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Policy Opportunities to Improve Care in the Safety Net through Accountable, Value-Based Payment Reform

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EXECUTIVE SUMMARY

Over the last two decades, health systems across the United States have increasingly adopted accountable care arrangements. The goal of accountable care reforms is to help providers improve outcomes and lower costs through greater flexibilities to deliver care than possible in a fee-for-service (FFS) structure. To date, safety net providers have been less likely to participate in accountable care despite the benefits of more coordinated, comprehensive care for the higher-risk populations and communities they serve.

To close this gap, safety net providers need additional policy supports to participate in payment reforms that expand accountable care relationships for historically underserved and under-resourced communities. This finding is consistent with the Center for Medicare & Medicaid Services' (CMS) strategic vision for increasing accountable care relationships, with an explicit focus on safety net inclusion in payment and care delivery reforms.[1,2] Increased awareness, together with the CMS focus on this issue, are encouraging and could spur the necessary modifications of payment models to address decades of historical disinvestment, fragmentation, and siloed care delivery that have impeded safety net providers from making transformative delivery system changes required for longitudinal, comprehensive care.

This report describes a pathway to capitalize on momentum to advance accountable care among safety net providers. Drawing from a targeted literature review, proceedings from expert-focused convenings, and informational interviews, the Duke-Margolis Center for Health Policy proposes that safety net payers and funders—including Medicaid, Medicare, categorical funding, Marketplace plans, and grant providers—can create ***accountable funding streams:*** funds that are simple, predictable, flexible, and explicitly tied to the goals of advancing accountable care reforms. While there is no one-size-fits-all payment approach, aligned funding streams can adopt common design features to reduce the administrative burden associated with managing dollars across multiple payers and funders.

The safety net is diverse, including many types of organizations that care for traditionally underserved populations.

State and federal policymakers should facilitate these accountable funding streams and support providers on their path to accountable care through four complementary actions:

- **Support cross-program alignment—**Safety net providers manage a complex web of funding streams spanning payers, public funders, and private sources, each with distinct requirements and administrative processes. To simplify existing payment models, reduce administrative burden for providers and payers, and maximize the impact of existing resources, policymakers and payers should modify and align program parameters of existing payment models—and existing grants—calibrated to safety net providers. A Federal coordination workgroup should identify areas of alignment across programs and set shared objectives for accountable funding streams across safety net providers. States should act concurrently through existing flexibilities within Medicaid programs, like State Plan Amendments, "in-lieu-of" non-medical services, or Section 1115 demonstration activities, to implement accountable care.

Duke-Margolis proposes that safety net payers and funders—including Medicaid, Medicare, categorical funding, marketplace plans, and grant providers—can create accountable funding streams: funds that are simple, predictable, flexible, and explicitly tied to the goals of advancing accountable care reforms.

- **Facilitate access to upfront investments and ongoing payments—**Many providers lack a pathway to capitalize risk due to historical underfunding and high uncompensated care costs. These providers require additional upfront capital along with increased reimbursement rates to remain financially viable in accountable care. Policymakers can address this challenge by allowing providers to re-purpose time-limited grants toward developing the capabilities needed to take on longitudinal care. Accountable payment models also could include easier access to upfront investments through ongoing care management fees, such as Primary Care First and other accountable primary care payment reforms, or through advanced payments, such as the ACO Investment Model. Further, funding levels should reflect actual resources required to manage care for complex populations since safety net providers have historically been underfunded.

- **Provide guidance and technical assistance to states and providers—**Providers need assistance getting started with accountable care transformation. Federal agencies, which have supported a range of technical assistance initiatives, should develop a "roadmap" for providers that includes guidance on ways to braid funding streams (coordinate without blending) and examples of how safety net providers can coordinate different funding sources to take on accountability. States also need assistance to identify available strategies to drive state-wide accountable care reforms. Federal agencies should issue structured guidance for states on available Medicaid flexibilities and create quicker, standardized approvals for Medicaid managed care arrangements.

- **Create a pathway to integrate social and community supports to address social needs—**Safety net providers are uniquely positioned to bridge trusted connections between individuals in need and social and community-based resources. Federal and state policies should build on successful examples to support partnerships between safety net providers and community-based organizations and invest in initiatives that drive population health outcomes, including existing efforts with Federal interagency support, such as Community Care Hubs,[3] to strengthen community linkages to safety net providers seeking to address social needs; clarify and expand funding approaches to sustain partnerships with social and community-based organizations; and utilize grants to improve regional and state data exchange capabilities.

These four areas encompass near-term steps (summarized in the table below) for policymakers to advance safety net participation in accountable care models, facilitate coordinated and integrated care, and strengthen community linkages in the safety net. This report provides more detail on a menu of recommendations for policymakers across these areas. In turn, these accountability steps provide a stronger foundation for supporting additional safety net funding and flexibility, as such steps would be more clearly aligned with measurable impacts on health and well-being.

Many providers lack a pathway to capitalize risk due to historical underfunding and high uncompensated care costs. These providers require additional upfront capital along with increased reimbursement rates to remain financially viable in accountable care.

TABLE 1 Summary of Recommendations

Support Cross-Program Alignment Across Safety Net Payers	
Federal Actions	• Align Medicaid: Create templates and guidance for states to adopt accountable care reforms • Create a Federal coordination workgroup to align efforts around advancing accountable care across the safety net • Clarify and align allowable uses of Federal grant funding for accountable care initiatives, including development of key capabilities • Promote a core set of person-focused performance measures for safety net care across Federal programs • Align accountable payment model components to reflect distinct needs of safety net providers
State Actions	• Align efforts across other state-specific health payers (e.g., small markets, Marketplace plans, and Medicaid managed care plans) around accountable care capabilities • Align state funding with Federal grant dollars
Facilitate Access to Upfront Investments and Ongoing Payments	
Federal Actions	• Support upfront and sustainable accountable funding streams in Medicaid (e.g., CMCS can establish incentives for Medicaid managed care plans) • Support care in underserved communities in Medicare alternative payment models and plans through model features, such as risk adjustment, enhanced upfront payments, and support for infrastructure investment • Clarify approaches for using existing grant programs to fund safety net payment and delivery transformation initiatives
State Actions	• Leverage state authorities to facilitate access to upfront investments and ongoing payments including State Plan Amendments, Medicaid procurement rules, state-directed payment flexibilities, and Section 1115 demonstration waivers
Provide Guidance and Technical Assistance to States and Providers	
Federal Actions	• Create an accountable care roadmap that identifies and clarifies funding opportunities, approaches for moving into risk-based contracts, and strategies for braiding funding • Facilitate awareness and joint participation in technical assistance programs to support payment transformation
Create Pathways to Integrate Social and Community Supports	
Federal Actions	• Coordinate funding across Federal payers to support regional partnerships that link social services, community-based organizations, and safety net providers • Clarify existing opportunities for states to use Medicaid and Federal grant funding to support social and community-based organizations, e.g., through examples of model procurement contracts that promote social determinants of health (SDOH) data collection and sharing
State Actions	• Use Medicaid authorities to address health-related social need services as part of accountable care implementation • Enable predictable funding flows to community-based organizations for social services in accountable Medicaid payment reforms • Use federal grant funding from programs like CDC, ACL, and others to support HRSN investments and to support technology infrastructure investment for data exchange and care coordination across CBOs and safety net providers

INTRODUCTION

Safety net providers play an essential role in anchoring care for millions of Americans in underserved communities. Examples of safety-net institutions include (but are not limited to) community health centers, public and critical access hospitals, local health departments, community mental health centers, certified community behavioral health clinics, and special service providers such as family planning clinics and school-based health programs. Despite safety net institutions providing high-quality, cost-effective care to high-risk populations,[4] the safety net remains a largely fragmented collection of providers offering a disparate array of services, leading to both duplication and gaps in care. Further, the financial viability of safety net health systems was challenged during COVID-19, given revenue declines, which disproportionately impacted under-resourced communities.[5]

Value-based payment (VBP) models are accountable care tools that have the potential to mitigate these barriers and improve the quality and efficiency of care.[6-8] However, safety net representation in VBP models has been limited to date.[9-10] Reasons include the unique and diverse funding streams for the safety net that can discourage integration,[11] limited payer alignment,[12] historical siloes and underfunding,[13] and limited capital to fund infrastructure development and technical support in redesigning care. These specific reasons can result from the broader context affecting safety net institutions, including systemic racism, historical disconnects between behavioral and physical health systems, and broader challenges to accessing sufficient funding for programs for lower-income individuals. As a result, people who receive care through safety net providers today are less likely than other Americans to have access to accountable care due to the barriers that safety net providers face.

Momentum among public and private payers and safety net providers is growing to address the limitations that challenge safety net provider participation in VBP models. CMS has prioritized safety net engagement in model development and recently finalized changes to its Medicare Shared Savings Program (MSSP), such as increasing ramp-up time before assuming risk and providing upfront investment support for certain provider types, to improve safety net provider participation.[14] Similarly, states increasingly have introduced value-based arrangements in their Medicaid programs.[15,16] Safety net adoption of VBP will be critical to CMS' strategic vision for transitioning Medicare and Medicaid patients into accountable care relationships by 2030.[17]

Safety net adoption of VBP will be critical to CMS' strategic vision for transitioning Medicare and Medicaid patients into accountable care relationships by 2030.

To help advance these efforts, this report describes policy reforms and technical design considerations for policymakers and payers to advance safety net participation in accountable care models. This report draws from a targeted literature review on the safety net landscape, proceedings from expert-focused convenings, and semi-structured informational interviews with 55 stakeholders, including health care providers, payers, industry leaders, and state and federal policymakers.

The goal of these recommendations is to utilize a variety of Federal and state policies to support **accountable funding streams:** funds explicitly tied to supporting safety net provider adoption of accountable care reforms. These funds would be aligned across payers to create a simple, flexible stream of funding for providers who demonstrate accountable care capabilities for historically underserved and under-resourced communities. In turn, these providers would gain streamlined access to funding with fewer reporting and administrative burdens, which would enable providers to allocate resources more effectively based on the needs of their patients.

The first section of this report, "Vision for Reform," describes accountable funding streams and the complementary actions providers, payers, and policymakers must take to facilitate these funding streams. The next section, "Considerations for Value-Based Payment Models," addresses considerations for designing specific components of accountable funding streams. The final section, "Pathway to Reform," presents four action areas for Federal and state policymakers to achieve accountable funding: multi-payer alignment, upfront investment funding, guidance and technical assistance, and integrating social and community supports. The Appendices include further technical details on payment model components (Appendix A) and a list summarizing policy action by federal and state agencies (Appendix B).

Vision for Reform: Accountable Funding Streams

Safety net providers should be enabled to take longitudinal, comprehensive responsibility for both clinical and financial outcomes for the populations they serve. Duke-Margolis proposes a pathway, illustrated in Figure 1, to help safety net entities achieve this. The goal is to help these entities take meaningful steps to improve care coordination, identify and engage beneficiaries early in care management, provide improved and better-integrated access to needed services for social needs, and take other steps to address key unmet needs for whole-person care that are difficult to address under fee-for-service payment. Providers, whether community health clinics, free and charitable clinics, safety net hospitals, rural providers, and other safety net organizations that aim to become accountable entities, need the tools and infrastructure to build up underlying capabilities that support high-quality, whole-person care.

This approach calls for payers and funders, including states, Federal agencies, and grant funders, to facilitate a pathway for providers to access **accountable funding streams,** that is, funds explicitly tied to the goals of adopting accountable care reforms, so providers invest in these capabilities to sustain their accountable care models. Providers, in turn, must implement and build on the capabilities for accountable care. These accountable funding streams, including use of short-term grants and programs, would help safety net providers develop the tools, resources, and medical and community collaborations needed to deliver accountable care, and then sustain the implementation and further development of these care models.

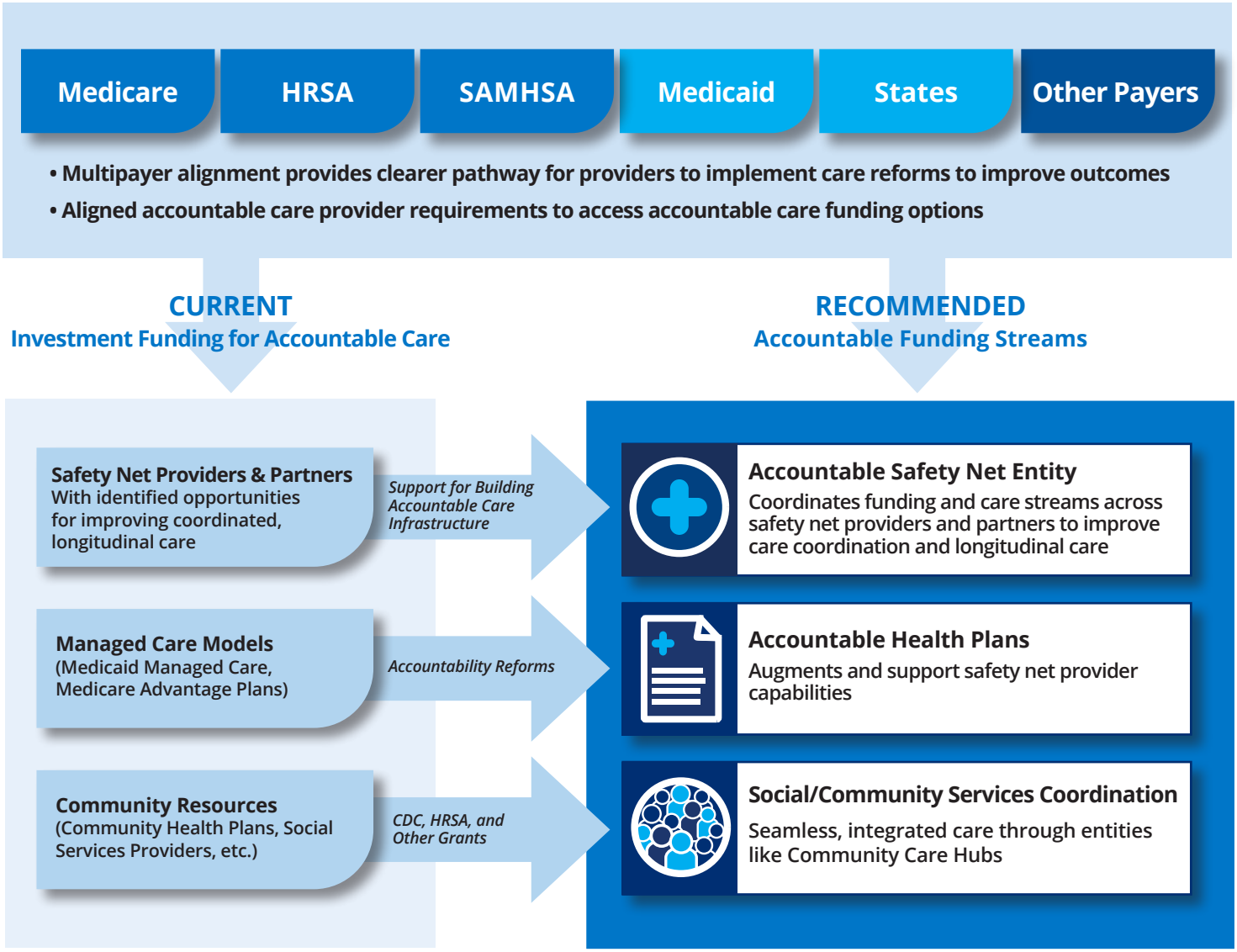
Multi-payer alignment for safety net care, shown in Figure 1, is critical to the creation of accountable funding streams. By aligning and coordinating funds across Federal agencies, states, and other payers, safety net providers can access funding more effectively from various sources to drive care reform. In addition, contracts in Medicaid managed care can be developed with input from safety net providers to ensure that financial incentives are supportive and meaningful for value-based care transformation. Also, partnerships with social services and community-based organizations are also critical to addressing health-related social needs and delivering whole-person, accountable care. Following are state examples of each of these approaches:

New Jersey aligned federal and state funding to support interventions that collectively tackle maternal and child health disparities. The state used a Title V Maternal and Child Health Block Grant as the primary funder for its maternal and child health programs, such as the Healthy Women, Healthy Families Initiative to reduce black infant and maternal mortality rates. To complement these activities, the state coordinated U.S. Centers for Disease Control and Prevention (CDC) funding to form a maternal mortality review committee, the Health Resources and Services Administration (HRSA) funding to establish a State Maternal Health Innovation Program, and state Medicaid funding to reimburse doulas as Medicaid providers.

Oregon established that its Coordinated Care Organizations, a version of a Medicaid Managed Care Organization (MCO) but locally governed and covering physical, behavioral, and oral health care services, meet specific value-based payment targets for providers and delivery areas with less experience in VBP.

Massachusetts, and other states, have strengthened partnerships with social services and community-based organizations by using flexibilities through Section 1115 demonstrations to expand Medicaid billing for health-related social needs services and provide upfront funding for social service infrastructures.[20] With these supportive payment streams, partnerships, and policies, safety net providers can become accountable entities, such as Medicaid ACOs, that deliver integrated, whole-person care throughout the patient care journey.

FIGURE 1 Safety Net Payers and Funders



To summarize, the pathway illustrated in Figure 1 is comprised of several overlapping components: a) the design and requirements of each accountable funding stream (the right hand arrow and corresponding three lower right boxes); b) provider actions to access these accountable funding streams (the three boxes on the lower left) and c) policy steps to align these accountable funding streams to support safety net providers (the top box). These three components are interdependent: the design of the accountable funding streams should factor specific safety net provider needs; the effectiveness of accountable funding streams depends on the ability of the accountable safety net providers to provide comprehensive, longitudinal care; and the coherence of the funding streams, that is, how the alignment of the funding streams together is more impactful than isolated, fragmented funding, depends on steps that payers and funders can implement to advance multi-payer alignment. These three elements are described briefly below and expanded on later for considerations for designing payment models.

Payment model designs should be simple, predictable, flexible, and accountable:

- **Simple—**reduce the administrative burdens and challenges with the current service-based reimbursement system;
- **Predictable—**reduce financial uncertainty and enable providers to plan for expected cost of delivering care for their patients;
- **Flexible—**allow providers to tailor resources to meet their unique patient population needs and allocate resources towards health-related social and non-medical services; and
- **Accountable—**links payments to performance measures that encourage providers to attain quality, equity, and cost goals.

Providers must meet certain requirements and capabilities to access these accountable funding streams.

- **Accountability—**Providers must be able to track key longitudinal patient care needs and report on population health metrics relevant to safety net populations;
- **Care Coordination—**Providers must demonstrate that they are coordinating with other providers and community-based organizations (e.g., through data sharing arrangements, governance requirements, etc.); and
- **Promote Equity—**Providers should identify health equity gaps in the communities they serve and develop a health equity plan to measure and address health disparities with the goal of providing accessible, linguistic, and culturally competent, whole-person health care.

Policymakers should take key actions to support safety net providers on their path to accountable care. A more aligned government approach can take further steps to coordinate the disparate funding streams on which safety net providers depend.

- Federal agencies should establish a multi-stakeholder Federal coordination workgroup that builds on existing intra- and inter-agency efforts to identify areas of misalignment across programs and establish shared objectives for value-based payment across relevant payers and agencies such as CMS, The Center for Consumer Information and Insurance Oversight (CCIIO), HRSA, and the Substance Abuse and Mental Health Services Administration (SAMHSA). In addition to aligning payment and funding programs, federal agencies should provide guidance for states to use existing authorities more effectively to advance VBP and provide support and technical assistance to safety net providers on how to access funds to develop the capabilities to succeed in accountable care.
- States should align payment reform across Medicaid and Marketplace plans to coordinate with Federal payment models; utilize existing authorities to encourage partnerships between managed care plans and providers around the goals of accountable care; and leverage Medicaid flexibilities, Medicaid State Plan Amendments, Section 1115 demonstrations and "in lieu of services" (ILOS) waivers, and Section 1332 waivers to support enhanced funding streams and accountable care arrangements.

The following section presents considerations for designing the technical components of payment models to achieve accountable funding streams. The focus is on broad functions recognizing that no one-size-fits-all payment model will work given the diversity of providers and the communities they serve. Four recommendations for federal and state policymakers to support a pathway to accountable care are detailed below.

A more aligned government approach can take further steps to coordinate the disparate funding streams on which safety net providers depend.

Considerations for Value-Based Payment Model Design

Currently, most payment models are not fully designed to address the unique challenges safety net providers face. For instance, safety net organizations may need a longer time frame to participate in risk-bearing arrangements than current models allow, since providers have tight operating margins for their existing core services due to decades of underfunding and disinvestment. Alongside these concerns, design elements like risk adjustment and benchmarking methodologies do not fully capture the acuity of caring for communities with higher levels of medical and social complexity. As Table 1 describes, these technical challenges circumscribe safety net provider engagement in value-based payment arrangements or inadvertently penalize those that do.[21-24]

TABLE 2 Technical Challenges for VBP Models in the Safety Net

Time Horizon	Current contracting practices do not incentivize or facilitate investment in preventative services that may not demonstrate a benefit or return during the life of the contract, which is generally short (commonly one year).
Financial Benchmark	Safety net organizations experience significant patient population fluidity and historical underfunding, with current benchmarking efforts mostly reflecting historical spending. Rural and lower-resource providers may be less able to generate savings year after year to support accountable care investments, making them more hesitant to take on the responsibility of downside risk for a multi-year contract.
Risk Adjustment	Safety net providers serve a large number of individuals with complex health and social needs that are not always accounted for in risk adjustment methodologies, leading to under-adjusted risk estimates and reduced benchmarks, which compound historical inequities. Additionally, many safety net providers do not have experience in advanced coding practices and have not invested in the data infrastructure needed to accurately capture the acuity of care for the populations they serve.
Siloed Funding Streams	Safety net organizations obtain reimbursement and funding from payers (e.g., Medicaid [traditional and MCOs], Medicare, and sometimes commercial); grants from HRSA, SAMHSA, CDC, and states; and supplementary funding such as disproportionate share hospital (DSH) payments and uncompensated care pools. These siloed funding streams across programs with similar or complementary goals make VBP models difficult to sustain. Additional legal and regulatory constraints can limit the ability to coordinate funding and take on shared savings or risk.
Attribution	Stable and accurate patient attribution is critical for helping providers successfully manage patient care. However, attribution methodology that accurately reflects patient populations is challenging given their fluidity and inaccurate patient rosters or data lags.
Performance Measurement	Many current performance measures are not aligned across payers, leading to excessive reporting requirements with less impact on quality. A need exists to incorporate performance measures that are better aligned around meaningful dimensions of quality, simplifying reporting requirements for safety net providers and increasing the impact of performance measures.
Incentive Payments	Current incentive approaches are limited to the context of specific health care services rather than being tied to the value services confer across an individual's life course.
Sufficient Reimbursement	Current payment rates, especially under fee-for-service, are generally not conducive to the provision of preventative and health promoting interventions, including care coordination and prospective population health management. Concerns around the financial viability of safety nets have grown in response to potential funding shortfalls, payment rates that have not kept up with rising costs and inflation, and rising uncompensated care costs.[21-23]

Payment models should address these challenges to ensure safety net organizations are viable in the Marketplace while providing high-quality, whole-person care. While there is no one-size-fits-all payment model, common design considerations exist to attune payment models to better account for the needs of safety net organizations. These considerations are described below (adapted in part from Roiland et al)[24] and expanded on further in Appendix A.

Accountable Governance Structure—A designated entity must assume primary accountability for the longitudinal health of the attributed population that it serves in order to access the accountable funding streams. This entity must have in place a way of using the funding streams to promote investment in and the provision of effective services for disproportionately underserved patients. Participating providers in the accountable entity could include, but are not limited to, community health centers, free and charitable clinics, safety net hospitals, critical access hospitals, and behavioral health clinics.

The accountable entity could be one organization or a coalition of providers operating under a single legal structure. Some evidence suggests that value-based payment participation tends to be associated with the size of the organization.[25] Smaller providers are therefore more likely to benefit from the coalition approach, partnering with other providers through clinically integrated networks, independent practices associations, accountable care organizations, or other accountable care enablers to pool resources for shared analytic capabilities and administrative functions, which is often critical for successfully participating in risk contracts.[25] As detailed in Box 1, organizations have taken a variety of approaches to create these accountable governance structures.

Related, community and beneficiary representation in the governance structure of the accountable entity is a key strategy to promote equity in payment models.[26] In some instances, Federal policies already require governing bodies to include community representation, as in ACO REACH[26] federally qualified health centers (FQHC).[26] However, these requirements must also provide sufficient opportunities for integrating providers under shared ownership.[27]

BOX 1 Types of Accountable Care Partnerships

- **Horizontal Partnerships:** Accountable health centers, which comprise primary care providers that agree to coordinate care, take on financial risk, and pool capital. For example, Massachusetts's Community Care Cooperative (C3) is an FQHC-led ACO that pools resources across 18 FQHCs to take on two-sided risk.
- **Vertical Partnerships:** Accountable health systems, which comprise safety net hospitals, FQHCs, and other service providers governed by one entity to coordinate patient care. For example, Medical Home Network is a clinically integrated health care system with shared governance structures between FQHCs and hospitals.
- **Third-Party Partnerships:** Providers can partner with external parties that help identify and consolidate resources for safety net providers to build VBP technology, data sharing capabilities, and personnel. Examples of third-party enablers include Aledade, which provides capital and guidance for VBP transitions and specializes in risk coding; Yuvo, which handles administrative requirements; and technology vendors with population health management (Clinify), and social data integration and coordination capabilities (UniteUs, Findhelp). Medicaid-focused startups are underdeveloped but there is growing potential for private-public partnerships to facilitate VBP engagement.[28] While enablers can help provider participation in VBP, Federal and state policies should also provide direct infrastructure investment to provide multiple pathways to VBP.

Payment Approach and Glidepath to Risk—Pathways for safety net providers to generate savings are challenging since many providers have low operating margins, high fixed costs, and low patient volumes, especially rural providers. Additionally, the transition to VBP takes significant resources and time, requiring practice changes, adequate staffing levels, and quality data reporting and integration that many safety net providers lack. With limited financial margins and limited access to capital, safety net providers face higher barriers to pursuing these resource-intensive investments.

Payment models should be designed to address these challenges. Specifically:

1. Payment models may need to be coupled with supports like risk corridors, stop-loss protection, or reinsurance which stabilizes funding and protects providers from steep losses.
2. A longer glide path to downside risk can help safety net providers develop the capacity for value based contracting and practice transformation. A pre-performance period could help providers prepare for risk arrangements without jeopardizing financial stability.
3. VBP models should provide upfront and ongoing funding to support both the fixed and variable costs of maintaining and improving VBP infrastructures.
4. Payment models should reimburse for health-related social services and allow for safety net entities to arrange sustainable payment mechanisms with community-based organizations and other social services organizations.

Historically based benchmarks may short-change safety net providers who have been traditionally underfunded and may reflect under-utilization patterns caused by inequitable access to care.

Multiple ways exist to structure payment models to support longitudinal accountability. A phased approach, from less to more advanced payment models, may be needed depending on the accountable entity's experience and comfort with risk-arrangements. For instance, initial payments could include specific financial incentives for organizations to coordinate and integrate care through cooperative agreements, care for more socially complex patients, and/or supplemental payments for care management and quality incentives based on continued access to all necessary services. Over time, the accountable entity could transition into a more advanced payment arrangement like global capitated payments for the total cost of care of the attributed population's health and health-related social needs. However, there are concerns that downside risk may create too much financial pressure for many safety net providers who treat marginalized patient populations. Until these concerns are addressed, many safety net providers will prefer a lower-risk path for their higher-risk populations.

Benchmarking—Benchmarking is the process of setting financial, clinical, or other performance rates to compare a provider's year-over-year performance. Financial benchmarks for health care expenditures will need to be set at a level that supports preventative and health promoting interventions, including care coordination and prospective population health management. To set benchmarks at an appropriate level for safety net providers, benchmarks should not solely reflect a provider's historical expenditures. Historically based benchmarks may short-change safety net providers who have been traditionally underfunded and may reflect under-utilization patterns caused by inequitable access to care. Quality and performance benchmarking thresholds should therefore reflect the actual resource needs and constraints of safety net providers and should account for population complexities like high patient turnover and prevalence of social needs. Additionally, benchmarking methodologies generally compare a provider's performance to all other providers without adequate distinction, meaning a smaller provider who treats more underserved patients could be compared to larger, better-resourced health systems. Until such population differences are adequately addressed,

benchmarks could be stratified to ensure providers are compared to more similar peer organizations, an approach taken in the Hospital Readmission Reduction Program and Hospital-Acquired Condition Reduction Program.[29]

Risk Adjustment—Risk adjustment refers to the process of adjusting the amount providers are paid based on the risk factors of the individual receiving care. Safety net providers serve many individuals with complex health and social needs that are not always accounted for in risk adjustment methodologies. This gap leads to under-adjusted benchmarks, relative to the complexity of the patient populations. To address this discrepancy, payers should modify risk adjustment methodologies to deliver equitable reimbursements for safety net providers that care for socioeconomically disadvantaged patients and communities. For instance, risk adjustment methodologies in some accountable care models have begun to incorporate social risk measures that factor in both patient-level and community-level needs (e.g., housing status indicators and neighborhood stress scores, respectively). ACO REACH uses benchmarks that better support providers working in underserved communities through health equity benchmark adjustments.[30] As these adjustments are adopted, further evidence will enable refinements of risk methodologies to improve their fitness for safety net providers.[31]

A one-size-fits-all approach to measuring quality is ill-suited to evaluating safety net providers given heterogenous community needs. Safety net VBP model designers should consider four dimensions to performance measurement.

Attribution Methodology—Attribution methodology refers to the process of assigning patients to providers who are responsible for the patient's health care. Stable and accurate patient attribution is critical to helping providers manage patient care and take accountability for them in quality and cost models. However, accurately identifying patients for provider attribution is challenging given high patient churn in the safety net and that providers often report inaccurate patient rosters or data lags (e.g., due to claims run out periods). Ideally, payments should account for both assigned and unassigned patients, including hard-to-reach patients disconnected from the health care system. One approach is to incorporate checks to ensure a patient is reachable and has had an opportunity to choose a provider before attributing accountability for quality and cost models. Attribution approaches also should mitigate implicit biases in patient attribution and patient selection by broadening outreach strategies for voluntary alignment, expanding attribution settings, and testing new attribution design methods. [32]

Performance Measurement—Performance measures are used to evaluate and track how a provider is performing across quality, cost, and outcome goals. Again, a one-size-fits-all approach to measuring quality is ill-suited to evaluating safety net providers given heterogenous community needs. Safety net VBP model designers should consider four dimensions to performance measurement. First, health equity must be embedded in evaluation methods, for instance, by stratifying performance along sociodemographic factors (e.g., race, income) or incorporating measures specific to subpopulations.[32] Second, ideally measures will capture an individual's whole-health, which requires measuring health-related social needs, behavioral health, and patient-reported outcomes. Third, measure sets should include some assessment of activities that meaningfully integrate care (e.g., closing referral loops) and engage patients (as anecdotal evidence suggests providers perform worse in these two areas[32]). Fourth, performance measures should be parsimonious to reduce reporting burden--a particular challenge for providers that have limited to resources to track different reporting requirements across payers.

Pathway to Reform: Policy Steps to Create Accountable Safety Net Entities

This section proposes four steps for policymakers to support longitudinal, comprehensive care in the safety net:

1. **Recommendation 1** discusses actions for Federal and state policymakers to align payment models and funding programs to reduce administrative complexity and maximize the impact of existing resources. These efforts include aligning program measures, payment model components (e.g., attribution, risk adjustment, upfront payments), data collection standards, and grant funding requirements (like application processes, eligibility rules, and reporting requirements). A Federal coordination workgroup should lead alignment efforts by identifying priorities and establishing shared objectives across safety net payers. States should concurrently align Medicaid and Marketplace plans with Federal program requirements using existing regulatory flexibilities like State Plan Amendments (SPAs).

2. **Recommendation 2** describes how Federal and state agencies can provide more upfront and ongoing support to safety net providers with limited resources. Federal payers can build in upfront, sustainable payments to existing reimbursement models and grant-based programs. For example, CMCS can provide direction in Medicaid Managed Care guidelines for states seeking to implement upfront managed care payments for safety net providers, CMS can scale enhanced investment supports across their models, and grant-based funders like HRSA can tailor existing grants to fund long-term delivery improvements in the safety net. States can also utilize Medicaid flexibilities (such as, State Plan Amendments, Medicaid managed care contracting authorities, or Section 1115 demonstrations) to create funding streams with upfront, sustainable payments for safety net providers. While many states have pursued Section 1115 demonstrations to change their Medicaid payment methodologies, State Plan Amendments and Medicaid managed care strategies may offer more feasible paths for payment reform.

3. **Recommendation 3** focuses on complementary guidance and technical assistance that Federal policymakers should provide for states and providers to undertake payment and delivery reforms. States have a variety of funding opportunities and tools available, but they may be unaware or uncertain about their uses. Federal guidance should compile and share available sources of funding, such as grants and equity-focused payment models, and clarify methods for states to coordinate these funds and reform payment models through Medicaid policy vehicles. Guidance and technical assistance also should target safety net providers to help them develop accountable care capabilities and build accountable care partnerships that allow them to pool resources, coordinate care delivery, spread out risk, and assume collective accountability.

4. **Recommendation 4** focuses on pathways for Federal and state policymakers to integrate social and community supports with safety net providers to address health-related social needs. Federal inter-agency support can leverage existing initiatives like Community Care Hubs to strengthen community linkages with safety net providers, as well as clarify and expand funding approaches to sustain these partnerships. Similarly, states can use Medicaid authorities, such as Section 1115 demonstrations, guidance on implementing payments for in-lieu-of-services, and managed care requirements, to expand coverage for social determinants of health services and provide predictable funding flows for social and community-based organizations. States also should invest in the infrastructure for health-related social needs services, including data exchange networks, closed-loop referral systems between clinical and non-clinical providers, and community health workforces.

1. Recommendation 1: Support Cross-Program Alignment Across Payers and Policymakers

TAKEAWAYS Recommendation 1

- Multi-payer alignment is necessary to create a streamlined pathway for providers to access the financial supports needed to participate in accountable care models.
- Building on existing CMS payment alignment initiatives, Federal and state payers should review elements of payment model components (e.g., performance measures, attribution, and risk adjustment) that could be aligned and calibrated to safety net provider needs, with the goal of promoting care coordination and reducing administrative burden.
- Simultaneously, funders like HRSA, SAMHSA, and CDC should identify leading opportunities to align grant dollars with the goal of supporting providers in VBP, expand allowable uses of grant funding, and align grant requirements, where their statutory purposes are similar or complementary (e.g., aligned application processes, permissible uses, and reporting requirements that shift toward aligned population impact measures).

Accelerating safety net participation in VBP requires broad coordination across Federal, state, and commercial payers to align reimbursement models. Safety net providers currently manage a complex web of funding streams spanning payers, public funders, and private sources each with distinct requirements and administrative processes. As the Institute of Medicines noted over 20 years ago,[33] this fragmented funding reinforces siloed delivery models, impedes the development of partnerships, and constrains providers from allocating resources tailored to the unique needs of their communities. To simplify existing payment models, reduce administrative burden for providers and payers, and maximize the impact of existing resources, policymakers and payers should modify and align program parameters of existing payment models and existing grants to target safety net providers.

FEDERAL RECOMMENDATIONS

Aligning Medicaid: Create Templates and Guidance for States to Adopt Accountable Care Reforms

While states have tools available to promote accountable care reforms in their Medicaid programs, interviewed experts reported that states are often uncertain which activities are allowable under these authorities and could benefit from further guidance. Some of the most common tools to promote payment reform include:

- ***Section 1115 demonstrations***—Authorizes states to test innovative alternative payment demonstrations but are subject to budget neutrality requirements and time limitations, and innovations are not easily replicable across states. However, recent updates to the Section 1115 demonstration policy framework eased limitations, allowing states to more easily fund health-related social needs and test value-based payment models.[41]
- ***State Plan Amendment***—A process for states to update Medicaid state plans. From an administration perspective, this pathway is easier than Section 1115 demonstrations to implement changes as it does not expire and is not subject to budget neutrality constraints.

1. FEDERAL RECOMMENDATIONS

- ***Medicaid Managed Care Contracts—***States can use Medicaid managed care contracts to require MCOs to implement value-based payment reform. For example, states can set requirements on minimum percentages for VBP spending and require MCOs to adopt certain VBP models.

CMCS could create templates and use cases of Section 1115 demonstrations, State Plan Amendments, and Medicaid managed care contracts to create a quicker path for states to pivot towards VBP with reasonable expectation of approval. These templates can be designed based on previously approved activities. Furthermore, State Medicaid Director letters can provide insights on applicant approval and denial decisions for demonstrations that present specific provisions for advancing safety net accountable care. These letters can guide implementation efforts based on CMCS experience to date. For instance, CMCS could issue a State Medicaid Director letter that summarizes key features in the recently approved Section 1115 demonstrations in Arkansas, Arizona, Massachusetts, and Oregon as precedents for how states can design payment features that improve social determinants or how to interpret budget neutrality rules.[35] Other guidance letters could clarify VBP contracting targets and how to provide more timely access to cost data.

State Plan Amendments can advance many of the same accountable care goals and are easier to implement, but have received less attention than Section 1115 demonstrations. Both Ohio and Minnesota used SPAs to create supplemental per-beneficiary, per-month (PBPM) payment streams and implement a Medicaid ACO program, respectively.[36,37] In contrast to Section 1115 demonstrations, SPAs permit long-term changes without budget neutrality constraints and are quicker to receive to CMCS approval. However, SPAs are still limited by Federal Medicaid regulations, and may therefore offer less room for innovation than Section 1115 demonstrations. As an example of SPA guidance, CMCS previously released a State Medicaid Director letter that detailed how states can design their SPA submission to gain coverage for 12 months of postpartum care.[38] CMCS should continue to explore where further guidance is needed to facilitate states on their path to VBP.

Use existing Medicaid managed care rules to align MCO contracts. CMS could provide further guidance and examples of how states can use existing Medicaid managed care contracting rules to advance VBP without additional federal approval (in most cases). With nearly three-quarters of Medicaid members enrolled in managed care plans, Medicaid MCOs are pivotal to promoting accountable care in the safety net.[39] Yet, this research identified several challenges across states in both the designs of contracts and the relationships between plans and providers, such as inaccurate attribution lists, misaligned reporting requirements across MCOs, and insufficient data sharing between plans and safety net providers. Addressing these challenges and creating common parameters across contracts could reduce provider burden, as safety net providers often must negotiate multiple contracts with separate MCOs, each with distinct reporting requirements.

While many states have adopted some VBP requirements in MCO contracts, adoption of advanced payments remains uneven. Generally, VBP arrangements are comprised of Health Care Payment Learning and Action Network (HCP-LAN) Category 2 performance payments or other similar FFS arrangements with basic links to quality and no population-based accountability. Some states follow broad definitions of value-based activities, while others prescribe strict directives like requiring provider organizations to conduct SDOH screenings using a standard protocol (e.g., PRAPARE).[40,41] To help standardize state approaches, Federal policymakers should set practical guidelines and priorities for MCOs without being overly prescriptive.

At the same time, Federal policymakers should consider standardizing contracting language to ensure safety net providers are advancing towards similar goals across states. CMCS could use existing procurement rules to ensure states are designing contracts in a way that comports with accountable care goals. Standard elements may include:

- Specifying payment model design components, such as benchmarking methodology and risk adjustment;
- Establishing core measures that are aligned with CMS' Universal Foundation and HRSA's Uniform Data System (UDS) for FQHCs;

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- Requiring routine data sharing (e.g., monthly, to avoid lag), which may specify enrollment rosters, claims history, quality performance, and any other data that would support safety net providers' population health management activities;
- Including additional upfront funding components in contract designs to help safety net providers develop accountable care capabilities; related, a portion of underwriting gain (funding to reimburse MCOs for the cost of bearing risk) could be passed on to safety net provider groups who take on a share of downside risk; and
- Establishing VBP targets with a path toward increasing adoption and alignment across Medicaid plans. Many states have established a minimum percentage of payments tied to VBP; however, the resulting contracts may not be aligned.

Create a Federal coordination workgroup to align federal efforts around advancing accountable care across the safety net

As a first step, a Federal coordination workgroup should identify areas of non-alignment across public programs that can be addressed without statutory change. A non-comprehensive list of key programs includes traditional Medicaid, Medicaid managed care, Medicare, Medicare Advantage, CMMI-led models, Marketplace plans, HRSA health center programs, and agencies that oversee safety net providers in various capacities (like DOL, HUD, or USDA). The Federal coordination workgroup should identify short-term actionable steps within statutory authority on foundational elements, such as: performance measurement and reporting, key payment model components (discussed above in model design considerations), data sharing, and technical assistance. This approach is informed by a framework for multipayer alignment.[42] Voluntary public-private collaborations, such

BOX 2 Examples of Inter-Agency Collaboration and Alignment

- HHS led a whole-of-government approach to align 35 federal agencies on the seven vital conditions for health as a framework to guide health equity efforts.[45]
- The Coordinating Council on Access and Mobility, composed of HHS, DOT, USDA, HUD, SSA, and other Federal agencies, worked together to coordinate funding across agencies to target underserved populations with transportation needs.[46]
- CDC and CMS supported an Umbrella Hub Arrangement to connect safety net organizations with Medicaid payment systems and streamline billing and claims processes.[47]
- The Partnership for Sustainable Communities was an interagency program that compiled grants from the EPA, HUD, and DOT into one application, allowing applicants to braid together multiple different funding streams without the need to apply for each one separately.[48]
- CDC collaborated with HRSA to develop a joint process for states to receive HIV/AIDS funding from both agencies through one integrated plan.[49]
- CMCS partnered with USDA to use data-sharing agreements to directly enroll students in food assistance programs and Medicaid based on joint eligibility data.[50]

as the HCP-LAN can help inform and encourage such efforts toward alignment. Cross-agency coordination also comports with federal initiatives like CMMI's strategy to use enhanced federal partnerships to advance health equity and boost value-based care adoption.[17]

Leadership for cross agency initiatives is critical for catalyzing broader change, and existing initiatives can inform these efforts. For instance, during the pandemic, several states created cross-governmental Federal coordination workgroups to target COVID-19 disparities, which helped set new priorities for health equity goals to incorporate the social and structural determinants of health.[44] Box 2 provides further examples of inter-agency collaboration and alignment.

Clarify and Align Allowable Uses of Funding for Priority Accountable Care Initiatives, Including Development of Key Capabilities

Aligning CMS models. CMS should take further steps to facilitate alignment across payment models to drive safety net participation in VBP. Examples of alignment components are listed in "Considerations for Payment Model Design Components" and include attribution, risk adjustment, benchmarking methodologies, timeline to downside risk, upfront payments, and developmental supports for priority infrastructures that enable clinical interoperability and data exchange across payers and providers. To provide more long-term clarity about pathways to accountable care for safety net organizations, CMS can combine new primary care models with further steps in existing population-based payment models like MSSP or ACO REACH to effectively support coordination between providers, give providers the flexibility to allocate resources as needed, and ensure providers are accountable for delivering comprehensive, longitudinal care. Importantly, both technical modifications and application process improvements should be applied across existing CMMI, MSSP, and Medicaid models to ensure consistency across programs and to reduce the administrative burdens of fragmented systems. For instance, CMS could apply the health equity benchmark in the ACO Realizing Equity, Access, and Community Health (REACH) Model to other population-based accountable care models to ensure safety net providers have a more predictable revenue stream. A detailed summary of potential technical changes is discussed in Appendix A.

Recent changes to CMS's flagship ACO programs demonstrate the administration's commitment to creating equal opportunity for providers serving safety net communities to participate in payment reform initiatives. For instance, the health equity adjusted benchmark in ACO REACH provides increased spending for organizations serving higher proportions of underserved beneficiaries. Similarly, recent programmatic changes to MSSP are intended to support organizations that traditionally have not had the resources to participate in VBP (e.g., advanced shared savings payments, flexible onramps to downside risk, health equity adjustments to quality scores, and benchmark modifications that support program retention for new ACOs in rural and underserved areas).[14] CMS also has begun to incorporate a Health Equity Index in Medicare Advantage and Part D Star Ratings.[51]

Align and clarify grant funding. The financial viability of safety net providers currently depends on piecemeal funding streams beyond traditional reimbursement mechanisms—such as implementation grants, supplemental payments in Medicaid, and Federal supports. The process for providers to access funding and the mechanics for distributing funding must be aligned to streamline funding flows, especially given that safety net providers have limited cash on hand,[52] and to reduce the administrative burdens of applying and reporting to multiple different funders. While some models like Washington State's Accountable Communities of Health have allowed

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safety net providers to coordinate and streamline funding from different sources,[53] regulatory and reporting variations across funds makes this difficult for most safety net organizations.

To reduce administrative burdens, agencies should work to align funding requirements where statutorily feasible. To the extent possible under current law, this entails aligning application processes, permissible uses, and reporting requirements that shift toward aligned population impact measures while acknowledging statutory constraints. For example, HRSA can collaborate with CMS to align Section 330 grants to promote accountable care (e.g., by awarding supplemental grants to enhance care coordination or reduce the cost of care).[54]

Coordinated funding programs, with joint application designs that share the same set of requirements and deadlines, would reduce the administrative burdens that may otherwise be a limiting factor for individual grant funding. For example, CDC and HRSA developed an Integrated HIV Prevention and Care Plan for HIV/AIDS funding that satisfies the joint review of both agencies,[49] and The Partnership for Sustainable Communities allowed applicants to simultaneously apply to multiple grants across agencies (Box 2).[48] These types of partnerships can be enforced by cross-governmental leadership, such as the aforementioned interagency federal coordination workgroup, which promotes coordinating and aligning funding policies to expand access to resources for safety net organizations.

Explore alignment of additional funding streams to the goals of accountable care. Policymakers can link funding for undercompensated care costs to accountable care goals to ensure that patients seen in the safety net receive comprehensive, affordable care. For example, technology infrastructure grants can be adapted to fund population health and care coordination technology, Section 330 grant dollars can direct a portion of funds to target VBP capability developments, and enhanced match infrastructure reimbursements and supplemental payments can align with state value-based reforms by providing overhead support for technical assistance, capacity building, data sharing infrastructures, and longitudinal care management strategies. Policymakers also should consider approaches to use community benefit requirements for non-profit hospitals to promote value-based care. For instance, to meet its community benefit requirements, Trinity Health, a national health care delivery system, is providing capital and technical assistance for community-based organizations in order to address health-related social needs in the community.[55,56] More clearly defined requirements can help ensure thatbcommunity benefits are promoting activities thatbsupport longitudinal, whole-person health.[57]

Given that safety net providers often serve as a hub of collaboration for medical and social services, cross-sectoral agencies should align funds from HUD, DOT, SNAP, and other Federal departments and programs (e.g., each agency can commit to match grant dollars) to support a whole-of-government approach to improving the health of populations seen by safety net providers.

Align toward a core set of person-focused performance measures for safety net care across federal programs

Payers should build off the Universal Foundation[58] to establish a parsimonious core set of performance measures aligned across safety net payers, including CMS, HRSA, and state Medicaid programs. As noted earlier, the fragmented safety net reimbursement environment creates duplicative reporting requirements and administrative complexity. A Federal coordination workgroup should establish a parsimonious set of measures that can be improved over time and aligned with existing measure sets like the Uniform Data System and the Electronic Clinical Quality Improvement library ("Standard Model of Care for the Scope of Work"). CMS should ensure that the push to submit electronic clinical quality measures in alternative payment models (APMs) does not inadvertently penalize safety net providers as some may not have the infrastructure in place yet. Further, these core metrics should incorporate measures unique to safety net populations in both Medicare and Medicaid, especially on care coordination, SDOH, and equity.

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The increased nationwide focus on advancing health equity also presents considerable alignment opportunities, such as coalescing stakeholders around standard approaches for collecting and modernizing race, ethnicity, and language data to drive actionable improvements in health disparities.[59] CMS' current efforts to align health equity data across CMS programs should be expanded to ensure data is also available to HRSA, SAMHSA, and other relevant agencies that oversee safety net providers.[60] These efforts can expand and align with equity-focused payment models like ACO REACH, which requires ACOs to report beneficiary-supplied demographic data and collect social determinants of health data through a validated screening tool.[29] Rather than create new screening assessment tools for social risk factors, CMS should continue to encourage and leverage validated screening instruments (like PRAPARE) that many Federally Qualified Health Centers already use to collect and report on for HRSA's Uniform Data Services.[61] As reported in the 2022-2023 CMS Framework for Health Equity,[62] CMS is working in collaboration with HHS to standardize demographic and SDOH data collection and reporting (e.g., through USCDI standards).

States and plans should facilitate accurate data sharing to undergird measure alignment. Many complex barriers exist to data sharing, including concerns with violating patient privacy laws, incomplete or low-quality data, and lack of interoperability. Medicaid, in particular, suffers from poor data quality and inconsistent data methods across states, [63] leading to improper payments and data lags.[64] Although CMS has taken steps to improve Medicaid data transparency,[65] there are still critical gaps in information, such as ethnicity and race data.[66]

CMS can provide oversight to ensure that states exchange routine cost data with providers and other payers as complete claims information that captures data on patient enrollment, medical information, spending, and any other data needed to track and monitor patient population health.

CMS can address these data discrepancies and improve data quality by facilitating data exchange and transparency across states and providers. For instance, health plans could publicly release their data requirements, including types of enrollment, cost, and utilization data collected, in order to share information that can be used to promote program integrity. CMS can provide oversight to ensure that states exchange routine cost data with providers and other payers as complete claims information that captures data on patient enrollment, medical information, spending, and any other data needed to track and monitor patient population health. This data exchange of essential patient data can be facilitated by clarifying data sharing arrangements between MCOs and providers and ensuring that providers have the tools to implement payer-to-payer Application Programming Interfaces (API), which allow separate electronic health systems to exchange and interpret shared data.[67]

CMS can encourage payer-to-payer APIs by further establishing and creating an implementation path for interoperability rules that require payers and providers to use compatible electronic health systems.[67] Across public programs, payers can build an integrated data warehouse that allows data sharing across public payers and funders (CMS, CMCS, HRSA, SAMHSA, and other safety net agencies). Cross-agency data sharing can help streamline and ensure that eligible recipients enroll in Medicaid and other federal assistance programs.[69]

Payers and model designers also must assess activities that meaningfully integrate care. For instance, CMS can build off of the Interoperability and Patient Access final rule[67] by requiring that hospitals not only share Admission, Discharge, and Transfer (ADT) information with providers but also that providers receive ADT notifications and act upon them. Admission and discharge data from HUD-funded shelters can similarly be shared and integrated with health systems to better monitor and address housing insecurity as a social determinant of health. These types of seamless, real-time data sharing can improve care coordination and allow providers to care for patient needs in a timely fashion.

1. STATE RECOMMENDATIONS

Align Efforts Across Other State-Specific Health Payers (e.g., Small Group Markets, Marketplace Plans, and MCOs) Around Accountable Care Capabilities

Align Medicaid. States should modify their Medicaid programs so that model design components are structured similarly, both across state-specific health payers and with federal payment models (e.g., ACO REACH). To do so, states can use flexibilities in Medicaid authorities, such as State Plan Amendments, Section 1115 demonstrations, state-directed payments, and other Medicaid managed care authorities. States also use MCO contracts, directed provider payments, or leverage Medical Loss Ratio (MLR) criteria to advance payment and delivery goals. For instance, during the procurement process states could include specific provisions for MCO alignment on accountable funding for safety net providers. Where standard approaches exist and plan differentiation is administratively burdensome, states can require MCOs to use specific aligned VBP models or features. Box 3 provides examples of how states have applied these authorities.

Align Medicaid with other state-led health payers. Where feasible, states should align Medicaid programs with Marketplace and other state-led health plans. As an example, Colorado's Alternative Payment Alignment Initiative delineates ways for state payers to align on measures, attribution, and other model components.[75] Similarly, California aligned their Marketplace plans around a core set of metrics derived from CMS' quality measures.[76] States also can explore the coordination of Section 1115 and 1332 waivers to test and align Marketplace plans with innovative approaches in Medicaid or in the small group insurance market.

BOX 3 Examples of State Medicaid Reform

- California, Colorado, Oregon, and Washington have used Section 1115 demonstrations to implement upfront, capitated PBPM payments for FQHC providers.[70]
- Arkansas, Arizona, Massachusetts, and Oregon used Section 1115 demonstrations to expand Medicaid billing for health-related social needs services and provide upfront funding for social service infrastructures.[35]
- Maine used a State Plan Amendment to create a value-based sub-pool of funding for safety net hospitals participating in its Accountable Communities program.[71]
- Ohio used a State Plan Amendment to develop an episode-based payment model for Medicaid that gives incentive payments based on cost and quality performance.[36]
- At least 29 states have set VBP requirements for MCOs, which can define minimum thresholds for the percentage of MCO expenditures that must be linked to value, or more strictly, the target percentage of contracted providers in VBP arrangements.[40]
- Pennsylvania used state directed payments to require its MCOs to implement episode-based payments for maternity care providers with shared savings incentives.[72]
- Georgia used state direct payment authority to establish a multi-year contract with Grady Memorial, with 10 percent of payments at risk based on certain performance measures.[73]
- North Carolina's Medicaid managed care strategy aims to align quality goals and measures across Medicaid managed care plans.[74]

1. STATE RECOMMENDATIONS

Align and Coordinate State Funding with Federal Payers to Support State Medicaid Initiatives

States can align the elements of state-led payment programs with Federal payers to maximize the impact of funding and reduce administrative burden. Where possible, payments also should be coordinated by pairing different funding streams around a shared goal. For instance, as part of New York's Medicaid Payment Reform Roadmap, the state is working to coordinate Medicaid and Medicare funding to allow its Medicaid members to enroll in CMS-sponsored VBP models.[77] States also can leverage Federal funding from grants, enhanced matching, and other Federal sources of support to complement state payment and delivery reforms. For example, as part of New Jersey's strategy to improve maternal and child health, state leaders paired Federal funding, including grants from HRSA and CDC, with state funds and Medicaid reimbursements to tackle maternal health disparities and support the workforce of community doulas.[18]

TABLE 3 Summary of Alignment Actions

	Payment Models and Related Programs	Grant Funding
Federal	• Build an inter-agency federal coordination workgroup that coordinates multisector activities around safety net communities • Create a standard pathway for states to pursue accountable care reforms: - Model Section 1115 waiver - SPA templates - Standardized terms for MCO contracts with requirements for transparency, data sharing, and VBP arrangements with safety net providers • Align measures and data collection standards across Federal programs (e.g., align CMS reporting requirements with UDS), especially on care coordination and equity-related measures for safety net providers • Align payment model components (attribution, risk adjustment, benchmarking, etc.) to account for the unique needs of safety net providers	• Clarify and align funding requirements (e.g., application processes, eligibility rules, and reporting requirements) • Expand allowable uses of funding and grant dollars to create more flexible funding streams that safety net providers can braid and blend to support building capacities for accountable care that are aligned with grant goals • Identify innovative or non-clinical funding streams and directly link them to the goals of value-based, accountable care (e.g., technology infrastructure grants, community benefit requirements, 340b funding)
State	• Align in-state payment model components across state payers (e.g., standardize measures across state MCOs and statewide data exchange) • Align state components with CMS-sponsored models and other federal programs	• Coordinate state funding with federal dollars to support state Medicaid initiatives • Build statewide Community Care Hubs to braid federal grants with state funding

2. Recommendation 2: Provide Upfront Investments and Sustainable Payments to Support Safety Net Payment Reforms

TAKEAWAYS Recommendation 2

- Safety net providers have limited resources and capital to support the upfront and ongoing costs of implementing VBP models.
- Federal payers (CMCS, CMS, HRSA, and other funders) can strengthen existing programs for safety net providers by providing upfront investments as a standard component of VBP arrangements and targeted grants.
- States also can provide upfront funding as a component of Medicaid programs using state-directed payments and other Medicaid managed care rules, State Plan Amendments, and Section 1115 demonstrations.

Many safety net providers have been historically underfunded and are not financially equipped to undertake payment and care delivery reforms. These providers need additional upfront and ongoing resources to support transitioning to VBP models. As this section lays out, policymakers can facilitate access to resources by embedding upfront, sustainable payments to existing reimbursement models and grant-based programs. For example, CMCS can set clear directives in Medicaid Managed Care Rules for managed care plans to provide upfront funding for safety net providers, similar to MSSP's Advance Investment Payments. CMS also can scale enhanced payments or similar financial support across its portfolio of models, and grant-based funders like HRSA can tailor existing grants to fund long-term delivery improvements in the safety net. States also can utilize Medicaid flexibilities to direct non-federal funding with upfront, sustainable payments for safety net providers.

FEDERAL RECOMMENDATIONS

Policymakers should reform payment models and funding programs so that providers can more easily access and direct upfront (and ongoing) capital to meaningful transformation initiatives. For example, reforms should ensure providers can invest in workforce recruitment and development and invest in the organizational capabilities needed to address a broader range of clinical and health-related social needs. These upfront investments can be embedded into CMS and state payment model approaches, HRSA's Section 330 grants along with other Federal grants, and technical assistance or statewide learning collaboratives that make the transition process more efficient.

Support Upfront and Sustainable Accountable Funding Streams in Medicaid

CMCS should ensure that states provide adequate base payments in Medicaid reimbursement rates. Many safety net providers operate on thin margins and have limited budgets to deliver care to their patients as is, much less invest in delivery and payment transformation projects. Compared to Medicare and commercial payers, the fee-for-service Medicaid rates that safety net providers receive are below the actual costs of care,[78] which challenges their ability to meaningfully engage in VBP. CMCS should issue clear directives for state Medicaid agencies to incorporate sufficient baseline rates into VBP arrangements with safety net providers. For example, as a condition of approval for California's recent Section 1115 waiver, CMCS required that the state raise provider payments for maternal, primary, and behavioral health care.[79]

2. FEDERAL RECOMMENDATIONS

Second, CMCS should promote sustainable funding through Medicaid managed care. Based on Medicaid efforts to date, CMCS can provide guidance, incentives, and stronger requirements for Medicaid managed care plans to provide upfront funding for safety net providers. In addition to provider reimbursements, approximately half of supplemental and other payment programs flow through MCOs, but only 21 percent of MCOs in VBP contracts provide upfront funding for accelerating delivery reform.[39,80] To ensure that providers receive sufficient upfront funding for MCOs' VBP strategies, CMCS can provide guidelines for how states can set criteria for MCOs to provide upfront VBP funding for safety net providers, while still meeting the requirements for federal contract approval.

Federal rules or guidelines to standardize Medicaid MCO contracts can help states set higher levels of MCO support for safety net providers while reducing administrative burdens. For example, CMCS can provide guidelines on state-directed payments to provide enhanced direction for health plans to increase financial support for faster progress on accountable care (e.g., directed support for coordination-related activities or addressing social needs, or guidance and clarity on aligning provider and plan incentives). CMCS also can update the Medicaid Managed Care Rate Development Guide to show how MCOs can create upfront capitated payments for safety net providers, consider strategies to enable states to use directed payments for providers to build the capabilities and infrastructure for coordination-related activities, and issue guidance on sharing incentives with providers such that financial rewards flow to the accountable provider for improving care.

Furthermore, CMCS should revise Medicaid supplemental hospital payments to align with value and quality for patients served by safety net providers. By some estimates, supplemental payments account for nearly one-quarter of Medicaid funding for hospitals.[81] However, supplemental payments are currently operationalized differently across provider types, which complicates administration and oversight. As part of Federal efforts to support sustainable funding for Medicaid payment reform, policymakers can develop formalized policies for supplemental payments, such as amending the Upper Payment Limit (UPL) threshold for approval to meet value-based criteria for safety net providers.

Supplemental payments also need more transparent and standardized tracking based on measures of value and population health. For instance, some evidence suggests that DSH payments are not always directed towards the intended providers.[82] Some have therefore called for changes to overcome inefficiencies in the present methodology.[83] While it remains an open question what method is best suited to allocate payments more appropriately, policy proposals have suggested targeted designations for essential hospitals and safety net indices that account for shares of low-income patients and uncompensated care.[83,84]

Support Upfront and Sustainable Accountable Funding Streams in Medicare Payment Models and Plans

While CMS has demonstrated a commitment to value-based payment reform with programs such as MSSP, ACO REACH, and Medicare Advantage (MA) rules, additional participation pathways are needed and can be achieved by embedding greater upfront support for safety net providers in the payment structures of Medicare's VBP models. For instance, the health equity adjustment in ACO REACH is a positive step to support safety net provider engagement in VBP, though the amount may be insufficient to attract less-resourced providers.[83]

CMS should embed upfront and ongoing funding for safety net providers in the design of existing payment models. First, CMS should ensure programs do not inadvertently penalize safety net providers. For example,

the Area Deprivation Index (ADI) used in ACO REACH's health equity benchmark to identify medically underserved beneficiaries may over emphasize certain variables, potentially excluding intended beneficiaries.[85] Second, any enhanced payment adjustments for safety net providers should be scaled across CMS models. For instance, CMS can build off of MSSP's Advance Investment Payments for new, low-revenue ACOs and apply the ACO REACH equity benchmark adjustment to other payment models, which CM is considering for MSSP.[86] Similarly, CMS can modify MA incentives and requirements to support capability development by, for example, setting STARS incentives or plan requirements to improve safety net care and equity and to support provider alternative payment models. To jumpstart initial investments, CMS also can consider a grant program similar to the CMS State Innovation Models grant with clear requirements for implementing safety net accountable care.

Clarify Approaches for Using Existing Grant Programs to Fund Safety Net Payment and Delivery Transformation Initiatives

Safety net providers generate a substantial portion of their revenue from grant-based funding. For instance, nearly one-quarter of community health center revenues came from HRSA's Section 330 grants and other grants or contracts in 2021.[87] Although grants account for a large amount of safety net funding, these grant-based funds tend to be time-limited and burdensome to maintain, and often raise issues of renewal uncertainties, budget fluctuations, funding restrictions, and administrative and reporting requirements. The precarious nature of grant funding disincentives long-term investments in payment and delivery reform.

To address this, Federal agencies should ensure existing grants support providers in developing the capabilities necessary to succeed in VBP. Actionable guidance can create a defined pathway on how to leverage existing funding to maximize reform potential. Examples of grants that can be used to fund safety net care transformation include HRSA grants for capital development, IT infrastructure, and quality improvement; SAMHSA grants for behavioral health integration and Certified Community Behavioral Health Clinics (CCBHCs); and CDC grants for local capacity development to help community-based organizations partner with safety net providers.

Grants should be designed with a focus on sustainability. For example, HRSA's care coordination grants aimed to create care coordination programs that would continue after the conclusion of the grant.[88] The grant required providers to develop a sustainability pathway that would make long-term operational changes to enhance revenues and reimbursements for services. As an example, Telehealth Technology-Enabled Learning Program grants helped rural providers learn from one another by supporting learning community models.[89] Table 4 provides a examples of additional funding sources that can be applied for sustainable VBP changes in the safety net.

2. FEDERAL RECOMMENDATIONS

TABLE 4 Examples of Safety Net Funding Sources and their Value-Based Uses

Funding Source	Potential Uses that Align with Value-Based Care
CMCS Data Infrastructure Funding	Medicaid Enterprise Reuse provides a 75 percent Federal match rate to state Medicaid agencies for ongoing health IT initiatives (or 90 percent match rate for new initiatives).[90] The funding supports the development of electronic health records (EHR), health information exchange systems, and other IT investments. Similarly, the Health Information Technology for Economic and Clinical Health provided a 90 percent match rate for states' administrative expenses to adopt electronic health records (ended in 2021).[91]
HRSA Grants	Varies by grant but can cover staff training, care coordination, operations, and infrastructure investments, such as Service Area Competition grants,[92] Building Bridges to Better Health Challenge,[93] Small Rural Hospital Improvement Program,[94] school-based services,[95] etc.
340B Drug Pricing Program	Savings can be reinvested in value-adding activities, such as comprehensive medication management, behavioral and social needs programs, and preventive care services.
AIM pre-paid savings	Provides upfront savings to new ACOs in rural and underserved areas (discontinued but adopted into MSSP).[96]
2023 Appropriations Bill	Includes funds for Behavioral Health Integration into Community-Based Settings, Title X, and School-Based Health Centers.[97]
Commercial Lending	Lenders such as BlueCross BlueShield's Patient-Centered Medical Home (PCMH) program can help finance development of CHCs and support them in hiring and training staff, setting up data exchanges, and implementing behavioral health screenings, and more.[98]
SAMHSA's PAMA Funding	Funds CCBHCs' community behavioral health service improvements.[99]
USDA's Community Facilities Direct Loan & Grant Program	Supports creation or improvement of essential community facilities in rural areas.[100]
Supplemental Payments to low-volume, Medicare-Dependent Rural Hospitals	Offers the financial flexibility for rural safety net organizations to tailor their services to the needs of their local rural communities (e.g., telehealth, expanded rural networks, transportation support).
Telehealth Funding	Builds the technology and organizational capacity to implement telehealth services, which supports value-based care in areas with limited access to in-person healthcare.[101]
CDC Funding for SDOH	CDC programs, like the Social Determinants Accelerator Program, assists local governments in screening for and addressing the social drivers of health, especially for populations with the greatest health disparities.[102]
Philanthropy Initiatives	Philanthropies like Robert Wood Johnson Foundation have provided grants, technical assistance, and learning collaboratives for advancing payment reform in the safety net.[103]
Patient-Centered Medical Home (PCMH) Certification	Incentivizes safety net providers to integrate physical, behavioral, and social care with linkage to community-based resources.
Teaching Health Center Graduate Medical Education (THCGME) Program	Trains primary care residents in community health centers to support their workforce and increase assess to comprehensive primary care services.[104]

2. STATE RECOMMENDATIONS

Leverage State Authorities to Facilitate Access to Upfront Investments and Ongoing Payments

States can leverage Medicaid authorities to direct funding towards safety net providers implementing delivery and payment transformation. Although safety net representation in payment reform models have largely focused on Medicare populations, Medicaid dollars account for the majority of safety net reimbursement.[9] To date, Medicaid reimbursement models and supplemental payments like Upper Payment Limit (UPL) and DSH payments have traditionally been tied to the quantity of encounters or services with no link to performance.

States have a variety of tools to provide upfront and ongoing funding through the Medicaid program. Through a combination of waiver authorities, SPAs, directed payments, MCO contracting, and other payment workarounds such as in-lieu-of services and value-added services,[105] many state Medicaid programs have successfully piloted payment reforms for safety net providers. Table 5 illustrates how states have used these levers to promote value-based payment models.

TABLE 5 Examples of Safety Net Funding Sources and their Value-Based Uses

Payment Strategies	State Examples	Policy Vehicle
Supplemental Payment Incentives (e.g., Pay-for-Performance Bonuses)	**Texas –** Medicaid MCOs provide quality-linked payment incentives	1115 Waiver, State Statute
	District of Columbia – FQHCs earn performance payments from a funding pool separate from their PPS	SPA
Episode-Based Payment Models	**Tennessee –** Medicaid providers are required to participate in retrospective, episodic payments for certain acute conditions	CMS State Innovation Grant
	Pennsylvania – MCOs are required to implement episode-based payments for maternity care providers with shared savings incentives	State-Directed Payments
Partially Capitated PBPM Payments	**Colorado –** Combines FFS payments and PBPM fees for FQHC reimbursements, which are contingent on meeting quality thresholds	SPA, MCO Procurement
Shared Savings Through Accountable Care Organizations	**Massachusetts –** ACOs are eligible for shared savings or losses based on meeting quality and total-cost-of-care targets	1115 Waiver
	Minnesota – Formed Integrated Health Partnerships which share savings and/or losses	SPA
Global Capitation	**Oregon –** FQHCs are paid on a fully capitated PBPM basis, and the state reconciles payments to meet the PPS equivalency	1115 Waiver, SPA
Combination	**Ohio –** Uses a combination of PPS baseline rates, shared savings, and PBPM	SPA

2. STATE RECOMMENDATIONS

Prospective Payment System (PPS) rates and VBP. Whether payment reform will lead to lower PPS rates and whether states can implement reforms given Federal statutes are prominent concerns shared by community health centers. As Table 5 illustrates, in some instances, states have maintained PPS rates while still promoting VBP. The baseline PPS level serves as a protective floor for safety net providers to receive adequate reimbursement for their services, and opportunities for supplemental, value-based bonus payments to incentivize providers to improve care quality and provide flexibilities for population-based care.

Medicaid managed care. As noted above, states also can include specific provisions to promote accountable funding reforms across MCOs. One strategy is to require MCOs to maintain a certain percentage of their contracts with safety net providers in HCP-LAN Category 2C or higher. For example, Ohio's directed payment model requires its managed care plans to participate in the Comprehensive Primary Care (CPC) payment model and be accountable for care coordination for certain specialized populations (e.g., pregnant people), and New York requires its MCOs to provide enhanced funding to PCMH.

Currently, at least 29 states have set VBP requirements for MCOs, which can define minimum thresholds for the percentage of MCO expenditures that must be linked to value, or more strictly, the target percentage of contracted providers in VBP arrangements.[40] Despite common use of managed care contracts, states vary considerably in their categorizations of VBP and do not widely deploy advanced accountable care payments: most VBP arrangements in MCO contracts are comprised of HCP-LAN Category 2 performance payments or other similar FFS arrangements with basic links to quality and no population-based accountability.

Other potential approaches for states to consider include:

- Modifying MLR criteria to incentivize VBP arrangements with safety net providers. For instance, states can allow upfront funding for FQHCs to strengthen value-based care coordination models to count against the MLR;
- Add social risk adjustments into rate calculations for MCOs. For example, Massachusetts' risk adjustment methodology incorporates social risk factors into payments to MCOs;
- Give auto-enrollment preference to MCOs that have comprehensive VBP arrangements with safety net providers. This strategy could steer beneficiaries to managed care plans that prioritize VBP arrangements; and
- Incorporate measures of longitudinal care coordination in annual MCO performance assessment, as part of Federal regulations stipulating states set forth minimum oversight activities of health plans.

Whether payment reform will lead to lower PPS rates and whether states can implement reforms given Federal statutes are prominent concerns shared by community health centers.

2. STATE RECOMMENDATIONS

TABLE 6 Summary of Federal and State Actions to Provide Upfront and Sustainable Safety Net Payments

Federal Recommendations	State Recommendations
CMCS: Employ Federal Medicaid authorities to ensure Medicaid programs provide access to upfront and sustainable payment streams • Issue clear directives for states to provide adequate base payments in Medicaid reimbursement rates • Consider strategies to enable states to use directed payments for providers to build the capabilities and infrastructure for coordination-related activities • Align Medicaid supplemental hospital payments with value and quality, and ensure that supplemental payments reach safety net providers by adopting a refined, patient-based operational definition for the safety net **CMS:** Provide enhanced upfront investment supports across Medicare payment models and plans • Apply health equity components across CMS-sponsored payment models (e.g., scale the ACO REACH health equity benchmark) • Consider a grant program similar to the CMS State Innovation Models grant with clear requirements for implementing safety net accountable care. **Grant-Based Funders:** Re-tool existing grants to fund safety net payment and delivery transformation initiatives • Review existing grants from HRSA, CDC, SAMHSA, and other federal agencies that can be used to support providers in developing the capabilities necessary to succeed in VBP (Table 4) • Develop grants that would enable safety net providers to make long-term, sustainable delivery system improvements after the end of the grant	States have a variety of levers to incorporate upfront and ongoing payments into Medicaid payment programs: • **Section 1115 Demonstration—** Allows for Medicaid innovations that are exempt from certain federal regulations but requires lengthier approval process. • **State Plan Amendment—**Allows for Medicaid changes within Federal guidelines. Compared to Section 1115 Demonstrations, SPAs have a quicker approval processes but are often narrower in scope. • **Medicaid Managed Care Strategies—** – Create financial incentives for VBP arrangements with safety net providers, quality withholds, MLR modifications, and auto-enrollment preferences – Establish minimum VBP targets in contracts – Direct managed care spending towards supporting payment and delivery reforms

3. Recommendation 3: Provide Guidance and Technical Assistance to States and Providers

TAKEAWAYS Recommendation 3

- Structured guidance can help states and safety net providers make full use of the tools and resources at their disposal to optimize care and delivery transformations.
- Federal policymakers should provide guidance to states on available funding opportunities and methods for coordinating them, as well as identify and describe existing state Medicaid authorities to support payment reform.
- For safety net providers, federal and state agencies can issue guidance, technical assistance, toolkits, and learning collaboratives to help safety net providers develop accountable care capabilities. Guidance on accountable care partnerships, such as ACOs, CINs, and co-investment opportunities with third-party enablers, can expedite this process and help safety net providers develop the infrastructural backbone to share resources and take on risk.

Safety net providers would benefit from assistance in accessing and developing the capabilities needed to deliver whole-person care. Providers are concerned about their ability to remain financially sustainable in VBP models or whether these models are feasible given their obligation to serve marginalized communities, including many underinsured or uninsured individuals. Below we describe ways for Federal agencies to provide further guidance and technical assistance for states and providers.

GUIDANCE TO STATES

Create a Financial Roadmap to Identify Funding Opportunities Across the Principal Funders for Safety Net Organizations and Clarify Allowed Uses of Funds

The Federal coordination workgroup or some designated Federal entity should undertake a comprehensive review of Federal funding programs and payers to develop a roadmap that provides guidance and examples on how states can coordinate different funding sources to build a financial path towards sustainability.

Financial guidance should advise states on strategies that can be used to help coordinate and leverage disparate sources of funding. One approach is braiding, where different funding is coordinated but not combined. Safety net accountable care entities and Community Care Hubs could serve as coordinating entities to braid funding and manage funding flows for a network of safety net providers and community-based partners.[3] For example, multiple states have used Community Care Hub structures to braid federal funds from CMS, HRSA, SAMHSA, and CDC with state sources (like SPAs or Section 1115 Medicaid demonstrations) and philanthropic and local resources.[106] Additional funding streams exist, such as 340b and local public health funding, that while more challenging to integrate, could present further opportunities to explore.

While central coordinating entities are useful for managing disparate funding sources, many states and providers lack the capacity and budget to design complex funding systems

3. GUIDANCE TO STATES

that align with reporting and administrative requirements for each separate stream of funding. To help states and providers navigate the complex nature of disparate funding streams, the financial roadmap should compile funding opportunities, identify their allowed and nonpermitted uses, and clarify other funding requirements. The roadmap should include reviewing existing HRSA grants, Marketplace and Medicare Advantage plans, and other potential funding programs (see Table 4, above) that can be used to support providers in delivery reform. To identify categorical grants, policymakers should collaborate with community-based organizations that have expertise and experience navigating public health funding streams and community-building grants that could be leveraged for strengthening whole-person care in the safety net.

An example of a tool to facilitate funding coordination for safety net providers is the No Wrong Door toolkit,[107] developed by CMS and Administration for Community Living (ACL). The toolkit guides states on the process of coordinating funding streams with Medicaid claims, clarifies permissible funding sources and activities, and assists with public and private partnership building.

Further, policymakers can provide guidance and examples on private partnerships or "co-investment" to augment safety net provider capabilities (e.g., value-based contracts with Medicare Advantage or Medicaid Managed Care Plans). Federal policymakers should establish appropriate guardrails for accountability to ensure that investments lead to sustained improvements in quality of care (for example, by requiring that governing boards include members of the community served).

Guidance on Existing State Authorities and Policy Levers to Drive VBP for Safety Net Providers

As noted above, states have a variety of Medicaid authorities, including Section 1115 waivers, SPAs, state directed payments, and MCO contracts, that can be used to reform Medicaid payment models for safety net providers. Federal policymakers should provide clear guidance to help states use these levers to the fullest extent. As an example, CMCS previously provided a state guide on criteria for Medicaid managed care contract review and guidance on how states can cover health-related social needs like housing and transportation by providing them in-lieu-of other services.[108,109]

States have a variety of Medicaid authorities, including Section 1115 waivers, SPAs, state directed payments, and MCO contracts, that can be used to reform Medicaid payment models for safety net providers. Federal policymakers should provide clear guidance to help states use these levers to the fullest extent.

Federal policymakers also can provide standardized VBP contracting language for states to use when working with MCOs and issue guidance on state-directed payments, including clarifications on data sharing arrangements between MCOs and providers. CMCS can expedite the review process of MCO arrangements by listing pre-approved value-based strategies in Medicaid managed care rules (e.g., structured guidance on ILOS parameters) and publicly releasing examples of MCO contracting language or preprints that have been previously approved (preprints are the standard application form CMS uses for directed payment arrangements). For pre-print guidelines, states should be encouraged to indicate how they will promote coordination and inclusion of safety net providers in VBP models and prioritize their development and evaluation. CMCS also can guide state agencies to require or create incentives for MCOs to meet specific performance metrics that promote coordination across the safety net (e.g., timely access to ADT feeds) and measures tied to improving population health outcomes in underserved communities. Standardizing the payment and reporting

3. GUIDANCE TO STATES

strategies of MCO contracts through overhead guidance will further help alleviate administrative burdens for safety net providers that contract with multiple MCOs.

Policymakers also can provide guidance to states on how to expand flexibilities in Medicaid coverage using standard processes within state parameters. For example, California has a pre-approved list of in-lieu-of services,[110] and states can incorporate social service coverage through case management service categorizations. Federal funding, such as enhanced match infrastructure reimbursements and supplemental and directed payments, also can align states' value-based reforms by providing overhead support for technical assistance, capacity building, data sharing infrastructures, and longitudinal care management strategies.

GUIDANCE TO PROVIDERS

Safety net providers could benefit from assistance in accessing and developing the capabilities needed to deliver whole-person care. Providers are concerned about their ability to remain financially sustainable in VBP models or whether these models are appropriate given their obligation to serve marginalized communities. Federal and state agencies can provide further guidance and technical assistance to demonstrate how safety net providers can successfully participate in VBP models.

Federal and state agencies can provide further guidance and technical assistance to demonstrate how safety net providers can successfully participate in VBP models.

Guidance on Ways to Braid Funding Through Accountable Entities and Participate in Payment Reform

Safety net providers' revenue streams are exceedingly diverse, with funding from payers, public funders, and private sources, whose disjointed regulations and funding processes make it particularly difficult to navigate and weave together these different threads of funding. Some safety net providers and states have overcome fragmented funding by establishing a central coordinating entity to organize disparate sources of funding and distribute them across providers. ACOs could serve as a coordinating entity to braid funding and manage funding flows. For example, Community Care Cooperative (C3), an FQHC-led ACO in Massachusetts, used its ACO to braid state and local dollars, including grant dollars, Medicaid FFS, and Managed care dollars, to help health centers develop the capabilities needed to succeed in VBP.

By forging sustainable models of value-based payment systems, C3 has successfully reinvested its shared savings into building up social resources, community health initiatives, and care coordination services.

Based on the journeys of safety net organizations like C3, policymakers should craft guidelines for other safety net providers and states to follow to help navigate existing financial paths and strategies for building sustainable VBP models. These guidelines, tailored towards safety net providers, can catalyze and streamline value-based care for the safety net population.

3. GUIDANCE TO PROVIDERS

Guidance on Approaches for Building Accountable Care Capabilities and Moving Into Risk-Based Contracts

Federal agencies and states can share technical assistance for providers to develop the organizational capabilities needed to become an accountable safety net entity. While toolkits, learning collaboratives, and other resources exist to address these concerns, policymakers should also support efforts to showcase how exemplar safety net providers are already leveraging VBP to transform delivery and coordinate care. The experiences of these exemplar organizations illustrate innovative strategies for accessing upfront funding, managing risk, integrating and coordinating services, and developing the capabilities needed to meaningfully strengthen care for their communities. This effort includes building partnerships with community organizations and human services; integration of primary, specialty, and behavioral healthcare; and data infrastructure for care coordination.

Foundational elements are necessary to successfully participate in accountable care, including dedicated leadership and organizational structures, continuity and coordination of care, data and IT infrastructures to track longitudinal patient data, and financial management capabilities. Guidance and training can help providers develop these essential building blocks. Policymakers can help prepare safety net providers for implementing VBP models by conducting readiness assessments, such as the National Association of Community Health Center's (NACHC) Payment Reform Readiness Assessment Tool, which informs providers their strengths and areas of development prior to participation.[111] Washington state, for instance, has a structured process of assessing provider readiness as a prerequisite for participation in the state's VBP model.[112] Toolkits, case studies, and learning collaboratives that highlight exemplar safety net organizations also can provide guidance for safety net providers and illustrate that VBP participation can be achieved through a stepwise approach of limited reforms (e.g., LAN Category 2/3A) that advance over time.

Other ways to streamline capability development for new VBP providers are to foster collaborative entities consisting of networks of providers that can share in learning and resources, such as HCCNs, IPAs, and ACOs. To facilitate these collaborative entities, policymakers should encourage providers to pool resources and risk in organizational structures that have the infrastructural backbone to take on two-sided risk arrangements, such as via the pathways listed in Box 1.

Federal and state agencies can also provide technical assistance to strengthen safety net participation in VBP. A multitude of state initiatives (e.g., Massachusetts' Technical Assistance Program and learning collaborative for Medicaid ACOs)[113] and federal initiatives (e.g., HITEQ)[114] can be leveraged to train and support providers in building the right capabilities for VBP participation. Federal centers like CMCS can issue guidance for states and HHS agencies to align their technical assistance programs and may consider contracting with Federally funded research and development centers to streamline existing technical assistance programs. Further, CMS can build off of health equity technical assistance programs to curate cross-sectoral health equity plans for safety net providers to improve care for under-resourced populations through equity-focused VBP models.[32] States and provider groups can scale successful initiatives to pool and share data and learnings. For example, NextGen Healthcare launched a Community Health Collaborative to provide FQHCs with data benchmarking, comparative analytics, reporting services, and community health best practices.[115]

4. Recommendation 4: Create Pathways to Integrate Social and Community Supports to Address Health-Related Social Needs

TAKEAWAYS Recommendation 4

- Partnerships with social services and community-based organizations are critical to addressing health-related social needs and delivering whole-person, accountable care.
- Policymakers have identified Community Care Hubs as a promising mechanism for building and financing these partnerships. Community Care Hubs can coordinate financial and administrative functions for community-based organizations, safety net providers, public health systems, and other cross-sector stakeholders.
- Medicaid authorities also can support sustainable partnerships between safety net providers and community-based organizations. States can ensure adequate funding for these partnerships by providing coverage for health-related social needs services. Federal guidance on strategies to reimburse for social services, such as Section 1115 waivers, in-lieu-of-services, and managed care activities, can help states develop predictable funding flows.
- In addition, states should invest in the infrastructure needed to maintain linkages between community-based organizations and safety net providers, including integrated data platforms, referral tools and information exchange networks, and workforces of community health workers.

As anchors of care in underserved communities, safety net providers are uniquely positioned to connect patients who are disproportionately impacted by health-related social challenges with social and community-based resources. Indeed, HHS has called for a multi-sectoral approach to support the social drivers of health in under resourced communities,[116] but such community and clinical integration remains challenging due to siloed financing and operating streams between health and social sectors and significant underinvestment in social and community-based resources. This section proposes policies to strengthen care coordination across safety net providers and community-based organizations through sustainable financing mechanisms for addressing health-related social needs.

FEDERAL RECOMMENDATIONS

Improving collaboration across medical and social sectors requires coordination across stakeholders, including Federal agencies. Existing initiatives provide foundations for expanding coordination. For instance, CMCS partnered with USDA on use data-sharing agreements to enroll students directly in food assistance programs and in Medicaid, based on joint eligibility data.[50] Federal agencies also may consider inter-agency waivers that simplify application processes and pool funding, such as a joint Medicaid and HUD waiver to support enhanced funding for Medicaid home supports. To enact the recommendations below, Federal agencies will need multi-sector coordination and collaboration across HHS, CMS, USDA, HUD, DOT, CDC, and other relevant agencies.

4. FEDERAL RECOMMENDATIONS

Coordinate Funding Across Federal Payers to Support Regional Partnerships That Link Social Services and Community-Based Organizations With Safety Net Providers

Community Care Hubs, when supported by well-aligned Federal grants (e.g., ACL or CDC community support grants),[117] have successfully built community partnerships and linked safety net providers and patients to community-based resources using coordinated funds from Federal, state, local, and private sources. Box 5 showcases examples of how Community Care Hubs have coordinated multisector stakeholders to organize networks of community-based organizations.

Policymakers should develop and scale financing models based on Community Care Hubs. In the future, CMMI may consider models for Community Care Hubs that allow them to earn shared savings with safety net providers. This approach would build off of recent guidance enabling Community Care Hubs to receive MSSP Advance Investment Payment by working with ACOs to manage health-related social needs.[118]

Clarify Existing Flexibilities For States to Use Medicaid funding to Support Social and Community-Based Organizations

Safety net providers need sufficient funding to build and maintain their networks of social supports, as well as a path to pay for social services. Recent CMS guidance on using ILOS has created new opportunities for states to cover health-related social needs.[109] Recent Section 1115 waiver approvals also allowed new HRSN services to be covered under Medicaid, which includes housing, nutrition, and case management supports.[34] CMS can use these recently approved waivers in Arkansas, Arizona, Massachusetts, and Oregon as guidance for other states seeking to develop similar flexibilities,[35] as well as update Medicaid managed care rules to be more specific and directive on HRSN activities.

BOX 5 Examples of Community Care Hubs

- ACL's No Wrong Door initiative is a coordinated system of government and local, community-based organizations that serves as a one-stop point of access to public and community services for patients in need of long-term care.[107]
- Rhode Island's Health Equity Zones (HEZ) are local, place-based partnerships between community-based organizations, safety net providers, and Medicaid managed care plans. Essential to the HEZ framework are "backbone" organizations—or central agencies that coordinate across funding streams, organize with stakeholders, and distribute funds according to identified areas of community need.[119]
- CMMI piloted the Accountable Health Communities model to support partnerships between health systems and community-based organizations. Participating organizations have the flexibility and self-governance to allocate their funding towards addressing the most pressing social needs and health equity challenges in their local regions.[120]

4. STATE RECOMMENDATIONS

State policies can facilitate similar multisector programs that promote social service integration and person-level alignment to support the infrastructure for addressing social needs. For instance, North Carolina launched the Healthy Opportunities Pilot, a Medicaid program that relies on a formal network of community-based organizations to refer and reimburse providers for resources to address social needs like transportation, nutrition, and housing.[121] In Massachusetts, Medicaid ACOs are encouraged to partner with community-based organizations to leverage their existing resources and expertise in providing social services to the local community.[122] New York also has used its Section 1115 waiver to create Health Equity Regional Organizations (HERO), or regional collaboratives of safety net providers, health systems, community-based organizations, managed care organizations, and other local stakeholders that coordinate through one centralized planning body, to address the most pressing health equity and population health needs of their communities.[123]

Use Medicaid Authorities to Cover Health-Related Social Needs Services as Part of Accountable Care Implementation

States can provide adequate and sustainable funding for HRSN services from social and community-based organizations through Medicaid authorities, such as Section 1115 waivers, SPAs, ILOS, and managed care contracting requirements.

Multiple states have utilized Section 1115 waivers to implement VBP models that fund social and community-based services. Massachusetts directed a portion of its Delivery System Reform Incentive Payment (DSRIP) funding to launch a Flexible Services Program that provides funding for Medicaid ACOs, which provides nutritional and housing services for qualified enrollees. Arizona and Oregon also have utilized Section 1115 demonstrations to gain new flexibilities for benefits that address social needs, such as approval to provide rental assistance.

Using managed care levers, states can add HSRN services as a covered benefit through ILOS. California streamlined this process by providing a list of 14 pre-approved ILOS, which encompass a range of social supports, like housing and nutritional services.[110] States also can set VBP requirements that involve addressing social drivers of health and collaborating with social and community-based organizations. For example, New York requires that its managed care plans in two-sided risk arrangements contract with at least one community-based organization[124] and California's MCOs are required to reinvest at least 5 percent of their profits into community-building activities.[125] Other states have incentivized MCOs to address SDOH through innovative methods like bonus incentives, quality withholds, community reinvestment requirements, social risk adjustment, and auto-assignment preferences.[126] States looking to advance HRSN-related benefits in managed care models must also ensure that government-designated health centers are not excluded, as their unique PPS rate is calculated separately from MCO capitation rates.

As part of state funding for HSRN, it is important that states embed predictable funding flows to community-based organizations in accountable Medicaid payment dollars. For instance, Massachusetts' Flexible Savings Program allows ACOs to develop payment arrangements for social services, including fee-for-service billing, bundled payments, and PBPM capitation. These predictable payment mechanisms will help ensure the long-term sustainability of provider and community-based partnerships.

4. STATE RECOMMENDATIONS

Invest in Health Technology Infrastructure to Support Seamless Data Exchange Across CBOs and Safety Net Providers

The ability of safety net providers to effectively coordinate with social service and community-based organizations depends on the infrastructure to support seamless data exchange and referrals and capabilities for identifying health-related social needs. Arkansas, Arizona, Massachusetts, and Oregon used their Section 1115 waivers to direct Medicaid funds towards building the infrastructure to address health-related social needs, including investments into the community workforce and data systems improvements. Technology software like Unite Us and FINDConnect, which tends to be underused in Medicaid,[28] can help build a strong referral network and track referrals to community-based organizations through robust data systems.

States can leverage Federal funding to support these infrastructure developments. Funding from CDC, community block grants, and other public health grants can help financially support community health workers and social service organizations, as well as strengthen partnerships between community organizations and safety net providers. States also can leverage the 90 percent match rate for enhanced Medicaid matching funds to develop IT infrastructures and data sharing capabilities across CBOs and providers. Teaching grants from HRSA can also be used to support training and education programs for community health workers and safety net providers.[104]

Funding from CDC, community block grants, and other public health grants can help financially support community health workers and social service organizations, as well as strengthen partnerships between community organizations and safety net providers.

Finally, states also can target technical assistance for health technology that exchanges data with social service and community-based organizations and builds closed-loop referral systems for social supports. For example, North Carolina's NCCARE360 is a statewide electronic network that allows providers to connect patients with community organizations and resources to address unmet health-related social needs.

CONCLUSION

A cross-governmental approach to ensure financial and operational sustainability for safety net providers can enable and accelerate safety net participation in VBP models. Policy reforms need to provide sufficient technical and financial support, infrastructural investments, and flexible, population-based payment structures that account for the safety net's history of systemic underinvestment. Given the essential role that safety net providers play in providing care to the nation's most disadvantaged populations, expanding access to VBP models for safety net providers will have major implications for health equity. The Duke-Margolis vision and principles for transforming payment and delivery systems in the safety net offer a comprehensive pathway to develop accountable care capabilities and enhance funding streams for safety net providers, supporting patients in the safety net to access improved, more coordinated care.

ACRONYMS AND ABBREVIATIONS

ACH – Accountable Communities for Health
ADT – Admission, Discharge, and Transfer
ACL – Administration for Community Living
ACO – Accountable Care Organization
ACO REACH – The ACO Realizing Equity, Access, and Community Health
API – Application Programming Interface
APM – Advanced Payment Model
CBO – Community Benefit Organization
CCBHC – Certified Community Behavioral Health Centers
CCIIO – The Center for Consumer Information and Insurance Oversight
CCSQ – Center for Clinical Standards and Quality
CDC – The Centers for Disease Control and Prevention
CIN – Clinically Integrated Networks
CMMI – The Center for Medicare & Medicaid Innovation
CMCS – The Center for Medicaid and CHIP Services
CM – Center for Medicare
CMS – The Centers for Medicare & Medicaid Services
DOL – Department of Labor
DOT – Department of Transportation
DSH – Disproportionate Share Hospital
DSRIP – Delivery System Reform Incentive Payment
EHR – Electronic Health Record
EPA – Environmental Protection Agency
eCQM – Electronic clinical quality measures
FFS – Fee-for-Service
FQHC – Federally-Qualified Health Center
HCP-LAN – Health Care Payment Learning and Action Network
HHS – Department of Health and Human Services
HITECH – Health Information Technology for Economic and Clinical Health
HRSA – The Health Resources and Services Administration
HRSN – Health-Related Social Needs
HUD – Department of Housing and Urban Development
ILOS – In Lieu of Services
MA – Medicare Advantage
MCO – Managed Care Organization
MLR – Medical Loss Ratio
MSSP – Medicare Shared Savings Program
PBPM – Per-Beneficiary, Per-Month
PCMH – Patient-Centered Medical Home
PPS – Prospective Payment System
PRAPARE – The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experience
PROMs – Patient-Reported Outcome Measures
RHC – Rural Health Centers
SAMHSA – The Substance Abuse and Mental Health Services Administration
Section 1115 Demonstration – Section 1115 of the Social Security Act
SDOH – Social determinants of health
SIM – State Innovation Model
SPA – State Plan Amendment
SSA – Social Security Agency
SNAP – Supplemental Nutrition Assistance Program
UDS – Uniform Data System
UPL – Upper Payment Limit
USDA – The United States Department of Agriculture
VBP – Value-Based Payments
USCDI – United States Core Data for Interoperability

TERMS

Accountable Care – An approach to delivering care that holds providers responsible for improving quality, care coordination, and patient outcomes while using resources efficiently.[127] According to the HCP-LAN accountable care "centers on the patient and aligns their care team to support shared decision-making and help realize the best achievable health outcomes for all through equitable, comprehensive, high quality, affordable, longitudinal care."[128]

Accountable Safety Net Entity – A designated organizational entity that assumes primary responsibility for managing the health of the population that it serves. The accountable entity could be one organization or a coalition of providers operating under a single legal structure.

Advanced Payment Models – Payments designed to sustain population health management by shifting further away from fee-for-service. These are typically classified as Category 3 or Category 4 in the HCP-LAN Alternative Payment Model Framework.

Directed Payments – A type of payment arrangement in which states may require Medicaid managed care organizations to direct expenditures to providers according to specific rates or methods, including value-based arrangements.

Disproportionate Share Hospital Ppayments – Payments made in Medicare and Medicaid to offset qualifying hospital uncompensated care costs.

Preprints – The standard application form CMS uses for directed payments in Medicaid managed care.

Section 1115 Demonstration Waiver – Section 1115 of the Social Security Act waiving Medicaid rules, allowing states to test experimental, pilot, or demonstration projects.

State Plan – An agreement between the state and federal government describing how the state plans to administer its Medicaid program.

State Plan Amendments – A process for states to amend the Medicaid State Plans to reflect changes in the nature and scope of the Medicaid program.

Supplemental Payments – Medicaid payments to providers, typically hospitals, that are separate from base payments for health services and may include, disproportionate share hospital payments and upper payment limit payments.

Whole-Person Care – Approaches for payers, providers, and community partners to address the medical and non-medical drivers of health, including meeting people's social needs, addressing behavioral health, and improving health equity in communities.

Value-Based Payments – Payments designed to achieve certain outcomes (value) in contrast to payments based on volume.

APPENDIX A: Example of Potential Changes to VBP Models to Better Engage the Safety Net

	Barriers & Considerations	Recommendations for Medicare and Medicaid Programs
Accountable Entity	Organizational entity that can assume primary accountability for population health management. Can include (but is not limited to) community health centers, safety net hospitals, critical access hospitals, behavioral health clinics, and school-based clinics. Providers have historically functioned independently and often do not have the infrastructure or trust to easily integrate operations. Large safety net organizations may have the financial stability to take on downside risk, but network structures are needed to support small safety net providers to share risk and resources together.	• Require contracting language to stipulate (1) selection of entity/entities in charge and (2) how funding will flow to participating providers. Ensure the selected entity has the infrastructure and technical capabilities to consolidate and report on necessary metrics, and that participating safety net providers meet the requirements for accountable funding streams. • Ensure incentives/risk are allocated equitably to participating providers. • Allow for flexible selection of participants within ACOs to account for regional variation and different organizational structures (e.g., FQHCs vs. health systems). • Facilitate the formation and participation of network structures like clinically integrated networks, independent practices associations, accountable care organizations, or other accountable care enablers (Box 1) to allow smaller providers to successfully take on pooled risk. • Set requirements for governance boards to be representative of the community served. For example, CMS and Medicaid programs can align with HRSA's board requirements for FQHCs, which require the board majority to consist of patients seen by the health center.
Payment Approach and Glidepath to Risk	Because safety net providers have been systemically underfunded, payment methods should focus on supplying upfront and ongoing reimbursements, not reducing costs based on historical spending. There must be sufficient financial incentives and safeguards for safety net providers to transition. Rural and lower-resourced providers may be less able to generate yearly savings, making them hesitant to take on the responsibility of downside risk for a multi-year contract. Given that safety net populations are disproportionately affected by socioeconomic disadvantages, payment models should also reimburse for fulfilling patient needs around housing stability and food/nutritional supports.	• Provide bonuses to providers serving patients with complex health needs (e.g., ACO REACH's High Needs Population ACO category) • Provide supplemental support for SDOH and care coordination activities (e.g., MassHealth's Flexible Services Program;[20] Enhancing Oncology Model awards dual-eligible beneficiaries an extra $30 PBPM payment for care management services) • Link financial incentives to cost and quality, stratified by HCP-LAN categories.[128] • Offer prospective and predictable population-based payments (like Category 4A[128] APMs) to enable flexibility in allocating resources towards traditionally unreimbursed services, like community-based programs, social needs assessments, and telemedicine. However, any rate conversions from encounter-based to population-based payments (like PBPM) should factor in the full costs of value-based care, including the additional costs of providing SDOH services and care management. • Allocate upfront payments for infrastructure to low-revenue ACOs and supplemental incentives for care coordination. For long-term VBP buildup, it is crucial that temporary upfront payments are followed with incremental investments that support both the fixed and variable costs of developing and maintaining infrastructure.

APPENDIX A: *Example of Potential Changes to VBP Models to Better Engage the Safety Net Continued*

	Barriers & Considerations	Recommendations for Medicare and Medicaid Programs
Payment Approach and Glidepath to Risk *continued*		• Offer a multi-year on-ramp to downside risk, with support for building infrastructure and data-sharing capabilities. This longer on-ramp can be implemented through a phrased approach to help safety net entities build up experience and comfort with advanced payment models: – A pre-performance period could help providers prepare for risk arrangements without jeopardizing financial stability. – Initial payments could include specific financial incentives for organizations to coordinate and integrate care through cooperative agreements, care for more socially complex patients, and/or supplemental payments for care management and quality incentives based on continued access to all necessary services. – Over time, the accountable entity could transition into a more advanced payment arrangement like global capitated payments for the total cost of care of the attributed population's health and health-related social needs. • Couple standardized payments with supports such as risk corridors, stop-loss protection, or reinsurance. • Require a Care Coordination Plan as a condition of payment (similar to the Health Equity Plan in ACO REACH and the Accountable Health Communities Model) to describe how the organization will coordinate with CBOs and HSRN providers in the community **Medicaid:** • CMS can update Medicaid managed care regulations to count value-added services in capitation rate-setting, currently only counted in MLR calculations. • Require provider organizations to strengthen care coordination and community supports beyond federal baselines (e.g., the Oregon Health Authority requires its CCOs to coordinate with Area Agencies on Aging via a Memorandum of Understanding required by the Secretary of State's administrative rules). • Design VBP initiatives to provide pre-paid savings to low-revenue provider groups, as in ACO REACH, and incorporate bonuses for care management, especially for socially complex patients. • Expedite the turnaround for reconciliation payments to FQHCs and rural health centers (e.g., reconciling supplemental payments on a quarterly basis) • Set minimum contracting requirements for MCOs to engage with safety net providers ready to shift towards value-based payment models. • Specify in managed care contracts that plans should address non-medical risk factors and engage in broader SDOH initiatives (e.g., as was done for TennCare's Health Starts Provider Partnerships).[41] One approach is to encourage health plans to provide incentive payments to their providers to screen for SDOH using Medicaid managed care rules. • Incorporate predictable funding flows for accountable entities to partner with Social Services Organizations to fulfill patient needs in these areas to improve health outcomes and decrease TCOC. For instance, Massachusetts' Flexible Savings Program allows ACOs to develop payment arrangements for social services, including fee-for-service billing, bundled payments, and PBPM capitation.

APPENDIX A: *Example of Potential Changes to VBP Models to Better Engage the Safety Net Continued*

	Barriers & Considerations	Recommendations for Medicare and Medicaid Programs
Benchmarks	Financial benchmarks for health care expenditures will need to be set at a level that supports preventative and health promoting interventions, including care coordination and prospective population health management. To set benchmarks at an appropriate level for safety net providers, benchmarks should not solely reflect a provider's historical expenditures which can disadvantage safety net providers by not accounting for actual services rendered, patient population fluidity, or historical underfunding. History-based benchmarks also put safety net providers at a structural disadvantage compared to large hospital systems, as the latter tends to have high relative price indices and therefore higher historical costs of care.	• Utilize benchmarks that support providers working in underserved communities (e.g., ACO REACH's health equity benchmark). • Benchmarks should focus on additional factors beyond historical expenditures such as regional benchmarking. • Stratify benchmarks to compare providers' performance to similar peer organizations, as done in the Hospital Readmission Reduction Program and Hospital-Acquired Condition Reduction Program. This will ensure that smaller providers serving undeserved patients are not benchmarked against larger, better-resourced health systems.
Risk Adjustment	Safety net providers serve many individuals with complex health and social needs that are not always accounted for in risk adjustment methodology, leading to under-adjusted benchmarks, relative to the complexity of the patient populations. For instance, CMS's Hierarchical Condition Category (HCC) does not adjust for acute conditions, newly diagnosed chronic conditions, or health-related social needs. As a result, patients often have higher total costs of care than reflected in their HCC score. Additionally, many safety net providers do not have experience in advanced coding practices.	• Adjust payments by community-level measures of social risk to better account for health, socioeconomic, and sociodemographic complexities (e.g., Area Deprivation Index, Social Vulnerability Index, Neighborhood Health Index). • Incorporate other evidence-based data sources to inform risk adjustment calculations besides historical cost data, such as social vulnerability (homelessness indicators), pharmacy claims data, and structured EMR extract data. • Develop individual-level measures of social risk that account for major individual factors leading to lower service utilization given health status among populations served by safety net providers. • Use Z-codes and more detailed assessments than ICD-10 code to capture SDOHs for patient-level risk adjustment; support development of USCDI+ electronic standards for reducing burden. • Implement a risk adjustment index that combines community- and individual-level risk factors (e.g., Massachusetts Medicaid uses[129] a neighborhood stress scorefrom individual medical and sociodemographic information)

APPENDIX A: *Example of Potential Changes to VBP Models to Better Engage the Safety Net Continued*

	Barriers & Considerations	Recommendations for Medicare and Medicaid Programs
Patient Attribution	Stable and accurate patient attribution is critical to helping providers manage patient care and take accountability for them in quality and cost models. However, accurately identifying patients is challenging given patient churn and inaccurate patient rosters or data lags. High rates of patient churn and outdated attribution lists create challenges to accurately assign patients to providers.	• Assure that mechanisms for beneficiary choice in alignment with an accountable entity are appropriate and well-supported for underserved populations • Attribution methods will be dependent on the structure of the model: hospital and systems-based models should incorporate facility-based primary care services and home health visits, and other hospital utilizations for primary care services into attribution; whereas FQHC-based models should calculate attribution based on primary care and clinical utilization • Identify attributed patients at least one year in advance of the model to allow time for empanelment, risk adjustment, developing coding and baseline metrics, and testing new delivery approaches; but also, attribution methods should not penalize providers for accepting unassigned patients • Factor in telehealth, home health visits, or other non-traditional patient encounters in attribution methods to give credit for reaching patients with access barriers to in-person care visits • Incorporate checks to ensure patient is reachable and has had an opportunity to choose before attributing accountability for quality and cost models. For example, allow three attempts to contact an attributed patient before removing them from the list and incorporate a grace period for providers to reach out to unengaged patients, connect them with the healthcare system, and verify their assignment prior to holding them accountable for cost and quality performance. • Use stable and accurate patient attribution methodologies that retrospectively adjust for unforeseen utilization from unassigned patients, particularly given the fluidity of patient populations (e.g., California's APM adjusts the payment rate of FQHCs based on the proportion of unassigned walk-in visits relative to the assigned population)
Performance Measurement	Many current performance measures do not accurately assess the quality of care furnished by safety net providers. Additionally, performance measures are not aligned across payers, leading to excessive reporting requirements with little impact on quality. There is a need to incorporate performance measures that account for a broader spectrum of factors while simplifying the number of measures to reduce reporting burden.	• Align and simplify meaningful measures across payers and safety net funders. Ideally measures will capture an individual's whole-health which requires measuring health-related social needs, behavioral health, and patient-reported outcomes. Examples of performance measures identified by CMS' Universal Foundation cover domains across: – Wellness and Prevention – Chronic conditions – Behavioral health – Seamless care coordination – Person-centered care – Equity – Note that these domains can incorporate other core measures. For example, instead of only using all-cause readmissions as a proxy measure for care coordination, quality measures can factor in more process-oriented coordination measures such as closing referral loops, communication between primary and specialty providers, patient wait time, and seamlessness of care transitions. • Collect data and track changes in health disparities and health equity. • Incorporate measures that account for care delivery redesign progress (e.g., SAMHSA's deployment of community health workers and mobile mental health crisis teams) and patient engagement. • CMS can build off the Interoperability and Patient Access final rule by requiring not only that hospitals share ADT information with providers, but that providers received ADT notifications and acted upon them. • Embed health equity into performance evaluation methods—for instance, by stratifying performance along sociodemographic factors (e.g., race, income) or incorporating measures specific to subpopulations • Standardize SDOH screening questions (e.g., NQF's Screen Positive Rate, expanded use of PRAPARE Screening Tool, AHC's HRSN screening tool).[120] • Identify and incorporate clinical tracer quality measures (e.g., HTN, SM control, PHQ-9 for depression severity).

APPENDIX B: RECOMMENDATIONS BY FEDERAL AND STATE AGENCIES

Federal Coordination Workgroup

HHS or the Administration should establish a federal coordination workgroup, building on existing intra- and inter-agency efforts, to identify areas of non-alignment across public programs and departments (e.g., CMS, HRSA, SAMHSA, CDC, HUD, DOT, USDA) that can be addressed without statutory change. A critical initial step is to align on key performance measures that reflect the shared goals of federal programs to deliver more accountable care to the safety net:

- Measure Alignment
  - Review existing measures and data sharing initiatives that can be used to establish a parsimonious set of measures that can be improved over time (PROMs, CCSQ equity-specific composite measures, behavioral health measures) and aligned with UDS and eCQI library
  - Greater weight should be given to activities that meaningful integrate care (e.g., timely access to ADT feeds)
  - Incorporate measures beneficial to safety net population in both Medicare and Medicaid (e.g., HIV screening and treatment adherence, performance measures related to screening and effective care for SMI)
- Data standardization
  - Standard approaches for collecting and improving race, ethnicity, language, and socioeconomic data.
  - Leverage validated screening instruments already widely used (e.g., HRSA's UDS reporting requirements).
  - Facilitate exchange of essential patient data (e.g., clarifying data sharing arrangements between MCOs and providers)

Centers for Medicare and Medicaid Services

- Coordinate Across HHS Agencies and CMS Centers
  - Voluntary public-private collaborations such as the Health Care Payment Learning and Action Network (LAN) can help encourage and inform such efforts toward alignment. The federal government should take supportive steps, for example through the Health Care Payment Learning and Action Network (LAN), to coordinate with commercial payers in advancing safety- net goals. This includes setting goals for partnership building with community organizations and human services, integration of primary, specialty, and behavioral healthcare, and data infrastructure for care coordination.
- Provide guidance and technical assistance for providers to develop capabilities and identify pathway to financial sustainability
  - Issue guidance/tools to summarize available supports for accountable safety net organization. For instance, create a financial roadmap that identifies funding opportunities on a regular basis, their potential allowed and non-allowed uses, and other funding requirements.
  - Provide guidance and examples on private partnerships or "co-investment" to augment safety net provider capabilities. As an example, guidance could be developed on how to leverage private third party enablers to provide technical supports for safety net organizations to work across multiple organizations at scale, or how to partner effectively with Medicare Advantage plans and/or Medicaid Managed Care plans.
  - Develop toolkits, case studies, land earning collaboratives that highlight exemplar safety net providers
  - Consider contracting with federally funded research and development centers to streamline existing technical assistance programs
  - Provide guidance and examples on how providers can coordinate disparate sources of funding. For instance, highlight examples of how braiding has successfully been achieved in the field (e.g., Accountable Communities for Health, Community Care Hubs, leveraging ACOs)

APPENDIX B: RECOMMENDATIONS BY FEDERAL AND STATE AGENCIES

- Provide upfront funding and align payment models
  - Review CMS portfolio and identify opportunities to replicate MSSP advance investment payments
  - CMS should ensure new care models align with existing population-based payment models like MSSP or ACO REACH. New and existing models should be designed to enable providers the flexibility to allocate resources as needed and ensure providers are accountable for delivering comprehensive, longitudinal care. Importantly, both technical modifications and application process improvements should be applied across existing CMMI, MSSP, and Medicaid models to ensure consistency across programs and to reduce the administrative burdens of fragmented systems.
- Identify additional innovative (or traditionally underused) funding and payment streams to achieve whole-person health goals
  - Consider pathways to link community benefit spending to VBP initiatives

CMS Innovation Center

- Align technical components across models to better support safety net providers. Examples include:
  - **Accountable Entity –** Require contracting language to stipulate selection of one entity that assumes primary accountability for population health management.
  - **Payment Design –** Offer prospective and predictable population-based payments, including up-front payments for organizations with limited capital to develop capabilities, to enable flexibility in allocating resources towards traditionally unreimbursed services, like community-based programs, social needs assessments, telemedicine, and care coordination.
  - **Risk Adjustment –** Implement a risk adjustment index that combines community- and individual-level risk factors. Social risk measures should factor in both patient-level needs, such as housing and food insecurity, and community-level needs that reflect neighborhood stress scores.
  - **Attribution –** Incorporate checks to ensure patient is reachable and has an appropriate opportunity to choose an accountable entity before attributing accountability for quality and cost models.
  - **Benchmarking –** Set benchmark at a level aligned with the provision of preventative and health promoting interventions in safety net populations. Stratify benchmarks to ensure providers are compared to peers and adjust benchmarks to not focus solely on historical spending.

Center for Medicaid and CHIP Services

- Provide guidance on funding opportunities
  - Create templates for State Plan Amendments, based on previously approved activities, to create a quicker path for states to pivot towards VBP with reasonable expectation of approval
  - Guidance for states on how to use existing flexibilities
  - Develop State Medicaid Director letter on Section 1115 demonstrations that focus on accountable care in the safety net.
    - Provide insights on applicant approval and denial decisions for Section 1115 demonstrations with strategies and specific provisions for advancing safety net accountable care
  - Consider approaches to issue guidance for directed payments.
  - Issue State Medicaid Director letters to guide implementation efforts based on CMS experience to date. For instance, guidance for states could clarify VBP contracting targets and how to provide more timely access to data.
  - Include in state plan preprint requirement that states indicate how they will promote coordination across safety net providers.

APPENDIX B: RECOMMENDATIONS BY FEDERAL AND STATE AGENCIES

- Issue New Medicaid Managed Care Rules to encourage care coordination and VBP participation
  - Propose new Medicaid Managed Care rules to allow states to provide more direction to health plans on plan expenditures, to increase financial support for faster progress on accountable care (e.g., directed support for coordination-related activities or addressing social needs, or guidance and clarity on aligning provider and plan incentives)
  - Require MCOs to use aligned VBP models or features, where standard approaches exist and plan differentiation is administratively burdensome
  - Monitor and take steps to encourage that incentives are shared. For instance, health system incentives for better care (e.g., decreased rehospitalization) could flow to hospitals and primary care/behavioral health care providers managing post-discharge care.
- Direct state contracting strategies to encourage care coordination and VBP participation
  - Encourage and provide guidance to Medicaid agencies on sharing essential patient data (e.g., design MCO contracts to better facilitate VBP participation by, for instance, clarifying data sharing arrangements between MCOs and providers)
  - Consider more specific guidance on how states select MCOs to encourage accountable care in the safety net. For instance, CMS could direct state agencies to require or create incentives for MCOs to meet specific performance metrics that promote coordination across the safety net (e.g., timely access to ADT feeds) or measures tied to improving population health outcomes in underserved communities.
  - CMS could consider ways to leverage readiness review for waiver approval to promote VBP activities across safety net providers (e.g., assessing MCO ability to share member eligibility files and claims data in timely fashion with providers).
  - Require states to incorporate measures of care coordination in annual MCO performance assessment, as part of federal regulations stipulating states set forth minimum oversight activities of health plans

Center for Medicare

- Align technical elements of MSSP with other CMS/CMMI models.
  - See above – includes attribution, risk adjustment, benchmarking, and performance measures.
- Modify Medicare Advantage incentives/requirements to support capability development
  - For instance, modify STARS incentives and/or plan requirements to improve safety net care and equity, and to support provider alternative payment models

Consumer Information and Insurance Oversight

- Identify opportunities to align Marketplace plans with CMS-led reforms for safety net providers
  - For instance, identifying ways to leverage essential community provider requirements to promote VBP

HRSA, SAMHSA, CDC

- Clarify and align grants for developing workforce, data infrastructure, other capabilities, where their statutory purposes are similar or complementary
  - Review existing grants that can be used to support providers in developing the capabilities necessary to succeed in VBP (particularly around workforce support and accessing upfront capital)
  - Increase awareness of opportunities where alignment has already occurred (HHS led a whole-of-government approach to align 35 federal agencies on the seven vital conditions for health as a framework to guide health equity efforts)

APPENDIX B: RECOMMENDATIONS BY FEDERAL AND STATE AGENCIES

- To the extent possible under current law, align application processes, permissible uses, and reporting requirements that shift toward aligned population impact goals. For example, CDC and HRSA developed an Integrated HIV Prevention and Care Plan for HIV/AIDS funding that satisfies the joint review of both agencies while acknowledging statutory/legislative constraints.
- Expand allowable uses of grant funding to support building capacities for accountable care that are aligned with the grant goals (e.g., HUD funded shelters that produce timely "ADT-style" notifications of admits and discharge, to help assure effective use of such shelters to improve housing status).

- Identify opportunities to directly link grant, supplemental payment, and non-clinical-services funder streams with the goals of VBP.
  - For instance, link technology infrastructure grants for safety net providers to the adoption of population health and care coordination technology to help reduce the burden with participating in value-based payments

State Medicaid Agencies

- Direct Medicaid managed care plans to drive VBP initiatives
  - Incorporate measures of longitudinal care coordination in annual MCO performance assessment as part of federal regulations stipulating states set forth minimum oversight activities of health plans
  - Contracts could include specific performance metrics that promote coordination across the safety net (e.g., timely access to ADT feeds) or measures tied to population health outcomes

- Align federal and state funding around shared objectives
  - States can also take the initiative to integrate federal and state payment programs with shared objectives (e.g., New York's Medicaid Payment Reform Roadmap[77] which proposed allowing Medicaid members to enroll in CMS-sponsored VBP models)

- Promote integration with social and community partners
  - States can provide infrastructure support to help link social services with health system partners (e.g., NC InCK, Medicaid Healthy Opportunities Pilots)
  - Incorporate incentives for plans to partner with CBOs
  - Develop state-led regional partnerships (e.g., New York "Performing Provider Systems" and Section 1115 waiver created a coordinated network for CBOs)
  - Support platforms such as Community Care Hubs and Accountable Health Communities to serve as coordinating entities for disparate funding sources (federal, state, local, and private) and build community partnerships that link patients with community-based resources (e.g., HUD, workforce development dollars)

CITATIONS

1. Brooks-LaSure C, Fowler E, Seshamani M, Tsai D. Innovation At The Centers For Medicare And Medicaid Services: A Vision For The Next 10 Years. *Health Aff Forefr.* doi:10.1377/forefront.20210812.211558
2. Hughes DL. CMS Innovation Center Launches New Initiative To Advance Health Equity. *Health Aff Forefr.* doi:10.1377/forefront.20220302.855616
3. Chappel A, Cronin K, Kulinski K, et al. Improving Health And Well-Being Through Community Care Hubs. *Health Aff Forefr.* doi:10.1377/forefront.20221123.577877
4. Nocon RS, Lee SM, Sharma R, et al. Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings. *Am J Public Health.* 2016;106(11):1981-1989. doi:10.2105/AJPH.2016.303341
5. Sarkar U, Chen AH. Beyond Survival To Transformation: Investing In Safety-Net Innovation To Address The Impacts Of COVID-19. *Health Aff Forefr.* Accessed March 16, 2023. https://www.healthaffairs.org/do/10.1377/forefront.20201001.259533/full/
6. Wang S, Gonzalez-Smith J, Smith C, et al. Value-Based Care And A Path To Achieve Comprehensive Care In The Safety-Net. *Health Aff Forefr.* doi:10.1377/forefront.20230227.974107
7. Liao JM, Navathe AS, Werner RM. The Impact of Medicare's Alternative Payment Models on the Value of Care. *Annu Rev Public Health.* 2020;41:551-565. doi:10.1146/annurev-publhealth-040119-094327
8. Bhatia J, Tobey R, Hochman M. Value-Based Payment Models for Community Health Centers: Time to (Cautiously) Take the Plunge? *JAMA.* 2017;317(22):2275-2276. doi:10.1001/jama.2017.5174
9. McCullough J, Natasha Coult MS, Michael Genau MS, Ajay Raikhelkar MS, Kailey Love MBA, William Riley P. Safety Net Representation in Federal Payment and Care Delivery Reform Initiatives. 2019;7. Accessed March 16, 2023. https://www.ajmc.com/view/safety-net-representation-in-federal-payment-and-care-delivery-reform-initiatives
10. Gabow PA, Smith M. Separate or United: The Safety Net in the Era of Health Care Integration. *J Health Care Poor Underserved.* 2017;28(3):853-859. doi:10.1353/hpu.2017.0082
11. Murphy J, Ko M, Kizer KW, Bindman AB. Safety Net Integration: A Shared Strategy for Becoming Providers of Choice. *J Health Polit Policy Law.* 2015;40(2):403-419. doi:10.1215/03616878-2882267
12. Browning L, Minnes K. The Next Generation of Paying for Value in Medicaid. The Commonwealth Fund. Published October 11, 2018. Accessed March 16, 2023. https://www.commonwealthfund.org/blog/2018/next-generation-paying-value-medicaid
13. Melek SP, Davenport S, Gray TJ. Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement. *Ment Health Treat Res Inst Milliman Res Rep.* Published online November 19, 2019.
14. Centers for Medicare & Medicaid Services. Calendar Year (CY) 2023 Medicare Physician Fee Schedule Final Rule - Medicare Shared Savings Program | CMS. CMS.gov. Published 2022. Accessed March 16, 2023. https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-final-rule-medicare-shared-savings-program
15. How Are Payment Reforms Addressing Social Determinants of Health? Policy Implications and Next Steps. Milbank Memorial Fund. Accessed March 16, 2023. https://www.milbank.org/publications/how-are-payment-reforms-addressing-social-determinants-of-health-policy-implications-and-next-steps/
16. Hersey C, Wiecha N, Greenwald L, Kissam S. Medicaid ACOs and Managed Care: A Tale of 2 States. 2022;10. Accessed March 16, 2023. https://www.ajmc.com/view/medicaid-acos-and-managed-care-a-tale-of-2-states
17. Centers for Medicare & Medicaid Services. Strategic Direction. Strategic Direction. Published July 5, 2022. Accessed August 5, 2022. https://innovation.cms.gov/strategic-direction
18. New Jersey Department of Health. *Maternal and Child Health Services Title V Block Grant: State Narrative for New Jersey MCH Block Grant.;* 2022. https://www.nj.gov/health/fhs/maternalchild/documents/MCH%20block%20grant/MCH-BG_NarGL070722.pdf
19. Oregon Health Authority. *Value-Based Payment Roadmap for Coordinated Care Organizations.;* 2019. https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-CCO-VBP-Roadmap.pdf
20. Kaye N. Massachusetts Fosters Partnerships Between Medicaid Accountable Care and Community Organizations to Improve Health Outcomes. NASHP. Published March 12, 2021. Accessed March 16, 2023. https://nashp.org/massachusetts-fosters-partnerships-between-medicaid-accountable-care-and-community-organizations-to-improve-health-outcomes/
21. Khullar D, Song Z, Chokshi DA. Safety-Net Health Systems At Risk: Who Bears The Burden Of Uncompensated Care? *Health Aff Forefr.* doi:10.1377/forefront.20180503.138516
22. Garthwaite C, Gross T, Notowidigdo MJ. Hospitals as Insurers of Last Resort. *Am Econ J Appl Econ.* 2018;10(1):1-39. doi:10.1257/app.20150581

CITATIONS

23. Karpman M, Coughlin TA, Garfield R, 2021. Declines in Uncompensated Care Costs for The Uninsured under the ACA and Implications of Recent Growth in the Uninsured Rate. KFF. Published April 6, 2021. Accessed March 16, 2023. https://www.kff.org/uninsured/issue-brief/declines-in-uncompensated-care-costs-for-the-uninsured-under-the-aca-and-implications-of-recent-growth-in-the-uninsured-rate/
24. Roiland RA, Singletary EA, Saunders RS, et al. Alternative Payment Models to Support Child Health & Development: How to Design and Implement New Models. In: ; 2020.
25. Tobey R, Maxwell J, Turer E, et al. Health Centers and Value-Based Payment: A Framework for Health Center Payment Reform and Early Experiences in Medicaid Value-Based Payment in Seven States. *Milbank Q.* 2022;100(3):879-917. doi:10.1111/1468-0009.12580
26. Health Resources and Services Administration. Chapter 20: Board Composition. In: *Health Center Program Compliance Manual. ;* 2018. Accessed March 16, 2023. https://bphc.hrsa.gov/compliance/compliance-manual/chapter20
27. Timbie JW, Kranz AM, Mahmud A, Setodji CM, Damberg CL. Federally Qualified Health Center Strategies for Integrating Care with Hospitals and Their Association with Measures of Communication. *Jt Comm J Qual Patient Saf.* 2019;45(9):620-628. doi:10.1016/j.jcjq.2019.06.004
28. Norden J, Ostrovsky A, Shah NR. How Startups And Medicaid Can Collaborate To Improve Patient Outcomes. *Health Aff Forefr.* doi:10.1377/forefront.20230223.536947
29. Bleser WK, Tchuisseu YP, Shen H, et al. ACO REACH And Advancing Equity Through Value-Based Payment, Part 2. *Health Aff Forefr.* doi:10.1377/forefront.20220517.755520
30. Centers for Medicare & Medicaid Services. Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model | CMS. CMS.gov. Published 2022. Accessed March 16, 2023. https://www.cms.gov/newsroom/fact-sheets/accountable-care-organization-aco-realizing-equity-access-and-community-health-reach-model
31. Sheingold S, Zuckerman R, DeLew N, Sommers BD. Health Equity And Value-Based Payment Systems: Moving Beyond Social Risk Adjustment. *Health Aff Forefr.* doi:10.1377/forefront.20210726.546811
32. Bleser WK, Tchuisseu YP, Shen H, Thoumi A, Kaye DR, Saunders RS. Advancing Equity Through Value-Based Payment: Implementation And Evaluation To Support Design Goals. *Health Aff Forefr.* doi:10.1377/forefront.20221103.813959
33. Institute of Medicine (US) Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers. *Americas's Health Care Safety Net: Intact but Endangered.* (Ein Lewin M, Altman S, eds.). National Academies Press (US); 2000. Accessed March 16, 2023. http://www.ncbi.nlm.nih.gov/books/NBK224523/
34. Mann C, Lipson M. CMS' New Policy Framework for Section 1115 Medicaid Demonstrations. The Commonwealth Fund. doi:10.26099/nb7g-3c10
35. Centers for Medicare & Medicaid Services. HHS Approves Groundbreaking Medicaid Initiatives in Massachusetts and Oregon | CMS. CMS.gov. Published 2022. Accessed March 17, 2023. https://www.cms.gov/newsroom/press-releases/hhs-approves-groundbreaking-medicaid-initiatives-massachusetts-and-oregon
36. Centers for Medicare & Medicaid Services. *State Plan Amendment Transmittal #17-043.;* 2018. https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OH/OH-17-043.pdf
37. Centers for Medicare & Medicaid Services. State Plan Amendment Transmittal #15-0015.; 2016. https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MN/MN-15-15.pdf
38. Center for Medicaid and CHIP Services. RE: Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP). Published online 2021. https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf
39. Hinton E, Raphael J, 2023. 10 Things to Know About Medicaid Managed Care. KFF. Published March 1, 2023. Accessed March 16, 2023. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/
40. Guidehouse. Most States Require Managed Care Organizations to Implement VBP Models with Providers. Published 2022. Accessed March 16, 2023. https://guidehouse.com/insights/healthcare/2022/blogs/managed-care-implement-vbp-models?lang=en
41. Wise N, Campbell K. Tennessee Medicaid's Health Starts Provider Partnerships. Milbank Memorial Fund. Accessed March 17, 2023. https://www.milbank.org/publications/tennessee-medicaids-health-starts-provider-partnerships/
42. Japinga M, Tchuisseu YP, Saunders R, McClellan M. A Path Forward for Multipayer Alignment to Achieve Comprehensive, Equitable, and Affordable Care. Margolis Center for Health Policy. Accessed March 16, 2023. https://healthpolicy.duke.edu/publications/path-forward-multipayer-alignment-achieve-comprehensive-equitable-and-affordable-care
43. National Academy of Medicine. Multi-Payer Alignment on Value-Based Care. Published 2022. https://nam.edu/programs/value-science-driven-health-care/multi-payer-alignment-on-value-based-care/

CITATIONS

44. Pandemic-Driven Health Policies To Address Social Needs And Health Equity | Health Affairs Brief. Accessed March 16, 2023. https://www.healthaffairs.org/do/10.1377/hpb20220210.360906/full/
45. Office of Disease Prevention and Health Promotion. Announcing the Federal Plan for Equitable Long-Term Recovery and Resilience. Published 2022. https://health.gov/news/202211/announcing-federal-plan-equitable-long-term-recovery-and-resilience
46. Federal Transit Administration. Coordinating Council on Access and Mobility. United States Department of Transportation. Published 2022. Accessed March 16, 2023. https://www.transit.dot.gov/coordinating-council-access-and-mobility
47. National Association of Chronic Disease Directors. Umbrella Hub Arrangement Overview. National DPP Coverage Toolkit. Published 2023. Accessed March 16, 2023. https://coveragetoolkit.org/umbrella-hub-arrangements/uha-overview/
48. United States Environmental Protection Agency. Partnership for Sustainable Communities: Supporting Environmental Justice and Equitable Development. US EPA. Published 2014. Accessed March 16, 2023. https://www.epa.gov/smartgrowth/partnership-sustainable-communities-supporting-environmental-justice-and-equitable
49. Ryan White HIV/AIDS Program. Integrated HIV Prevention and Care Plan Guidance, CY 2022-2026 Frequently Asked Questions. Health Resources & Services Administration. Accessed March 17, 2023. https://ryanwhite.hrsa.gov/grants/program-letters/integrated-hiv-prevention-care-plan-guidance-faq
50. Tsai D. United States Department of Agriculture (USDA) Demonstration Project to Evaluate Using Medicaid Eligibility Data to Directly Certify Children for Free and Reduced Price School Meals. USDA Food and Nutrition Service. Published 2021. Accessed March 16, 2023. https://www.fns.usda.gov/cn/usda-demonstration-project-evaluate-using-medicaid-eligibility-data-directly-certify
51. Centers for Medicare & Medicaid Services. CMS Releases 2023 Medicare Advantage and Part D Advance Notice. CMS.gov. Published 2022. Accessed March 17, 2023. https://www.cms.gov/newsroom/press-releases/cms-releases-2023-medicare-advantage-and-part-d-advance-notice
52. Capital Link. *Federally Qualified Health Centers Financial and Operational Performance Analysis 2018-2021.;* 2022. https://caplink.org/fqhc-analysis-2022
53. Washington State Health Care Authority. Accountable Communities of Health (ACHs). Accessed March 17, 2023. https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp/accountable-communities-health-achs
54. Legal Information Institute. 42 U.S. Code § 254b - Health centers. Cornell Law School. Accessed March 16, 2023. https://www.law.cornell.edu/uscode/text/42/254b
55. Rozier M, Enard K. Leveraging Community Benefit To Increase Health Care Value. *Health Aff Forefr.* doi:10.1377/forefront.20220519.808327
56. Trinity Health. Investing in our Communities: Community Impact at Trinity Health. Accessed March 16, 2023. https://www.trinity-health.org/our-impact/community-health-and-well-being/investing-in-our-communities
57. Mathews AW, McGinty T, Evans M. Big Hospitals Provide Skimpy Charity Care—Despite Billions in Tax Breaks. *Wall Street Journal.* https://www.wsj.com/articles/nonprofit-hospitals-vs-for-profit-charity-care-spending-11657936777. Published July 25, 2022. Accessed March 16, 2023.
58. Jacobs DB, Schreiber M, Seshamani M, Tsai D, Fowler E, Fleisher LA. Aligning Quality Measures across CMS — The Universal Foundation. *N Engl J Med.* 2023;388(9):776-779. doi:10.1056/NEJMp2215539
59. Rowen NP, Stekelenburg BV, Nohria R, Saunders RS, Whitaker RG. How To Improve Race, Ethnicity, And Language Data And Disparities Interventions. *Health Aff Forefr.* doi:10.1377/forefront.20220912.464083
60. CMS Office of Minority Health. *The Path Forward: Improving Data to Advance Health Equity Solutions.;* 2022. https://www.cms.gov/files/document/path-forwardhe-data-paper.pdf
61. National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. PRAPARE Implementation and Action Toolkit. PRAPARE. Published 2022. Accessed March 16, 2023. https://prapare.org/wp-content/uploads/2022/09/Full-Toolkit_June-2022_Final.pdf
62. Centers for Medicare & Medicaid Services. *CMS Framework for Health Equity 2022-2032.;* 2022. https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf
63. Zhang Y, Koru G. Understanding and detecting defects in healthcare administration data: Toward higher data quality to better support healthcare operations and decisions. *J Am Med Inform Assoc JAMIA.* 2019;27(3):386-395. doi:10.1093/jamia/ocz201
64. Beaton T. Poor Data Quality in CA Medicaid Drives $4B in Improper Payments. HealthPayerIntelligence. Published 2018. Accessed March 16, 2023. https://healthpayerintelligence.com/news/poor-data-quality-in-ca-medicaid-drives-4b-in-improper-payments

CITATIONS

65. Centers for Medicare & Medicaid Services. CMS Takes Historic Steps to Increase Public Access to Medicaid and CHIP Data. Published 2019. Accessed March 16, 2023. https://www.cms.gov/newsroom/press-releases/cms-takes-historic-steps-increase-public-access-medicaid-and-chip-data
66. Improving Medicaid Data To Advance Racial And Ethnic Health Equity In The United States | Health Affairs. Accessed March 16, 2023. https://www.healthaffairs.org/do/10.1377/forefront.20220517.465853
67. Centers for Medicare & Medicaid Services. Policies and Technology for Interoperability and Burden Reduction | CMS. CMS.gov. Accessed March 16, 2023. https://www.cms.gov/regulations-and-guidance/guidance/interoperability/index
68. Centers for Medicare & Medicaid Services. CMS Proposes Rule to Expand Access to Health Information and Improve the Prior Authorization Process | CMS. CMS.gov. Published 2022. Accessed March 16, 2023. https://www.cms.gov/newsroom/press-releases/cms-proposes-rule-expand-access-health-information-and-improve-prior-authorization-process
69. Sadler C, Park C. Better Data Sharing for Benefits Delivery. New America. Published 2022. Accessed March 16, 2023. http://newamerica.org/oti/briefs/better-data-sharing-for-benefits-delivery/
70. Change Healthcare. *Value-Based Care in America: State-by-State.;* 2019. https://www.changehealthcare.com/insights/value-based-reimbursement-by-state
71. Center for Medicaid and CHIP Services. State Plan Amendment (SPA) ME-22-0013. Published online 2022. https://www.medicaid.gov/medicaid/spa/downloads/ME-22-0013.pdf
72. Pennsylvania Department of Human Services. *HealthChoices Physical Health Agreement.;* 2021. https://www.dhs.pa.gov/HealthChoices/HC-Services/Documents/HC%20Agreement%202021.pdf
73. Georgia Department of Community Health. State Directed Payment Programs. Georgia Department of Community Health. Accessed March 16, 2023. https://dch.georgia.gov/programs/state-directed-payment-programs
74. North Carolina Department of Health and Human Services. *North Carolina's Medicaid Managed Care Quality Strategy.;* 2021. https://medicaid.ncdhhs.gov/media/9968/download?attachment
75. DORA Division of Insurance. Colorado Alternative Payment Model (APM) Alignment Initiative. Accessed March 17, 2023. https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/colorado-alternative-payment-model
76. California's Marketplace Innovations: Driving Health Plan Accountability For Quality And Equity | Health Affairs. Accessed March 16, 2023. https://www.healthaffairs.org/content/forefront/california-s-Marketplace-innovations-driving-health-plan-accountability-quality-and
77. New York State Department of Health. A Path toward Value Based Payment: Annual Update. Published 2016. Accessed March 16, 2023. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/1st_annual_update_nystate_roadmap.htm
78. Kaiser Family Foundation. Medicaid-to-Medicare Fee Index. KFF. Published 2017. Accessed March 16, 2023. https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/
79. U.S. Department of Health & Human Services. HHS Approves California's Medicaid and Children's Health Insurance Plan (CHIP) Demonstration Authority to Support Care for Justice-Involved People. HHS.gov. Published January 26, 2023. Accessed March 16, 2023. https://www.hhs.gov/about/news/2023/01/26/hhs-approves-californias-medicaid-and-childrens-health-insurance-plan.html
80. Institute for Medicaid Innovation. *Annual Medicaid MCO Survey.;* 2022. https://medicaidinnovation.org/_images/content/IMI-Medicaid-MCO_Survey-2022.pdf
81. Medicaid and CHIP Payment and Access Commission. *Medicaid Base and Supplemental Payments to Hospitals.;* 2022. https://www.macpac.gov/wp-content/uploads/2022/05/Base-and-supplemental-payments-to-hospitals.pdf
82. Chatterjee P, Sinha S, Reszczynski O, Amin A, Schpero WL. Variation And Changes In The Targeting Of Medicaid Disproportionate Share Hospital Payments. Health Aff (Millwood). 2022;41(12):1781-1789. doi:10.1377/hlthaff.2022.00153
83. Medicare Payment Advisory Commission. Supporting safety-net providers. In: *Report to the Congress: Medicare and the Health Care Delivery System.;* 2022. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch3_MedPAC_Report_to_Congress_SEC.pdf
84. Dickson E, Purves S, Shields C. To Protect America's Safety-Net Hospitals, Establish A New Federal Designation. *Health Aff Forefr.* doi:10.1377/forefront.20220930.780363
85. Bleser WK, Tchuisseu YP, Shen H, et al. ACO REACH And Advancing Equity Through Value-Based Payment, Part 1. *Health Aff Forefr.* doi:10.1377/forefront.20220513.630666
86. Jacobs D, Rawal P, Fowler L, Seshamani M. Expanding Accountable Care's Reach among Medicare Beneficiaries. *N Engl J Med.* 2022;387(2):99-102. doi:10.1056/NEJMp2202991

CITATIONS

87. Kaiser Family Foundation. Community Health Center Revenues by Payer Source. KFF. Published December 5, 2022. Accessed March 16, 2023. https://www.kff.org/other/state-indicator/community-health-center-revenues-by-payer-source/

88. Health Resources and Services Administration. Rural Health Care Coordination Program. Accessed March 16, 2023. https://www.hrsa.gov/grants/find-funding/HRSA-20-030

89. Health Resources and Services Administration. Telehealth Technology-Enabled Learning Program. Accessed March 16, 2023. https://www.hrsa.gov/grants/find-funding/HRSA-21-107

90. Medicaid Enterprise Reuse. Medicaid.gov. Accessed March 16, 2023. https://www.medicaid.gov/medicaid/data-systems/medicaid-enterprise-reuse/index.html

91. Center for Medicaid, CHIP and Survey & Certification. Re: Use of administrative funds to support health information exchange as part of the Medicaid EHR Incentive Program. Published online 2011. https://downloads.cms.gov/cms-gov/archived-downloads/SMDL/downloads/SMD11004.pdf

92. Health Resources and Services Administration. FY 2023 Service Area Competition (SAC) and Service Area Competition Additional Areas (SAC-AA). Accessed March 17, 2023. https://bphc.hrsa.gov/funding/funding-opportunities/service-area-competition

93. U.S. Department of Health & Human Services. HHS Announces National Competition to Spark Innovation that Will Improve Patient Access to Primary Care. HHS.gov. Published June 9, 2022. Accessed March 16, 2023. https://www.hhs.gov/about/news/2022/06/09/hhs-announces-national-competition-spark-innovation-will-improve-patient-access-primary-care.html

94. Health Resources and Services Administration. Small Rural Hospital Improvement Program (SHIP). Accessed March 16, 2023. https://www.hrsa.gov/grants/find-funding/HRSA-23-033

95. Health Resources and Services Administration. School-Based Service Expansion. Accessed March 16, 2023. https://bphc.hrsa.gov/funding/funding-opportunities/school-based-service-expansion

96. Centers for Medicare & Medicaid Services. ACO Investment Model. CMS.gov. Accessed March 16, 2023. https://cmmicoordinator.survey.fm/was-this-helpful?iframe=https%3A%2F%2Finnovation.cms.gov%2Finnovation-models%2Faco-investment-model&ft=1

97. Connolly G. *Consolidated Appropriations Act,* 2023.; 2022. https://www.congress.gov/bill/117th-congress/house-bill/2617

98. Patient-Centered Primary Care Collaborative. CareFirst Patient-Centered Medical Home - DC. Primary Care Collaborative. Published 2014. Accessed March 16, 2023. https://www.pcpcc.org/initiative/carefirst-patient-centered-medical-home-dc?language=en

99. Substance Abuse and Mental Health Services Administration. *Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics.* https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria-2022.pdf

100. U.S. Department of Agriculture. Community Facilities Direct Loan & Grant Program. Rural Development. Published January 8, 2015. Accessed March 16, 2023. https://www.rd.usda.gov/programs-services/community-facilities/community-facilities-direct-loan-grant-program

101. Health and Human Services Department. Funding opportunities. telehealth.hhs.gov. Accessed March 16, 2023. https://telehealth.hhs.gov/funding-opportunities

102. Centers for Disease Control and Prevention. Funding: Social Determinants of Health Accelerator Plans. Centers for Disease Control and Prevention. Published November 3, 2022. Accessed March 16, 2023. https://www.cdc.gov/populationhealth/sdoh/funding/SocialDeterminantsOfHealth-NOFO-CDC-RFA-DP22-2210.htm

103. Sim SC, Ducas A. How Two Funders Collaborated To Address Challenges In The Safety Net And Rural Health Care. *Health Aff Forefr.* doi:10.1377/forefront.20210623.547825

104. Health Resources and Services Administration. Teaching Health Center Graduate Medical Education (THCGME) Program | Bureau of Health Workforce. Accessed March 16, 2023. https://bhw.hrsa.gov/funding/apply-grant/teaching-health-center-graduate-medical-education

105. Hinton E, Stolyar L, 2021. Medicaid Authorities and Options to Address Social Determinants of Health (SDOH). KFF. Published August 5, 2021. Accessed March 16, 2023. https://www.kff.org/medicaid/issue-brief/medicaid-authorities-and-options-to-address-social-determinants-of-health-sdoh/

106. Trust for America's Health. *Braiding and Blending Funds to Support Community Health Improvement: A Compendium of Resources and Examples.;* 2018. https://www.tfah.org/wp-content/uploads/2018/01/TFAH-Braiding-Blending-Compendium-FINAL.pdf

CITATIONS

107. Sustaining A No Wrong Door System. No Wrong Door. Accessed March 16, 2023. https://nwd.acl.gov/sustaining-a-nwd-system.html

108. Center for Medicaid and CHIP Services. *State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval.;* 2022. https://www.medicaid.gov/medicaid/downloads/mce-checklist-state-user-guide.pdf

109. Center for Medicaid and CHIP Services. Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care. Published online 2023. https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf

110. California Department of Health Care Services. California Advancing and Innovating Medi-Cal (CalAIM) Community Supports for Social Drivers of Health. https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-CS-a11y.pdf

111. National Association of Community Health Centers. *NACHC Payment Reform Readiness Assessment Tool.;* 2018. https://www.nachc.org/wp-content/uploads/2015/11/NACHC_PR_ReadinessAssessmentTool_Final_CORRECTED_8.5.2014-2.pdf

112. Washington State Health Care Authority. *Paying for Health and Value: Health Care Authority's Long-Term Value-Based Purchasing Roadmap,* 2022-2025.; 2020. https://www.hca.wa.gov/assets/program/vbp-roadmap.pdf

113. Commonwealth of Massachusetts. Capacity Building for Accountable Care Organizations, Community Partners, and Providers | Mass.gov. Mass.gov. Accessed March 16, 2023. https://www.mass.gov/info-details/capacity-building-for-accountable-care-organizations-community-partners-and-providers

114. Health Information Technology Training and Technical Assistance Center. The HITEQ Center. Accessed March 16, 2023. https://hiteqcenter.org/

115. NextGen Healthcare. NextGen Healthcare Launches First-of-its-Kind Nationwide Community Health Collaborative to Advance Health Equity Among Underserved Populations. Published 2021. Accessed March 16, 2023. https://nextgen.com/company/newsroom/press-release/nextgen-healthcare-launches-first-its-kind-nationwide-community

116. De Lew N, Sommers BD. Addressing Social Determinants of Health in Federal Programs. JAMA Health Forum. 2022;3(3):e221064-e221064. doi:10.1001/jamahealthforum.2022.1064

117. ACL Announces Selected Participants of the Community Care Hub National Learning Community. Published 2022. Accessed March 16, 2023. https://acl.gov/news-and-events/announcements/acl-announces-selected-participants-community-care-hub-national

118. Centers for Medicare & Medicaid Services. *Medicare Shared Savings Program Advance Investment Payments (AIP) Roles for Community Based Organizations.* https://www.cms.gov/files/document/mssp-aip-glance-cbos.pdf

119. Rhode Island Department of Health. *Health Equity Zones (HEZs).* https://health.ri.gov/publications/guides/HEZLeads.pdf

120. Centers for Medicare & Medicaid Services. Accountable Health Communities Model. CMS.gov. Accessed March 16, 2023. https://innovation.cms.gov/innovation-models/ahcm

121. Healthy Opportunities Pilot. Impact Health. Accessed March 16, 2023. https://impacthealth.org/healthy-opportunities-pilot/

122. Byhoff E, Taylor LA. Massachusetts Community-Based Organization Perspectives on Medicaid Redesign. *Am J Prev Med.* 2019;57(6):S74-S81. doi:10.1016/j.amepre.2019.07.017

123. New York State Department of Health Office of Health Insurance Programs. *1115 Waiver Demonstration: Conceptual Framework - A Federal-State Partnership to Address Health Disparities Exacerbated by the COVID-19 Pandemic.;* 2021. https://www.health.ny.gov/health_care/medicaid/redesign/2021/2021-08_1115_waiver_concept_paper.htm

124. New York State Department of Health. *A Path toward Value Based Payment: Annual Update, New York State Roadmap for Medicaid Payment Reform.;* 2019. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2020/docs/2019-09_final_vbp_roadmap.pdf

125. California Department of Health Care Services. Request for Proposal #20-10029. Accessed March 17, 2023. https://www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/CSBmcodmcpHOME.aspx

126. Crumley D, Bank A. Financing Approaches to Address Social Determinants of Health via Medicaid Managed Care: A 12-State Review. Center for Health Care Strategies. Accessed March 16, 2023. https://www.chcs.org/resource/financing-approaches-to-address-social-determinants-of-health-via-medicaid-managed-care-a-twelve-state-review/

127. Accountable Care In 2023: Evolving Terminology, Current State, And Priorities | Health Affairs. Accessed March 17, 2023. https://www.healthaffairs.org/content/forefront/accountable-care-2023-evolving-terminology-current-state-and-priorities

128. Health Care Payment Learning & Action Network. Accountable Care. Health Care Payment Learning & Action Network. Accessed March 17, 2023. https://hcp-lan.org/accountable-care-commitment-curve/

129. Ash A, Mick E. UMass Risk Adjustment Project for MassHealth Payment and Care Delivery Reform: Describing the 2017 Payment Model. UMass Medical School Center for Health Policy and Research; 2016. https://www.mass.gov/doc/umass-modeling-sdh-summary-report-3/download