***** DRAFT FOR PUBLIC REVIEW AND COMMENT *****

September 17, 2024

PRINCIPLES FOR ALTERNATIVE PAYMENT MODELS

Catalyst for Payment Reform and URAC have partnered to investigate the development of a recognition program for value-based payment models.

Most US payers have implemented some form of value-based payment for health care providers. The goal of such payment is to align economic incentives with better patient care delivery and management. Value-based payment models (also known as "alternative payment models") now influence payment and care delivery across broad sectors of the health care landscape. Currently, there are no national programs that validate whether these models meet accepted best practices.

As value-based payment grows and matures, stakeholders have a shared interest in ensuring that health plans implement value-based payment programs thoughtfully and appropriately. CPR is working with URAC to establish appropriate standards and an accreditation program with the input of a variety of health care stakeholders.

For the first stage of this effort, CPR has convened an advisory committee that includes representatives of patients, providers, and health plans. The committee has drafted a set of principles which, when complete, will serve as the basis of URAC's accreditation program. The goal is to complete the principles in 2024 and then to pilot test the accreditation program in late 2025.

We are currently seeking public review and comment on these draft Principles for Alternative Payment Models. Please take some time to review this document and submit any comments or questions to CPR at connect@catalyze.org.

Comments are due by October 18.

About Catalyst for Payment Reform

Catalyst for Payment Reform is an independent, nonprofit corporation with the mission to catalyze employers, public purchasers, policy makers and others to implement strategies that produce higher value health care and improve the functioning of the health care marketplace. CPR's members include the nation's most innovative employers, public purchasers, union health plans, and health benefits consultants. www.catalyze.org

About URAC

URAC is the independent leader in promoting health care quality and patient safety through renowned accreditation programs. URAC develops its evidence-based standards in collaboration with a wide array of stakeholders and industry experts. The nonprofit's portfolio of accreditation and certification programs spans the health care industry, addressing health equity, workplace mental health, health care management and operations, pharmacies, telehealth, health plans, medical practices and more. URAC accreditation has been a symbol of excellence for nearly 35 years for organizations to showcase their validated commitment to quality and accountability. www.urac.org

PRINCIPLES FOR ALTERNATIVE PAYMENT MODELS

DEFINITIONS

Alternative payment model: a payment arrangement between a health plan and a health care provider organization that supplements or replaces fee-for-service payment with financial incentives to improve the quality and efficiency of health care. Synonymous with "value-based payment models" and similar terms.

Health care provider organization: a legal business entity that provides health care services to patients.

Health plan: An entity that contracts and sets payment terms with health care provider organizations for the provision of health care to a defined population of people.

PRINCIPLES

To conform to best practice, a health plan's alternative payment model (APM) should meet the following criteria:

Person-Centeredness

1. Defines intended benefits to patients. At a minimum, these benefits should include improvements to clinical quality and may also include cost savings; health outcomes; efficiency; patient experience; care coordination; equity; and addressing behavioral and social needs.
2. Defines the eligible/relevant patient population.
3. Defines the information that should be shared with patients to support the APM.
4. Considers any additional burden on or expectations of patients and their caregivers to achieve program goals and includes provisions to mitigate any such burdens.
5. If there are incentives for cost savings, the APM documents how it will monitor and mitigate potential negative impacts on patient access to care.
6. Aligns the APM with other aspects of plan design, including patient benefit design and cost sharing.
7. Includes a mechanism to gather and use patient feedback during the design, implementation, and evaluation processes.

Provider Engagement and Support

8. Makes key elements of the program transparent for participating providers including:
    - eligible/relevant patient populations
    - performance goals and measures
    - expected changes in care delivery
    - financial/payment structures
    - administrative requirements
9. Identifies any changes to the structure or process of care delivery necessary to support achievement of program goals.
10. Discloses the level of risk (including any downside risk) for the provider organization.

11. Identifies any additional burden on or expectations of providers to achieve program goals, including data reporting requirements and clinical process improvement programs.
12. Aligns the APM with other aspects of the health plan's medical management and provider contracting functions.
13. Includes education and support for participating provider organizations.
14. Includes a process for provider appeal of payment decisions.
15. Includes a mechanism to gather provider feedback during the design, implementation, and evaluation processes.

Health Equity

16. Monitors the impact on health equity, including trends in performance for different demographic sub-groups of the health plan's patient population.
17. Mitigates any observed adverse consequences on performance for different demographic sub-groups.
18. Enables and supports a diverse and culturally congruent health workforce.

Program Design

19. Includes measures relevant to the program goals and patient population.
20. Considers alignment of measures with those used in similar programs by other health plans (including different lines of business), provider organizations, and government programs.
21. Includes payment incentives for quality (which may include patient safety, clinical process quality, equity, patient outcomes, and patient experience).
22. Includes payment incentives for efficiency (which may include reduction of total costs of care, avoidance of unnecessary or wasteful care, avoidance of complications of care).
23. Categorizes the structure of payment incentives in accordance with the HCP-LAN framework for Category 2-4 APMs.
24. Documents the rationale for innovative program elements, especially for performance measures or payment structures that differ from existing APMs.
25. If the APM includes a prospective payment for a defined patient population, it maintains and keeps current a patient attribution methodology.
26. Includes bi-directional data exchange with participating providers.

Purchaser Engagement

27. Informs purchasers of key elements of the program, including:
    - eligible/relevant patient populations
    - performance goals and measures
    - expected changes in care delivery
    - financial/payment structures
    - addressing outlier and high-cost cases
28. If the APM includes performance guarantees, discloses the guarantees and process for remediation if the guarantees are not met.

Program Evaluation

29. Includes ongoing monitoring of the APM, including a process to mitigate any adverse or unintended consequences.
30. Includes a process for periodic formal evaluation and review of the APM, no less than every three years.
31. APM monitoring and evaluation includes feedback from patients and health care providers.
32. During periodic evaluation, consideration is given to adding more risk sharing and accountability for population health.