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Advancing State-Based Health Reform through the NC State Transformation Collaborative: A Multistakeholder Initiative in Action

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Policy Points

- The NC State Transformation Collaborative (NC STC) is a public-private partnership that uses a process other states can apply to advance multistakeholder alignment on value-based care
- The NC STC's progress is supported by a neutral convener, strong stakeholder collaboration, a focus on achievable goals, responsiveness to stakeholder feedback, and its alignment with state and federal priorities
- Frequent stakeholder engagement through in-person convenings and individual calls was key to the NC STC's progress

ABSTRACT

Many health providers are interested in making the shift to value-based payment (VBP), as these models can give greater flexibility in providing whole-person care, but administrative burden, variation in payer contracts, and a rapidly changing policy environment can impede their participation and success in these models. Streamlining the administration of payment models and adding supports like data sharing across payers and providers can make it easier for organizations by enabling more flexibility in care delivery, timely access to actionable information, and increased support for the health care workforce. The NC STC, a multistakeholder public-private initiative, aims to do just that and has leveraged an alignment framework to identify shared, actionable goals and drive progress. Key components of the framework include 1) engage a critical mass of stakeholders; 2) establish shared goals and key strategies; 3) develop consensus for collective action; and 4) implement alignment opportunities and refine. This report provides lessons for other states on strategies to advance value-based care through multistakeholder alignment.

INTRODUCTION

The ability to advance health care transformation relies on the development of shared goals across stakeholders — including payers, providers, employers and public health care purchasers, and patient advocates — and aligned action to meet those goals. Health care leaders are interested in adopting VBP models to enable more flexibility in care delivery, reduce health care costs, and improve health. VBP can also support the health care workforce by creating more opportunities to spend time with patients by focusing on the provision of high-quality care rather than the volume of services. It also allows for more consistent, resilient revenue streams (e.g., in the event of a public

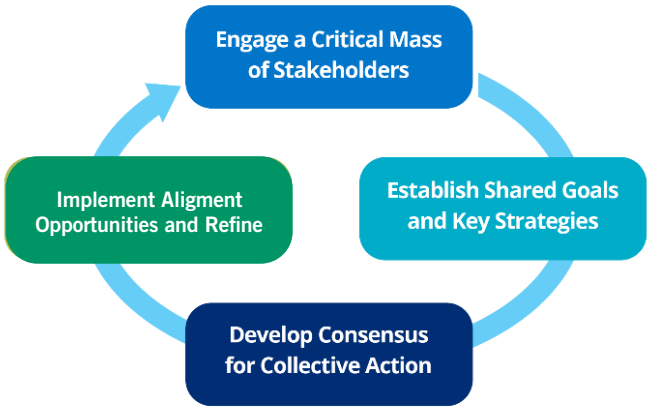
health emergency or natural disaster). However, lack of alignment across VBP models is a barrier both to provider participation in these accountable care arrangements and successful health care transformation, as health providers have to navigate a myriad of payment rules, performance measures, and data requirements across payer contracts.

Multistakeholder alignment on the components of payment models, such as performance measurement and data sharing, can make it easier for provider organizations to adopt VBP arrangements, but getting to agreement on the practical steps is a significant undertaking when payers' approaches vary (e.g., they design and implement bespoke payment models). Several states have launched multistakeholder initiatives, such as the Washington Multi-Payer Collaborative and California Advanced Primary Care Initiative), to build a collective approach to VBP models.

In February 2023, the NC State Transformation Collaborative (NC STC) was launched to promote high-value and whole-person care through multistakeholder partnerships. North Carolina is one of four states participating in the STC initiative, initially launched by the Health Care Payment Learning and Action Network (HCP-LAN) and the Centers for Medicare & Medicaid Services (CMS). In North Carolina, the STC is financially supported by the North Carolina Department of Health and Human Services (NCDHHS) with the Duke-Margolis Institute for Health Policy (Duke-Margolis) serving as the neutral convener.

Unlike other multistakeholder initiatives, the NC STC identifies action steps that meet organizations where they are, and develops pilot programs tailored to address specific barriers to the participation and scaling of VBP. This approach has laid the foundation for scalable statewide solutions and evaluations of success.

Figure 1. NC STC Alignment Framework



THE NC STC'S APPROACH TO MULTISTAKEHOLDER ALIGNMENT

To identify shared goals and make progress, the NC STC modified the Duke-Margolis multipayer alignment framework, creating an Alignment Proposal to outline action areas and short- and long-term alignment opportunities to focus efforts for each of the key strategies. **Figure 1** shows the modified alignment framework.

In this section, we detail how the NC STC applied each component of the modified multipayer alignment framework.

1. Engage a Critical Mass of Stakeholders

Building a critical mass of stakeholders to share feedback, develop strategies, and ultimately support action on those strategies is fundamental to making and sustaining progress in the NC STC. In this context, a critical mass means ample participation and engagement in activities and decision-making across all stakeholder types, including representation from Medicaid health plans and payers that cover the majority of North Carolinians. The NC STC includes health system representatives, health care providers, health plans, clinically integrated networks (CINs), subject-matter experts, community-based organizations (CBOs), employers, and state government entities such as NC Medicaid and the NC Health Information Exchange Authority (NC HIEA). Over time, stakeholders have been added as gaps or needs arose, or as relevant stakeholders have asked to join the initiative. For example, the NC STC integrated employers in the initiative given their interest in

improving access to primary care and reducing provider burden. Engaging with and providing stakeholders with the resources and knowledge to actively participate in NC STC activities, convenings, and conversations is critical to advancing overall goals.

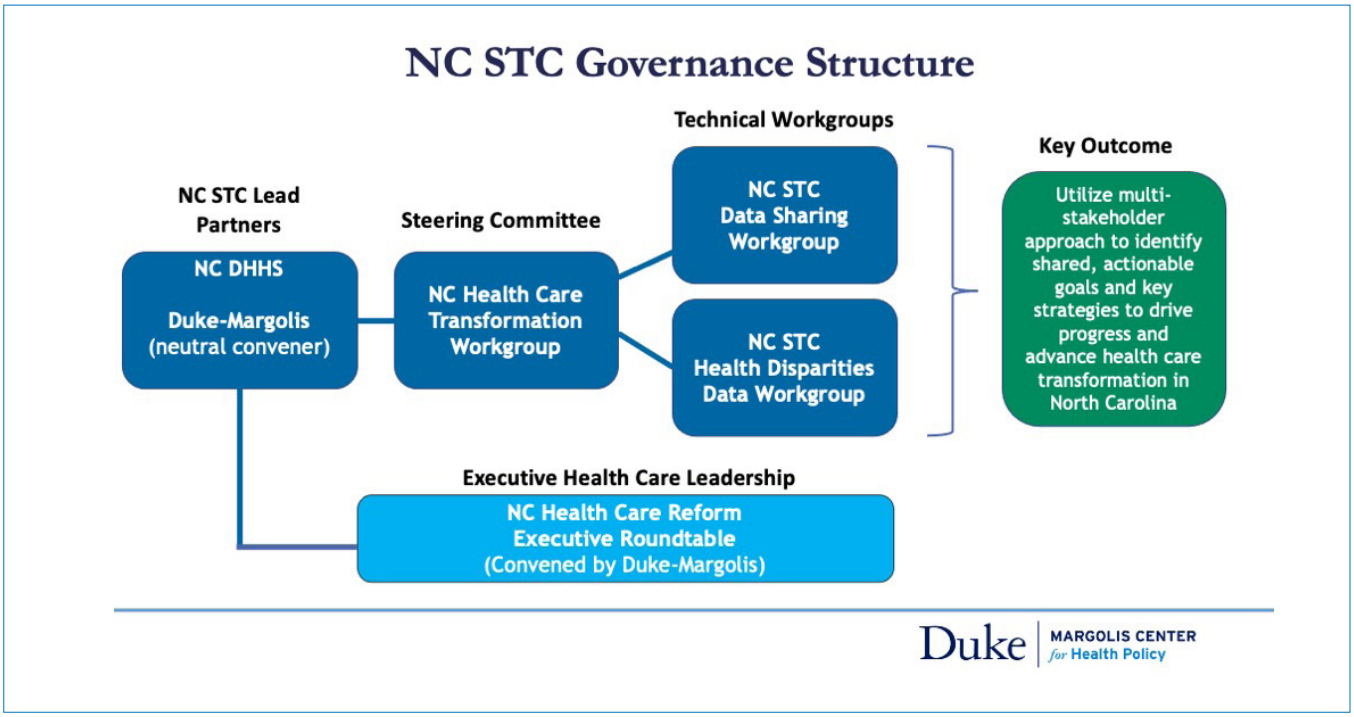
The NC STC uses a number of convening bodies representing different perspectives to drive progress and garner support at multiple levels in an organization (**Figure 2**). The NC STC is guided by the lead partners (NCDHHS and Duke-Margolis), the NC Health Care Transformation workgroup (a multistakeholder steering committee convened by Duke-Margolis composed of representatives from health systems, providers, plans, clinically integrated networks, employers, and state government), as well as technical expertise provided through the Data Sharing and Health Disparities Data Workgroups. Additionally, Duke-Margolis convenes the NC Health Care Reform Executive Roundtable, composed of executive health care leadership, to encourage strategic discussions and identify areas for collective action related to critical issues in health reform. The group helps sustain C-suite level engagement and guidance on the NC STC.

As the neutral convener, Duke-Margolis plays a critical role in identifying champions, ensuring transparency, and navigating differences between the national landscape and state-specific implementation efforts. Since the NC STC's launch, Duke-Margolis has conducted landscape analyses and surveys, engaged stakeholders through 20 STC-focused convenings and other statewide, multistakeholder convenings, and led over 100 learning calls to identify areas most amenable to progress. Duke-Margolis also conducts one-on-one engagement through learning calls, which has been essential to building trust, particularly for stakeholders who may not be willing to speak on a topic in a larger setting.

Key Takeaways:

- Building trust and momentum through relationship building can spur action on shared goals, enabling future payment and delivery reform alignment efforts. For the NC STC, relationship building has been facilitated by:
    - Creating a transparent governance structure that supports building consensus through its guiding Health Care Transformation workgroup, technical workgroups, and executive leadership
    - Engaging a neutral convener that has the bandwidth and neutrality needed to enable progress on multi-stakeholder and cross-payer alignment and drive the initiative forward
    - Conducting one-on-one engagement with stakeholders to build trust by providing a venue

Figure 2. NC STC Governance Structure



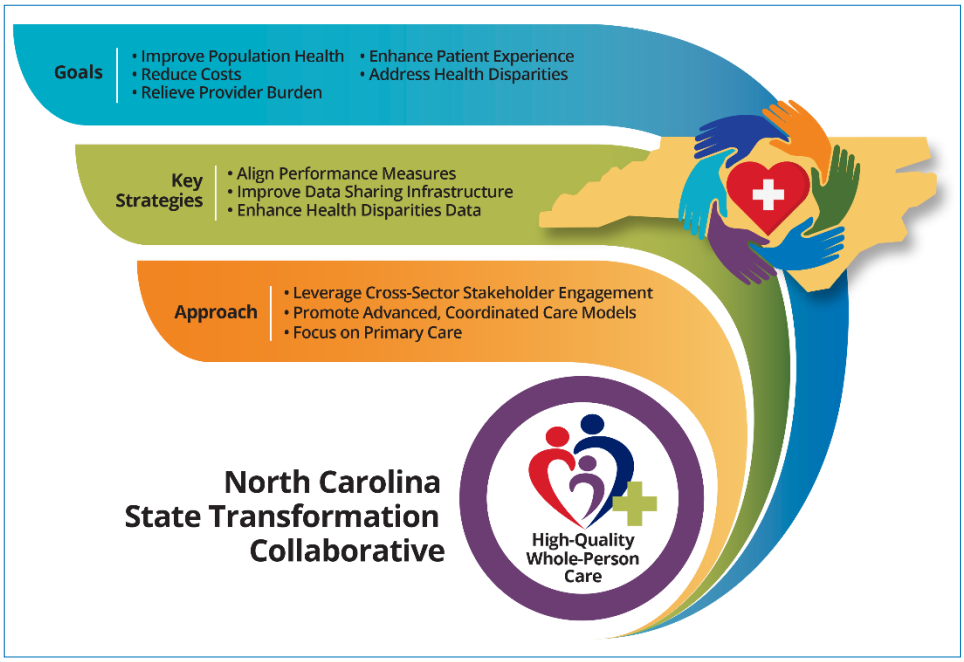
for stakeholders to raise issues that they may not feel disposed to share in a group setting. The personal conversations are needed to make progress, especially on sensitive topics.

2. Establish Shared Goals and Key Strategies

The NC STC established goals and strategies following extensive stakeholder engagement designed to understand the key challenges to and opportunities for advancing VBP in North Carolina. Health care leaders identified five shared goals: 1) improving population health, 2) relieving provider burden, 3) enhancing patient experience, 4) addressing health disparities, and 5) reducing costs. To achieve these goals, Duke-Margolis held one-on-one interviews with health systems, independent practices, federally qualified health centers, health plans, and other key stakeholders. Through these interviews, stakeholders identified common sources of administrative burden that create barriers for advancing health care transformation, including variability in measures and measure implementation across payers and providers.

Three key strategies to address these challenges were identified through additional stakeholder engagement and research on existing federal and state initiatives: 1) aligning performance measures, 2) improving data sharing infrastructure, and 3) enhancing the collection, sharing, and use of health disparities data.[1] Through this process, some options were taken off the table due to lack of broad support (e.g., at the time, prior authorization reforms) or because they fell outside the NC STC's scope. To make progress on the three key strategies, the NC STC focused work in the context of advanced, coordinated care models, starting with primary care. Together, NC STC stakeholders identified potential action areas and corresponding alignment opportunities, or the specific steps for NC STC stakeholders. For example, for the improving data sharing infrastructure strategy, NC STC stakeholders identified streamlining supplemental data submissions – the process of providing information beyond standard claims or administrative data to health plans for performance measurement – as an action area. To address the burden added by this process, NC STC stakeholders identified enabling the use of standardized templates for supplemental data sharing between providers and health plans as the corresponding alignment opportunity. As the neutral convener, Duke-Margolis often held follow-up conversations with stakeholders to assess and pressure test potential approaches. **Figure 3** outlines the goals, strategies, and approach that the NC STC is using to achieve its vision of high-quality whole-person care for all.

Figure 3. NC STC Goals, Strategies, and Approach



Key Takeaway:

Identifying actionable, shared goals (e.g., relieving provider burden) through stakeholder engagement can help make progress, motivate support, and inform strategy development.

[1] CMS defines health disparities data as the combination of quantitative and qualitative elements that enable the examination of health differences between populations and their causes.

3. Develop Consensus for Collective Action

Duke-Margolis leveraged a gradual approach to consensus building by working from collective agreement on shared goals and strategies during early phases of the work, toward increasingly specific action areas. For this section, we've selected two examples to help illustrate the consensus building process and highlight key lessons learned.

Example 1: Improving Data Sharing for Performance Measurement to Relieve Provider Burden and Improve Population Health

During learning calls and early convenings, NC STC providers shared a number of interconnected challenges to participating in VBP contracts with health plans. In particular, providers reported performance measurement posed a significant burden because of both the proliferation of measures across contracts and the variation in how the measures were implemented (e.g., differences in measure specifications and data collection and reporting processes across payers). In response, NC STC opted to identify a subset of measures that are universally adopted in VBP contracts and explore solutions for improving the data sharing process as a starting point for deeper discussion; aligning on measure concepts alone would not sufficiently address the persistent challenges related to providers and payers sharing data to evaluate performance.

Duke-Margolis developed a shortlist of proposed priority measures informed by a review of existing performance measure sets (e.g., CMS's Universal Foundation, North Carolina Medicaid's Advanced Medical Home measure set), the clinical relevance of measures, and provider feedback on which ones present greater data sharing challenges. During an in-person meeting, NC STC stakeholders were asked to vote on the proposed shortlist and initially selected three measures — Childhood Immunization Status (CIS) (Consensus-Based Entity [CBE] # 0038), Glycemic Status Assessment for Patients with Diabetes (GSD) (CBE # 0575, 0059) and Controlling High Blood Pressure (CBP) (CBE # 0018) — with the understanding that the NC STC could focus on additional measures in the future.

Duke-Margolis then convened a Data Sharing Workgroup comprising technical experts from NC Medicaid managed care plans, Medicare Advantage plans, commercial health plans, provider organizations, pharmacy groups, and CINs. Over the course of two meetings, Duke-Margolis leveraged the small-group, primarily in-person meetings to brainstorm challenges and potential solutions for each measure.

Duke-Margolis also held numerous individual meetings with key stakeholders and national experts from organizations such as the NC HIEA and the National Committee for Quality Assurance (NCQA). Finally, three action areas were identified and discussed with NC STC stakeholders:

- Streamline supplemental data submissions for performance measurement
- Identify ways to move toward national interoperability standards
- Build a robust ecosystem to support data sharing in North Carolina

Across all three action areas, stakeholders underscored the importance of multistakeholder efforts that would address the full spectrum of readiness for data sharing, from large health systems prepared to adopt interoperability standards to small, underserved and rural providers that have yet to implement certified electronic health records or need additional staffing and technical assistance to implement bi-directional data sharing.

Once action areas were identified, Duke-Margolis continued to communicate with stakeholders to build momentum. For example, Duke-Margolis prioritized connecting the proposed work to existing state initiatives, including ongoing initiatives with the NC HIEA to support improvements to NC Medicaid's data exchange for the purposes of improving quality measurement and population health. Duke-Margolis also highlighted how the proposed actions of the STC align with the broader federal emphasis on transitioning to digital quality measurement and data exchange by CMS in their digital quality measure roadmap and NCQA via their commitment to transition to fully digital HEDIS reporting by 2030. This emphasis on overlap with other initiatives aimed to reduce stakeholder burnout given the myriad of ongoing health care transformation efforts. commitment to transition to fully digital HEDIS reporting by 2030. This emphasis on overlap with other initiatives aimed to reduce stakeholder burnout

given the myriad of ongoing health care transformation efforts.

In recognition of the dynamic nature of consensus-building, Duke-Margolis maintained open lines of communication with stakeholders throughout each phase of the process to solicit feedback and facilitate continued stakeholder buy-in. For instance, following the initial identification of three priority measures, some stakeholders raised concerns about including the Childhood Immunization Status (CIS) measure due to strategic and data considerations. Strategic considerations included the challenges of meeting targets for a measure already trending toward increasingly poor performance due, in part, to declining vaccine rates in North Carolina and nationally among children under two years of age. Regarding data, stakeholders noted that while the other two measures will continue to require collaborative improvements around data sharing — a key component of the NC STC — immunization data already is strong and largely available as a result of automated data sharing via the North Carolina Immunization Registry. In light of these considerations, a majority of the NC STC stakeholders voted to remove CIS from the NC STC's Alignment Proposal and concentrate aligned implementation efforts on the remaining two measures. CIS continues to be a critical measure prioritized by payers and providers given the clinical importance of immunizations for children at an individual level and population level to reduce the incidence and spread of preventable disease. Given CIS' importance for public health, the NC STC will continue to work on issues related to childhood immunization status in support of the NC STC's overall goals.

Looking ahead, these performance measurement efforts can also support data sharing for population health management and prior authorization.

Example 2: Enhancing Health-Related Social Needs Data to Reduce Health Disparities

Addressing health-related social needs (HRSN) — or unmet social needs like housing instability, food insecurity, or transportation barriers, that are linked to poor health outcomes — is crucial for improving population health, managing chronic diseases, and mediating disparities in outcomes between those with unmet needs and those without. Providers, payers, and community partners require consistent and high-quality data to address HRSN. Through surveys on the current North Carolina health disparities data landscape, stakeholder interviews, and a landscape review, the NC STC found that variation in how organizations collect, share, and use HRSN data creates burden on patients and staff and challenges for directing resources and tailoring interventions to address identified needs. Differences in HRSN data quality and completeness within and across health care organizations can impede interoperability and hinder whole-person care coordination.

To enhance the collection and use of HRSN data to reduce health disparities in North Carolina, Duke-Margolis hosted a NC STC Health Disparities Data Workgroup. The workgroup — comprising health care providers, health systems, health plans, subject-matter experts, CBOs, NC Medicaid, and the NC HIEA — met to identify key barriers, potential opportunities, and guiding principles for multistakeholder action to improve HRSN data collection, sharing, and use in North Carolina. The workgroup aimed to build on the existing state and federal focus on HRSNs, such as screening requirements across Medicaid payers and existing programs like the North Carolina Healthy Opportunities Pilots, a state Medicaid initiative addressing social needs.

The workgroup selected three priority multistakeholder actions to improve the collection, sharing, and use of HRSN data. For example, to address interoperability challenges stemming from the inconsistent application of health disparities data standards and improve the care team's ability to intervene on HRSN, the workgroup recommended that payers, providers, care managers, and CBOs adopt and consistently apply the Gravity Project's standardized terminologies and message formats. The Gravity Project is a national initiative that develops consensus-driven standards for representing and exchanging HRSN data. This approach was selected due to its national recognition, alignment with CMS interoperability objectives and exchange formats, and existing state-level momentum as it builds on NC Medicaid's state-based data pilot for interoperable Medicaid HRSN data connectivity.

Next Steps for Consensus and Collective Action

To work towards securing public commitments from NC STC stakeholders within the Alignment Proposal,

Duke-Margolis held a series of in-person meetings to get feedback on the document. In addition to leveraging live voting during the meetings to get quick reactions, Duke-Margolis conducted pre- and post-meeting individual calls to vet the content. Stakeholders were asked to publicly support the Alignment Proposal by voluntarily signing onto the document, while also having the opportunity to voice concerns and suggest modifications.

As of June 19, 2025, Duke-Margolis reported that 34 of NC STC organizations had signed on to the Alignment Proposal, signaling their commitment to the NC STC and support of enabling whole-person, high quality care in North Carolina. While the stakeholder commitments to the Alignment Proposal are voluntary and will be accepted on a rolling basis, shared accountability for action will be encouraged through continued regular in-person and virtual meetings, support from state agency leads and executives across the state, and collaboration with stakeholders on implementation steps and mechanisms for evaluating success to move support into action. Engagement from lead partners like NC Medicaid will be leveraged to promote accountability across stakeholders, as NC Medicaid may adopt and formalize the NC STC's multistakeholder recommendations for Medicaid plans and providers.

Key Takeaways

- Engage technical representatives, such as data sharing experts and CBOs, in smaller workgroups to identify action steps
- Ensure that multistakeholder efforts are linked to and build upon ongoing state work by agencies, health systems, and other stakeholders
- Conduct informal voting during meetings to help neutral conveners identify areas of consensus around next steps, as well as gaps and opportunities for follow-up. These strategies must be combined with a responsiveness to stakeholder feedback as priorities shift.

4. Implement Alignment Opportunities and Refine

At the same time, the NC STC developed an implementation and evaluation plan to operationalize stakeholder momentum and monitor progress on alignment goals. The implementation plan, still in draft, outlines potential roles, scope, overall feasibility, and success metrics. Even during this phase, Duke-Margolis has had to regularly revisit and reaffirm stakeholder priorities. Implementation steps include pilot programs to test data flows and apply supplemental data templates, as well as the formation of technical workgroups to guide HRSN data collection, screening, and use.

Key Takeaway:

- Securing conceptual agreement on shared challenges, priorities, and actions early on lays the foundation for a meaningful implementation process that is responsive to evolving stakeholder priorities

Looking Ahead

The NC STC, now in the implementation phase, began with an alignment framework focused on the foundational elements of value-based care to identify strategies where meaningful progress could be made to drive consistency on these elements. Building trust among stakeholders has helped to lay the groundwork for additional potential alignment and innovation, such as data sharing for new agreed-upon measures (e.g., pediatric, behavioral health, or maternity measures) and more advanced data interoperability (e.g., transitioning to data sharing via Bulk Fast Healthcare Interoperability Resources) for value-based care. The NC STC's approach provides lessons for other states looking to leverage multistakeholder alignment to achieve shared goals, such as using a neutral convener, intentionally engaging stakeholders, establishing a transparent governance process, focusing on achievable goals, remaining responsive to stakeholder feedback, and aligning initiatives with state and federal priorities.

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ABOUT THE AUTHORS

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Elizabeth Kasper, MSPH, is the care delivery and payment reform senior advisor at North Carolina Medicaid. In this role, she leads the design and implementation of population health and value-based payment policies and programs that aim to advance NC Medicaid's priorities and improve care for members. Liz has worked for over 20 years in health policy and health services research, including work on health quality and public health measures, primary care reform, federally qualified health centers, Medicaid clinical policy, and pharmaceutical regulation and reimbursement. Liz earned a Master of Science in Public Health from the University of North Carolina at Chapel Hill and a BA from Oberlin College in Ohio. She is the daughter of a family physician and mother to three school-aged children who consider her work "boring."

Leonard Croom is the value-based payment operations lead at the North Carolina Department of Health and Human Services (NC DHHS). In this role, he guides the implementation and oversight of population health initiatives and value-based payment programs that advance NC Medicaid's priorities and improve care for members. Leonard has over a decade of experience in health policy, Medicaid program development, and care delivery reforms, contributing to innovations such as NC Integrated Care for Kids (NC InCK), Healthy Opportunities Pilots, Nutrition Insecurity Cross-Enrollment Pilot, and Advanced Medical Home programs. He earned a Bachelor of Science in Biological Sciences from Campbell University and was nominated for Medicaid's Unsung Leader Award of Excellence in 2022.

Janelle White, MD, MHCM, FAAP, is a physician and health care leader with a mission to improve the quality of patient care and population-based health outcomes by leveraging an ecosystem model of care delivery. Dr. White has provided clinical oversight to the design and execution of a broad portfolio of community-based strategies and interventions aimed at reducing the life expectancy gap of vulnerable populations and has advocated for health care policies that improve the care of underserved populations. Dr. White currently serves as the Chief Medical Officer of North Carolina Medicaid and is dedicated to leading innovative health care initiatives with a determination to tackle complex problems focused on improving the health and well-being of vulnerable populations. Dr. White earned her undergraduate degree from the University of Miami, medical degree from the University of Florida College of Medicine, and master's degree in Healthcare Management from Harvard's T.H. Chan School of Public Health.

Hilary Campbell is an adjunct assistant professor with Duke-Margolis as well as area lead for Institutional Research and Analytics, where her input spans the Institute's research and educational aims. On the research side, Hilary contributes to a range of timely projects, including her focus on launching the Center's 21st century public and population health initiative. Hilary also plays a key role in strategic efforts to expand the Institute's quantitative research capabilities by growing and maintaining the Institute's analytic and data resource capacity. Additionally, she works collaboratively with our education and operations teams to develop strategies and manage the systematic collection, evaluation, and dissemination of metrics and data relevant to Duke-Margolis analytic and educational programs. Hilary received her JD from Duke School of Law, her PharmD from UCSF, and brings a unique interdisciplinary perspective to her health policy work. Most recently Hilary served as director of the North Carolina Health Professions Data System at UNC's Sheps Center for Health Services Research.

Robert Saunders, PhD, is senior research director, health care transformation, at Duke-Margolis. In this role, he oversees the Institute's workstream on payment and delivery reform initiatives, including generating practical evidence on these reforms; translating that evidence into recommended solutions; and accelerating progress on effective policy actions at the state, national, and international levels. The team includes portfolios focused on Medicare accountable care transformations, health care transformation for health equity and social needs, Medicaid and state health care transformation in North Carolina and other states, medically and socially underserved populations, and bolstering

population health. Prior to joining Duke-Margolis, Dr. Saunders was a senior director and then senior advisor to the president of the National Quality Forum, senior program officer at the Institute of Medicine, and managed health care legislative affairs for Representative Rush D. Holt during the Affordable Care Act debates. He received his PhD from Duke University and his undergraduate degree from William and Mary.

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About the Duke-Margolis Center for Health Policy

The Robert J. Margolis, MD, Center for Health Policy at Duke University is both an academic research center and a policy laboratory. Its mission is to improve health, health equity, and the value of health care through practical, innovative, and evidence-based policy solutions. To learn more, please visit healthpolicy.duke.edu.

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