CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

January 14, 2020

Cory King
Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 691
Cranston, RI 02920

Dear Cory,

Thank you for the opportunity for the Care Transformation Collaborative of Rhode Island (CTC-RI) and PCMH Kids to provide feedback to your recent document "Advance Notice of Proposed Rulemaking with respect to 230-RICR-20-30-4: Powers and Duties of the Office of the Health Insurance Commissioner". We are very appreciative of the time and effort which you have put into obtaining input and your careful deliberation around changes that will make positive differences in quality and cost. We applaud your efforts to strengthen the ability of patients to obtain behavioral health services in primary care. We fully support your planned efforts to develop APM plans for specialists. We welcome the opportunity to work with you on the proposed OHIC regulations and offer the below recommendations from CTC-RI and PCMH Kids for your consideration:

1. 4.3 Definitions: (15 d) Patient-Centered Medical Home: A primary care practice which has demonstrated development and implementation of meaningful cost management strategies and clinical quality performance attainment and/or improvement. The requirements for meaningful cost management strategies and for clinical quality performance attainment and/or improvement and the measures for assessing performance, shall be determined annually by the Commissioner.

   Recommendation: Consider review of Primary Care First performance-based payment tied to clinical quality, patient experience, health improvement, cost and/or utilization measures. Outside of CTC-RI contract, presently there are limited quality measures tied to patient experience or utilization in the aligned core quality measures.

2. 4.3 Definition: (18) Qualifying Integrated Behavioral Health Primary Care Practice: a) A primary care practice that is recognized by a national accreditation body (such as NCQA) as an integrated behavioral health practice, or b) A primary care practice that participated in a successfully completed an integrated behavioral health program under the oversight of the collaborative initiative endorsed by R.I. Gen. Laws Chapter 42-14.6 or c) a primary care practice

that completes a qualifying behavioral health integration self-assessment tool approved by the Commissioner and develops an action plan for improving its level of integration.

Recommendation: Consider under b) participated in or "currently participating in integrated behavioral health initiative". Consider providing greater clarity around option c): How will progress be monitored and tracked? For practices with 5000 adult patient attributed lives or 3500 pediatric attributed lives, CTC-RI recommends a staffing plan that supports patient access to behavioral health clinician within 72 hours of identified need and implementation of universal screening for depression, anxiety and substance use disorders. Consider an IBH track option for practices with less than 5000 attributed patient lives such as being supported in use of community health teams which provide behavioral health support for high-risk patients and families.

3. 4.3 Definitions: (19) "Risk exposure cap" means a cap on the losses which may be incurred by the provider under the contract, expressed as a percentage of the total cost of care or the annual provider revenue from the insurer under the population-based contract; (21) "Risk sharing rate: means the percentage of total losses shared by the provider with the insurer under the contract after the application of any minimum loss rate.

   Recommendation: Align with Primary Care First (see Appendix A for Primary Care First Alignment Grid).

4. 4.9: Affordable Health Insurance-General: A.2 "Improved integration of behavioral health services into the primary care delivery system to meet the physical and behavioral health needs of the public; 5. Reduced provision of low-value care".

   Recommendation: Align with Primary Care First core model principles to include: rewarding value-based outcomes over process; supporting efforts to improve primary care — specialist collaboration, supporting actionable data aggregation including a "community analytics" approach to reduce costs across the system, using data to drive practice accountability and performance improvement and leveraging multi-payer alignment; consider strategies to address pharmacy costs, and identify and address health-related social needs.

5. 4.10 Affordable Health Insurance-Affordability Standards C. Primary Care Transformation "One element of primary care transformation is the integration of behavioral health care into primary care practice. 1. Primary Care Practice Transformation and Patient-Centered Medical Home Financial Support model. a. Primary care practices which meet the requirements of a Patient-Centered Medical Home in 4.3 (A) (15) of this Part shall be deemed eligible for practice support payments".

   Recommendation: Primary care practices which integrate behavioral health would benefit from having infrastructure payment support and training support while the practices credential behavioral health clinicians and learn how to successfully integrate behavioral health services and bill for services. CTC-RI understands that OHIC will be working on developing an alternative

payment mechanism (APM) that includes IBH. While this APM development work is in process, added infrastructure care management and incentive payments are needed at least in IBH Year 1 as billing alone, even with added codes, will not adequately support the costs of the IBH clinician and infrastructure support needed for billing and reporting of quality information.

Recommendations: Align infrastructure and incentive payment with Primary Care First and increase payment amount presently provided to PCMH Kids practices to more adequately cover expenses associated with providing care management and advanced primary care.

- Agree with 1(3) Health insurers shall not impose a minimum attribution threshold for making care management PMPM or infrastructure payments to a PCMH;
- Recommend adding an attribution option that is available in Primary Care First called "voluntary alignment" whereby a beneficiary can attest to his or her choice of primary care practitioner;
- Recommend that there be language added that practices which continue to meet the definition of PCMH, practices/SOC shall not experience a gap in infrastructure and care management payment(s);
- Recommend that the health insurers provide a system, a contact person and on-going prospective payment schedule to practices/ SOC.

6. 4.10 (2) Behavioral Health Integration (a): "Health insurers shall take such actions as necessary to decrease administrative barriers to patient access to integrated services in primary care practices."
   (1) Financial Barriers: Health insurers shall eliminate copayments for patients who have behavioral health visit with an in-network behavioral health provider on the same day and in the same location as a primary care visit at a qualifying integrated behavioral health primary care practice as defined in 4.3 9A) (18) of this part.

   Recommendations:
   - Add language around credentialing process whereby practice is notified by health insurer within 1 month if behavioral health credentialing application is complete and in the case of missing information, which added information should be provided to health insurer by the practice;
   - Add language that behavioral health screenings be considered preventive services not subject to co-pay;
   - Add language that health insurers not restrict screening payment when more than 1 screening is done;
   - Add language that when behavioral and mental health screenings in pediatrics are provided according to Bright Futures, the national AAP standard for quality pediatric care, that these screens be recognized with payment for each and every screen that is provided during the visit. Each screening should be paid for by the insurer and paid "with first dollar", not dropping the deductible as this is the pediatric standard of care.

   (2) Billing and Coding Policies: Health insurers shall adopt policies for Health and Behavioral Assessment/Intervention (HABI) codes that are no more restrictive than current Centers for Medicare and Medicaid Services (CMS) Coding Guidelines for HABI codes.

Recommendation: Add language around adopt, align with other insurers and publish policies for HABI codes because policies can be difficult to find and implement, particularly when there is lack of alignment across health insurers.

- Psychiatric Collaborative Care Codes: Add language around covering Psychiatric Collaborative Care Codes which financially would help support access to psychiatry integration within primary care.
- Pediatric: Integrated Family Care Codes: Two recent reports by the CT Health Foundation "Transforming Pediatrics to Support Population Health: Recommendations for Practice Changes and How to Pay for Them" and United Hospital Fund Report "Plan and Provider Opportunities to More Toward Integrated Family Health Care" by Suzanne Brundage discuss work that is being done by other states to promote and provide payment for dyadic (parent-child) mental health interventions. This approach could be particularly relevant in Rhode Island, given the recent eco-system maltreatment analysis and the opioid epidemic. A recent American Academy of Pediatrics report on the principles of financing the medical home for children recommends first dollar coverage without deductibles or co-pays or other cost sharing for necessary preventive care services; adoption of a uniform definition of medical necessity across payers that embraces services promoting optimal growth and development, and prevent, diagnose and treat the full range of pediatric physical, mental, behavioral and developmental conditions.
- Qualifications of eligibility for billing services:
  Licensed Clinical Social Workers:
    - Standardize the option of using licensed clinical social workers (LCSW) across all payers. A LCSW has successfully completed a 2-year masters-level social work program and passed the social work licensing exam. Presently Managed Medicaid allows LCSWs to provide services that are billed under LICSWs. Blue Cross and Blue Shield of Rhode Island does not allow practices to use and bill for behavioral health services that are provided by LCSW and supervised by LICSW. Rhode Island College now has a 2-year masters of social work program with an integrated behavioral health track including a field placement in a primary care practice setting. This option of using qualified LCSW staff in primary care would be very helpful, particularly given the challenges associated with hiring behavioral health clinicians, especially in primary care practices which require clinical staff that speak languages other than English. The differences between an LCSW and LICSW is that an LICSW has completed a master's program, received two years of clinical supervision and passed a licensing exam.
    - Recommend that there be alignment among health insurers standardize and make available supervision requirements when billing for LCSW services that are provided under the supervision of an LICSW CTC-RI requested health plan documents that clearly define the supervision requirements related to LCSW and have not yet received them.

(3) Out-of-Pocket Costs for Behavioral Health Screening: Health insurers shall adopt policies for the most common preventive behavioral health screenings in primary care that are no more restrictive than current applicable federal law and regulations for preventive services. For

administrative simplification purposes, the Commissioner shall issue interpretive guidance on strategies to align screening codes across health insurers and publish them, along with any supporting documentation, on the OHIC website.

Recommendation: See billing and coding recommendations. Include efforts to improve support for screening services when provided by OB/GYN providers. Vermont, for example, has implemented infrastructure and payment transformation strategies to impact screening for depression, anxiety, substance use disorder, social determinants of health, and intent for getting pregnant in OB/GYN practices with impressive results. This strategy is particularly important for RI to consider particularly in light of the opioid epidemic.

(4) Behavioral Health Integration (b) The Commissioner shall determine which practices are Qualifying Integrated Behavioral Health Practices beginning in the fall of 2020 for Health Insurer administration beginning January 1, 2021, and by November 30 each calendar year thereafter. The Commissioner shall issue guidelines on any time limitations for practices to quality under 4.3 (A) (18) (a) and (b) of this Part.

Recommendation: Expand multi-payer strategy options to more clearly commit to training and rapid, early adoption of integrated behavioral health in a capitation model. In the interim, allow for infrastructure and incentive payment for behavioral health clinician/practice/SOC while participating in an IBH primary care initiative in the same way that nurse care management is referenced. Alternatively, one could broaden the definition Primacy Care Transformation and Patient-Centered Medical Home Financial Support Model 4.10 C b (2) to provide care management PMPM for behavioral health clinicians who are participating in IBH transformation activity.

(5) 4.10D Payment Reform: "The purpose of this 4.10D of this Part is to improve the affordability and quality of health care through the implementation of alternative payment models. Alternative payment models are provider contracting practices that are designed to align provider financial incentives with the efficient use of health care resources and encourage the proactive management of the health needs of their patient populations. Furthermore, the Commissioner finds that provider contracting practices that incentivize the efficient use of health care resources and which invest in the capacity of health care providers to manage population health are essential to support the care transformation agenda articulated in 4.10© of this Part and to meet OHIC's legislative mandate to direct health insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral health care delivery.

Recommendations:

- CTC-RI applauds the added focus on primary care pre-payment as an important next step in strengthening comprehensive primary care and improving affordability. Feedback for consideration includes ensuring that insurers develop their pre-payment contracts in an aligned manner to help the involved practices reach the 60% threshold that is believed to be a tipping point for their workflows and processes. Additionally, Medicaid should be encouraged to align with these efforts.

- Pre-payment for pediatric practices needs to be considered separately since there are sufficient differences that require special approaches. It is important to also support this process in a multi-payer way in order to help a burgeoning crisis in pediatric care.
- Continued support for community-based services, such as the statewide Community Health Team network (or equivalent) also should be seen as impacting affordability and quality of care for high-risk patients with increased behavioral health and/or social needs. Health plans should continue to explore ways to support and strengthen these efforts and should be encouraged to consider reducing health plan care coordination expenses that duplicate providing care coordination services through community health teams and primary care practices;
- Align with primary care first which also provides a risk adjustment to account for factors including but not limited to health status and patient demographics; this approach recognizes and pays for the added effort that is involved with caring for more vulnerable adult and pediatric populations.

(6) h. Population-based contracts shall not carve out behavioral health or prescription drug claims.

Recommendation: Agree.

(7) c. For primary care practices recognized as Qualifying Integrated Behavioral Health Primary Care Practice under 4.3 (A) (18) of this Part, Health Insurers shall develop and implement a prospectively paid alternative payment model for primary care that compensates practices for the primary care and behavioral health services delivered by the site.

Recommendation: Similar to other aspects of primary care transformation, CTC-RI recommends that there be alignment among the health insurers for IBH APM and that consideration be given to the differences between adult and pediatric population needs and support.

7. Telemedicine Behavioral Health Pilot:
Massachusetts Health Policy Commission (MPC) recently published a paper (May 2019) "Integrating Telemedicine for Behavioral Health: Practical Lessons from the Field". The MPC invested $2.5 million in 5 provider organizations to implement 12-18 month tele BH pilots for high –need patient populations with the aim or identifying and discussing practical lessons learned and implementation challenges to increase this underutilized service. Rhode Island could benefit from a telemedicine behavioral health pilot program.
4. a. Specialist alternative payment models: "It is in the interest of the public to expand innovative alternative payment models to specialist physician practices to encourage more efficient use of health care resources, reduce unwarranted variation in episode treatment costs and improve the quality of care through the reduction of potentially avoidable complications".

Recommendation: Expand language and strategies to consider how to improve quality outcomes by setting standards with accountability for high-value care coordination and communication between primary care and specialists. Poor communication leads to poorer

quality and more expensive care. Primary care providers presently spend considerable time tracking down specialist test results in areas such as eye exams for patients with diabetes and in obtaining colonoscopy results. Other areas of consideration could be to hold accountable both primary care and specialist providers for closing the referral loop. Having systems in place whereby there is confirmation that specialists have sent reports to primary care prior to being paid might assist with improving care coordination. Analysis of low-value care findings could provide additional direction for strategy opportunities.

Recommend Alignment with Primary Care First: Under the Primary Care First Model, the professional PBP will be adjusted to account for "leakage rate", or the percent of primary care service furnished outside of the practice to the Primary Care First to Primary Care First practice's attributed beneficiaries. This adjustment incentivizes a sustained practitioner — patient relationship.

8. 4.11 Administrative Simplification Task Force

Recommendation: Consider adding CTC-RI to the Task Force as the CTC-RI Clinical Strategy Committee has as a key objective to have providers, systems of care and health insurers to work together to identify and implement strategies to reduce administrative burden and increase provider experience.

9. *Other recommendations:*

(1) Assess Community Behavioral Health Spend: Expand strategy to include financial support for community health teams which meet patient needs for behavioral health services and additionally address patient needs for community health workers who can assist with responding to patient social determinants of health and connection to community resources.
(2) Measuring, Monitoring and Improving Customer Experience: Primary care practices participating in CTC-RI are eligible for incentive payments and monitored on their customer experience performance. Especially as systems of care move toward shared savings, it is essential that there be a method for measuring and monitoring how well primary care practices are meeting patient experience needs.
(3) Price Transparency and Health Care Spending Analysis: The Massachusetts Health Policy Commission 2018 Annual Health Care Cost Trends Report makes recommendations that might benefit Rhode Island including: efforts to reduce drug spending growth around high-cost drugs and ability of the state to negotiate directly with drug manufacturers; advancing specific data-driven interventions to address provider price variation, implementing site-neutral payments for select services, and flexible funding to address health-related social needs.
(4) All-Payer Claims Database Investments: Onpoint Health Data has the capability to include information on diagnosis as part of the utilization performance reports, but this added functionality is not yet available. This information would be very helpful in being able to identify and analyze utilization and cost trends.

(5) Early in Life Prevention: As noted in the AAP article on financing of pediatric PCMH, consider covering services that can be integrated into the medical home including home visiting during pregnancy and early childhood.
(6) Transition from Pediatrics to Adulthood: Recommend consideration of enhanced rate for services that are delivered when there is effective transition of care, especially from pediatric to adult providers, as well as from hospital to home care.

CTC-RI and PCMH Kids welcome the opportunity to work with OHIC on your policy efforts to improve the care for all Rhode Islanders.

Sincerely,

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Primary Care First Multi-Payer Alignment Principles

Primary Care First (PCF) is a multi-payer model, like Comprehensive Primary Care Plus (CPC+) Tracks 1 and 2. CMS will partner with selected payers, including Medicare Advantage plans, commercial health insurers (including plans offered via state or federally facilitated Health Insurance Marketplaces), states (through the Medicaid and CHIP programs, state employees program, or other insurance purchasing), Medicaid/CHIP managed care organizations, state or federal high risk pools, and self-insured businesses or administrators of a self-insured group (Third Party Administrator (TPA)/Administrative Service Only (ASO)). Payer partners must commit to offering participating practices a primary care payment model that is aligned with Primary Care First.

CMS believes that multi-payer engagement is critical for amplifying the impact of PCF and driving primary care transformation. Aligned multi-payer partnerships increase the potential impact of value-based primary care models by:

1) Promoting consistent value-based incentives across a practice's entire patient population, which strengthens the influence of those incentives;
2) Encouraging practices to work towards similar objectives for their entire patient panel. This enables them to develop one comprehensive care approach rather than having to apply different care delivery models depending on payer status, which is administratively burdensome and at odds with patient-centered care; and
3) Reducing the administrative burden that practices face working with all of their payers, resulting in a larger net reduction in burden and a greater increase in resources to devote to direct patient care.

Payer partners need not offer identical primary care models in order to make progress towards these goals. Aligned models may differ on specific details, including in the mechanics of their payment methodologies, as long as they are aligned with PCF's four core model principles and objectives. The four core principles of PCF are: (1) moving away from a fee-for-service payment mechanism; (2) rewarding value based outcomes over process; (3) using data to drive practice accountability and performance improvement; and (4) leveraging multi-payer alignment as a critical tool for driving adoption of value-based care models. The table below provides a rubric for how CMS will review payer partner proposals, including specific criteria tied to each of the four core PCF principles. For each of the criteria, the table defines what would be deemed "not sufficient alignment," "acceptable alignment," and "preferred alignment." CMS encourages prospective payer partners to design an aligned payment model that meets as many of the "preferred alignment" criteria as possible. However, CMS will still accept payers who meet "acceptable alignment" criteria in some areas, with the expectation that these payers will work towards meeting "preferred alignment" standards during the course of their participation in the model. CMS will also consider proposals from payers that fall under "not sufficient alignment" on one or two criteria, and will seek follow-up conversations with those payers about the reason for the lack of sufficient alignment before making a final decision about whether to select them as payer partners. CMS recognizes that state Medicaid agencies may face specific constraints that make it challenging to meet some of these alignment criteria, and intends to work closely with interested state agencies to facilitate their participation in the model.

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Principle 1: Move away from fee-for-service payment mechanism			
Minimize volume-based incentive	• Partial primary care capitation with more than 50% of revenue reimbursed through capitated or other non-visit-based payment *OR* • Full primary care capitation	• Primary care episodes *AND/OR* • Shared savings/shared losses *AND/OR* • Partial primary care capitation with less than 50% of revenue reimbursed through capitated or other non-visit-based payment	• Fee-for-service plus care management fee *OR* • Fee-for-service plus at-risk care management fee *OR* • Reimburse additional codes for non-face-to-face services *OR* • Higher fee-for-service rates for primary care services
Risk adjustment	• Alternative to FFS payment is risk adjusted to account for factors including but not limited to health status and patient demographics	*Same as preferred alignment*	• Alternative to FFS payment is not risk adjusted
Principle 2: Reward outcomes, not process			

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Practices' reimbursement influenced by outcomes, not process	• Performance-based payment tied to clinical quality, patient experience, health improvement, cost and/or utilization measures *AND* • Performance-based payment tied at least in part to utilization and/or total-cost-of-care measure(s) *AND* • Performance-based payment not tied to achievement of care delivery processes (though care delivery processes/ certifications may be used to determine practice eligibility at start of model)	• Performance-based payment tied to clinical quality, patient experience, cost and/or utilization measures *AND* • Performance-based payment tied at least in part to utilization and/or total-cost-of-care measure(s) *AND* • Performance-based payment tied in part to achievement of care delivery processes	• Practices' reimbursement not influenced by performance in any way *OR* • Performance-based payment tied in full to achievement of care delivery processes *OR* • Performance-based payment not tied to utilization and/or total-cost-of-care measure(s) in any way
Performance can have substantial impact on practices' payment	• Maximum possible performance-based payment adjustment can increase practices' primary care revenue by more than 15%	• Maximum possible performance-based payment adjustment can increase practices' primary care revenue by between 5% and 15%	• Maximum possible performance-based payment adjustment can increase practices' primary care revenue by less than 5%
Performance-based payment adjustment can be negative if practice has poor outcomes	• Performance can both increase and decrease payment, though potential upside is larger than potential downside	• Performance can both increase and decrease payment; potential upside is equal to potential downside	• Performance can only increase payment

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Alignment with PCF measure set	• Payer uses the same quality and utilization measures as PCF to evaluate and reward or penalize practice performance *AND* • Payer uses few or no additional measures above and beyond the PCF measure set	• Payer uses at least three of the same quality and utilization measures as PCF to evaluate and reward or penalize practice performance[1] *AND/OR* • Payer uses no more than 10 total measures, including PCF-aligned measures and additional measures *AND* • Additional measures are drawn from CMS's "Meaningful Measures" initiative, which used broad stakeholder feedback to identify the highest priority areas for quality measurement and improvement, and includes measures that are applicable across multiple CMS programs and patient populations	• Payer uses none of the same quality and utilization measures as CMS[1] *OR* • Payer uses a large number of additional measures above and beyond the CMS measure set
Principle 3: Deliver meaningful, actionable data reports to drive practice accountability and performance improvement			
Attribution	• Practices receive list of prospectively attributed members at least monthly	• Practices receive list of prospectively attributed members at least quarterly	• Practices receive list of attributed members less than quarterly

[1] CMS may consider additional flexibility on this requirement if payer can demonstrate that the PCF measures are not appropriate or relevant for their attributed populations

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Frequency[2]	• Payers provide service utilization and cost data at least quarterly	• Payers provide service utilization and cost data at least bi-annually	• Payers do not provide service utilization and cost data
Type of data[2]	• Payers provide practices with service utilization and cost of care data for attributed members	• Payers provide practices with some limited service utilization and cost of care data for attributed members	• Payers do not provide practices with service utilization or cost of care data for attributed members
Format of data[2]	• Data is delivered in user-friendly format that enables practices to readily identify improvement opportunities *AND* • Data is accompanied by tailored support and guidance to help practices use the data *AND* • Data can be exported into electronic formats (cvs, xls, etc.) for analysis in an EHR, Excel or other analytic software tools.	• Data is delivered in user-friendly format that enables practices to readily identify improvement opportunities *AND* • Data is accompanied by general (non-practice-specific) guidance about how to use the data *AND* • Data can be exported into electronic formats (cvs, xls, etc.) for analysis in an EHR, Excel or other analytic software tools.	• Data is not formatted in a way that allows practices to readily gain actionable insights; data cannot readily be exported into electronic formats (cvs, xls, etc.) for analysis in an EHR, Excel or other analytic software tools *OR* • No resources are provided to help practices navigate the data *OR* • Payer does not provide data reports to practices
Level of data[2]	• Payers provide practices with beneficiary-level service utilization and cost data	• Payers provide practices with practice-level or practitioner-level service utilization and cost data	• Payers do not provide practices with utilization and cost data

[2] Note: For payers who participate in data aggregation, i.e. combining data from multiple payers into a single platform, the frequency, type, format, and level of data will be dictated by their data aggregation platform. Payers who are not participating in data aggregation should work to align with CMS and other payers in their region on these dimensions to the greatest extent possible, per the "alignment with CMS and other local payers" criteria

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Alignment with CMS and other local payers	• Payer either already participates in or is actively working towards participating in regional data aggregation with CMS and other regional payers, which provides multi-payer data in a single platform	• Payer participates in efforts to align data reporting with CMS and other local payers, including by aligning on the four preceding dimensions (i.e., frequency, type, format, and level of data)	• Payer makes no effort to align data reporting with CMS and other regional payers, including by aligning on the four preceding dimensions (i.e., frequency, type, format, and level of data)
Principle 4: Multi-payer alignment is critical for driving adoption of value-based care models			
Participation in regional multi-payer collaborative activities	• Payer actively participates in and contributes to regional multi-payer collaborative activities related to PCF	• Payer attends multi-payer collaborative events, but does not actively participate in or contribute to them	• Payer does not participate in multi-payer collaborative activities related to PCF that are available in their region
Goal-setting and continuous improvement	• Payers work with their regional peers to set annual goals for regional multi-payer collaboration and alignment, and develop plan for achieving goals/alignment targets AND • Payers demonstrate progress towards goals throughout the year	*Same as preferred*	• Regional payers do not set annual goals for regional multi-payer collaboration and alignment or develop plan for achieving goals/alignment targets

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Transparency on non-payment related topics	• To the greatest extent possible, payer will share information about non-payment related topics, e.g. attribution and risk adjustment methodologies, quality measurement strategies, and practice coaching activities with CMS and other local payers to inform payer alignment and collaboration activities	*Same as preferred*	• Payer does not make an effort to share information about non-payment related topics with CMS and other local payers in order to inform payer alignment and collaboration activities
Enable sufficient practice participation to drive broad-based payment and delivery reforms	• Payer sets reasonable eligibility criteria, e.g. minimum attributed member thresholds, that enable most or all participating PCF practices in their region to participate in the payer's PCF-aligned model	• Payer sets moderately restrictive eligibility criteria, e.g. minimum attributed member thresholds, that would meaningfully limit the number of participating PCF practices in their region that could participate in the payer's PCF-aligned model AND • Payer provides data-driven to CMS rationale for how eligibility criteria is set, e.g., member threshold is set to allow for valid and reliable calculation of performance measures	• Payer sets highly restrictive eligibility criteria, e.g. high minimum attributed member thresholds, that prevent the majority of participating PCF practices in its region from participating in the payer's PCF aligned model