1. **Use prospective, budget-based, and quality-linked payment models** that improve health, affordability, and equity.[1]

   1.1. Pay providers in advance to provide a defined set of services to a population when possible. HCP-LAN classifies these models as Category 4A, 4B, and 4C.[2] Research finds that prospective payment of at least 60% of a provider organization's total payments results in meaningful change in clinical practice and reduces administrative burden.[3]

   1.2. If Category 4 payment is not feasible for a certain line of business or provider, advanced payment models that include shared savings and when appropriate, downside risk, should be used when possible. This includes models that promote higher value hospital and specialty care. HCP-LAN classifies these models as Category 3A and 3B.

   1.3. Design core model components to align with models already widely adopted in California whenever possible. Examples include the Medicare Shared Savings Program (MSSP)[4] and the Realizing Equity, Access, and Community Health (REACH)[5] program. Core components may include prospective payment, benchmarking and attribution methodologies, performance measures, minimum shared savings and risk thresholds, and risk corridors. If full alignment with an existing model is not feasible, review and incorporate stakeholder perspectives and lessons learned from the CMS published reports on models.

2. **Implement payment models that improve affordability** for consumers and purchasers.

   2.1. Align financial incentives to reduce utilization and excess spend on high-cost care such as low-value specialty pharmacy, unnecessary specialty care, and avoidable emergency room and hospital ~~-based~~ care.

   2.2. Create incentives to ~~reduce~~reward prevention, disease management, and evidence-based care while discouraging harmful ~~-or~~, low value care, and over-treatment.

   2.3. Reduce administrative inefficiency across the health care payment and delivery system by streamlining contracting, billing, credentialing, performance programs, and other documentation such as prior authorization.[6]

   2.4. Efficiency and cost savings generated through APMs should lead to lower costs for consumers and decrease barriers to care.

[1] Any health care entity taking significant financial risk needs to be regulated by the Department of Managed Health Care (DMHC). Compliance with these APM standards does not obviate the need for compliance with other provisions of California law.
[2] Health Care Payment Learning & Action Network (HCP-LAN) 2022
[3] Basu S, Phillips RS, Song Z, Bitton A, Landon BE. High Levels Of Capitation Payments Needed To Shift Primary Care Toward Proactive Team And Nonvisit Care. Health Aff (Millwood). 2017 Sep 1;36(9):1599-1605. doi: 10.1377/hlthaff.2017.0367. PMID: 28874487.
[4] Centers for Medicare & Medicaid Services (CMS) 2022
[5] Centers for Medicare & Medicaid Services (CMS) 2023
[6] Bentley TG, Effros RM, Palar K, Keeler EB. Waste in the U.S. Health care system: a conceptual framework. Milbank Q. 2008 Dec;86(4):629-59. doi: 10.1111/j.1468-0009.2008.00537.x. PMID: 19120983; PMCID: PMC2690367.

3. **Allocate spending upstream to primary care and other preventive services** to create lasting improvements in health, access, equity, and affordability.

   3.1. Provide sufficient primary care payment to support the adoption and maintenance of advanced primary care attributes such as primary care continuity, accessible and integrated behavioral health, and specialty care coordination.

   3.2. Facilitate equitable access to diverse, interdisciplinary care teams to assess and address consumers' medical, behavioral, and social needs.

   3.3. Support use of technology to strengthen consumer-care team relationships, make care more accessible and convenient, and increase panel capacity without increasing provider workload.

   3.4. Encourage consumers to choose a primary care team to promote access to and use of primary care and enable payment model success.

   3.5. Reduce financial barriers for primary care visits, behavioral health visits, and preventive services by decreasing or eliminating out-of-pocket costs for consumers (e.g., copays ~~and not applying the deductible~~, co-insurance, or deductibles in benefit ~~designs.~~design).

4. **Be transparent** with providers in all aspects of payment model design and terms including attribution and performance measurement.

   4.1. Share attribution methodologies and outputs widely and in formats accessible to providers.

   4.2. Clearly articulate the performance measures used, provide the technical specifications including risk adjustment methods, and share how incentive payments are calculated.

5. **Engage a wide range of providers** by offering payment models that appeal to entities with varying capabilities and appetites for risk, including small independent practices and historically under-resourced providers.

   5.1. Provide upfront financial support to new entrants to assist them in hiring care team members, improving analytic capabilities, and making other investments to foster long-term success in the model.

   5.2. Make timely incentive payments that reward improvement and attainment, ideally no later than six to nine months after the performance period.

   5.3. Give providers – particularly those with lower revenues – a gradual, stepwise approach for assuming financial risk ~~and moving into downside risk arrangements.~~that protects provider financial solvency and supports sustainability.

   5.4. Utilize risk adjustment methodologies that incorporate clinical diagnoses, demographic factors, and other relevant information. Monitor emerging methodologies and explore opportunities to incorporate social determinants of health in risk adjustment methodologies.

6. **Collect demographic data**, including RELD-SOGI data, to enable stratifying performance.
   6.1. Participate in state and national efforts to identify and promote emerging best practices in accurate and complete health equity data collection, such as those identified in the CMS Framework for Health Equity.[7]
   6.2. Align internal race, ethnicity, language, disability status, sex, sexual orientation, and gender identity (RELD-SOGI) data collection with the United States Core Data for Interoperability (USCDI) set where applicable and appropriate to reduce administrative burden.[8]
   6.3. Support providers in collecting information on individual consumers' social needs through standardized, validated screening tools.
   6.4. Prioritize using self-reported demographic data. When self-reported data is incomplete or unavailable, leverage population-level data or indices.

7. **Measure and stratify performance** to improve population health and address inequities.
   7.1. Select a limited number of nationally standardized measures that reflect multiple domains (e.g., quality, equity, utilization, cost, consumer experience) and populations (e.g., pediatric, adult, older adults). Prioritize outcome measures, whenever possible.
   7.2. Align measures and technical specifications with those used by the Department of Managed Health Care, California Department of Health Care Services, Covered California, the California Public Employees' Retirement System, and the Office of Health Care Affordability, when available.
   7.3. Include measures that monitor for unintended consequences of the payment model, such as ~~stinting or~~ not providing appropriate, necessary care to consumers to save money. For example, track changes in potentially avoidable emergency department visits and hospital admissions.

8. **Invest in strategies to address inequities** in access, patient experience, and outcomes.
   8.1. Increase payments to providers serving populations with higher health-related social needs to support enhanced medical and behavioral care and social care coordination.
   8.2. Support providers in using data to identify and address inequities, including by providing care consistent with the National Culturally and Linguistically Appropriate Services Standards.[9]
   8.3. Develop partnerships with community-based organizations and leverage local resources to address health-related social needs.

[7] Centers for Medicare & Medicaid Services, The CMS Framework for Health Equity (2022-2032) (2022).
[8] United States Core Data for Interoperability: Updates for Versions 2 and 3, USCDI+ 2022
[9] U.S. Department of Health and Human Services Office of Minority Health, National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care, 2013. https://thinkculturalhealth.hhs.gov/clas

9. **Equip providers with accurate, actionable data** to inform population health management and enable their success in the model.

   9.1. Data and information shared should reflect providers' varying analytic needs and capabilities ranging from clear actionable reports to claims-level data.

   9.2. Offer analytic support, such as hands-on training and example dashboards, to develop the capacity of providers, interdisciplinary care teams, and non-clinical staff to ingest and benefit from information.

   9.3. Facilitate data exchange across providers, community-based organizations, and payers, particularly through use of the California's Health and Human Services Data Exchange Framework.

10. **Provide technical assistance** to support new entrants and other providers in successful APM adoption.

    10.1. Payers and providers should work collaboratively to develop a technical assistance plan that identifies potential barriers to success and conditions necessary to build capacity in these areas. The plan should offer clear action steps for what assistance will be provided and the format and frequency of the assistance.

    10.2. Technical assistance should focus on supporting providers to perform well on the metrics that impact their payment.

    ~~10.2.~~ 10.3. Develop partnerships with collaborative technical assistance organizations or other payers to collectively support technical assistance to providers.