

# Adopting Multipayer Value-Based Payment Models

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Value-based payment (VBP) is a health care purchasing strategy used to hold health care providers accountable for the quality and cost of care they deliver to patients. In contrast to fee-for-service models, which incentivize provision of a higher volume of services, VBP models can promote higher-quality, more equitable, more cost-effective, and better-coordinated care. Moreover, these models can potentially slow the rate of health care cost growth by applying a budgeting mechanism to payment.

VBP models are most effective and sustainable when multiple payers align around a common VBP model, such as one featuring similar quality measures and payment structure. As discussed later in this guide, such multipayer VBP models can involve different degrees of alignment, from nearly full to quite loose.

States have tested a variety of multipayer VBP models, including hospital global budgeting, episode-based payment, and total-cost-of-care contracting. This guide lays out concrete steps for states to plan and implement multipayer VBP models to slow spending growth in the commercial market and potentially improve the overall quality of care.

The following steps present a sequence of important decisions for states to work through. States should be prepared for a process that is both *iterative*, where questions may need to be revisited over time, and *dynamic*, to account for new questions and new answers that may emerge.

**Step 1.** Determine goals for adopting a multipayer VBP model and confirm readiness to proceed.

**Step 2.** Select payment model(s).

**Step 3.** Determine who should convene, facilitate, and manage the multipayer VBP arrangement(s).

**Step 4.** Determine how to engage stakeholders during the VBP model design process.

**Step 5.** Reach consensus on VBP model goals with stakeholders.

**Step 6.** Design the VBP model.

**Step 7.** Incorporate health equity into the model design, implementation, and evaluation.

**Step 8.** Determine whether to make participation voluntary or mandatory.

**Step 9.** Determine how aligned the multipayer model will be.

**Step 10.** Identify opportunities for alignment with federal efforts.

**Step 11.** Decide how the state will support providers to succeed in their VBP model.

**Step 12.** Create a supportive health information infrastructure.

**Step 13.** Create a plan for how the state will monitor progress toward its goals and use those results to inform any design modifications.

**Step 14.** Anticipate negative consequences in the model design and create a plan for monitoring and correcting them during model implementation.

We describe these steps in detail below.

**Step 1. Determine goals for adopting a multipayer VBP model and confirm readiness to proceed.**

*Goal development.* The state should consider what its goals are for the multipayer VBP initiative before engaging stakeholders. A clearly articulated and widely adopted set of goals will clarify for stakeholders what the state aims to achieve and why a multipayer VBP model will benefit the state and other stakeholders. States will need to make a compelling case for vested stakeholders to commit time and energy to development and adoption of the model. That rationale has to answer the question, What's in it for me and my constituents?

The process of defining goals should involve all the key state agencies, as collaboration across agencies (and sometimes with the legislature) is often necessary to succeed. This can be achieved with all actors assembled or through a series of individual conversations.

*Environmental assessment.* Each state's environment is unique and will change over time. Before committing to a large-scale payment initiative, the state should consider these questions:

1. Has the state previously attempted to establish a VBP model, and what were the lessons learned?
2. Is there sufficient leadership support across state government for a new effort?

3. Is the environment conducive for a new model? For example, is there a lack of competition? Are any payers and providers already testing the model at a small scale?
4. Are key external stakeholders willing and able to collaborate?
5. Are there sufficient resources within or outside the state to provide the necessary staff and financial support?

The state should conduct an environmental assessment at the outset to determine the perspectives of key stakeholders and learn where there might be opportunities and barriers. First, the state should identify whether there is requisite leadership to champion a statewide shift toward an multipayer VBP model. Sustained leadership is a common factor among states that have successfully implemented multipayer VBP models. Without at least one champion, the state will have difficulty garnering support. Leadership may come from the governor's office, the Medicaid agency, the insurance commissioner, the legislature, or some other executive branch agency.

Next, the state should talk to key stakeholders and other knowledgeable parties who can be valuable in determining the degree of external stakeholder support and readiness. We have listed some viewpoints that state staff should anticipate.

**External Stakeholder Opinions That States Should Anticipate**

Stakeholder	Potential opportunities for a multipayer VBP model	Potential threats from a multipayer VBP model
Consumers and consumer advocates	<ul style="list-style-type: none"> <li>Improved affordability, access, equity, quality of care, and population health</li> </ul>	<ul style="list-style-type: none"> <li>Harmful unintended consequences to access, equity, quality of care, and population health</li> </ul>
Employer purchasers (e.g., businesses, labor organizations)	<ul style="list-style-type: none"> <li>Greater influence from aligning, which leads providers to be more responsive</li> <li>Improved affordability, access, equity, quality of care, and population health</li> </ul>	<ul style="list-style-type: none"> <li>Loss of autonomy under a regulated payment model</li> <li>Design needs not considered by state</li> </ul>
Insurers	<ul style="list-style-type: none"> <li>Improved ability to engage providers in change</li> <li>Improved access, equity, quality of care, and population health</li> </ul>	<ul style="list-style-type: none"> <li>Loss of autonomy under regulated payment model</li> <li>Lack of fit with existing models and systems</li> <li>Burden associated with adopting new model</li> <li>Difficulty compelling providers to participate unless mandated by state</li> </ul>
Legislators	<ul style="list-style-type: none"> <li>Improved affordability, access, equity, quality of care, population health, and system accountability</li> </ul>	<ul style="list-style-type: none"> <li>Extending government’s role in private commercial market</li> </ul>
Provider organizations	<ul style="list-style-type: none"> <li>Agreement on interests with payers, which may reduce conflict and administrative costs</li> <li>Steady, predictable revenue, especially during times when care is disrupted</li> <li>More flexibility in providing nonbillable services</li> </ul>	<ul style="list-style-type: none"> <li>Assumption of financial risk for managing costs, burden associated with adopting new model, especially for smaller providers with limited resources</li> <li>Potentially more difficult to price discriminate (e.g., charging more to commercial market than the public sector pays)</li> <li>Loss of revenue growth opportunity that exists with fee-for-service-dominant models</li> <li>Some providers may be concerned about impact on ability to deliver needed care</li> </ul>
State agencies	<ul style="list-style-type: none"> <li>Improved affordability, access, equity, quality of care, and population health</li> </ul>	<ul style="list-style-type: none"> <li>Need for new statute</li> <li>Legislator and key stakeholder opposition</li> <li>Burden associated with implementing and regulating new model</li> <li>Harmful unintended consequences to access, equity, and quality</li> </ul>
Centers for Medicare and Medicaid Services (CMS)	<ul style="list-style-type: none"> <li>Improved affordability, access, equity, quality of care, and population health</li> <li>Amplify impact of Medicare initiatives through alignment with existing Medicare VBP models</li> </ul>	<ul style="list-style-type: none"> <li>State desire to modify CMS standard models</li> <li>State desire for financial support</li> </ul>

Finally, the state should evaluate the financial resources and personnel (including contracted personnel) that will be needed to support the work. If they are not already in place, the state should assess the likelihood that it can pull together the resources it needs.

*Decision on whether to proceed.* The preceding steps should provide the state with sufficient information to decide whether the circumstances are ripe for proceeding. Because of the considerable effort required to succeed with such an endeavor, the state should be confident that there is a sufficient window of opportunity to foster success.

## Step 2. Select aligned payment model(s).

*Identification of where to focus.* To slow commercial market spending growth and make health care more affordable, the payment model should address those areas where a) health care spending has risen the most, b) spending has been high relative to other states, or c) spending has varied greatly across the state. The state should start by assessing the cost drivers in its commercial market over the last three to six years, recognizing that there will be aberrant utilization and spending patterns in 2020 and 2021 due to the coronavirus pandemic. The state should keep in mind that there may be instances when spending growth is favorable, such as when there is more investment in primary care.

The state can analyze cost drivers by using its all-payer claims database (APCD), if it has one, or by using state employee health plan data as a proxy if it does not. Commercial claims databases are also available from vendors and can be used for supporting analyses.

A report by the Health Care Cost Institute identified the following areas with the [greatest per capita growth](#) between 2015 and 2019:

- Spending on facility payments for outpatient services increased by \$399 per person.
- Spending on prescription drugs increased by \$286 per person (excluding manufacturer rebates).
- Spending on professional services<sup>1</sup> increased by \$243 per person.

Of course, data will vary from state to state. During this same period, for example, an analysis of Connecticut's APCD revealed that annual per capita spending growth in the commercial market was [very high for inpatient hospital services](#) and low for professional services.

*Selection of VBP model(s).* The remainder of this section will focus on the options for VBP models that address drivers of cost growth. We focus on budget-based models that are more likely to constrain spending growth. And we include payment models that target hospital, professional, and pharmacy services, as well as those that include the total

<sup>1</sup> Professional services generally consist of specialty physician services, but they also include primary care physician services and nonphysician professional services (for example, care provided by nurse practitioners, behavioral health counselors, or physical therapists).

cost of care. In particular, we examine specialty payment models, rather than primary care models, since primary care represents a small percentage of total spending and is not a driver of cost growth.

States may choose one or more VBP models, with multiple payment models potentially used in complementary fashion. These models will generally be more applicable to larger providers. States may want to (or, politically, need to) consider additional VBP models, not discussed in this guide, that are more viable for small, rural, and/or safety net providers.

When considering payment model options, states should consider these questions:

- How will the state balance the opportunity to mitigate cost growth with the realities of political and operational feasibility?
- Which model(s) will it be easier to get stakeholder buy-in for, and which will be more difficult?
- Does the state have experience with a model that has been implemented successfully?
- How might incentives for quality and equity be built into each payment model?

### **Focus: Hospital Spending**

States should consider two VBP models for hospitals: hospital global budgets and episode-based payment. These models are quite different in their approach, scope, complexity, and potential impact.

*Hospital global budgets* are intended to cover most or all of the services provided by a hospital facility over a given period (usually, a year). Budgets are defined prospectively and administered either through prospective payment (examples include some payers in [Pennsylvania](#) and [Vermont](#)) or through fee-for-service payments that are adjusted during the year based on budget performance (for example, in [Maryland](#)). They typically include all facility services but may also include employed professional services (such as specialty physician services, primary care physician services, and nonphysician professional services) and those delivered by other hospital-owned service providers (such as skilled nursing facilities). We discuss this payment model in detail in [Adopting Multipayer Hospital Global Budgets](#).

In contrast, *hospital episode-based payments* bundle payment for all services related to a specific episode of care, which is usually connected to a specific service or condition. For example, CMS’s [Bundled Payments for Care Improvement Advanced \(BPCI Advanced\) Model](#) was a single retrospective bundled payment model with two-sided risk (providers shared savings with payers but were also responsible for a portion of losses) and payment tied to performance on quality measures. These typically include surgical procedures, such as joint replacement,

but they can also include maternity care and treatment of health conditions. Hospital episode-based payment budgets are defined prospectively and administered either through prospective payment or through fee-for-service payment that is retrospectively reconciled. Hospital episode-based payment models can include non-hospital-employed professionals, but their inclusion will add administrative complexity.

We summarize the strengths and challenges of these two models below.

**Strengths and Challenges of VBP Models: Hospital Global Budgets and Hospital Episode-Based Payments**

Model	Strengths	Challenges
Hospital global budget	<ul style="list-style-type: none"> <li>• Provides mechanism to control annual growth in hospital spending, controlling both price growth and service growth</li> <li>• Gives hospitals more certainty regarding revenue, thereby aiding financial stability</li> <li>• Can include hospital-employed professionals and other nonhospital lines of service</li> <li>• Evidence from <a href="#">Maryland</a> and <a href="#">New York</a> of positive financial impact</li> </ul>	<ul style="list-style-type: none"> <li>• Requires universal or near-universal payer participation, including Medicare</li> <li>• Hospitals will likely advocate for increased funding, including from Medicaid</li> <li>• Unfamiliar to hospitals</li> <li>• Complex to administer</li> <li>• This budgeting mechanism will be effective only if hospitals don’t use market power to drive high annual budget growth</li> </ul>
Hospital episode-based payment	<ul style="list-style-type: none"> <li>• Many hospitals have experience with it through Medicare</li> <li>• Provides strong incentive to change and improve care delivery, especially care coordination</li> <li>• <a href="#">Evidence from Medicare</a> of positive financial impact</li> </ul>	<ul style="list-style-type: none"> <li>• May constrain only small percentage of total hospital spending increases by only focusing on specific care episodes</li> <li>• Does not address financial incentive to increase volume</li> <li>• Ideally includes professionals but is complex to do so</li> <li>• Budgeting mechanism will be effective only if hospitals don’t use market power to drive high annual episode price growth</li> <li>• No agreed-upon, standard set of episode definitions</li> </ul>

**Focus: Professional Spending**

States should understand *which* professional spending categories they wish to prioritize for VBP before selecting a model. To inform this decision, states should determine which professional specialty services have seen the greatest health care cost growth, as well as where total spending differs from external benchmarks or varies across the state. They should also take into consideration the composition

of the provider markets for these services. For example, are there large independent groups, or are professionals either hospital-employed or organized in small practices?

States should consider two VBP models for professional services: specialty capitation and episode-based payment. We focus here on specialty payment models rather than on primary care, since primary care represents a small percentage of total spending and is not a driver of cost growth.

**Specialty capitation** (or specialty prospective payment) involves a prospective per capita monthly payment for all patients for which a specialty group is accountable. The payment is only for the services to be delivered by the specialty group, meaning it does not include hospital or other facility services, nor does it include professional services other than those for which the payment has been made. In this case, we refer to an organization of non-primary-care professionals as a “specialty group.” Payers confer accountability for a patient population through some manner of patient attribution.

**Professional episode-based payments** are also prospective. They are in many ways analogous to hospital episode-based payments and are sometimes preferred because professionals often dictate care delivery. As with hospital episode-based payment, “episodes” may include surgical procedures, maternity care, and treatment of medical conditions such as hypertension or diabetes. They may also include treatment of behavioral health conditions. Professional episode-based payment budgets are defined prospectively and administered either through prospective payment or through fee-for-service payment that is retrospectively reconciled. Professional episode-based payment models can include both professionals

and hospitals in the financial arrangement, but doing so introduces added administrative complexity.

Several states have launched multipayer episode-based payment models. In 2012, **Arkansas** established statewide episodes of care under the Arkansas Health Care Payment Improvement Initiative, with mandatory participation of Medicaid and voluntary participation for commercial health plans. Episodes included total hip and knee replacements, congestive heart failure, and perinatal care, among others. All episodes in Arkansas Medicaid’s Episodes of Care program were phased out over 2020 and 2021.<sup>2</sup>

In 2014, **Tennessee** implemented an episodes-of-care program through TennCare, its Medicaid program, supported by a federal State Innovation Model (SIM) grant. (We discuss Tennessee’s model in greater detail later in this guide.)

We summarize the strengths and weaknesses of these two models below.

<sup>2</sup> According to the Arkansas Department of Human Services, the Episodes of Care Program was **phased out** because the positive incentives (gain share) began outweighing the negative incentives (risk share), and the program “exhausted any practical selection of new or additional conditions or procedures for which to study.”

**Strengths and Challenges of VBP Models: Specialty Capitation and Episode-Based Payment**

Model	Strengths	Challenges
Specialty capitation	<ul style="list-style-type: none"> <li>Provides mechanism to limit annual growth in specialty provider spending, controlling both price growth and service growth</li> <li>Much simpler to implement than episode-based payment</li> </ul>	<ul style="list-style-type: none"> <li>Requires significant risk assumption by providers</li> <li>Only viable with larger specialty providers</li> <li>Requires rigorous mechanisms to guard against inadequate care and adverse selection</li> <li>Budgeting mechanism will be effective only if providers don’t use market power to drive high annual capitation rate growth</li> </ul>
Episode-based payment	<ul style="list-style-type: none"> <li>Provides strong incentive to change and improve care delivery</li> <li>Significant experience with model in multiple states over many years</li> <li>Can capture significant portion of given specialty’s spending if implementing multiple episodes</li> </ul>	<ul style="list-style-type: none"> <li>Complex to administer</li> <li>Less practical experience with episodes of chronic conditions, which offer greatest savings potential</li> <li>Need to implement on broad scale to capture large percentage of spending</li> <li>Does not address the financial incentive to increase volume</li> <li>Challenging to implement with small providers</li> <li>Budgeting mechanism will be effective only if providers don’t use market power to drive high annual episode price growth</li> <li>No standard set of episode definitions</li> </ul>

**Focus: Pharmacy Spending**

Despite high rates of pharmacy spending growth across commercial markets, Medicaid, and Medicare, there has been very limited use of VBPs in this sector. There are many reasons for this, including that pharmacy spending is considered a good and not a service. Also, patent protections provide drug manufacturers with tremendous market power. As a result, few states have applied value-based approaches to payment for prescription drugs. Examples are primarily in instances where commercial insurers negotiate payments for new drugs with manufacturers and where they are able to link payment terms or coverage terms to assessments of efficacy.

**Oklahoma** was the first state to sign a value-based contract for a prescription drug. The state now has value-based arrangements that use supplemental rebate agreements for products that manufacturers and the state agree on. Oklahoma currently has agreements on long-acting injectable antipsychotics, an epilepsy drug, and an antibiotic used mainly in emergency departments. The state’s value-based arrangements relate to financial outcomes, including adherence, costs, and hospitalizations. If a drug fails to meet certain benchmarks, the manufacturer must make additional payments to the state in the form of a supplemental rebate.

**Strengths and Challenges of VBP Models: Performance-Based Outcome Guarantee and Conditional Coverage for Prescription Drugs**

Model	Strengths	Challenges
Performance-based outcome guarantee	<ul style="list-style-type: none"> <li>• Payer receives a rebate from manufacturer if drug does not achieve desired outcomes</li> </ul>	<ul style="list-style-type: none"> <li>• Requires considerable manufacturer negotiation and evaluation</li> <li>• Limited to new drugs</li> <li>• There may be very few drugs for which manufacturer would agree to be held accountable for outcomes</li> </ul>
Conditional coverage	<ul style="list-style-type: none"> <li>• Continuing coverage of drug is predicated on meeting metrics of effectiveness</li> </ul>	<ul style="list-style-type: none"> <li>• Requires considerable manufacturer negotiation and evaluation</li> <li>• Limited to new drugs</li> </ul>

**Focus: Total Cost of Care**

Payment models encompassing the total costs of care may be the most common VBP payment model in the United States. Unlike the other payment models, which focus on specific services, total-cost-of-care models extend financial accountability to contracted provider entities for the entirety, or near-entirety, of covered services. The ability to capture such a high percentage of spending accounts for the model’s popularity with public and private payers alike.

Most applications for total-cost-of-care VBP models have involved setting prospective budgets, making fee-for-service payments, and retrospectively reconciling against the budget. The provider entity often shares in any savings but is not subject to financial penalties should spending exceed the budget. These are also referred to as “shared savings,” “upside only,” or “one-sided” risk arrangements.

While this model introduces an incentive to manage costs and cost growth and improve quality, the incentive is not particularly strong, because provider entities do not bear the risk of financial losses. The model also maintains the underlying (and inflationary) fee-for-service payment system. For this reason, states should consider two VBP models for hospitals: global capitation and total cost of care with shared risk.

*Global capitation* involves a prospective budget and prospective payment. It provides a strong cost-management incentive, so it is also an incentive for the contracting provider entity to reimburse its affiliated providers using a modality other than fee-for-service. Quality can be integrated into global capitation in multiple ways. **Montefiore Health System** in **New York** and Nationwide’s **Partners for Kids** in **Ohio** are examples of provider systems that have entered into *global capitation contracts with payers*.

*Total cost of care with shared risk* involves a prospective budget with fee-for-service payment and retrospective reconciliation. Provider entities share in both gains and losses relative to the budget (two-sided risk) upon reconciliation, with the reconciled gains and losses modified by quality performance. **Vermont** is currently in an all-payer model agreement with CMS for Medicare (originally a five-year agreement from 2018–2022, with a one year extension in 2023 and optional transition year

in 2024). Medicaid also participates, as do Blue Cross Blue Shield of Vermont and MVP Health Care (for lives covered through the state health insurance marketplace). Under Vermont’s model, payments from each payer flow to OneCare Vermont, the state’s only accountable care organization.<sup>3</sup>

<sup>3</sup> Vermont’s model includes a mix of prospective and retrospect payments because the state does not dictate a universal payment modality.

**Strengths and Challenges of VBP Models: Global Capitation and Total Cost of Care with Shared Risk**

Model	Strengths	Challenges
Global capitation	<ul style="list-style-type: none"> <li>Provides mechanism to control annual growth in total spending, which controls both price growth and service growth</li> <li>Simple design yields significant cost savings</li> </ul>	<ul style="list-style-type: none"> <li>Requires significant risk assumption by providers</li> <li>Only viable with larger provider organizations</li> <li>Provider entities may be challenged to pay affiliated providers using non-fee-for-service payment</li> <li>Requires rigorous mechanisms to guard against inadequate care and adverse selection</li> <li>Budgeting mechanism will be effective only if providers don’t use market power to drive high annual growth in capitation rates</li> <li>If budget is based on historic spending and provider’s prices are already higher than competitor prices, it locks in those high prices going forward</li> </ul>
Total cost of care with shared risk	<ul style="list-style-type: none"> <li>Sets annual budget for spending with incentive for restraining growth while limiting provider downside risk (loss of revenue if spending exceeds agreed-upon financial thresholds)</li> <li>Significant provider experience with model nationwide</li> <li>Some evidence of positive financial impact in <a href="#">commercial market</a>, but less in <a href="#">Medicare</a></li> </ul>	<ul style="list-style-type: none"> <li>Retains underlying fee-for-service payment model</li> <li>Providers often resist significant downside risk, which diminishes incentive to restrain spending growth</li> <li>Budgeting mechanism will be effective only if providers don’t use market power to drive high annual growth in total-cost-of-care budgets</li> <li>If budget is based on historic spending and provider’s prices are already higher than competitor prices, it locks in those high prices</li> </ul>

**Step 3. Determine who should convene, facilitate, and manage the multipayer VBP arrangement(s).**

Once the state has identified its internal goals and preferred VBP model, it should select a primary convener to facilitate and manage the multipayer arrangement. There are two general approaches to this: select a state convener or a nonstate convener.

*State convener.* A state may choose to run its multipayer VBP initiative through a state agency if there is requisite leadership and political will within the government. Which agency is best positioned to lead the work depends largely on the state’s preferred VBP model and where leadership is concentrated. Because the locus of state

health policy leadership varies considerably, we make no recommendation on a preferred state convener. Regardless of which agency is the primary convener, the model will likely require communication and participation across multiple agencies.

*Nonstate convener.* A nonstate convener can serve as a trusted, independent, neutral party; bring additional staff resources and capabilities to the table; and protect the initiative from changes in administration and the budgeting process. The weaknesses of having a nonstate convener are that it may not have expertise in state policymaking and may not be able to compel attention from or action by stakeholders.



## Michigan Multipayer Initiatives

**Michigan Multipayer Initiatives** (MMI) is a nonprofit organization that has served as Michigan's convening and policy alignment hub for CMMI demonstrations and voluntary multipayer efforts. These include the Multipayer Advanced Primary Care Practice CMS Demonstration (2012–2016), the Patient-Centered Medical Home Initiative of Michigan's State Innovation Model (SIM) (2017–2019), and the Comprehensive Primary Care Plus initiative (2017–2021).

MMI convenes a steering committee to advise on multipayer initiatives. Its members include payer, practice, and physician organization representatives; subject matter experts; and a regional convener who supports payers in coordination and operations. MMI's standard operating costs are shared by payers.

*Resources and staffing.* Regardless of whether the initiative is convened by a state agency or nonstate convener, there should be a plan for how the work will be resourced and staffed for planning, implementation, monitoring, and evaluation. If the work involves a formal state agreement with CMMI, it will require ongoing reporting and meetings. If the work is governed or advised by any stakeholder bodies, staffing support will be necessary to prepare for and facilitate meetings. If the work is performed pursuant to legislation, periodic legislative reporting and legislative testimony may be necessary. Resources and staffing should also be appropriately allocated for the planned monitoring and evaluation activities (see **Step 12**).

### Step 4. Determine how to engage stakeholders during the VBP model design process.

There are many ways states can engage stakeholders throughout design, implementation, and evaluation, but two broad approaches are to either design the model and then collect stakeholder input, or to engage stakeholders from the beginning of the model design process.

*State-led design process with stakeholder public comment.* Under this approach, a state would initially design a straw VBP model and then invite stakeholders, and possibly the public, to comment. Because there isn't a need to reach consensus with stakeholders on each design decision, the process is likely to require fewer state resources. However,

strong stakeholder buy-in might be difficult to obtain unless there is significant preexisting support.

*Stakeholder-led design process.* If the state chooses to engage stakeholders in the design from the beginning, it should create a formal process for making each design decision with stakeholders. This may involve assembling a formal work group with all of the relevant stakeholders, as well as facilitating meetings where the group discusses the design decisions and comes to a consensus on each decision. Full consensus may be difficult to achieve but is necessary for successful multipayer model implementation.

This approach may be necessary to secure buy-in from stakeholders but is more resource-intensive and will extend the timeline for the planning phase. It is most appropriate when there is no significant preexisting buy-in.

*Which stakeholders to engage.* Regardless of when a state seeks input during the design process, it should engage the following stakeholders:

- leadership of health care delivery organizations, including midsized and small providers
- the hospital association and medical society
- relevant state agencies, including the Medicaid agency
- commercial insurers
- private employers
- consumers, patients, and their advocates
- key legislators
- possibly the state employee health plan.

The state should be mindful of equity considerations when designing the process (see **Step 7**).

### Step 5. Reach consensus on VBP model goals with stakeholders.

*Stakeholder goal development.* While the state will have developed internal goals for the multipayer VBP model in **Step 1**, it now needs to gain consensus on goals with stakeholders. Obtaining agreement on the goals, and acknowledging and committing to address and resolve each key stakeholder's concerns, can set up the effort to succeed. Conversely, designing a multipayer VBP model

without such agreement and commitment can mean months of work are halted by lack of buy-in when it is most needed.

Agreement on goals is most critical for commercial insurers, as without a legislative mandate, there is nothing that can compel their universal participation. Experience shows that in states with dominant domestic insurers that operate only in those states, or in a few states in that region, there is a greater likelihood of insurers voluntarily collaborating on a multipayer model. Domestic insurers will likely be more willing to customize their programs to the state or states in which they do business. States with commercial markets controlled by national insurers are likely to have difficulty achieving voluntary alignment on a multipayer model. National insurers typically resist customizing their payment approach for each locale to meet state-specific preferences or requirements.

There is a second reason why success of a multipayer VBP model initiative depends on clearly articulated and widely adopted goals: these goals should become a set of guiding parameters for the design process, helping stakeholders make key design decisions as they move from general concept to operational model. Using goals in this manner ensures integrity of the design process, and it increases the likelihood that the end product will be consistent with the shared objectives that initially brought the parties together.

*Potential goal statements.* To slow spending growth in the commercial market, it makes sense for states to start with a goal statement focused on improved affordability. For example: “The multipayer VBP model should be designed to restrict per capita spending growth to [state median wage growth/state economic growth/the state’s cost growth target].”

If the payment model targets a particular set of services or provider type, the goal language can be more tightly drawn around that focus area.

Given the focus on a value-based payment model, there will likely be several other goals, such as better access, quality, equity, and population health. Goals might also address creating financial stability in a specific provider market, for example, a primary care, hospital.

In addition, the multipayer VBP model should not create barriers to necessary care or deepen health inequities. And it should reward provider organizations that produce statistically meaningful improvement or achieve predefined levels of excellence on a common set of prioritized quality and equity measures.

*Measuring progress toward goals.* No matter which goals the state and its stakeholders select, those goals should be measurable for implementation, monitoring, and evaluation purposes (see **Step 12**). However, because the measures will depend on the selected model design and the plans to implement that design, it may be best to define and adopt the measures at the end of the design process.

#### **Step 6. Design the VBP model.**

Designing a VBP model requires consideration of a series of payment model design decisions. Some of those design decisions apply across all models (for example, which covered populations it will include), while others are specific to the model (whether to include multiple entities in an episode-based payment arrangement). Some decisions can be considered in sequence, while others are iterative and may need to be revisited along the way.

The table below lists some of the significant design decisions that states should consider for particular VBP models. (It does not include hospital global budgets, which are the focus of *Adopting Multipayer Hospital Global Budgets*.) The table also excludes pharmacy VBP strategies, because they differ greatly from other models and have limited application.

**VBP Model Design Decisions States Should Consider**

Design decisions	Type of VBP model			
	Episode-based payment	Specialty capitation	Global capitation	Total cost of care with shared risk
What general services will the VBP model focus on? (For example, hospital or specialty)	√	√		
If the state chooses an episode-based payment model, which episodes will be included?	√			
Will any services be excluded or carved out?	√	√	√	√
Which provider types will be included in the model and share in financial accountability? (For example, professionals, hospitals, or both)	√	√		
Will the provider contracts focus on a single provider type (such as surgical groups) or multiple provider types (such as surgical groups, hospitals, and postacute providers)?	√	√		
Which specific provider organizations does the VBP model aim to include, and will there be qualifications for inclusion or exclusion?	√	√	√	√
Which payer markets (commercial, Medicare, and Medicaid) and which payers are expected to participate?	√	√	√	√
What should the methodology be for developing the VBP model's budget?	√	√	√	√
Will payment be prospective or retrospective with budget reconciliation?	√			
Will provider financial risk be limited and, if so, how and to what degree?	√	√	√	√
How will provider payment be tied to performance on quality of care?	√	√	√	√
How will risk adjustment be used, and how will it be protected against changes in coding practice?	√	√	√	√

**Step 7. Incorporate health equity into the model design, implementation, and evaluation.**

It is critical that states incorporate the goal of improving health equity in their VBP model design, implementation, and evaluation. VBP models have the potential to reduce disparities, but they may also [perpetuate historical inequities](#) in access to care and utilization. What's more, they run the risk of rewarding payers and providers for serving patients who have not historically suffered from discrimination and [penalizing those that serve individuals most affected](#) by inequities. We highlight three strategies for mitigating these impacts below.

*Ensure representation in governing bodies.* States should ensure diverse voices have positions of influence in the planning, implementation, monitoring, and evaluation processes. The people most affected by inequities are not always represented among stakeholders, so states should ensure that the advisory bodies designing and overseeing the VBP model are representative of the

state's demographics. Creating representative governing and advisory bodies ensures that all perspectives are included during decision-making and can foster trust and buy-in from the community. States should support diverse participation by providing funding and staffing to overcome barriers to participation.

*Adjust the model to account for social risk and correct inequities in payment.* Social risk adjustment is a mechanism states can use to promote health equity. Similar to how clinical risk adjustment calibrates payment for clinical diagnoses, social risk adjustment can calibrate payment for social factors such as socioeconomic status, race, and ethnicity. The goal of social risk adjustment is to use a transparent mechanism to adjust resources that are allotted to providers based on the social risk of their patient population, given the strong connection between social risk and health outcomes. For example, **Massachusetts** adjusts Medicaid payments using a [Neighborhood Stress Score](#).

However, social risk adjustment is an emerging concept, with very few tested adjustment models and significant challenges to data collection. Despite these challenges, social risk adjustment, if thoughtfully executed, may be a mechanism for VBP models to support providers that serve historically underserved groups.

States should also keep inequities in payment in mind when designing and implementing their VBP models. Those models may inadvertently penalize providers that serve mainly disadvantaged populations for not achieving high quality scores. Risk-adjusting quality measures for [social factors](#) is one approach payers can take to improve equity in payment, but there is little evidence of how social risk impacts quality measures, nor is there much experience with adjustment. Applying social risk adjustment also means accepting different levels of care for different populations and could run the risk of lowering quality standards. Another strategy for states to consider is increasing upfront payment for organizations that care for socially vulnerable populations.

*Assess improvements in quality and equity.* States should consider linking payment to disparities-sensitive quality measures and to [equity measures](#). When assessing performance, states should stratify their results using health equity data to the greatest extent possible, whether by race and ethnicity, language, disability status, gender identity, geography (by zip code, for example), income, insurance status, sexual orientation, and other social risk factors. States can use health equity targets in their VBP model that aim to reduce inequities in performance and improve performance for subpopulations experiencing known inequities.

### **Step 8. Determine whether to make participation voluntary or mandatory.**

States will need to determine whether alignment with its VBP model will be mandatory or voluntary, whereby health care organizations can choose to participate in the model and generally have an option to leave the model at any time.

*Voluntary approach.* Under a voluntary approach, states can ask health care organizations to participate in the VBP model without any legal or regulatory requirement that they do so. One way to secure participation is to ask organizations to enter into a compact saying they will participate in a certain VBP model. The compact may

contain a set of common principles, VBP model guidelines, and implementation targets. While the compact is not legally binding, signing it demonstrates a commitment to the VBP guidelines and targets. States should try to garner signatures from all health plans, providers, and relevant government entities.

### **Oregon's Voluntary Value-Based Purchasing Compact**

To slow growth in health care spending, Oregon created the voluntary [VBP Compact](#) in 2021 through the state's legislatively mandated Sustainable Health Care Cost Growth Target Implementation Committee. The compact includes a set of principles that are intended to push payers and providers to adopt advanced VBP models and to align efforts across public and private initiatives and markets to the greatest extent possible.<sup>4</sup> The compact encompasses 2021-2024 and sets yearly targets for payers to have a certain percentage of their payments under advanced VBP models.

As of September 2021, Oregon's VBP Compact had 47 signatories and covered 73 percent of the state's population. Oregon subsequently created a VBP Implementation Work Group to ensure the VBP Compact would be successfully implemented. The workgroup has:

- identified paths for accelerating adoption of VBPs across the state
- identified the technical assistance needed to meet the needs of diverse providers
- highlighted challenges and barriers to implementation and recommended policy change and solutions coordinated and aligned with other state VBP efforts.

The workgroup also will monitor progress on achieving the compact's principles, including the VBP targets.

<sup>4</sup> Advanced VBP models include Health Care Payment Learning & Action Network (HCP-LAN) Categories 3A and higher. This encompasses payment models with upside risk only, combined upside and downside risk, as well as prospective payment models. Prospective payment models include capitation, global budgets, prospective episode-based payment, and budget-based models with prospective payment and retrospective reconciliation. See <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.

*Mandatory approach.* States can set regulatory or statutory requirements for payers to increase their use of VBP methods as well as use the purchasing authority of their Medicaid, marketplace, and state employee benefit plans. States can create legislation or regulations that set mandatory annual targets for insurers regarding their participation in VBP models.

Medicaid purchasing authority can be used to add mandatory VBP expenditure targets to Medicaid MCO contracts, either through a model-oriented approach (aligning payment models across all MCOs) or a goal-

oriented approach (establishing goals for the proportion of MCO Medicaid payments made through VBP models that meet specific criteria).

Commercial participation can be ensured by requiring third-party administrators (TPAs) of state employee health plans to adopt a VBP model with common elements or require the same administrators to implement a VBP within a certain percentage of their book of business.

Several states have compelled an increase in VBPs (but not necessarily compelled aligned models).

### **VBP Mandates in Rhode Island, Louisiana, Washington, and Tennessee**

**Rhode Island** has used regulation to require commercial payers to participate in VBP models. In 2010, the state's Office of the Health Insurance Commissioner established a comprehensive set of [affordability standards](#) that addressed commercial payers' adoption of VBP arrangements in their provider contracts for fully insured business. The current standards require that insurers have [at least 50 percent of payments](#) made through an alternative payment model. The commissioner issues guidelines each year that specify the types of payments and payment models that may be credited toward the 50 percent target.

Other states have used their Medicaid MCO contracts to require participation in VBP models. In 2018, **Louisiana** included a [1 percent withholding requirement](#) in its MCO contracts tied to VBPs. The state required that insurers increase their contractual arrangements linked to qualifying VBP models (as defined by the state) and that insurers submit an annual report to the state demonstrating how their VBP models align with Louisiana's MCO incentive-based and other contractual performance measures.

In **Washington**, under the Delivery System Reform Incentive Payment (DSRIP) program, the state, MCOs, and providers are accountable for achieving VBP transformation targets. By the end of 2022, 90 percent of total MCO payments must be made to providers through designated VBP arrangements for the state to secure maximum available DSRIP incentives. Washington has indicated plans to [transition from VBP withholdings to penalties](#).

**Tennessee** required participation in its VBP model through its Medicaid MCOs and its state employee health plan. In 2014, the state implemented an [episodes of care program](#) through TennCare, its Medicaid program, supported by a federal State Innovation Model (SIM) grant. TennCare required all of its Medicaid managed care organizations to implement episodes of care with the same design elements (including the trigger event), quality measures for the designated principal accountable providers, and approach to calculating shared savings and losses. In 2017, Tennessee's Benefits Administration required the two insurers administering its self-insured state employee contracts to implement the episodes of care for their fully insured commercial members.

*Combined voluntary-mandatory approach.* It is important to note that voluntary and mandatory approaches need not be mutually exclusive — states can choose to make some elements of their VBP initiative voluntary and others mandatory. For example, a state may implement a VBP

model through Medicaid and require state employee benefits plans to align with some or all of Medicaid's VBP model design, while encouraging but not requiring all other commercial insurers to align with the model for their fully and self-insured commercial lines of business.

### Step 9. Determine how aligned the multipayer model will be.

Achieving complete alignment in implementation of multipayer VBP models can be extremely difficult. Insurers have invested in automated VBP platforms and software licensing, and CMS has limited flexibility to make state-specific design modifications in a statutorily defined national program. Providers with the greatest market power will likely push back against strict alignment requirements because they may view the model as constraining organizational market power and because they may have succeeded in having private payers align with *their* preferences.

Despite these factors, some significant degree of alignment must occur for a multipayer VBP model to avoid the serious shortcomings of nonaligned models: confusing and perhaps even contradictory economic signaling to providers; increased provider administrative costs; and most seriously, diminished likelihood of improving affordability, quality, and equity.

*Degrees of alignment.* The range of alignment options fall along a continuum from nearly identical to very loose. Three examples of points on the continuum:

- Nearly identical, with deviation only where necessary (for example, for population-relevant quality measures or compliance with statutes and regulations). This approach sends a strong signal to providers about cost-containment and quality priorities and minimizes their administrative burden. But it requires payers to change their existing systems, including any existing VBP models. Of course, this incurs costs and extends the implementation timeline.
- In accordance with consensus payment model parameters, but with room for payer customization where parameters are either general or silent. This approach is less costly to payers but may be more burdensome for them to administer. It may also muddle the economic signal to providers.
- Loosely aligned across payers only in areas of the highest provider priority (such as quality measures or payer provision of data or reports). This approach minimizes administrative costs to payers and would be most burdensome for providers. However, it risks sending a confused economic signal to providers.

*Top opportunities for alignment.* Some areas of alignment are most likely to benefit providers. These areas might also be more achievable than others. They are:

- base payment model but not payment amount or risk assumption level (for example, bundled payment for a particular procedure, with autonomy on prices and how much of provider spending is at risk)
- quality and equity measures used for incentive purposes
- quality and equity incentive methodology.

Exact alignment will be much more difficult to achieve in the areas of patient attribution, risk adjustment methodology, and included and excluded services. But general principles — if not more specific payment model parameters — can minimize the impact of nonalignment in these and other areas.

### Step 10. Identify opportunities for alignment with federal efforts.

When designing a VBP model, states should consider aligning their incentives with those developed by CMS through the Center for Medicare and Medicaid Innovation (CMMI). States should determine whether they will align actively or passively with federal efforts.

*Active alignment.* A state could actively align by formally partnering with CMS on a new state VBP model. CMMI has a strong interest in partnering with states and has led a series of multipayer demonstrations in the past two decades. For example, CMS has offered a series of demonstrations focused on primary care transformation, including the [Multi-Payer Advanced Primary Care Practice demonstration](#), [Comprehensive Primary Care Initiative](#), [Comprehensive Primary Care Plus](#), and, most recently, [Primary Care First](#).

CMS has also tested hospital global budgets through [Maryland's All-Payer Model](#) and [Pennsylvania's Rural Health Model](#), and in a total-cost-of-care model through [Vermont's All-Payer ACO Model](#).

Finally, CMS and the Health Care Payment Learning and Action Network have partnered to create [State Transformation Collaboratives](#). These are initiatives dedicated to accelerating the movement toward alternative payment models, which four states have taken up: [Arkansas](#), [California](#), [Colorado](#), and [North Carolina](#).

*Passive alignment.* If not formally partnering with CMS, states could passively align by selecting a model that is based on existing Medicare programs. For example, episode-of-care models could be based on CMS's [Bundled Payments for Care Improvement Advanced Model](#). ACO total-cost-of-care models could try to mirror CMS's [Next Generation ACO Model](#). And primary care payment models could mirror CMS's [Primary Care First Model](#).

Passive alignment may also take the form of aligned performance and outcome measures. States can align measures used in their VBP model with those used in other CMS programs or initiatives, such as the CMS Medicare Part C and D Star Ratings measures, CMS Medicare Shared Savings Program ACO measures, and Next Generation ACO and CMS Merit-based Incentive Payment System measures. In doing so, states will need to ensure that measures are relevant and meaningful to the populations covered.

*Section 1115 demonstrations.* A state may require additional flexibility to adopt a CMMI model or pursue alternative payment methodologies not available through its Medicaid program. Section 1115 of the Social Security Act gives CMS the authority to approve states' [experimental demonstration projects](#) that promote the objectives of the Medicaid program. States may apply for a Section 1115 demonstration to waive certain federal requirements and authorize federal matching for expenditures that the federal government would not otherwise match. If pursuing an 1115 demonstration, states should plan for additional reporting requirements. States that are proposing to implement value-based payments through these demonstrations are required to undergo robust monitoring and evaluation.

### **Step 11. Decide how the state will support providers to succeed in their VBP model.**

Providers, particularly smaller providers and those without extensive VBP experience, will require technical assistance to support their transition to VBP models. States should plan how they will support providers in this work. Supports may include investment in practice transformation (such as practice coaching, learning collaboratives, or other peer learning opportunities) and investment in health information infrastructure to bolster providers' data sharing and analytic capabilities (see [Step 12](#)). States can also provide trainings, toolkits, and learning

collaboratives on topics such as VBP payment methods and care delivery transformation strategies.

Depending on a state's budget, it may require payers to fund these supports to be delivered by the state. Or, to avoid added burden, a state may choose to require that its insurers, TPAs, and Medicaid MCOs provide the relevant learning opportunities. States may also establish expectations for payers to support providers in their success. Examples of this include providing timely, high-quality cost and quality performance data; holding sessions on how VBP models work; and helping providers use data to manage patient care.

### **Step 12. Create a supportive health information infrastructure.**

A supportive health information infrastructure is essential to successfully implementing a multipayer VBP model. Providers need reliable, up-to-date data to coordinate patient care and track quality measures. Providers should also be able to share data with the state, other providers, and community-based organizations. States might invest in one or more of the following infrastructure supports:

- **Health information exchange:** An electronic system that gives medical professionals and patients access to protected health information (such as prescriptions, lab tests, and hospital visits) from multiple sources in one secure place.
- **Robust quality reporting systems:** A state-sponsored electronic system or state-facilitated protocol for the collection, calculation, and exchange of quality reporting data.
- **All-payer claims database (APCD):** A state database that includes medical claims, pharmacy claims, and eligibility and provider files collected from private and public payers.
- **Provider and payer access to state registries:** Secure access to state registries with vital patient information, such as vaccinations.
- **Provider directory:** A regularly updated list of in-network providers in a specified geographic area and within a particular insurance plan, or a list of providers associated with certain provider organizations.

**Step 13. Create a plan for how the state will monitor progress toward its goals and use those monitoring results to inform any design modifications.**

States undertaking multipayer VBP initiatives should plan how they will assess whether the model is achieving its proposed objectives (see **Step 1** and **Step 5**). State monitoring approaches will differ depending on whether participation in and alignment with the model is mandatory or voluntary.

*Oversight of a mandatory VBP model.* The state will be responsible for overseeing the payment model and stakeholder adherence to the model's parameters. To monitor adherence to the VBP model, the state should routinely perform market conduct exams and review contracts to ensure that health plans are appropriately aligning to the model specifications. The state should also require periodic reporting on progress. Finally, the state should meet with provider organizations regularly to ensure that health plans are abiding by the terms of the statute or regulation.

*Oversight of a mandatory and voluntary VBP model.* Regardless of whether participation in the state's model is mandatory or voluntary, the state should convene a stakeholder body to meet regularly to report progress toward meeting goals laid out in the established compact (see **Step 8**) or statute, share feedback on model implementation, and discuss any changes needed. The state may also consider establishing a governing body that provides oversight of the multipayer activities, creates transparency, and fosters accountability.

*Communicating progress toward VBP model goals.* The state should create a plan for communicating its progress. Keeping the VBP model and its metrics visible is important for maintaining commitment and holding stakeholders accountable. A state's communication plan may involve creating a dashboard with the VBP objectives and metrics, holding public forums, or publishing annual reports.

**Step 14. Anticipate negative consequences of the model design and create a plan for monitoring and correcting them during model implementation.**

VBP models may lead to negative consequences, including market consolidation, price increases, selectively caring for patients that are a better risk, and limiting care, all of which could disproportionately harm people most

**Vermont's All-Payer Accountable Care Organization Model Agreement**

Vermont's [All-Payer Accountable Care Organization Model Agreement](#) with CMS contains goals and benchmarks that are measured over the agreement period (initially 2018–2022, with a one-year extension to 2023 and optional transition year in 2024). The goals include:

- *A financial target:* Between 2018 and 2023, Vermont will keep average cost increases to 3.5 percent and no more than 4.3 percent.
- *A scale target:* By 2022, 70 percent of all Vermont insured residents, including 90 percent of Vermont Medicare beneficiaries, are attributed to an ACO.
- *Health outcomes and quality of care targets:* Vermont must meet four of six population health outcome measures and targets, six of nine health care delivery system quality measures and targets, and five of seven process milestones.

Vermont's Green Mountain Care Board oversees monitoring and reporting on progress toward achieving the alternative payment model targets and publishes progress metrics on a [Performance Summary Dashboard](#).

impacted by inequities and drive up spending growth. States should “pressure test” their VBP model design and implementation plans by asking what could go wrong. This includes, but is not limited to, anticipating provider responses (and lack of response) to the economic incentives embedded in the model. States should use measures to monitor quality of care, undertreatment, and stinting on care for populations with greater health needs. Strong oversight mechanisms and consumer protections are also vital to minimizing negative consequences.

**Conclusion**

Implementing a successful multipayer VBP model requires sustained state leadership, broad stakeholder buy-in, robust provider supports, and regular monitoring and oversight. If implemented successfully, multipayer VBP models can be an important strategy for limiting cost growth while incentivizing higher-quality, more equitable, and better-coordinated patient care.



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