related to health equity** includes implementing aligned efforts to stratify performance measures by race, ethnicity, language, indicators of socioeconomic status, and geography, which in turn helps motivate initiatives such as addressing social needs and engaging community resources and perspectives more effectively.
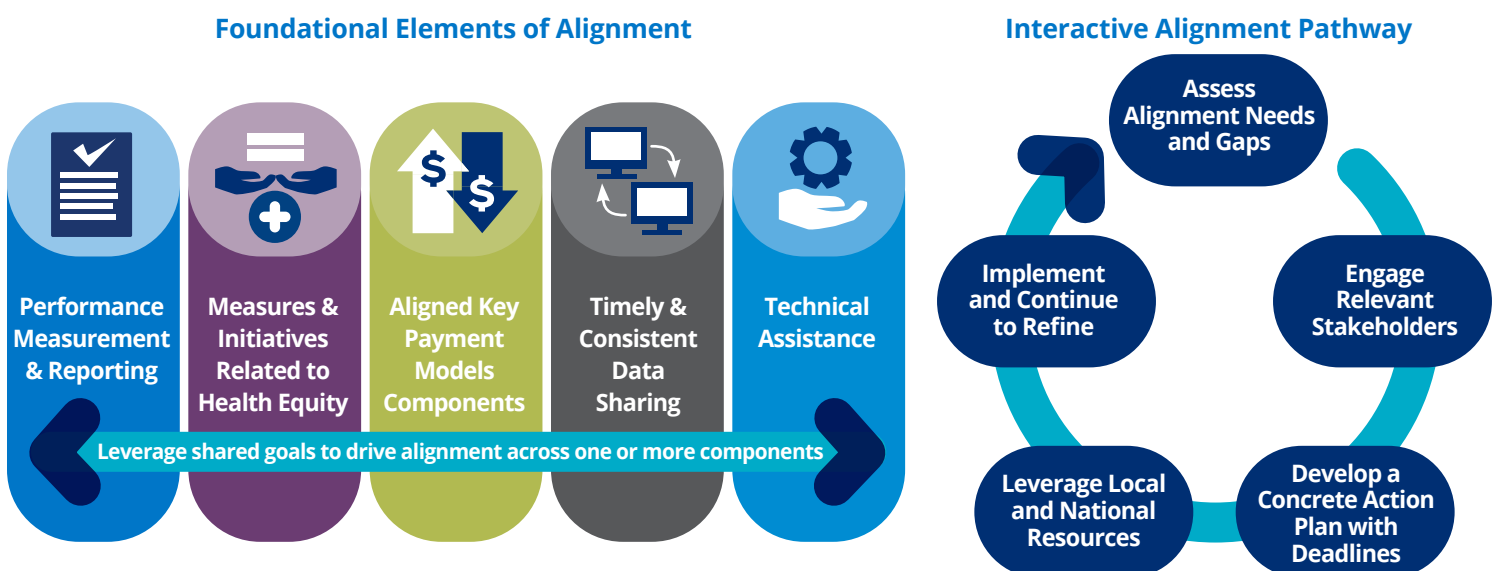
- **Aligned key payment model components,** such as attribution, benchmarking and risk adjustment, are important because different approaches to the "componentware" of payment reforms can add to implementation burdens and blunt the impact of many initiatives.

- **Timely and consistent data sharing** can provide more meaningful and actionable information that enables providers, plans, and other stakeholders to better collaborate, identify gaps, and accelerate progress on goals.

- **Technical assistance** facilitates the dissemination of best practices and evidence-based steps and resources needed to accelerate progress, particularly for smaller organizations and local communities with limited resources.

Within these categories, states and regions have selected different foundational elements to prioritize, with specific initial and follow-on steps based on their current needs, context, and infrastructure. Because these foundational elements are interconnected, it will likely be beneficial to align across all these elements over time. For example, states that have already made progress on quality measurement alignment have used that foundation to align equity measures and implement further steps to align other key payment model components where the administrative simplification outweighs any benefits of having distinct approaches.

Once started on alignment steps, multipayer initiatives can use an iterative approach to make continued incremental progress with clear short-term goals (shown on the right side of **Figure 2**). This iterative pathway aims to describe steps that multipayer initiatives can use to make clear, feasible, and increasing progress on directional alignment in key areas including:

- **Assess priority alignment needs and gap**s to accelerate progress on key alignment goals;

- **Engage relevant stakeholders** in determining actions to support alignment initiatives that garner local and regional support—with a convener who can coordinate the process of identifying and implementing these actions, and with public and private purchasers who can help drive actions by payers;

- **Develop a concrete action plan with deadlines** for specific, directionally aligned initiatives across foundational elements;

- **Leverage local and national resources** to reduce the cost of making these investments in multipayer alignment; and

- **Implement** multipayer alignment steps while monitoring progress and challenges, **and continue to refine** the approach by incorporating lessons learned in the collaboration.

Figure 2 | **Pragmatic, Iterative, Multipayer Alignment Framework**

Foundational Elements of Alignment

Performance Measurement & Reporting · Measures & Initiatives Related to Health Equity · Aligned Key Payment Models Components · Timely & Consistent Data Sharing · Technical Assistance

Leverage shared goals to drive alignment across one or more components

Interactive Alignment Pathway

Assess Alignment Needs and Gaps · Engage Relevant Stakeholders · Develop a Concrete Action Plan with Deadlines · Leverage Local and National Resources · Implement and Continue to Refine

The remainder of this section describes each foundational element in more detail, along with examples of step-by-step progress. Previous efforts and growing national resources, including Medicare implementation activities and CMS resources for Medicaid quality measurement, should reduce the cost of implementing these initiatives in the future.

Applying the Multipayer Alignment Framework across Foundational Elements

Aligning and Reporting Performance Measures

Measure alignment is the most common element of multipayer initiatives due to the importance of measuring performance gaps and improvement for maintaining shared motivation around key goals. As described earlier, a large number of performance measures are in use today, which can create administrative burdens if the priority measures are not aligned effectively. There are many examples of quality measure alignment initiatives across the country, with states focusing on alignment for advanced primary care and equity (e.g., CA, NC, CO, WA), on common episodes of care in Medicaid and for nonelderly populations (AR), in maternity care (NY, OH), and in behavioral health (RI). Illustrative state examples include Massachusetts' aligned measure set for global budget-based risk contracts (which includes patient experience measures, chronic condition management measures, screening for clinical depression, and follow-up) and California's aligned quality and disparities sensitive measures (which includes chronic condition management measures, cancer screenings, childhood immunizations, depression screening and follow-up, and pharmacotherapy for opioid use disorder). Further, the CQMC has core measure sets on primary care/accountable care, behavioral health, cardiology, gastroenterology, HIV and Hepatitis C, medical oncology, neurology, obstetrics and gynecology, orthopedics, and pediatrics.

Most of these initiatives began alignment efforts using claims-based measures, due to limited capabilities and additional costs for standardizing additional data. Many current measure alignment efforts have built on CMS-adopted measures (including NQF-endorsed measures) and CQMC measures. Given the limitations of current measures, there is a need to incorporate measure refinement (with new and better measures) in alignment efforts. More advanced initiatives could focus on implementing electronic clinical quality measures (eCQMs) using CMS's recent resource on eCQM implementation and reporting,

which are intended to ease future reporting burden but require upfront investment in aligning electronic data systems. These electronic approaches build on the United States Core Data for Interoperability (USCDI)'s set of standardized electronic data elements. NQF also provides technical support for patient-reported outcome performance measures. We return to how CMS and Medicare measure refinement can better support and align with state efforts below.

Advancing Health Equity

Alignment around health equity offers straightforward and timely opportunities to both address health disparities and reduce administrative burden. Most efforts to track and address disparities are relatively new, meaning there are fewer existing standards to modify and thus fewer barriers to alignment resulting from preexisting efforts. For example, existing CMS data standards related to race, ethnicity, and language are limited, and, while CMS has a standard urban/rural measure, it may not adequately capture different degrees of geographic isolation. Further, more measures related to socioeconomic status are now being incorporated into performance measures and equity-related initiatives, but so far these are generally regionally based measures, like the Area Deprivation Index (incorporated into ACO REACH), and they are not widely or consistently used. Thus, there is considerable opportunity now for prospective alignment, which would help stakeholders adopt consistent and increasingly well-validated new standards rather than having to develop their own approaches.

There are ongoing national efforts to support advancements in health equity, with an emphasis on refined data collection to support performance metrics that help assess disparities and equity. The LAN launched the Health Equity Advisory Team (HEAT) to identify opportunities to improve health equity across care delivery, payment incentives and structures, and performance measurement. As part of this effort, the HEAT has encouraged multipayer alignment across select payment model components and outlined key strategies to achieve meaningful progress in reducing health inequities. These strategies include collecting standardized data related to race, ethnicity and language, linking these measures to payment reforms aiming to reduce disparities (e.g., MSSP's proposed health equity payment adjustments, potential Medicare Advantage equity payment adjustments), and using these measures

to engage and support community-based organizations in collaborative efforts to improve health equity (e.g., Accountable Communities for Health and Community Care Hubs).

To support state and regional action, dissemination of best practices and an adoption path for standard, enhanced data on race, ethnicity and language could significantly reduce costs and increase impact. Such steps could also help assure that they are aligned with and inform future Federal reporting requirements. These data will enable health care organizations to identify and intervene more effectively on issues related to health disparities, but the challenges related to availability, reliability, and trust related to use of such data remain substantial.

Aligning on Key Payment Model Components

Beyond performance measures, variation in other key payment model components—including attribution, benchmarking, and risk adjustment—complicates provider participation in multiple payment models and may diminish the effectiveness of financial incentives and supports. For example, the methods and quality of data to determine attribution significantly affects providers' ability to respond to accountability measures.

While aligning exactly on specific payment model components has been challenging, multipayer initiatives have sought to identify broad areas of directional alignment and then iteratively reduce variation. For example, Colorado's Alternative Payment Alignment Initiative has a set of options on ways to align on attribution, and other model components, in addition to measures. For patient attribution, Colorado plans to use patient attestation as the preferred method of attribution and will require payers to provide prospectively notify to practices of patients included in their alternative payment model (APM) and reattribute patients regularly. For risk adjustment, Colorado has a proposed set of principles to facilitate alignment, which includes: being transparent about risk adjustment methodologies and how they are applied to payments, and encouraging payer-provider collaboration on determining appropriate risk adjustment methods for pediatric APMs.

Best practices that account for differences across populations and goals, and common approaches to these key components of payment reform models, are still emerging. The LAN has developed conceptual resources for many of these areas, including resources to facilitate alignment on patient attribution, financial benchmarking,

and various components of clinical episode payment models. Further national collaborative work supported by CMS and the LAN could incorporate recent experiences and provide needed resources for multipayer initiatives across the country.

Facilitating Data Sharing

Reliable and timely data access is critical both for tracking progress and for enabling health care organizations to identify gaps and actionable steps to address them. Accountable care organizations and providers participating in other advanced primary care models need admission, discharge, and transfer (ADT) feeds to know when their attributed beneficiaries are in the hospital (or leaving the hospital) so that they can support care transitions; health care organizations needed COVID-related prevalence, utilization, and vaccination data during the pandemic to manage local population health; health care delivery organizations need claims data to understand the care that their patients are receiving from other clinical practices (in order to coordinate care and understand where they should develop partnerships); and accountable providers and plans need social drivers of health data to address underlying health needs and inequities. Multipayer initiatives so far have mostly relied on individual health plans and providers to work out data sharing to support their performance improvement initiatives, but that is changing.

With substantial investments in electronic standards and data interoperability, and with increasing availability of health information exchanges and similar shared platforms for exchanging key health data, there are increasing opportunities to collaborate with or support regional and state data exchange infrastructures. These efforts are especially important given that by the end of 2022, most electronic health record systems are required to update their software to support bulk Fast Healthcare Interoperability Resource (FHIR) standards, which allows for data sharing at a population level. Other standards facilitating data sharing include USCDI (a standardized set of health data classes and data elements) and a set of vocabulary/terminology, content, and transport standards.

States have taken steps to further align efforts to facilitate data sharing. For example, California's Health and Human Services Agency (CalHHS) recently released its Data Exchange Framework which consists of its first statewide data sharing agreement among various health care entities, government agencies, and social service programs to safely

share health information starting in 2024. Colorado also has an updated Health IT roadmap designed to support and facilitate data integration and sharing across the state. Further, states can also take broader infrastructure steps, such as assessing areas where timely and reliable data access will have the greatest impact on improving care goals. They could also pool community and social resources for addressing social risk factors to support equity initiatives, such as North Carolina's NCCare360 initiative for providing closed loop referrals between health care and human services organizations.

National support, particularly from CMS and ONC, can help advance best practices and facilitate progress, both in terms of consistent standards and (as a result) broader and more impactful data sharing. The 2022 update to CMS's Strategy Refresh highlighted multiple opportunities to leverage CMS data, such as providing more data that can support high-quality referrals, improve data on demographic characteristics to reduce disparities, and support the adoption of data sharing standards (like FHIR). In addition, CMS has developed secure interoperability systems to provide timely access to bulk Medicare claims data for beneficiaries participating in accountable care arrangements like the Medicare Shared Savings Program; similar tools could potentially be developed or encouraged for state plans and private payers with CMS infrastructure support. CMS's FY 2023 Inpatient Prospective Payment System final rule also included policies promoting interoperability under the Trusted Exchange Framework and Common Agreement published by ONC (e.g., this involved the inclusion of a new measure incentivizing eligible hospitals to use certified EHR technology to support bi-directional exchange of public health).

Providing and Leveraging Technical Assistance

Even with progress on the common areas of alignment to support multipayer goals that we have described, the work of redesigning care systems, building shared understanding and effective approaches to collaboration, and other supporting steps needed to achieve measurable progress on key goals remains challenging.

Consequently, many states and regions are investing in such technical assistance for their multipayer initiatives. For example, the California Maternal Quality Care Collaborative—a multi-stakeholder organization launched by the state of California and the Stanford University School of Medicine—provides research, quality improvement toolkits and statewide outreach to improve maternal health outcomes and reduce racial disparities in maternity care.

With so many reform efforts underway, there continues to be great value in ensuring that stakeholders benefit from evidence-based best practices, and supporting tools and resources, developed outside their own initiatives to help make progress on their key goals. While there may not be a single standard or best practice for an area of care or equity improvement, there are many opportunities to learn from the growing evidence base on these activities and how multipayer initiatives can best advance them.

CMS has played a major role in providing technical assistance to support its previous multipayer initiatives. Prior CMS models, like the Comprehensive Primary Care Initiative, included funding for learning tools, expert technical assistance, and convening support. CMS can also provide technical assistance to states, like guidance on future section 1115 waivers, state plan amendments, or Medicaid managed care directed payments to help streamline state efforts. In addition, states can also leverage matching funds from CMS to support state Medicaid infrastructure. As CMS shifts from a model-by-model approach to a set of key strategic directions that are well aligned with the goals of many multipayer initiatives, the CMS strategy for enabling greater alignment and impact on these shared goals should evolve as well.

CMS could also support learning collaboratives to share experiences and connect local efforts to national tools, best practices, and resources. This can help states understand what types of models are promising and how to build on prior work. The LAN's State Transformation Collaboratives provide a forum for such exchange. Other "learning networks" and collaborations, including the Health Care Transformation Task Force and the Institute for Advancing Health Value, are also providing resources. An intentional focus on identifying where multipayer collaboratives have the most limited or uneven support for participating health care organizations in improving care could help leverage all of these public and private efforts.

CMS Engagement and Leadership to Achieve and Sustain Progress

As our review of opportunities for accelerating alignment in state and regional activities makes clear, national support and particularly support from CMS can play an important role in reducing the cost and increasing the impact of multipayer initiatives across the nation. The current CMS strategic plan envisions more transparency and a clearer path to increase alignment for progress on shared goals related to affordability, outcomes, and equity. To further advance these alignment efforts, CMS can use its role as the nation's most influential payer and purchaser to build a stronger process in collaboration with state, regional, and employer-led multipayer initiatives to accelerate the iterative path to more effective alignment. Achieving more Medicare participation over time alongside states and employers, through increasing alignment, will also help these initiatives reach "critical mass" in support of meaningful accountable care reforms.

As we have noted, CMS faces unique challenges participating in multipayer initiatives. First, Medicare is a national program, and it can be difficult to customize national payment models for local areas. Many national commercial payers face similar challenges in actively engaging in multipayer initiatives. Second, CMS must operate under its statutory authorities, and important CMS actions are generally required by different provisions of law to operate on distinct Congressionally-prescribed "notice and comment" rulemaking schedules. CMS thus often faces a prescribed set of public engagement requirements to implement new payment reforms in the CMS Innovation Center (CMMI) or the overall Medicare program (and sets constraints on how a new initiative may be structured). Third, CMS faces practical resource limitations on what it can fund and staff, especially if states have different priorities and approaches.

These challenges to alignment are also opportunities, if CMS creates a more unified and strategic approach to bringing together its relevant Medicare programs (payment reform pilots, provider and Medicare Advantage regulations in the Center for Medicare, quality initiatives in the Center for Clinical Standards and Quality, etc.) and its various programs to support state reforms with the goal of supporting more comprehensive ongoing engagement with multipayer initiatives across the country. Reflecting these opportunities, **Table 1** presents a set of steps identified in our work with stakeholders on improving

CMS participation in multipayer initiatives and moving toward standard approaches. Medicare engagement is critical to national progress. The approach outlined here can help CMS refine its Medicare standards in ways that enable more aligned progress in and beyond the Medicare program—for example, by using more meaningful performance measures, definitional standards such as those related to race, ethnicity, and language, and data interoperability standards. It can also leverage CMS programs to support alignment through state reforms in Medicaid and other state programs.

Overall, these steps aim to increase communication, predictability, and clarity between state and regional multipayer initiatives and CMS, to facilitate more meaningful alignment where the benefits of common approaches —administrative burden reduction and more meaningful combined support—outweigh the costs of adapting existing systems and meeting distinct local goals. Clearly, more alignment will be possible in longer time frames than in the short term. But if implemented successfully, these steps could help state and regional initiatives and CMS establish a clearer, pragmatic "glide path" to alignment efforts that are particularly important for shared goals but take some time to adopt and get right. These steps can also help fulfill a vision for more effective transparency, stakeholder input, and well-aligned actions. For example, this process could help assure that future CMS incentives and support for improving care for Medicare beneficiaries in its payment rules and electronic data exchange standards will also achieve similar goals across payment models, providing not only more support for reforms that help Medicare beneficiaries but all other Americans as well.

TABLE 1 | **Proposed CMS Steps to Advance and Sustain Multipayer Alignment**

	Current Gap	Payers
"Multipayer Alignment Calendar"	States, employers, payers, and other stakeholders require time to implement multipayer activities, and may be unclear about coming CMS priorities and future actions that could support or complicate them.	- Provide a "multipayer alignment calendar" that previews the strategy and timeline for expected CMS payment reform pilots and relevant regulatory and payment developments across the spectrum of CMS regulatory and program announcements (e.g., MSSP regulations, CMS Quality Strategy implications in various payment rules, future CMMI pilots, potential CMCS Medicaid guidance, etc.)
Invest in State Multipayer Efforts	Limited state and regional capacity to build data infrastructure, invest in ongoing conveners to engage needed stakeholders, and implement supporting Medicaid policy reforms.	- Clarify enhanced Medicaid match availability for tools that can be leveraged to support multipayer initiatives, including IT supports for linking social service availability to assessments of social needs, Medicaid provider participation in FHIR adoption, information exchange improvements, meaningfully aligned performance measures using electronic data, and other types of enhanced data sharing. - Provide guidance and templates to streamline approval of Medicaid VBP efforts through state plan amendments (SPAs), 1115 waivers, and MCO directed payments - Link these supports to dissemination of existing and emerging standards and best practices across the foundational elements of multipayer alignment (described below)
Feedback Mechanisms	States and regional initiatives may not have a clear and timely mechanism for communicating about goals and planned components of multipayer initiatives to ensure that these efforts can increasingly align with CMS goals and specific program activities.	- Support regular and reliable public-private process for stakeholder engagement where stakeholders can identify opportunities and best practices to advance directionally similar initiatives, including linkage to relevant regulatory comment opportunities in Medicare multipayer alignment calendar
Medicare Participation in Multipayer Initiatives	Purchaser collaboratives and states face challenges in achieving alignment without Medicare participation	- Build on CMS-wide strategic initiatives to describe and (through appropriate public comment opportunities) receive stakeholder input on further CMS steps to increasingly align Medicare accountable care reforms with state and regional initiatives, such as through common Medicare metrics and key payment reform components – with a more transparent path for advancing these approaches (e.g., timeline and steps for moving to key patient-reported outcomes) - Develop efficient process for Medicare awareness of and guidance for state and regional alignment initiatives, both at the individual state level and through forums like the State Transformation Collaboratives
Technical Assistance for Medicaid/State Data Infrastructure	Need for different types of technical support based on different capabilities and short-term goals, along with a need to build competencies across states to support adoption of more advanced digital technologies that could support alignment	- Share episode/condition level measures or other types of timely data to facilitate comparisons, with advance notice and opportunities for feedback to align increasingly with state and regional approaches - Provide clear path for advancing electronic data standards, including broadening support for eCQMs and more automated approaches to risk adjustment, benchmarking, and other key payment reform components

CONCLUSION AND NEXT STEPS

Achieving progress on multipayer alignment is a necessary and important support for advancing health care reform goals and reducing the burden on the health care workforce. Successful initiatives show alignment is possible but requires multi-stakeholder commitment toward shared goals, an iterative and context-specific plan for improvement, and consistent participation and support from CMS. Our framework, developed with input from a range of stakeholders engaged in advancing multipayer reforms across the country, demonstrates both the range of opportunities states and local stakeholders have to align on shared goals, ways to support meaningful progress and build momentum for more complex initiatives. This approach should allow more states and localities to engage in multipayer initiatives with assurance that results can benefit all payers and all models and sustain progress beyond the life of any single effort, supporting a more streamlined and effective health care system.

Multipayer Alignment Workshop Series hosted by Duke-Margolis Center for Health Policy (April, May, & August 2022)

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