Colorado Multi-Payer Collaborative: Lessons Learned for Primary Care Improvement

APRIL 2023

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Milbank Memorial Fund

Executive Summary

The Colorado Multi-Payer Collaborative (MPC) was a voluntary association of health care payers that convened from 2012 through 2021 to coordinate efforts to improve primary care and reform health care payment in the state. As part of the MPC, members participated in federal primary care transformation initiatives such as Comprehensive Primary Care (CPC), Comprehensive Primary Care Plus (CPC+), and the Colorado version of the State Innovation Model (SIM).

Over the course of the 10-year collaboration, the MPC developed a collegial culture for the exchange of ideas, information, and perspectives on the challenges of primary care reform, along with a pragmatic, outcomes-oriented focus on health care transformation in Colorado. At the height of the MPC's activities, in 2018 to 2019, it supported more than 250 practices and nearly 2,100 individual providers across Colorado.

During their work together, MPC members initiated and participated in significant efforts to transform primary care in Colorado and lay the foundation for the transition from fee-for-service to pay-for-value care. Among other activities, the collaborative built and maintained trusted and productive relationships among public and private health care plans in Colorado; conducted two to four symposia per year where stakeholders shared innovations and lessons learned; aligned quality measures for pediatric and adult primary care; and facilitated the development of a tool (Stratus) that aggregated multi-payer claims data from health plans. A simple comparison of active and inactive Stratus users revealed that active users had 46% fewer emergency department admissions per 1,000 patients and 92% fewer 30-day readmissions.

This report summarizes observations from interviews with members of the MPC, state and federal collaborators, and health care practitioners who participated in primary care transformation initiatives undertaken by the MPC. Some of the observations and lessons learned were gleaned from a survey of providers that the MPC conducted in the spring of 2022.

Among other factors, the MPC's successes can be attributed to:

- the shared vision and values of its members;
- the use of a neutral convener and facilitator; an emphasis on communication between all levels; standardized quality data and procedures;
- the framework for whole-centered care; and
- simplified data collection.

MPC members navigated a number of significant challenges along the way, responding to evolving federal health care reform initiatives, fundamental changes in the health care market in Colorado, changes in state health care regulation and administration, and the unprecedented challenges of a global public health emergency. Although the program has ended, many Colorado practices are continuing the innovations it brought about.

LAYING THE FOUNDATION

The Colorado Multi-Payer Collaborative (MPC) was established in 2012 in response to requirements from the federal Comprehensive Primary Care (CPC) initiative, including (1) access and continuity, (2) planned care for chronic conditions and preventive care, (3) risk-stratified care management, (4) patient and caregiver engagement, and (5) coordination of care across the medical neighborhood.[1] For a decade, from 2012 through 2021, this self-funded collaborative of payer organizations brought together traditionally competing private and public health care groups to share resources, coordinate quality efforts, and align payment approaches to achieve improved outcomes and reduced costs in the Colorado primary health care market.

Founding membership included Aetna, Anthem Blue Cross Blue Shield of Colorado, the Centers for Medicare & Medicaid Services (CMS), Cigna, Colorado Access, Colorado Choice Health Plans, Health First Colorado (Medicaid), Humana, Inc., Rocky Mountain Health Plans, Teamsters Taft-Hartley Trust, UnitedHealthcare, and WellPoint. MPC membership changed over time as the Colorado marketplace evolved, and ultimately the collaborative consisted of a small number of primarily national payer organizations.

The MPC was organized with guidance, facilitation, and support from the Center for Evidence-based Policy (the Center), based at Oregon Health & Science University in Portland, Oregon. With assistance from the Center, the MPC coordinated resources and support for participating practices, including aligned metrics, technical assistance, an aggregated data platform, and other supports.

CPC sunsetted in December 2016, and MPC joined its successor, Comprehensive Primary Care Plus (CPC+), which launched on January 1, 2017, and ran through December 31, 2021. CPC+ provided medical practices with enhanced alternative payments, a robust learning system, and patient-level cost and utilization data that supported practice transformation. The MPC also met regularly to assist the Colorado State Innovation Model (SIM) office to plan and coordinate activities related to behavioral health and primary care integration. Colorado SIM operated from February 2015 through July 2019. More information on these three federal initiatives is found in Appendix A.

While heavily involved in federal initiatives, members of the Colorado Multi-Payer Collaborative also advanced their own shared efforts to transform the quality, cost, and outcomes of primary care in the state.

At the height of the MPC's practice transformation activities in 2018–2019, the collaborative supported more than 250 practices and nearly 2,100 individual providers across Colorado.

Lesson: Include both public and private payers.

Federal initiatives to transform primary care share a foundational objective of aligning the commitments and contributions of public and private payers. The fundamental value of multi-payer collaboration was readily understood and embraced in Colorado.

Judy Zerzan, former chief medical officer and deputy Medicaid director for the Colorado Department of Health Care Policy and Financing, was a member of the MPC and instrumental in the effort to include Medicaid as an active collaborative partner. Dr. Zerzan attests, "We wouldn't have been able to have a transformative impact if it had just been Medicaid. To really transform care at the clinical level there has to be a critical mass of payers."

Dr. Zerzan's observations are echoed in the final report of the Colorado State Innovation Model in July 2019: "The engagement of commercial and public payers through the Multi-Payer Collaborative in Colorado is highly valuable. This voluntary convening supported SIM practices with value-based payments and will remain Colorado's primary forum for sustaining efforts related to payment reform moving forward."[2]

A SHARED MISSION AND VALUES

Participating payers came together based on a shared commitment to increase quality, improve efficiency, gain higher value, and otherwise improve primary care in Colorado. They worked together to diffuse innovative and successful strategies to meet these goals. Rather than communicate guardedly with their competitors, the MPC's commercial members shared market intelligence with each other for the benefit of their individual organizations and the collective benefit of the MPC.

According to interviews with MPC members, the organization created a safe and nonpoliticized environment to promote practical conversation among payers. As a result, members were able to set common, consistent expectations for participating practices and providers; gain new perspectives; and foster unprecedented relationships and camaraderie among themselves. Most importantly, the MPC built and maintained trusted and productive relationships among public and private health care plans in Colorado, including Medicaid and Medicare. MPC meetings provided a safe setting for MPC members to engage in substantive discussions with state policy makers and managers on new public initiatives to advance health care reform beyond CPC and CPC+.

Individual primary care practices also felt they benefited. They shared information and experiences with this collaborative of public and commercial payers that they did not or could not

share with individual payers. In a survey, one primary care provider wrote: "Having a personal relationship with the payer partners has made me personally feel more engaged as well as more heard on issues that are critical to providers!"

Lesson: Centralize communications within one organization.

The MPC facilitated the development of consistent messages and developed talking points that reflected consensus perspectives of participating health plans. It served as a single point of access for organizations and individuals seeking the payer perspective on health care transformation.

According to Tara Smith, primary care and affordability director at the Colorado Division of Insurance, "When you look at the sequence of these initiatives [CPC and CPC+], they really did drive both payer and provider engagement in this type of health care transformation . . . [t]hat gave us the time and the space as a state to begin creating forums to really be opening lines of communication, and collaboration, and I think even at a more fundamental level, building the relationships and the trust between the entities that are involved in making these models work."[3]

Lesson: Acknowledge the risk of antitrust actions.

From its inception, the MPC recognized the need to establish a safe environment for the free exchange of ideas, while recognizing the legal and ethical limitations of collaborations involving competing payer enterprises. To these ends, the first order of business for the MPC was the establishment of an antitrust statement, followed by its recitation at the start of every meeting. The statement created necessary boundaries for successfully focusing the MPC's attention on primary care transformation.

Lesson: Use a neutral convener and facilitator.

Mindful of their pledge to avoid antitrust violations, members collectively contracted with the Center for Evidence-based Policy at Oregon Health & Science University to serve as an independent, impartial, and neutral convener and facilitator. In turn, the Center framed, shaped, guided, and facilitated their research, deliberations, and engagements. The Center served as a trusted operational partner to the MPC and an effective advocate for the contributions the MPC made. "You could not have had a payer lead this [data aggregation] effort," said Julie Turcheck, former director of UnitedHealthcare Networks Western Region. "It had to be a neutral party and [the Center Director Pam] Curtis. was really good at creating a structure and mechanism to get us to consensus."

MULTI-STAKEHOLDER SYMPOSIA: BOOSTING COMMUNICATIONS

Early in its existence, members of the MPC recognized the need to engage directly with practice representatives and collaborate on health care reform efforts. In 2014, the MPC established quarterly conference calls with a representative sample of physician leaders from across the state. In 2016, the effort expanded and the MPC launched a Multi-Stakeholder Symposia (MSS), which met in person for a full day twice per year. The MSS provided a unique and valuable opportunity for representatives from primary care practices, health plans, and other stakeholders to learn from each other, build closer partnerships, reflect on progress, discuss challenges and successes, and identify opportunities to support each other in transforming health care.

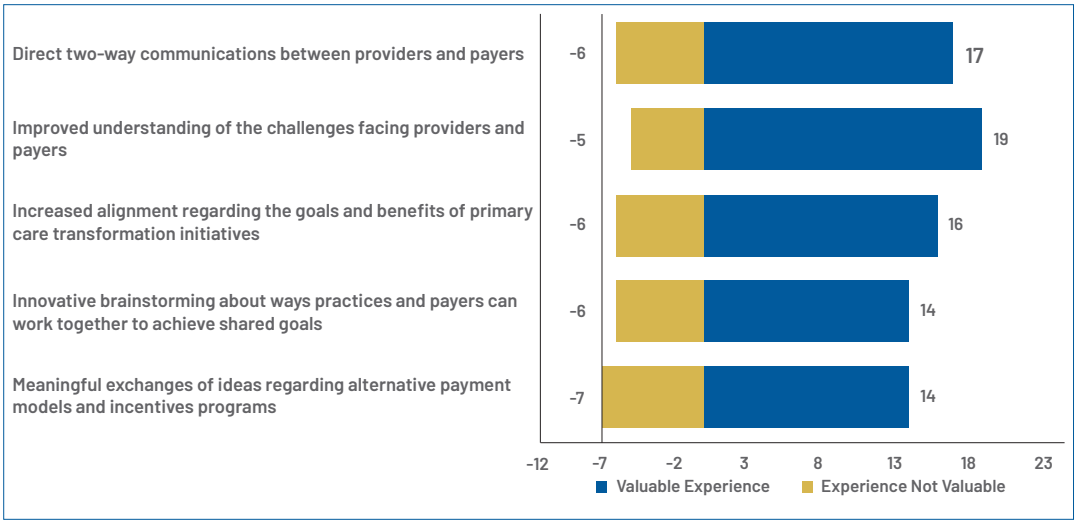
The Colorado SIM office provided the funding for the MSS and increased the meeting frequency to three symposia per year in 2018 and 2019. When the SIM initiative ended in July 2019, MPC members continued to see value in the MSS. After hearing resounding support from both CPC+ and SIM practices, along with requests for a continuing forum in which payers and practices could collaborate and share their experiences in health care transformation initiatives, the MPC funded two meetings per year to continue building on the important work begun under CPC+ and SIM. At this time, the MPC also decided to expand the group by inviting specialty practices to join.

Given public health concerns regarding COVID-19 and recognizing the need for payers and practices to focus on supporting their communities and the broader health care system, the MPC decided both the format and timing of the MSS needed to be adjusted to continue these meetings in 2020 and 2021. Supported by the Center, the MPC held one virtual multi-stakeholder symposium in each of those two years. Recognizing the significance of the moment, payers agreed the focus of these symposia should be on exploring the unique challenges and opportunities posed by the pandemic, as well as ways that payers and providers could work together to support patients and each other during the public health emergency.

The MSS served as a forum for addressing the concerns of providers and serving as a "reality check" for plans. The events provided payers with a direct line of communication with practices; decreased provider burden by coordinating expectations, information, and communication; and increased value and interest in individual payer programs from a provider perspective.

When surveyed on the value of MSS, between two-thirds and three-quarters of respondents provided affirmative scores (Figure 1). Practices particularly valued the opportunity to engage with payers to gain a better understanding of shared challenges to practice transformation. Practices were less likely to see value in the collaborative brainstorming in areas of shared goals, value-based payment models, and incentive programs.

Figure 1. Assessing the Value of Multi-Stakeholder Symposia



Despite the decision by members to close down the MPC at the end of 2021, payers and providers alike expressed a strong interest in continuing the symposia. In the MPC's concluding survey, practices and providers offered the following recommendations for future practice-payer engagements.

Lesson: Provide opportunities for individual practices to engage with payers.

Design engagements to promote honest and respectful communications to increase payer-provider understanding of each other's priorities, challenges, and abilities to make changes.

Lesson: Schedule fewer engagements, but make them more targeted.

Meetings should focus on a variety of critical issues, such as behavioral health integration; metrics that properly measure provider success in achieving transformation goals; and creating a standard set of metrics and measurements to reduce time spent on data collection and reporting. In addition, use the meetings to make tangible progress on alternative pay models that recognize the costs of care for high-risk, highly complex patients with advanced biopsychosocial needs, and pediatric care.

ALIGNMENT OF QUALITY IMPROVEMENT MEASURES AND REGULATIONS

One of the priorities of primary care transformation has been the adoption of value-based payment systems, supported by an alignment of quality measures by public and private payers. To this end, members of the MPC agreed to identify and align core quality measures for both adult and pediatric primary care. The measures are generally consistent with the core measures announced by America's Health Insurance Plans and CMS.

The MPC established aligned measures to decrease administrative burden for providers, lower the overall cost burden to consumers and the health care system, and ensure consistent high-quality care for patients. Members of the MPC used these aligned measures on a rolling basis as existing program agreements or contracts were renewed. The aligned measures were not exclusive, and some plans emphasized a subset or added measures based on their specific programs. See Appendices B and C for listings of the MPC's 13 adult primary care and 10 pediatric care quality measures.

By supporting the work of primary care providers to achieve the goals of the CPC and CPC+ initiatives, the MPC attained some success:

- In 2015, Colorado was one of four regions in the CPC program to earn shared savings by bending the cost curve while maintaining or improving key quality metrics.[4]
- During the CPC+ program, Colorado's average performance scores exceeded those of at least 9 of 13 other participating regions for three of the five program years.[5]

Lesson: Standardize reporting practices.

MPC worked with the Colorado SIM office to ensure SIM practice requirements were aligned across participating payers, as well as with CPC+, thus eliminating duplication and unnecessary reporting burdens for providers. It also facilitated the execution of necessary business associate agreements and data use agreements to aggregate claims data from participating private and public health plans and make them available at the point of care.

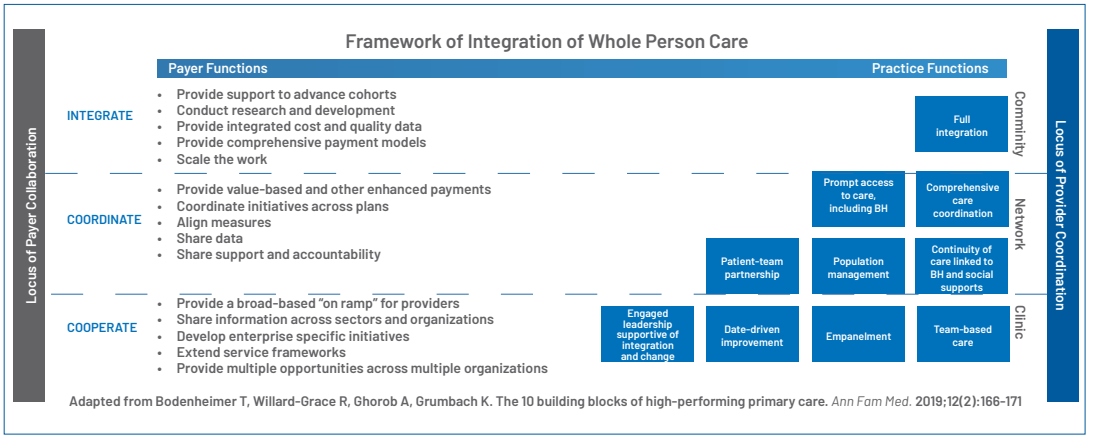
Lesson: Hire stellar navigators to work with providers.

One primary care practitioner wrote in a survey: "We had an amazing practice transformation advisor. She made SIM extremely helpful. SIM was what changed our outlook on all of the quality measures. Before SIM we honestly didn't understand how important they were."

A FRAMEWORK FOR INTEGRATED, WHOLE-PERSON CARE

The MPC developed a framework for transition to integrated whole-person care,[6] adapted from Thomas Bodenheimer and colleagues' 10 building blocks of high-performing primary care.[7] The framework establishes a shared understanding of the coordination of health care and social supports (including behavioral health) to improve individual and population health. The MPC held work sessions of payers, primary and specialty care providers, and other stakeholders to establish common definitions and milestones to guide transformation efforts to achieve whole-person care in Colorado communities. MPC members identified goals, measures, and metrics to measure transition to each of the core functions outlined by the adapted building blocks (Figure 2).

Figure 2. Framework for Integration of Whole-Person Care



To further assist practices with the integration of primary care and behavioral health, the MPC developed two summary guides: *Behavioral Health Provider Credentialing and Contracting*; and *Colorado Multi-Payer Collaborative Behavioral Health Support Programs*.

DATA AGGREGATION: IMPACT AND USE OF A DATA TOOL

In 2015, recognizing the importance of data to inform change, as well as the burden on practices to effectively use claims data across payers, the MPC developed an aggregated data tool to accelerate practice transformation. The Center assisted the MPC in developing a rigorous and transparent process to select a data aggregation tool for CPC practices. As a result, members of the MPC contracted with Rise Health, now part of Teladoc Health, to provide their Stratus data aggregation and analysis tool.[8] Before using Stratus, providers received individual reports from each payer and had to log on to several different websites to access patient data, making it cumbersome and inefficient to coordinate care outside the

clinic walls. In addition to care coordination, Stratus provided a single source for patient-level administrative information to help care providers and coordinators identify gaps in care, support care and medication management, build patient registries, and track progress on quality measures, care utilization, and costs. Financed by MPC member plans, Stratus was available free of charge to help providers manage patient and population health and view administrative data for all services a patient has received across the medical neighborhood. The tool made it possible for care providers to search and visualize data, as well as dynamically associate data to meet organizational goals for improving patient care.

Following initial implementation of Stratus, payers worked with Teladoc Health to support the inclusion of Medicare Shared Savings Program data, pilot the integration of clinical data, and incorporate tracking of adult primary and pediatric care quality measures.

In January 2018, the MPC compared clinical outcomes across a group of active Stratus users with those of inactive users. A simple comparison revealed that active Stratus users had:

- 48% fewer emergency department admissions per 1,000 patients
- 92% fewer 30-day readmissions
- 2% fewer high-cost patients
- 46% fewer in-patient stays per 1,000 patients

Additional research is needed to fully understand the causal factors driving these higher levels of performance and the role played by the availability of integrated multi-payer data.

Initially, practices were motivated to use Stratus primarily to track cost and utilization, identify care gaps, and build rosters of high-priority patients. Unfortunately, enthusiasm and usage of the Stratus tool began to fade after the first full year of operations, driven by a number of factors:

- Aggregated claims data were limited to populations served by practices participating in CPC, CPC+, and SIM. Most payers did not integrate data for the entire "book of business," such as self-insured lines of business, practices that were participating solely in payer-specific initiatives, and practices that may have been excluded from CPC+ or SIM. As a result, data analysis and reporting were limited to a small percentage of the overall panel activity of participating practices. For most practices, the analytical advantages of Stratus could not be realized without a more complete view of their entire patient population.
- Claims data were not sufficiently current to drive real-time support for clinical decision-making. Payers provided data with a three- to four-month lag, and files were updated quarterly rather than monthly. Only one payer was prepared to provide monthly updates on a consistent basis.
- The quality and quantity of aggregated data were inconsistent from one reporting quarter to the next. This issue became more pronounced as Colorado-based payers became increasingly dependent on enterprise-based data centers located outside of Colorado and subject to the national priorities of their parent companies.

- Stratus required participating providers to commit significant investments of staff time and resources. This was particularly true for individual and small group practices. Practices frequently had multiple data systems to master, including their electronic health record (EHR) system, and separate systems provided by payers for patient populations not participating in one of the initiatives. In addition, CPC+ practices used the Data Feedback Tool, a system supported by CMS. Adding Stratus to this mix provided too much information for some practices to handle. When given a choice, most practices gave their highest priority to the EHR systems, where they tracked their patients clinically and in real time.

The following findings from the MPC's concluding survey in the spring of 2022 suggest that practices and providers are still very interested in actionable data to drive practice transformation and willingly invest significant time and resources to that end, particularly through their use of EHR systems and the enterprise data reporting systems provided by individual payers.

- More than 50% of respondents surveyed following the conclusion of CPC+ reported that they or their practices dedicated more than 10 hours per week to data collection, analysis, and reporting (Figure 3).
- For nearly 70% of respondents, most of their commitment to data was focused on EHR systems at the expense of other data systems, including integrated multi-payer tools (Figure 4).

Figure 3. Weekly Commitment of Time on Data Collection, Analysis and Reporting

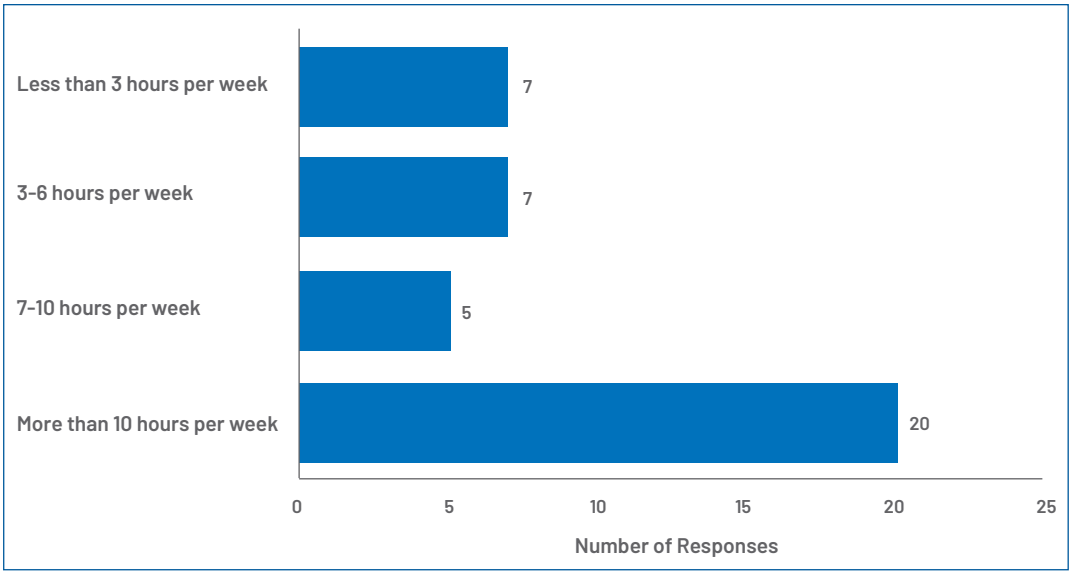
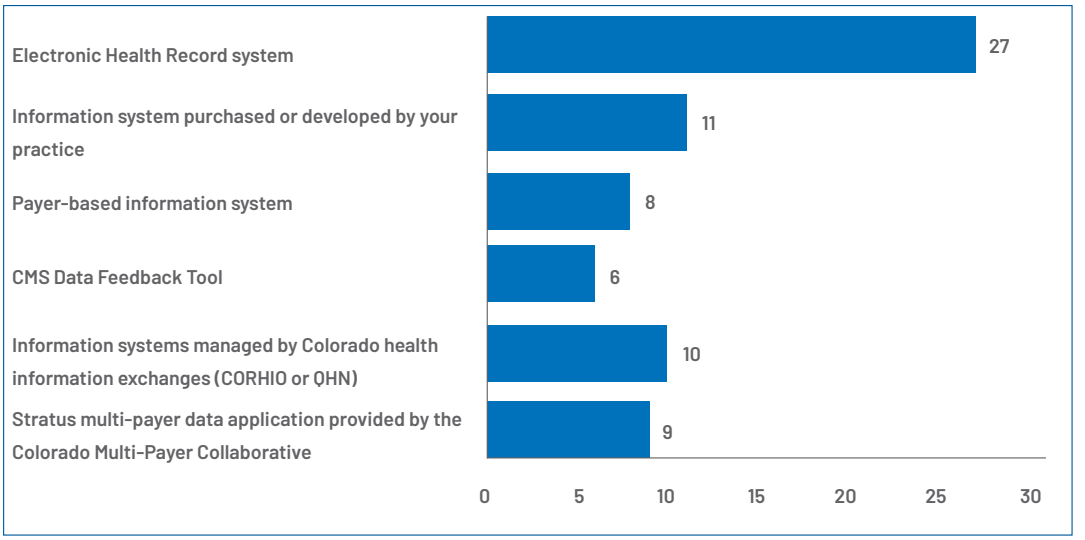


Figure 4. Information Systems Used Most by Practices to Plan and Manage Client Services and Transformation Effortss



Survey responses from participating practices identified the following as critical components of an effective data aggregated system.

Lesson: Claims and clinical data should be integrated into a common data warehouse.

Include all elements of the health care system, including physical and behavioral health, pharmaceuticals, labs, and hospitalization. Also, include data from all payers, including Medicaid and Medicare.

Lesson: Timeliness of aggregated data is important.

Increase timeliness by reducing the reporting lag time and increasing the frequency of data updates.

Lesson: Compatibility with EHR systems is crucial.

Find effective ways to integrate aggregated data into the EHR systems used by practices.

Lesson: Practices need support training and coaching to increase their ability to take full advantage of aggregated data in their daily operations.

Access to data analysis and reporting services helps practices make strategic and tactical decisions that increase the quality of care while maintaining or driving down the cost of care.

LEGACY OF THE MPC

The MPC's successes—multi-stakeholder symposia, aligned quality measures, the whole-person care framework, and an ambitious attempt at data aggregation—are all attributed to the sustained commitment of MPC members to build a table around which inspiration, innovation, and meaningful engagement could thrive. Their success was made possible with the talented assistance of a neutral convener and facilitator, financial support from their payer organizations, and significant support and partnership of the Colorado SIM program.

MPC members sustained these efforts out of a commitment to the goals of advanced primary care as articulated by CPC, CPC+, and SIM as well as the alignment of these goals with the organizational goals of their public and increasingly national commercial enterprises. And to some extent, they sustained these efforts as personal commitment to each other as they confronted significant changes in Colorado's health care marketplace and the state, regional, and national forces that shape it.

As with all such voluntary efforts, there comes a time when the shaping forces and initiatives that gave birth to a collaborative have ceased to exist and new realities require new strategies and collaborations. In Colorado, that time came with the end of CPC+ and decisions by commercial payers to attend to their own enterprise's national priorities. Although they no longer engage as a collaborative, the member organizations carry their collective legacy with them to inform and influence future public and private efforts to transform primary care and pursue its integration into whole-person care.

The MPC sustained itself for as long as the interests of the payer organizations were aligned with federal incentives to drive multi-payer collaboration and payer organization leadership was willing to commit resources to collaborative efforts in Colorado. These conditions were clearly present in 2012 when the MPC was formed. However, corporate consolidations, reorganizations, leadership changes, and market restructuring combined to dramatically undermine dedicated investments in Colorado as the final year of CPC+ approached. The changing national commitments of payer organizations was evident by 2020, when none of the MPC's commercial members elected to participate in Primary Care First, the current CMS program to drive primary care transformation beginning in January 2021. Without necessary resources and encouragement from the leadership of increasingly national payer organizations, MPC members agreed to disband the collaborative at the conclusion of CPC+.

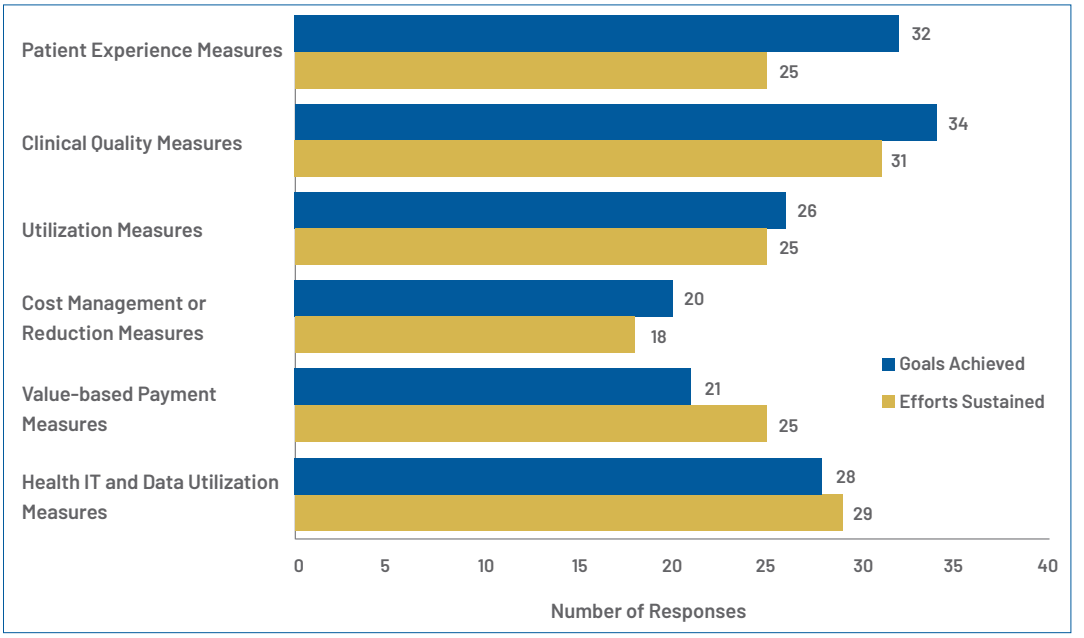
The following are noteworthy takeaways from this history:

- Toward the end of the decade, some commercial payers dropped out and frustrated efforts to transfer the work of the MPC into a broad, ongoing model of care and revenue in the Colorado market.
- Local markets did not drive change in national payer priorities and approaches. Instead, local managers in national, publicly traded payer organizations were directed to align local policies and activities in Colorado with national priorities.

- The important work of the MPC did not transfer to collaboration at a national level (organization to organization) among member payers.
- As payer organizations became increasingly national in their orientation, the parent organizations came to view the MPC as yet another "program" to be funded, as opposed to a way for plans to work together to advance transformation and leverage supporting market forces. National commercial leadership no longer saw a meaningful return on investment from their support for the MPC or from participation in the next round of CMS-sponsored initiatives.

In the final analysis, the success of the Colorado MPC may be best measured by the extent to which participating practices and providers achieved their transformation goals at the end of CPC+ and the extent to which they are willing to sustain their transformation efforts moving forward. Their responses are understandably varied depending on the transformation efforts that were undertaken (Figure 5).

Figure 5. Achieving and Sustaining Practice Transformation Goals



Respondents identified the most success in patient experience measures, clinical quality measures, utilization measures, and health IT/data utilization measures. Their achievements were less pronounced regarding cost management or reduction and value-based payment measures.

Turning to their commitments to sustaining practice transformation efforts, their leading focus was on clinical quality and health IT/data utilization measurement, in contrast with a lagging commitment to cost management and reduction measures.

These responses suggest that payer organizations have significant unfinished business addressing the challenges and obstacles that persist when it comes to the financial aspects of practice transformation and the widespread adoption of value-based payment models. Perhaps these challenges will provide the catalyst for a rebirth of a Colorado MPC in the coming years. If so, those future pioneers can look back to the work of their predecessors for valuable lessons and guidance.

APPENDIX A. FEDERAL INITIATIVES ALIGNED WITH MPC

Originally established in response to the federal Comprehensive Primary Care (CPC) initiative, the MPC later participated in CPC+ (a successor of CPC), as well as the Colorado State Innovation Model (SIM) initiative.

Comprehensive Primary Care Initiative

The CPC initiative was a four-year multi-payer initiative aimed at strengthening primary care through a core set of "comprehensive" primary care functions. Launched in 2012, CPC was designed and initiated by the Center for Medicare and Medicaid Innovation (CMMI). CMMI collaborated with commercial and public payers in seven US regions to offer population-based care management fees and shared savings opportunities to participating primary care practices. CPC tested whether core functions—supported by multi-payer payment reform, the continuous use of data to guide improvement, and meaningful use of health information technology—could achieve improved care, better health for populations, and lower costs. In Colorado more than 70 practices serving more than 400,000 patients participated in CPC.

With assistance from the Center for Evidence-based Policy, the MPC coordinated resources and support for CPC practices, including aligned metrics, technical assistance, an aggregated data platform, and other foundational supports. The CPC initiative concluded as planned in December 2016.

Comprehensive Primary Care Plus

The MPC's coordination, alignment, and support for primary care transformation continued with CPC+, the CMMI-sponsored initiative that succeeded and built on the foundation established by the initial CPC initiative. CPC+ was a national advanced primary care medical home (patient-centered) model that aimed to strengthen primary care through a regionally based multi-payer payment reform and care delivery transformation. CPC+ included two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices. CPC+ provided practices with enhanced alternative payments, a robust learning system, and actionable patient-level cost and utilization data to support practice transformation. CPC+ launched on January 1, 2017, and ran through December 31, 2021. CMS initially selected 14 regions to participate and added 4 more regions in 2018. The initiative engaged a total of 2,610 practices nationwide, including 207 practice sites in Colorado.

State Innovation Model

Colorado SIM was a broad-based reform initiative that included both public and private sector investments in comprehensive, whole-person care, designed to complement CPC and MPC efforts. Colorado SIM focused on behavioral health and primary care integration and was made available to practices at every stage of their transformations. The MPC met regularly throughout the initiative to assist the Colorado SIM office to plan and coordinate the following activities:

- Providing guidance and support to practice engagement and transformation coaching efforts
- Helping to coordinate practice reporting requirements for SIM and CPC+
- Providing aggregated data to participating practices
- Integrating Medicare into the payer collaborative
- Aligning quality measures
- Developing a shared framework for care
- Adopting the Health Care Payment Learning & Action Network framework for value-based payment reform, and using it to indicate changes in payment models
- Actively supporting and participating in Multi-Stakeholder Symposia with primary care providers and practices

APPENDIX B. ADULT PRIMARY CARE QUALITY MEASURES

Domain	Measure Name	Measure ID
Behavioral Health	Depression Remission at 12 Months following an index event	NQF 0710
Care Management	Comprehensive Diabetes Care: HbA1c Poor Control (>9%)	NQF 0059
Care Management	Diabetes: A1c Test During Year	NQF 0057
Care Management	Diabetes: Eye Exam	NQF 0055
Care Management	Diabetes: Medical Attention for Nephropathy	NQF 0062
Care Management	Medication Management: Patients with Persistent Asthma	NQF 1799
Prevention	Cervical Cancer Screening	NQF 0032
Prevention	Body Mass Index (BMI) Screening and Follow-up Plan	NQF 0421
Prevention	Breast Cancer Screening	NQF 2372
Prevention	Chlamydia Screening for Women	NQF 0033
Prevention	Colorectal Cancer Screening	NQF 0034
Prevention	Tobacco Use: Screening and Cessation Intervention	NQF 0028
Utilization	Use of Imaging Studies for Low Back Pain	NQF 0052

Source: National Quality Forum (NQF). Endorsed performance measures. https://www.qualityforum.org/Qps/QpsTool.aspx. Accessed March 15, 2023.

APPENDIX C. PEDIATRIC CARE QUALITY MEASURES

Domain	Measure Name	Measure ID
Appropriate Use	Appropriate Testing for Children with Pharyngitis	NQF 0002
Appropriate Use	Appropriate Treatment for Children with Upper Respiratory Infection	NQF 0069
Care Management	Medication Management: Patients with Persistent Asthma (ages 5 to 65 years)	NQF 1799
Prevention	Adolescent Well-Care Visits	HEDIS
Prevention	Maternal Depression Screening	CMS eCQM 82
Prevention	Screening for Depression and Follow-up Plan (ages 12 years and older)	NQF 0418
Prevention	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	NQF 0024
Prevention	Well-Child Visits 15 months [of life]	NQF 1392
Prevention	Well-Child Visits 3, 4, 5, 6 [years of age]	NQF 1516

Sources: National Committee for Quality Assurance, Healthcare Effectiveness Data and Information System (HEDIS). Child and adolescent well-care visits. https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed March 15, 2023; Centers for Medicare and Medicaid Services (CMS), Electronic Clinical Quality Measures (eCQM). Maternal depression screening. https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS82v6.html. Accessed March 15, 2023.

APPENDIX D. SIX KEY ELEMENTS TO ALIGNING PERFORMANCE METRICS ACROSS PUBLIC AND PRIVATE PAYERS

1. Prominent state leadership. Establishing high-level state government leadership and support is key to getting payers to the table and committed to the alignment process.
2. Multi-stakeholder governance. Developing a multi-stakeholder governance structure that promotes informed decision-making is critical. A steering committee made up of diverse stakeholder leaders representing state purchasers, health plans, providers, and consumers will be essential to making the tough choices.
3. Use of neutral convener. The convener(s) plays an important role in helping the partnership set goals, provide the overall framework for the effort, organize the partnership, and spread and sustain best practices.
4. Use of trusted facilitator. Selecting a trusted facilitator is critical to creating buy-in around difficult decisions. The facilitator needs to have a high level of trust, a reputation for being an honest broker, and the ability to develop consensus.
5. Access to technical information. Solid technical information is critical to informed decision-making but must be balanced against other stakeholder priorities.
6. Project management support. Efficient project management is essential for moving the process along.

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