July 27 – The State Transformation Collaboratives Multi-Payer Alignment Blueprint Launch

Dr. Judy Zerzan-Thul, Washington State Health Care Authority (00:02:17):

I'm super excited about our webinar today because Washington has been on its own multi-payer journey since 2019 around improving primary care in our state. I firmly believe in the power of multi-payer alignment both to improve health outcomes and change health care systems for the better. So today, we're going to talk about the State Transformation Collaboratives, or STCs, and their experiences. The STCs take a locally-focused approach to address the needs of state populations through alternative health care payment. The STCs- Arkansas, California, Colorado, and North Carolina- are comprised of payers with input from providers, health systems, purchasers, patient advocates, and community organizations. They are dedicated to transforming health care in their state by shifting the system's economic drivers away from fee-for-service and towards high-value care. The STCs provide a mechanism to foster and test approaches to multi-payer alignment that have the potential for regional or even national application with local priorities that are at the top of mind. Alignment is a gradual process, and by taking a directional approach to alignment that builds on common drivers of success but allows for innovation and flexibility, states can take measurable steps across different elements of alignment that build momentum towards more impactful initiatives in the future. Here's our agenda for the day, which will maybe come up on a slide. But here it is. So, we're going to talk about the Multi-Payer Alignment Framework. Then we're going to talk a little bit about what CMMI is doing to promote this alignment. I'm going to talk about our blueprint overview that launches today, and then we're going to spend the bulk of the time discussing the STC state initiatives, and that'll be a time for you to ask questions and join in the discussion. So, with that, I'm going to pass it on to Mark Japinga to talk about advancing multi-payer alignment. Mark, take it away.

Mark Japinga, Duke-Margolis Center for Health Policy (00:02:19)

Thank you, Judy, and thank you all for coming today. I'm Mark Japinga. I'm a research associate at the Duke-Margolis Center for Health Policy. I'm going to give a very brief overview of our Multi-Payer Framework in the next few minutes, which has informed the development of the Deloitte blueprint that's launching today, in which we hope will continue to inform a broad range of initiatives going forward. For a bit of background last year, with support from Arnold Ventures the Duke-Margolis Center convened experts from across the country, including many on this meeting today with the goal of addressing some of the critical challenges in multi-payer initiatives resulting in a paper we put out last December. We'll link to that paper in the chat if you'd like to learn more. So as everyone in this webinar knows, there's a lot of energy for multi-payer alignment, and we hear a lot of the same shared goals. We all want to improve things like affordability, quality, population health, equity, reduce burdens, and make our health system more accessible and easier to use for all parties. But translating those shared goals into action isn't easy. The differences in things like priorities, processes, contracts, and other components can make aligning on the exact same things extremely difficult across payers and providers. Most of the time, it just isn't feasible for everyone to do what Medicare does or what a large payer does, and some level of variation is pretty important. Different populations require different approaches and if you allow them, too. But if you allow for too much flexibility, it gets harder to scale initiative sustainably. You risk not meaningfully aligning on anything at all and potentially adding more burden for providers rather

than subtracting it, even risk nationally creating a world where you have 50 different aligned systems and 50 states built on 50 different initiatives.

Mark Japinga, Duke-Margolis Center for Health Policy (00:04:00)

So, what can help us thread the needle? The framework that's on your screen lays out the basics. On the left, we have five foundational elements, which across our convenings, we found clear consensus that these are basically the elements where we have the most energy and shared goals for pursuing alignment. On the right, you'll see the process, which is reflective of not only multi-payer initiatives but basically, any initiative you'll see in health care. So, how can this meaningfully inform development going forward? I think, first, what we really want to encourage is pursuing a set of alignment efforts across these foundational elements and stress the idea that any multi-payer initiative necessarily includes more than one part of this. If you're aligning our quality measures, you need to get the data sharing and technical assistance components right to make sure all parties can actually implement the measures you've agreed on. States might also prioritize something like equity standards, given that they're newer and easier to align on and doing so requires thinking about how they fit into payment models, and how these standards inform evidence generation. When you see how all these connect, you can also see why building a set of alignment initiatives is important. That moves across all these foundational elements. First, something like that can help build a critical mass of support. For a payer or an employer, it may be difficult to commit resources to aligning on just one set of quality measures.

However, with a broader vision of alignment and shared goals across these elements, it's easier to engage stakeholders and develop a concrete action plan. Also, building momentum can help states work toward addressing more complex issues. For instance, on measurement, starting with something like the Centers for Medicare & Medicaid Services (CMS) Universal Foundation and working around that, can help work towards more meaningful outcome measures in the future, or building around more complex model components, like attribution and benchmarking. None of this is going to happen overnight, as Judy said, but also none of this happens by just thinking about one thing at a time. Just laying out this slide path, though, is only one part of the equation. As I noted earlier, and has Judy noted, we need to make sure states have support for these efforts, that they're feasible for all parties, and that they can work towards cross-state and national alignment. That's why it's been exciting to hear more from CMS and CMMI lately about how they're trying to be a supportive partner to states and their alignment initiatives. When we think about the reach and resources that CMS has, there's no more important partner for facilitating meaningful Medicare participation, and just working with states in general to find paths forward that reflects both state and national priorities in ways that are not necessarily exactly the same in every state, but directionally the same. To learn more about how CMS is thinking about those things, I want to turn things over to Kate Davidson.

Kate Davidson, The Center for Medicare & Medicaid Innovation (00:06:33):

Thanks so much, Mark, and thank you to the Duke-Margolis Center as well as Arnold Ventures for your leadership in developing the Multi-Payer Alignment Framework. One of my roles at the CMS Innovation Center is to work with our model teams as well as across components within CMS like Center for Medicaid & CHIP Services (CMCS) or CM, as well as external partners, such as states and payers, to deliver on a goal that we set to implement a multi-payer alignment strategy across 100% of our payment

models where applicable by 2030. Another one of my roles at the Innovation Center is to ensure that we are embedding a patient-centered approach to all the models and initiatives that we support. And these two things may seem very different at face value. We're talking about really big macrosystem transformation at the national level and micro transformation at the point of care when a person or caregiver is receiving services in the office, at home, or even via Zoom. But I see these things as inextricably linked. We cannot change the way that people experience the health care system and make meaningful changes to the things that matter most to patients, such as affordability, access to care, and coordination of their care, unless Medicare, Medicaid, and commercial payers can align at least directionally as Mark shared on payment model design features. Said another way, we can't pay providers for health care in a fragmented way and expect to see seamless coordinated care delivery. At the Innovation Center, we've learned a lot over the past decade plus through our models about what does or does not work with regard to multi-payer alignment. We know that if we align too loosely, we will send the next signals to providers and unintentionally increase their administrative burden through things like quality reporting and use of multiple data portals. When we align too strictly, we limit the ability for our payer partners to innovate for their own members. We also have come to appreciate in a much more meaningful way that health care is local. It's about the relationship, relationships between the patient and their care team, relationships between primary care and specialty care, relationship between health care systems and community-based organizations, and relationships between payers.

We have to have a table to come together to collaborate. In many ways, the LAN serves as that table. Obviously, Medicare is a national program, and we face some of the same challenges that our large national payer partners face. Flexibility is hard, and we aren’t going to get to alignment by flipping a switch. But we need to keep trying at it. The Health Care Payment Learning and Action Network, or the LAN, is a private public partnership between CMS and our payer and provider partners with the goal of driving APM adoption across the US. Historically, the LAN has operated at the national level. We've made progress in shifting payment away from fee-for-service toward value, but not enough. A few years ago, we decided to launch a new initiative called the State Transformation Collaborative or STCs. The STCs offer the opportunity for CMS and other national payers to learn from states, providers, regional peers, and others in the community about what they need to support the broad adoption of accountable care.

The LAN chose four states to test this work: Arkansas, California, Colorado, and North Carolina. Through that work, and through the partnership with the state, payers, and providers in those states, the Innovation Center has learned a lot. The learnings that we unearthed as a result of our partnership with states to the LAN has helped them to think more broadly as we're making policy decisions. For example, in March, CMS announced a universal foundation set of quality measures. That list was informed by an environmental scan that the LAN team conducted at the measures being utilized in the STC states. And last month, the CMS Innovation Center announced a new advanced primary care model called Making Care Primary or MCP. The STCs gave us deeper insight into the primary care transformation efforts happening at the state level through regulation, contracting, and legislation. These learnings informed our model design. We aimed to develop a model that would build on existing efforts in Medicaid and in the commercial space. And we took into consideration the population differences that payers are accounting for in their own model, so that we are more flexible in our definition of payer partnership and MCP. You may have also seen that we released a request for information on our specialty care strategy two weeks ago. We're very interested in learning about the priorities from our care partners to understand how we can support alignment in the specialty care space.

We see our models of the vehicle to test this Multi-Payer Alignment framework and strategy. But we don't have all the answers yet. So, I wanted to spend a little bit more time today talking about what we are hypothesizing in our test and what we mean concretely about directional alignment. Could you all please pop this slide up for me, thank you so much. As you can see on this slide, we wanted to take the framework that Mark laid out and dive more into the details about possible ways that payers can directionally align through a phasic approach over time. At the top of the chart, you can see some potential areas for alignment, such as performance measurement and reporting, health equity measures and initiatives, payment approaches, data reporting and sharing, and technical assistance or learning activities. You'll hear from the STC states today, examples of how they've utilized their existing convening structures to align on goals and outcomes in their states. These goals and outcomes are tailored to the specific health and health-related social needs of the people living in their community. Below the alignment opportunity areas on this slide, you'll see examples of how payers, including CMS, can consider alignment. For example, aligning on a core set of measures and specifications, collecting and stratifying demographic data, [and] implementing a shared screening tool for health-related social needs. Through investment in the convening structures, we believe that there is an ability to build momentum on helping providers to move away from fee-for-service toward value-based care, and together to build a shared infrastructure that will support providers to adopt a population health approach to their care through data sharing and interoperability.

Finally, we want to underscore the importance of creating a learning health system across the country by sharing best practices in care and system delivery reform based on our collective experiences. Through these efforts, we think we can deepen alignment over time on some of the more nuanced model design features that Mark mentioned, such as risk adjustment, benchmarking, and attribution.

I want to thank the folks on this panel today for their continued hard work and advancing multi-payer alignment, as well as to thank the LAN for creating the opportunity for CMS to partner on these initiatives. And so with that, Judy, I'm going to hand the floor back over to you.

Dr. Judy Zerzan-Thul, Washington State Health Care Authority (00:13:05):

Great thanks, Kate. With that, I am delighted to introduce the LAN Multi-Payer Alignment Blueprint, and talk about how it can be used by states, payers, providers, and others. In the chat, you'll note a link to this document. And when you click, be prepared, it's 70 pages, and [it's] a collection of alignment case studies tactics used successfully across the STC states to achieve alignment and national and LAN perspectives on approaching alignment. It's really very exciting. Each dimension includes key tactics used to achieve this successful alignment, including state-driven initiatives. It can really be used as a guide to participate in or replicate successful voluntary collaboratives that are featured in the blueprint. You can learn about successful alignment efforts to include in your future programs. And it can help generate cross-state alignment partnerships. The alignment in these initiatives all include a multi-stakeholder approach to multi-payer alignment, which shows how the blueprint can benefit nonpayers such as providers, purchasers, consumers, and the broader health care industry.

Also, you'll find examples of how a health system, or other nonpayer, could apply the lessons from the multi-payer alignment blueprint to their own value-based care initiatives. For example, providers can benefit from the technical assistance and coaching programs that are included in initiatives to increase their participation in value-based care arrangements. This blueprint is going to be updated over time as states build on their successes and initiate new multi-payer alignment strategies. The best part is the

blueprint is now available on the LAN website, and we encourage you to review the content and work with your partners to apply its lessons in your own alignment work.

We're going to get started on our panel discussion. But before that, we have two polling questions that I'm going to pause and give everyone a chance to answer. So, thanks for answering these questions, they're going to help our discussion today. And now, I'd like to welcome our panelists. Each state is, oh I'm sorry poll number two is up, I thought poll number two was already up.

Great thank you. So, each state will introduce themselves on our panel and their initiatives that they've been working on. And then the panel will open to questions about how they achieved their success, lessons learned, and how they see their initiatives being relevant to other states.

We have Alicia Berkemeyer from [Blue Cross Blue Shield] Arkansas, Joe Castiglione from Blue Shield of California, Tara Smith from the Division of Insurance in Colorado, and Maria Ramirez Perez from North Carolina Medicaid. So, Alicia, do you want to start talking about what Arkansas has been up to?

Alicia Berkemeyer, Arkansas Blue Cross and Blue Shield (00:17:00):

Thank you, Judy. Thank you to the LAN for setting this up for us today. I'm very excited to be here and be a part of the discussion today, but even more excited about being one of the STC markets and states here today. Arkansas, truly - I'm sorry, Judy, I'm jumping off ahead here for you. Alicia Berkemeyer, Arkansas Blue Cross and Blue Shield Service, chief health management officer here. I've really been committed and working in the value arena about 2010 and as you can see as I jump into it, I'm very excited about it. And I think several of you know me, I could talk about this all day and do get excited. So, I appreciate the opportunity. But we are very excited to be one of the STC markets. Arkansas truly has been committed to moving away from the fee-for-service, and that commitment around moving to that patient-centered value care is very strong here in Arkansas. We've been very fortunate to be working on multi-state collaboration and work, really, on this journey back to 2012, appreciating the focus on the national alignment through this state transformation and really learning from others. Because I think that is one of the things about this work, many of us on this call have been collaborating that since that time, and we all learn from each other to make health care better that way where we truly are committed to all the foundational elements that Mark has reviewed for us here today. My comments are going to kind of lean towards technical assistance and the focus area for us. In three minutes, I thought I should narrow it down a little bit. So, I'm going to focus on that area because we're strong supporters and that's one of the things that we've learned through this value journey. Offering that technical assistance and support to the practices is truly critical. And so, what we've done over time is have our practice coaches assigned in certain territories and they're responsible for the performance, the quality measures, the performance of those practices, and even ties into their evaluations.

What we've seen over time and committing this resource and the support to those practices is any of our practices involved in the patients, their medical home, or primary care first, for example, outperform the non-value clinics in nearly all measures. And so we truly see that that relationship building, and the support tools, and the work that's done out in the field brings a better delivery of care to our patients, our members across the state. Our coaches have regular learning sessions both in person and virtual. Those even continue during COVID times. And that's when we learned how to do the multi version of collaboration and coordination. We've tested it through the virtual, it continued, and honestly, during COVID, the practices asked for it a little bit more. They wanted the learning sessions, they wanted the

discussions. And it was also alluded to earlier here on this call that what they love to hear is best practices and lessons learned from other practices. So, we include that continually to have star performers or performer practices that are having a challenge to have that collaboration and coordination and very good communication in those meetings.

Another area that the coached really invested in this past year has been a focus on mental health. Behavioral health has been one of our key priorities. And a few of those things that we've done in this area is recently we have trained all the coaches. They've gone through a mental health first aid, and offering that to the practice staff as well. And many of you might be familiar with our Arkansas Behavioral Health Integrated Network that was actually created through our CPC classic collaboration. It's a non-profit and really focuses on behavioral health integration. And how do you bring that skill and that support into those primary care practices? Through that, we've had great success, as well as another example. And this goes back to showing that when you build that relationship and you've had that connection with the practices, we need a resource. So, we worked with one of the universities here at the University of Little Rock, and they had social workers that they were training. And those social workers needed clinical sites to practice and we're having a little trouble matching. And so an example, we called upon those coaches that said, “Can we get those social workers into the clinics that are not able to afford or help that behavioral health? And maybe we work through it that way.” And that collaboration has brought resources to some real clinics that have never otherwise been able to get those services or support for the patient.

That's just one example that coaches and those relationships have really brought better health care delivery and has been very important to us. The payer collaboration has been in place for weekly/monthly for quite some time. We continue to do that, and we even work across the state boundaries as well. Quality, alignment, and measurement is included in that, but that also carries over in our others. So, we really try to take any initiative or value program in our market, our state.

We all try to bring awareness that we over rate and ask those clinicians repeatedly for value measures, and we've got to do a better job of aligning and coordinating those efforts.

So, Judy, I'll stop there, and pass it. And I look forward to really looking at opportunities that, well, actually going to add one more. I'll wrap it up with the coaches. Sorry, the other thing is one of the things we're doing for the very first time ever is because of our collaboration, we've been working with Oklahoma and Kansas City on the quality measures. But we're also working on the coaches. So, in September we are having our first ever training event for coaches in all three states. And they will be focusing on the coaches and consultants looking at recruitment coaching strategies and engagement, because prior to some of this work, no one ever heard of a practice coach in the transformation way we're doing things. And so, that's something we've learned in our multi-state area that we can all support one another and work across the country to build and help give tools better for coaches across the country. Thank you, Judy.

Dr. Judy Zerzan-Thul, Washington State Health Care Authority (00:23:13):

Thanks, Alicia. Joe?

Joe Castiglione, Industry Initiatives at Blue Shield of California (00:23:15):

Yeah, thank you so much for having me, my name is Joe Castiglione. I'm part of a team called Mainstream Initiative at Blue Shield, California. And back in 2021, Shield launched [a] team called Industry Initiatives. So that's the team, and we're dedicated to building partnerships that align stakeholders around the key strategic areas of interest for the larger organization. And as part of that work, we both funded and found ourselves the alliances and collaborative, and coalition to move policy and to drive alignment. So, I'm a a dedicated resource to driving alignment around primary care. I'll drop a link to our team website and in the chat. It's really maybe biased, but it's really valuable work and it's really exciting and I would love for you all to learn more about it. I see the team as part of the larger philosophy that probably a lot of us share that, you know, that meaningful and sustainable change in health care is really only possible through collaboration. And the advanced primary care initiative, which is what I'm here to talk about today, is really a great example of this work in action. So we funded, Blue Shield Industry Initiative, two partner organizations: the Integrated Healthcare Association (IHA) and the California Collaborative Quality Collaborative (CQC). I can mention that CQC is part of an initiative that's housed at the Purchaser Business Group on Health, which is a national organization that represents the public and private purchase members. So, we funded IHA to bring California's leading health plans together, and garner commitment to collectively transform primary care across the state through aligned investment, through value-based payment, and technical assistance. Really, again, driving alignment and standardization on all of these issues.

So, six plans are now in this initiative together, and we are in the midst right now of launching a multi-payer pilot and trying to really bring this program, these commitments, [and] this vision into reality. So, I'm really looking forward to sharing more with you all about that today.

Dr. Judy Zerzan-Thul, Washington State Health Care Authority (00:25:35):

Right. Tara?

Tara Smith, Colorado Division of Insurance (00:25:37):

Great. Yes, I think I'm up next. It's rare that Colorado is third on the list of alphabetical. Usually, we're right up at the top, but with this great collection of states I get the leisure of listening to a couple of colleagues first. So good afternoon, everybody. Again, my name is Tara Smith, and I am the Primary Care and Affordability director of the Colorado Division of Insurance (CDI). And I'm thinking about Colorado story, just overall in terms of care delivery and payment reform. Primary care has certainly always been a focal point of that activity in our state. And as you look back over the last couple of decades now, payer alignment, multi-payer alignment in the context of our story has been very much a partnership with CMMI. A lot of our underlying work and work today was done through participation in models in things like primary care, comprehensive primary care, CPC Plus, the State Innovation Model.

And so, we've kind of had this history; this ongoing journey. What has changed in our story more recently [is that] in 2019, we got a directive from our state legislature to specifically increase investment in primary care at the state. So, [we have an] understanding that a strong primary care infrastructure is essential to the functioning of our health care system. We are one of a handful of states has actually put in place an investment target in the commercial market that's requiring carriers to increase the percentage of their expenditures that are going to our primary care. And hand-in-hand with that has come a discussion about- as we're actually now talking about increasing investment, increasing the dollars flowing into one aspect of our health care system- we intentionally want to be doing that in a way

that's driving value into the system, which we know is not through fee-for-service. Right? So rather than trying to grab that over health care pie, we really wanted to be looking at how we were able to do that and increase that investment through alternative payment models so that we could be getting to those health outcomes, the cost savings over time, the benefits of what value-based payments and APMs bring.

So, in looking at what that looked like in our current context and in the Colorado marketplace, we actually have a lot of assets. We've had several national payers here that have been engaged in these efforts for a while that already have advanced APMs established for their primary care providers. Also our state Medicaid office, they've very much embraced value-based payments, and recognize the importance of utilizing that, particularly in the context of ensuring that their members have access to high-quality primary care. So, for us, the idea wasn't that we just, you know, it's not that we didn't have APMs and we just needed to increase the number of payers and providers that were using them. It was that we had multiple models that all had certain similarities but we're just different enough to really be increasing dramatically that provider burden. And that has been a major barrier in our state. So as a state, we started having a conversation about, you know, what does it look like to actually start thinking about a primary care model for primary care in Colorado? Does that mean that we're requiring payers to change from a current model, and we can all adopt a singular primary care APM that we can say this is Colorado's model? And we heard feedback from both payers and providers as to why that was a terrible idea, right? From both sides, having some flexibility in the models that are being utilized, there are valid reasons why payers are going to have differences in the types of models, and there are valid reasons why providers need flexibility within those payment arrangements because they serve different populations and all of those things. So, our conversation pivoted to one of you know, we think the most effective strategy here is trying to identify what are those elements across existing APMs that we will get the most value for aligning the existing models. What are those key components that we want to align around? And so, kind of based on those stakeholder conversations, and the consensus, that was the right approach to take. We had some legislation passed just last year which is now giving the Division of Insurance, which is why you've got a regulator amongst the group here, the authority to develop aligned payment parameters for APMs and we've identified four key areas in that space around quality measures, around patient attribution, risk adjustment, and core competencies for primary care. So, as you look at and consider that the history of STC and what this group was, Colorado was, of course, delighted to be part of this group as we are exploring literally each of the five elements in the framework that Mark outlined for us earlier. And also, why we're very excited to be now part of Making Care Primary. I mean, I think Colorado as a state, and as we're engaging with CMMI and other states in this initiative was right in that spot of what does directional alignment look like, right? What are those key elements where we actually think we need to have pretty strong alignment? So, we're actually getting at reducing provider burden. But where do we need flexibility? So, excited about both opportunities, the STC and the MPC. I'm happy to share a little bit more about Colorado's experience and actually operationalizing things around this for parameters as we move forward.

Dr. Judy Zerzan-Thul, Washington State Health Care Authority (00:31:06):

Great thanks, and Maria?

Maria Ramirez Perez, North Carolina Medicaid (00:31:10):

Yes, thank you, Judy. And I'll do a quick introduction for myself. I'm Maria Ramirez Perez, and I am very fortunate to be a part of a team that is launching, or that has launched, the Healthy Opportunities Pilot in North Carolina. But I'll be speaking to you all today more broadly about some of the strategies North Carolina has put in place that led into the development of those pilots. And that, I think, really has allowed us to bring together many different assets in order to have more coordination in these different investments that have gone into the SDOH space, which fortunately, led into this discussion. So, for quick background on this, North Carolina really began this journey around 2017, a little shifting from what Tara was speaking to, there were many different models that needed to come together. We were actually transitioning towards managed care in North Carolina. And so, really, we will have the opportunity to look at that through what we want Medicaid to look like in its future. We're able to incorporate that into our 1115 waiver, our proposal. So, within that we really looked at well, 88% of health is coming from not necessarily clinical care, but from what we know to be these other social drivers of health. And so there was a really conscious effort in trying to invest in the infrastructure that existed within the state that could be used across many different populations. And looking at, how can we bolster that infrastructure, embed that within Medicaid, and use the Healthy Opportunities Pilots as a mechanism to then evaluate how those services are being implemented, evaluate their impact on health and on health care costs for effectiveness and efficiency. Then also, through the pilots being able to add a pathway for sustainability for community-based organizations in particular.

So, we built a number of different assets as part of this process, 2017 was a busy year. Through the healthy opportunities process, there was the development of a hotspot map to be able to identify those areas of need. There was the development of a standardized screening questionnaire that was done in extensive collaboration with future managed care organizations as well as community-based organizations and other stakeholders. Then, crucially, there was also the development of a closed-loop referral system that would be statewide. And this was a public private partnership between NCDHS, Foundation for Health Leadership and Innovation, as well as a number of other organizations in the state. This came to be referred to as NCCare360, but is now kind of one platform through which we are able to really structure a lot of our managed care work that is bringing together both that clinical space as well as the social support space and allowing a space where they can both communicate with each other.

There was also, throughout North Carolina, the recognition of the need for extensive workforce development. So, there was in particular, through COVID fund investment, extensive development in community health work [and] driving up the workforce as well as work to invest more broadly in community-based organizations and in the work that they were already doing. I think, really leading back to what Kate was speaking to, of thinking about health care as being something that is local, and that needs to bring together, not just the payers and the state, but also bringing together community-based organizations, members, and others to be able to raise up their voice. And so today, I'll be trying to speak to any of number of these as others have referenced as well, but really trying to speak more towards the way that we have tried to look at performance measure reporting and health equity measures and initiatives in particular. We have really tried to, through the utilization of NCCare360, have been able to build one infrastructure for one system through which we can capture all of the different data that is flowing across many different sectors for everything from service referral service authorization all the way through to invoicing at the delivery of non-clinical services. Then also the way in which we have utilized NCCare as well as the broader, healthy opportunities infrastructure which provides services in

the food, housing, transportation, and interpersonal violence space to be able to lift up community-based organizations at many different levels of experience in, I will say, a wide range of different types of organizations. Everything from food pantries all the way through very large multi-state organizations, and really working to be able to invest in the capacity of those entities to be able to support and sustain the work that they are doing in their communities.

Dr. Judy Zerzan-Thul, Washinton State Health Care Authority (00:36:35):

Great. Thank you all. So, I'd like to encourage folks to ask questions throughout the event in the Q&A space. A number of people are already doing that, so that is great. And there's some specific state questions that I think I'll get to a little bit later because I want to continue with sort of a broad frame. So, I'm going to ask a question for all of you to answer first. What were the keys to fostering collaboration on your aligned priorities? And what kind of success have you achieved through this collaboration? I don't know who wants to start.

Alicia Berkemeyer, Arkansas Blue Cross and Blue Shield (00:37:17):

I can start. I'll go short on this one, how's that? I'll say patience.

Patience is an important key to fostering that collaboration, because it doesn't happen overnight. I think you have to spend the time you have to invest in the time and have a very collaborative open relationship with the group. You know, one of the examples is Northwest Arkansas, we've got the employers, the hospitals, the payers all sitting at the table, working on several things, such as quality measures. We've also just recently, you know, we all struggle with attribution. That's something that no one has a silver bullet to. And so, we did a persona exercise, basically having tables to identify. Okay, you're a pharmacy orphan that has been receiving pharmacy care without seeing a doctor this amount of time. How do you want to receive your health care? And then you're a young college student, what tools do you need in health care? So, looking at creative ways to come around some similarities and some focus to get you to that next step, and it may be a small step. It may be a large step, but being patient enough to come to that agreement and get you to the next level.

Joe Castiglione, Industry Initiatives at Blue Shield of California (00:38:33):

I'd like to pull on just one of the threads that Alicia mentioned, which is really you know, it's like you have a lot of different types of folks, like a cross-sector sort of collaboration there, and that I'd say is one of the biggest keys to success - what we're doing in California. So, for us, every organization brings their own credibility, their own legacy of work in this space. So, Integrated Healthcare Association (IHA) runs a multi-payer performance incentive program, California Quality Collaborative led a very large-scale technical assistance grant through CMS. And then CQC's parent organization, PBGH, brought the sort of upstream leverage of representing purchaser contract and a requirement. So, you know, Covered California is a PBGH member, and that was very motivating, to say the least, right? And they did some work to develop a primary care measure set that later became a predicate for what we're doing to align around payment. I think that iteration is actually referenced in the blueprint as well. And then, of course, I'd be remiss if I didn't mention my own organization, Blue Shield, right? We're out there in the field, scaling a primary care payment model and being very transparent and feeding our experience back into the multi-payer group about what does and does not work. I don't know if there are a whole lot of plans out there who are willing to be so candid about mistakes. Right? And I say we do have a vested interest

in seeing this pilot, multi-payer pilot, be successful. Because I think our leadership really makes the connection [and] understands the link between the success of this pilot and the ability for us to scale APMs across the entire business, because that is an objective for our organization- to be able to scale APMs across the entire company, across all lines of business, all product lines. And I think, you know, we're willing to play that role, Blue Shield's willing to play that role. The first to move, the first to fail, and hopefully the first to succeed. That's just a philosophical choice that we made. And I think each of our organizations (Blue Shield, CPC, PBGH, IHA) we've all had what I very much call a collaborative posture, right? Especially given how challenging some of the collaboration can be. That's the nature of collaboration. And you have to walk into these rooms knowing that compromise and sacrifice is something that has to happen from each of you, and that's not really easy at all. And I think without each of the plans that are committed to doing this with us- Aetna, United, Health Net, Elevance, Oscar- without each of these organizations we wouldn't be where we are now, and I do think we have a very long way to go truthfully. But I think there is a potential in that type of cross-sector collaboration from purchasers, payer, or probably down to providers and getting that member experience feedback as well.

Tara Smith, Colorado Division of Insurance (00:41:50):

I would echo both of those things. I'm not sure if we're supposed to go in order or not still. But I will just go ahead and jump in here. Certainly, I echo Alicia, patience and time. Right? A lot of this is about relationship building, and there's no way to speed that up. I mean, health care is the speed of trust. I think also, collaboration is similar. And I think creating forums to do that, even outside of Zoom webinars or traditional stakeholder conversation. In Colorado, something we actually started doing under our state innovation model [is] hosting something called Multi-Stakeholder Symposium, which are a day-long events which invited payers and providers to come to the table to talk about common goals [about] what we were actually trying to achieve in primary care delivery. It's top of mind because we just had one last month, our first one post-COVID. And [when] you look at the evaluations, consistently one of the favorite things was, "I was a provider sitting at a table with a payer, and I got to talk to them during lunch the whole time, and just got to see a completely different side and different perspective." So, I think that is important. I would also just add in building a consensus and stakeholder conversations is another one of the most basic lessons in the world, right? But being very clear about definitions and what you're talking about in some of these conversations. I think, as Colorado has been looking at exploring these different parameters that I mentioned, these components. People came into a conversation of patient attribution, and they all had a different idea of what attribution we were talking about. Is this attribution for payment? Is this attribution in terms of who I'm going to be reporting quality measures. I think the same thing with risk adjustment. Right? What do we risk adjusting for? So, it seems very basic. And you know we've been doing this a long time, and sure we all think we're speaking the same language, but you can find yourself two to three stakeholder conversations in and find, hey, we were not talking about the same thing with risk adjustment. So I think in terms of getting at those common goals, its an important step not to overlook.

Maria Ramirez Perez, North Carolina Medicaid (00:44:01):

Yeah, I'm trying to think of what I can add to this part. But one of the things that comes to mind is something that had to take place in North Carolina that really echoes a lot of what's already been said, is all of the work that had to go into hosting different types of convenings. So not- what you were speaking to Tara- not just holding, at that point there were hardly any virtual it was pre-COVID, but hosting just

different types of working sessions, acknowledging that we were trying to bring together many different types of sectors. And so, acknowledging the power dynamics that are inherently a part of that, as well, that you are bringing together. For example, very small organizations that may not traditionally have been in the same room as a payer and trying to bridge that gap of both allowing comfort for both entities to feel empowered to speak up for their perspective- equally valued in that space. And then also working to try to ensure that those organizations, then, through the model that is developed, have an infrastructure in place where they are continuously able to provide or to communicate with each other. And some of that certainly- the system certainly assists with that. But I think beyond that within North Carolina what we found is that the creation of a hub entity, which we refer to as a network lead, I think, has slightly different names and other states that have adopted something similar. But really thinking through, how do you have- essentially built it in to the broader model? There has to be an entity that is both responsible for, and then also is themselves a community-based entity that is able to take on that role of bridging that communication and creating that common language between entities. Especially, I think you were speaking to Tara in particular, of like bridging that gap even within one health care sector. But then for North Carolina, it was also, how do you bridge that gap between completely different, seemingly completely different areas of- you know you have social supports and clinical work. So that's yeah. The piece I would add to that, but completely echo others as well.

Dr. Judy Zerzan-Thul, Washington State Health Care Authority (00:46:08):

Excellent. Well, Thanks to the audience, there's a lot of really interesting questions coming in. So, we're going to try and get to most of them. And I think I want to start with one about having each of you talk a little bit about, are these efforts primarily Medicaid Medicare Commercial? And I know the answer, but I know that the audience doesn't. Can you talk a little bit about how you approach those different lines of business and the different populations that are in those- covered by those different plans? And how they're impacted by this? I don't know, maybe should we start with Maria since you've been last?

Maria Ramirez Perez, North Carolina Medicaid (00:47:08):

Yeah, I can kick this off and give away that my perspective is primarily for Medicaid. However, I will share one of the things that we've really been working towards within North Carolina, and that we've tried to embed even within our broader strategies. Really acknowledging that we are investing. We're making a lot of this investment through North Carolina, Medicaid, through the 1115 waiver authority as well as other authorities that we have, but we are making those kinds of upfront investments through Medicaid to then allow them to be utilized in other sectors. And so, for example, NCCare360, that's something that lives completely separate. As well, it's a statewide platform utilized across different across different areas outside of the Healthy Opportunities Pilots, outside of Medicaid. It lives side by side with our two on one navigator program as well. So, it's something that's, again, we have strongly encouraged payers as well as other entities, to utilize it outside of what they do within Medicaid, though we require its utilization within the Medicaid program. There's also, for example, our SDOH surveys essentially the other assets I listed at the top of the call. Those are all things that we essentially have released out into the world and continue to encourage others to utilize. I think really the perspective of our leadership when a lot of this infrastructure began to be developed was, we're going to make that upfront investment, but it's going to be available for other sectors to be able to utilize recognizing that it does take some time to make that first step. But then others should be able to take the second and third step without having to go through the concerns of all of the upfront investment.

Tara Smith, Colorado Division of Insurance (00:48:41):

We're doing the exact reverse again? Next time we're just doing wild cards. So Colorado, It's a great question, right? How can it be done right? How does this actually work across commercial and public payers? And we are finding out that that is challenging. But we think it's doable. And we think it presents a lot of exciting opportunities. So, with the focus on investment in primary care as a state right, that clearly set our state as a marketplace and that's what really led to this new intentional collaboration between the commercial plans in our state between the division of insurance and our Medicaid Agency, department of health care, policy and financing, and we also were engaging our state employee health plan. as part of that conversation at an intent to really be starting to look at that marketplace level. That's kind of where now the STC and MCP both fit into our story. Previously as a state, we were talking about how do we align that amongst state payers? With this opportunity, we really have been able to invite CMMI and Medicare to the table, as well as STC, to be exploring. What we were talking about as a state is to directionally align to the degree that would allow us to participate in something like Making Care Primary, which is now the model of what we have tangibly, where we can be looking at and testing and examining these components. And you know, a key part of Making Care Primary was initially, really looking at that Medicare Medicaid relationship and looking at the importance of alignment between those two sectors. But in Colorado, with this unique legislative tool that we have, this bill that's actually intentionally looking at commercial, we're now actually really excited to be able to be exploring again and testing and modeling these ideas. I would also just note when you're looking at this idea of looking at the different components of the model, that's where the challenges come and where we're seeing the biggest differences between what's in the commercial and what would be public payer. Around something like quality measures- actually, whatever payer is having that quality measure, all of us recording the same thing in the same way, right? Like everybody. Every payer can have a common numerator and denominator. And that's an important place where we need to have that. With something like risk adjustment models which are calibrated to populations. And we know that populations look differently across different payers, maybe kind of aligning around a single method. There is more around something like transparency, so that the level of information and how that's being described between payers and the providers is a little bit more consistent. And so, maybe with some of the other parameters we're looking at. And that's where that alignment across commercial and public, and where we land on that is going to look a little bit differently. So great question, still looking for answers. So please be writing ideas in your thoughts and experiences in the chat.

Dr. Judy Zerzan-Thul, Washington State Health Care Authority (00:51:59)

Yes, go ahead Joe.

Joe Castiglione, Industry Initiatives at Blue Shield of California (00:52:02):

Yeah. Similarly, you know, I think we are also looking for answers in California. So, the advanced primary care initiative is primarily right now focused on the commercial segment. And I think that's partly largely due to the fact that that's where we see the most fragmentation. Therefore, the ripest opportunity for driving alignment. Right? I will say that again our state exchange, Covered California, as well as our public employee benefits program are also both participating in this as well. So, there is other support, or I should say, and there's expectation that payers that are contracted with those organizations will participate in this as well. So there's some alignment with public purchasers there. We are participating in primary care first as well. So, there is a little bit of alignment with Medicare. On the Medicaid side,

California went through eight very, very large re-procurement over the last year, and so I think that can really occupied the minority of the state bandwidth, as it relates to trying to look at what we were doing with the BS primary care. But we have constant communication that they continue to be very supportive. There is a very significant focus through that re-procurement on shoring up primary care across the state. So, I do think you know, there is a lot of potential there, particularly once, you know the sort of next wave of Medicaid in California, and the next way of expectations start to be implemented. There is a ton of opportunity for driving alignment, but I think that is the next iteration of this work. And I think we're trying right now to demonstrate some proof of concept in the commercial segment first.

Alicia Berkemeyer, Arkansas Blue Cross and Blue Shield (00:53:49):

So, I will go next and tell you that the way we look at our State Transformation Collaborative, we include our value programs across that. So, it's not just one specific program. And so, through that we are able to cover really kind of all lines of business. Arkansas Medicaid has been at the table with us since 2012 with the early CPC and then patients in about home development things in that side. Also, through our collaborative health initiatives, that's considered like our ACOs included within that. And so, looking at our value programs, we started early on with just the commercial business commitment that we had risk for. We did invite the ASO and had a couple like our own employee group, our Walmart account, things like that that joined us early on. But what we're proud about is in the most recent is the work I was mentioning about Northwest Arkansas, where we do have large employers, now at the table addressing and discussing this work with us and engaged in it. So, with them at the table we really include even the hospitals, because many of the hospitals are employers too. So, having the hospitals with really two hats at the table, both their provider hat and the employer hat, is a lot of fun, because you get two different perspectives for one. And so we, we have our commercial, we have our exchange business. Arkansas Medicaid, certainly, but our employers as well. So, we cover all lines of business right now in some form of value.

Dr. Judy Zerzan-Thul, Washington State Health Care Authority (00:55:22):

Great. We've had a couple of questions about payer investment. So, I'm going to combine them into having each of you talk a little bit about how do you get payers to make upfront investments? Whether that's for community-based organizations and creating sustainable funding for that, data infrastructure, the coaching that Arkansas is doing for practices, quality measurement. How do you get payers on board for that and how does that work?

Joe Castiglione, Industry Initiatives at Blue Shield of California (00:55:56):

I think it's a really good question, and I think that this manifests in a few different ways. I think for Blue Shield of California stable most motivating factors, or one of two most motivating factors, is having a leadership team, or at least one or two leaders who are really bought in and really understand the core function that primary care has to play for the larger health care [system]. We're never going to have the health system that we all want to realize without a very well-funded and supportive primary care network at the core of it. And part of that, too, I think, includes independent primary care. I think I saw a question about that in the Q&A. You know, I think, as a network-based health plan, we feel that the state of independent small primary care are tied. Right? Fundamentally, they are tied, you know, we want to protect the small independent primary care networks that are out there. And that's that big focus of the initial iteration of our model. We develop the model that we have. And again, it's a partial cap model, so,

partial capitation partial fee-for-service, support for care coordination as well as the quality incentives, very well aligned with what you've seen in CMMI or the big implementing high quality primary care report that came out of NASIM that came out a couple years ago. Now, anyway, we developed that model actually, specifically, because we, as the health plan, understood and identified the primary care crisis that I think we all see is happening and wanted to make sure that we were getting dollars in primary care pockets. So, you know, I think there's always a bit of a tension between the folks who often understand that, like the folks who are more focused on system transformation. And then, you know, the chief financial officers of the world who are really more focused on the bottom line. I think there is a tension there, and you have to have leadership that's willing to stand up and say, look, you know, trying to squeeze value out of primary care is a losing game. You know, you have to understand that immediate investment in primary care- you're not going to realize the terms right? The return on investment (ROI) is at minimum three years, and that's if things really go well. It's likely closer to five or even longer. And so, I think that philosophical commitment is really important, I think supporting primary care with some of the things you said around performance feedback- really getting not only dollars, but the right data to providers in a way that is meaningful and usable for them- I think that was the big investment that we made in our model. How do we use how we get a dashboard that is simple, that reflects care gap data, that other quality performance data, financial data. And a lot of our practices, interestingly enough, one of the big pieces of feedback [is that] we have a very clear accuracy data visible on our platform. And that actually ended up being, I think, one of the most valuable pieces of that platform, because providers want to know who's about to fall off their roll so that they can make sure again, it's a partial cap model, right? So, they want to make sure that they schedule what to do with that member. They attribute it, they close it, they use that to close any care gaps. So I think again, a lot of it does come back to philosophical commitment to what you're doing. And then, two, having some of the leverage that might exist in the environment, whether it's from purchasers, public or private, again, Covered California has been an amazing advocate for our work. So, I really think that's what it came down to for us here in California.

Maria Ramirez Perez, North Carolina Medicaid (00:59:42):

And I can say for North Carolina, it's very similar. I think you need to have buy-in really, at every level. Part of what we did was really, again, kind of speaking to like- we made sure we brought everybody to the table as early as possible in the development of the model itself. So, for the Healthy Opportunities Pilots as well as for managed care transformation, we really focused on talking through like, here's what this is going to look like. Let's make sure that we're aligned on why this matters. Why in North Carolina we're trying to buy help and not health care, and what does that mean for every stakeholder that's going to be a part of this. And then I think that that allowed for a lot of that buy-in, especially as we were talking about like for example, health plans would not be working with potentially hundreds of community-based organizations and treating them more or less as they would a clinical provider. But these are organizations who are not accustomed to being clinical providers, and so that's kind of a more difficult conversation to have. And that's where we tried to build into that model like those additional supports of okay, well, here's where a hub organization or a network lead is going to help support that so that the pressure doesn't necessarily just fall onto the payer. We're still going to be driving towards having more of a value-based model, having that investment in SDOH that would have that return which we're testing out through this pilot, right? But we're just kind of saying through North Carolina, we're going to make this investment through Medicaid dollars to test the theory and try to bring everyone to

the table, essentially saying, here's the funding that's available through Medicaid. Everybody, philosophically, let's make sure we're aligned on what this means for patients. What this means for the teams and staff. We work a lot with care management entities. We're also kind of realigning what it means to provide whole-person care, because it's not just thinking about the clinical piece, it's also thinking about does this person need access to food or transportation? And it's a big part of that is just bringing everyone as early as possible to that table to talk through what exactly it is that you are trying to build? And then also building within the model mechanisms that allow each entity to feel like they are able to have support from some of the areas where there may not be as much of that strength. So, in this case we built those networks to be able to support that collaboration with community-based organizations.

Dr. Judy Zerzan-Thul, Washington State Health Care Authority (01:02:05):

Alicia or Tara. Anything to add to this?

Alicia Berkemeyer, Arkansas Blue Cross and Blue Shield (01:02:16):

I was going to let Tara go first, but I'll go ahead and jump in. Number one, I'll actually tell you that if it had not been for the Centers of Medicare Medicaid Innovation, we probably wouldn't have gotten the commitment, but we had the perfect storm, I guess. In a way, we kicked off our early patients center medical home pilot back in 2010. And back then, I was crazy enough to think if you get have claims information, the clinical information, and you have this perfect report, and we're going to have a perfect world. And to this day, I've learned still hard that no- garbage in and garbage out of those electronic health records (EHRs). And there's more challenge to that kind of stuff. But going through that pilot at that time is when we heard from the practices, hey, Blue Cross, like you're doing really good things here. But you couldn't pay me enough to change my whole practice. Other people have to be at the table. And so that was the very same time that the early application of the CPC came out. And so, having multi-payer funding and support, and like, I said, from a CMS standpoint, I credit them a lot for the growth of our practice, the transformation of our practices, because having the Federal Government at the table and really because they have such a voice of leadership, that's really what helped us get here And so through that. And then, Joe, everything he said, yes, thumbs up. For the fact, certainly, that that reporting and that proof of concept on the return on investment back now it's been, I guess, about three years ago we had an independent health care economist do evaluation of our program, because you know those self-funded accounts- they want to see return on investment before they spend their money.

And so, you've got to have some proof. You've got to continue to measure it. You've got to continue to show it. And that's why I think we're so proud to show that those practices that are in these programs that are supported, they're performing better on total cost as well as quality. And so, any measure we look at they're doing better. So, it's working. And so, it's those kinds of things that keep us going. But it's not an easy process. And like I said, each one of those conversations you have trying to convince people to invest money for something they may or may not get a return on. But it's the right thing to do. And I think that's where we land on is we are real Arkansas. We don't have enough primary care practices today. We need more, and we've got to pay them more for the services and really get them the support, technical, financial, whatever they need to deliver the care we need.

Tara Smith, Colorado Division of Insurance (01:04:48):

So, my strategy is now going to be the last so I can just say yes to everything that everybody just said, you know, leadership is really important. I agree, Alicia, you know, having CMMI as a partner I think that really did for some of us what we see and Colorado is that I think, for the large part commercial payers. It's not a hard sell to tell them that prospective payments are the way to be investing in primary care. I think a lot of them actually now have data that shows the value and the health outcomes that they see by having team-based care delivery and kind of all the good things that- the member satisfaction. Right? I think they see a lot of opportunity. So, for us it's our conversation, then what are those additional resources that are needed even outside of a perspective payment from one payer to your point of Alicia? Right? Like as one a single pay, or even if you're giving, you have respective payment. I'm not alone and it is not going to allow me to support or sustain my practice. So, what is the role of the other actors systemically, in terms of supporting this with things like practice, transformation. When you look at the big pushes that have come behind that in Colorado, a lot of them have been either through a model like State Innovation Model or grants right, where you get this money that's available to start practice transformation, but that creates a very cyclical pattern where you have people that are able to adopt. But when that funding drops off, then it's harder for them to kind of sustain the practices they need to deliver, this kind of care delivery. So, I think it's a conversation of kind of what is payer role in relation to other roles within the system to make sure we actually are adequately resourcing, which is primary care as an infrastructure. Data is a tough one. In Colorado, we actually were very fortunate to have a group of commercial payers come together voluntarily. Something called the multi-payer collaborative which existed here about ten years. There's a great article out there right now, if you're not familiar with it, that came together to support their participation as part of CPC. What could they be doing to work together to support the providers in their network that were participating. It made a very solid effort around trying to create a single data aggregator. Right? Thinking about that data aggregation system, what that looks like. And we didn't quite crack that nut, a lot of lessons learned out of that experience. I think Colorado is now transitioning to think about within just even data, our infrastructure. How are we connecting across systems rather than trying to maybe be a single system that rules all. Which is another thing that's highlighted in the 60-page blueprint. I'll put in another 76-page blueprint. I think different state efforts around that piece of it. So, I think it's an even outside of a how do you get payers, it's how are you thinking about it on the systemic level, even outside of just specific payer reimbursements to really get there?

Dr. Judy Zerzan-Thul, Washington State Health Care Authority (01:07:45):

Great. So, I have a rapid-fire question that I want you to be sort of more. Yes, no on. Are each of you doing two-sided risk models? Are you doing global capitation? What does that look like in your models?

Tara Smith Director of the Colorado Division of Insurance (01:08:03):

I'll go first, and I'll say it depends. I think different payers in our state are doing it differently so variable answer for us.

Joe Castiglione, Industry Initiatives at Blue Shield of California (01:08:14):

No downside risk in ours. The investment model, making sure we get dollars in the market, not currently planning for primary care risk.

Maria Ramirez Perez, North Carolina Medicaid (01:08:27):

It depends. I will say, yeah, it very strongly depends. Yeah, for North Carolina. I think within Medicaid we have primarily leveraged the capitation. But for things like the Healthy Opportunities Pilots, and other waiver programs, it will vary. So, I will leave it there and say, if there are specific questions about different elements, happy to answer it that way more specifically.

Alicia Berkemeyer, Blue Cross Blue Shield from Arkansas (01:08:59):

Yeah, and I'll finish up. Yes or no. Yes, but I'll go to yes, we do have capitation and downside risk in our models.

Dr. Judy Zerzan-Thul, Washington State Health Care Authority (01:09:09):

Great, so, what comes next for each of you? How are you going to advance your work? And also, where do you see opportunities for cross-state alignment or learning? And I'll start with Alicia.

Alicia Berkemeyer, Arkansas Blue Cross and Blue Shield (01:09:27):

Absolutely, Judy, you know we're going to continue certainly on the initiatives that the foundational levels we talked about earlier, all five of them. We're working. We have different projects in all of those foundational elements that have been listed. We've discussed it here today, but there are just a couple that I'm excited about, and I'll mention here one of those is as part of our State Transformation Collaborative, we are working with the National Quality Forum. I think everyone's heard me talk about the traditional matters and how it's checking boxes, and are not meaningful. And how do we have meaningful measures? So, I got the opportunity now to try to participate in a new measurement opportunity. And what I'm excited about is they'll focus on behavioral health measures and maternal health measures. Those are two key areas for the State of Arkansas. And so, we're looking at these measures in development, they'll be more timely. They're quicker to the market. They are both providers and patients at the front end of the measured development, and they truly are meaningful.

So, we are just kicking off that to get that. But it's going to be a pretty rapid process to try to develop these measures. We're talking to clinics already a little bit about how they'll test these, and we'll pilot these measures. So that's something I'm super excited about, and I think can make a difference. And hopefully we'll have great success, and we'll start getting more meaningful measures across. Another example that I think we'd look at different ways, really to make an impact. And this is something I'll build off it from a health equity framework you know we truly have been looking- Arkansas, unfortunately, is at the very bottom of the measurement for maternal mortality. And this is something we've got to as a state, we've got to improve and make it better. We've got some challenges with our state being rural and other things. But we truly are looking like a state multi-disciplined, multi-community effort of really pulling together the stakeholders. We've been bringing data together, and that data is now supporting us as to what the direction and the framework for this health equity focus. And in that looking at rural, low-income minorities, everything helping that data guide us to the opportunities to deploy our interventions and really try to get upstream ahead of this work and solving those problems. This kind of avenue and this kind of venue and the multi-stakeholder, trying to attack a problem, address a problem to make things better. That's just a couple of examples.

Dr. Judy Zerzan-Thul, Washington State Health Care Authority (01:12:00):

Great, Joe?

Joe Castiglione, Industry Initiatives at Blue Shield of California (01:12:02):

Yes, so we are actually also participating in the National Quality Forum innovation project. I'm very excited about that. Actually at the National Quality Assurance, NPQA, which takes a very different approach to measure development. So, I am very excited to see what potential coming out of NQF as it relates to what we're doing with the pilot, we're in like operationalization mode. So really, looking at picking our pilots by finalizing a lot of methodological details. I am working in technical assistance. You know, how we standardize that. I mean, I think we're very fortunate to have the commitment that we do from all the plan, because again, we're just up to our eyeballs in granular detail. As it relates to cross-state learning, I think there are a few areas that come to mind. The first of them, I'll say, is actually on the self-funded issue. So our internal council of lawyers really don't like it if I talk about my interpretation or our interpretation of statute so I won't say much, but I'll say that at least in California we think there may be barriers to implementing population-based payment in self-funded environments. Sounds like that may be happening in other parts of the country would be very curious to know how all and like what the mechanism for that is. And if there is any possible learning on more practical, you know, it's sort of methodological level. Our partner organization, IHA, working to finalize methods of addressing payment to account for both clinical and social risk? And I think there are a lot of options out there for social risk but I think it's actually quite difficult to pick one that perfectly balances ease of access and availability of data right, relevance to a specific market, evidence around use cases specifically to adjust payment to primary care providers in a value-based payment environment.

And then, I think, on the social side, you know, I think, that there is a- I'm sorry, the clinical side. I think that there is a a real [inaudible] in terms of a national standard for how to adjust payment to primary care providers. I think there are a lot of methods out there but nothing that's quite specific for primary care, because I think a lot of adjustment is based on our historical [inaudible] based on total cost of care. And I just don't know that we, as a plan, believe it's fair to hold PCPs, particularly small and independent PCPs, accountable for total costs. Especially in a PPO environment, which is, again, where a lot of our resources are held right now. PPO plans are designed for our members to seek care where they like. So, it just gives the PCPs a little bit less leverage in their control. So, you know, Blue Shield developed our own methodology. All the details about our model are available online on our website. We've made it again full transparency. We both love folks to write feedback on it. It's an incredibly innovative approach and we want to write it up but unfortunately, it may not be a bit for the multi-payer group just again given the access availability of data. So, coming back to the learning, how is it happening with ASO environments in other parts of the country? And how are you adjusting for clinical and social risk? I think those are really top priority items for us.

Dr. Judy Zerzan-Thul, Washington State Health Care Authority (01:15:37):

Tara?

Tara Smith, Colorado Division of Insurance (01:15:38):

Yeah, I certainly echo the importance of thinking about and engagement around self-funded plans as part of these efforts. And, I will also not peel off that can completely with 12 minutes left in a webinar. But I think that's going to be a place where Colorado is also interested. A very immediate next step in our story is actually promulgating this initial regulation, which we'll establish open parameters for the first time across payment models for primary care in Colorado. So, some more active stakeholder

conversations. We are statutorily required as a division to have a rule adopted by December 1st. So, a lot of work but exciting work to get done over the next couple of months. I think we are excited; you know. That's simply a tool to use. That is certainly not the end goal, to come up with a regulation. But I think we're really excited to see how that works in concert with Making Care Primary, and how we're actually looking at that as a vehicle to really be meaningfully and practically aligning commercial and public payers. I think one of the things that we are particularly, or I am particularly excited about, with Making Care Primary is really that focus on being able to engage with practices who have not yet gotten on the value-based payment at all in Colorado. We've got kind of the broad spectrum from the large systems to the smaller independent rural practices. And we've seen practices now that have gone through CPC and are very sophisticated. And we still have some that just haven't even started this journey. So, as a state we have been talking about and thinking about needing an on-ramp to engage those independent practices, those practices that are very new to this. And to the degree that Making Care Primary is really designed with those kinds of practices in mind. We're excited to work with CMMI to see what that looks like, and how we can actually be building that bridge and that transition for providers that we haven't reached yet. I would say just a a third thing for Colorado that I'm excited about is also now seeing how this work around primary care, payment reform, and investing in primary care infrastructure is really working with some of our affordability initiatives at the state level. Colorado- shout out at Judy- is a state that also has a public option in play that's looking at slightly different components in terms of reducing premiums and creating culturally competent networks. And it's using some value-based insurance design around no cost for primary care and mental health benefits as part of that plan to sign. We're really thinking how we're intertwining some of those steps that we're taking around affordability through that vehicle. How are we making sure that's lining up with some of the systemic things we're doing to actually change the way we're paying and incentivizing providers to be able to provide that care? And now that can relate to carriers that you know, being able to reduce their premiums. All of those are very exciting things that we have a vision for, how they're going to come together. And now we're actually in a place where we're going to be able to start structuring and hopefully realizing some of those benefits. So, that's an exciting place for us as a state.

Dr. Judy Zerzan-Thul, Washington State Health Care Authority (01:19:06):

And, Maria, I'm going to give you the last word.

Maria Ramirez Perez, North Carolina Medicaid (01:19:09):

All right, so, within North Carolina for the Healthy Opportunities Pilots, we are in implementation phase, and so fortunately have been able to serve now over 10,000 enrollees, as of the end of May. So, I think, in the near future, hoping to continue to grow that number and to continue to serve just additional individuals who have SDOH needs and trying to continue to test this model of providing these non-clinical services to members. Again, this is kind of all built within one closed loop referral platform that also provides invoicing and other- essentially all of our other eligibility data, invoicing data as well as broader overall data kind of all lives within that platform. So, as I'm talking about these 10,000 enrollees, that now 76,000, over 76,000 services, they've received all that data exist within that platform, which is great.

However, we are looking forward to continuing to improve data quality as we are now able to start to really dig through that data and start to understand, what is it really- what are we really seeing? What types of services are being utilized? What are the challenges that are inherent to that for the different

entities as they are working to try to continue to authorize and deliver on those services. And so, I think that's kind of an exciting space. We are also looking forward towards our weaver renewal again, we're a pilot that was authorized under the 1115, and so through October of 2024. So that's coming up fast. And so over the course of the next couple of months we're working on our waiver renewal proposal to be able to extend this effort that was unfortunately cut a little bit short, due to the pandemic. So, I think those are the two major items. I'll try to keep it pretty there.

Dr. Judy Zerzan-Thul, Washington State Health Care Authority (01:20:58):

Great thanks to all of you. I think this was a great discussion talking about your multi-payer alignment efforts. And I appreciate your time this afternoon. So, we're going to close out this session. I think we have hopefully learned a lot about how to use multi-payer alignment to move away from fee-for-service, and that meaningful and sustained change is only possible through collaboration. I l liked that message a lot and it warms my heart that all of you are working on primary care because I agree. Our primary care system is at risk, and we really need to do everything we can to shore it up to improve the health of our population. I think some of the pieces of alignment that struck me were providing support to practices. Thinking about quality and thinking about data. And really, how do you work together to decrease both provider burden and payer burden?

And then, I wrote down four things about ways to make this work that really resonated with my own work here in Washington, which includes patients, particularly around relationship building. I think, both when I was in Colorado and here in Washington, creating those relationships and trust with each other is a really key part to start off this work. Engaging purchasers and employers, there were a few different ways to talk about that. Being ready to compromise, that you're not going to get everything you want. But this kind of collaboration means meeting in the middle, and then finding a leader or a champion at each plan who can really help carry this along the finish line. So, I'd like to thank all the participants for joining. And I'm excited. This movement in a multi-payer way can really get to greater movement towards accountable care, which is what the LAN is all about and where we want to be.

I'd like to highlight that if you haven't seen the advertisements yet, the LAN Summit is going to be in person on October 30th in Washington, DC. There is registration information available on the website and will continue to be pushed this summer. And so, I hope to see you there and then finally, as you exit the webinar, there will be an evaluation that pops up on your screen. Please fill that out, and we will use that feedback to make more of these sessions tailored to your interest. And I appreciate you all for joining. Thanks a lot, and have a great afternoon.