HCP LAN
Health Care Payment Learning & Action Network

CLINICAL EPISODE PAYMENT MODELS

SUMMARY OF EPISODE RECOMMENDATIONS

Chapter 2: Summary of Episode Recommendations

The CEP Work Group conducted research and analysis on a range of existing episode payment initiatives. Based on their experience and the analysis of current initiatives, the Work Group identified a set of 10 episode payment model design elements (Figure 3). These elements reflect the decisions that payers and providers need to make prior to implementation. The tables below summarize the 10 recommendations, based on the design elements that are discussed in this White Paper.

Table 1: Summary of Joint Replacement Episode Recommendations

Episode Definition	The episode is defined as an elective and appropriate total hip or total knee replacement due to osteoarthritis.
Episode Timing	The episode should start pre-procedure (e.g. 30 days), and end 90 days post discharge in order to include the most resource-intensive aspects of care for elective joint replacement patients. Accountability for functional improvement and performance measurement goes beyond 90 days.
Patient Population	The episode should apply to the broadest-possible pool of patients, using risk and severity adjustment to account for age and complexity.
Services	All services needed by the patient that are related to the joint replacement procedure should be covered by the episode price.
Patient Engagement	Require use of shared decision making and patient engagement tools, transparency of performance and the payment model, shared care planning, access to full health records, care coordination, and patient-reported quality measures in patient-facing materials to maximize opportunities to engage patients and families in advancing high-value care, both for themselves and overall.
Accountable Entity	The accountable entity should be chosen based on readiness to re-engineer change in the way care is delivered to the patient and to accept risk. In this model, the accountable entity will likely require a degree of shared accountability, given the number of clinicians working to care for a patient.
Payment Flow	The unique circumstances of the episode initiative will determine the payment flow. The two primary options are: 1) a prospectively established price that is paid as one payment to the accountable entity; or 2) upfront FFS payment to individual providers within the episode with retrospective reconciliation and a potential for shared savings/losses.
Episode Price	The episode price should strike a balance between provider-specific and multi-provider/regional utilization history. The price should: 1) acknowledge achievable efficiencies already gained by previous initiatives; 2) reflect a level that potential provider participants see as feasible to attain; and 3) include the cost of services that help achieve the goals of episode payment.
Type and Level of Risk	The goal should be to utilize both upside reward and downside risk. Transition periods and risk mitigation strategies should be used to encourage broad provider participation and support inclusion of as broad a patient population as possible.
Quality Metrics	Prioritize use of metrics that capture the goals of the episode, including outcome metrics, particularly patient-reported outcome and functional status measures; use quality scorecards to track performance on quality and inform decisions related to payment; and use quality information and other supports to communicate with, and engage patients and other stakeholders.

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Table 2: Summary of Maternity Care Episode Recommendations

Episode Definition	The episode is defined to include the large majority of births, including the newborn care, that are lower-risk. While not necessarily lower risk, episode payment may also be considered appropriate for women who may be at elevated risk due to conditions that have defined and predictable care trajectories, such as gestational diabetes. As the CEP model matures, some groups with significant high-risk pregnancy experience and capacity may seek to manage the entire continuum of risk.
Episode Timing	The episode should begin 40 weeks before the birth and end 60 days postpartum for the woman, and 30 days post-birth for the baby.
Patient Population	The episode should primarily include the large majority of births, including newborn care, that are lower-risk. The Work Group also supports CEP for women who may be at elevated risk because of predictable risk factors that have defined care trajectories, such as gestational diabetes.
Services	Covered services include all services provided during pregnancy, labor and birth, and the postpartum period (for the women) and newborn care for the baby. Exclusions should be limited. Initiatives should also consider including high-value support services, such as doula care and prenatal and parenting education.
Patient Engagement	Engaging women and their families is critical in all three phases of the episode—prenatal, labor and birth, and postpartum/newborn—to contribute to the foundation for healthy women and babies.
Accountable Entity	The accountable entity should be chosen based on readiness to re-engineer change in the way care is delivered to the patient and to accept risk. In this model, the accountable entity will likely require a degree of shared accountability, given the number of clinicians working to care for a patient.
Payment Flow	The unique circumstances of the episode initiative will determine the payment flow. The two primary options are: 1) a prospectively established price that is paid as one payment to the accountable entity; or 2) upfront FFS payment to individual providers within the episode with retrospective reconciliation and a potential for shared savings/losses.
Episode Price	The episode price should strike a balance between provider-specific and multi-provider/regional utilization history. The price should: 1) acknowledge achievable efficiencies already gained by previous initiatives; 2) reflect a level that potential provider participants see as feasible to attain; and 3) include the cost of services that help achieve the goals of episode payment.
Type and Level of Risk	The goal should be to utilize both upside reward and downside risk. Transition periods and risk mitigation strategies should be used to encourage broad provider participation and support inclusion of as broad a patient population as possible.
Quality Metrics	Prioritize use of metrics that capture the goals of the episode, including outcome metrics, particularly patient-reported outcome and functional status measures; use quality scorecards to track performance on quality and inform decisions related to payment; and use quality information and other supports to communicate with, and engage patients and other stakeholders.

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Table 3: Summary of Coronary Artery Disease Episode Recommendations

Episode Definition	The episode is defined as care for a cohort of patients with diagnosed CAD, for a 12-month period that will ultimately align with the benefit year (see Episode Timing). Once aligned with the benefit year, the episode will continue for consecutive periods of 12 months of active care management for as long as a patient is under active management for CAD. PCI and/or CABG procedures deemed necessary during any given 12-month episode period will also be delivered within an episode payment model.
Episode Timing	The 12-month condition episode may commence at various points post-CAD diagnosis. For any nested procedure within the condition-level episode, the procedure episode begins 30-days pre-procedure and lasts 30-90 days post discharge.
Patient Population	Condition: Patients diagnosed with CAD and in same health plan for full 12 months. Procedure: Patients deemed to need PCI or CABG based on determination of appropriateness.
Services	For both the condition and procedure episodes, the services should include core services for CAD management (e.g., lifestyle changes, medication management, and secondary prevention); and core services for the quality delivery of a procedure (e.g., pre-operative diagnostics, drugs and devices, care transition support, and post-acute care including cardiac rehab).
Patient Engagement	Models should support patient and family involvement in episode payment design, implementation, and evaluation, and patient and family engagement in all phases of cardiac care. This should be facilitated by health information technology.
Accountable Entity	The accountable entity should be chosen based on readiness to re-engineer change in the way care is delivered to the patient, and to accept risk. In this model, the accountable entity will likely require a degree of shared accountability, given the number of clinicians working to care for a patient.
Payment Flow	The unique circumstances of the condition-level/nested procedure episode model makes upfront FFS payment to individual providers within the episode, with retrospective reconciliation and a potential for shared savings/risk, the more feasible option.
Episode Price	The episode price should strike a balance between provider-specific and multi-provider/regional utilization history. The price should: 1) acknowledge achievable efficiencies already gained by previous initiatives; 2) reflect a level that potential provider participants see as feasible to attain; and 3) include the cost of services that help achieve the goals of episode payment.
Type and Level of Risk	The goal should be to utilize both upside reward and downside risk. Transition periods and risk mitigation strategies should be used to encourage broad provider participation and support as broad a patient population as possible.
Quality Metrics	Prioritize use of metrics that capture the goals of the episode at both the condition and procedure levels. These include outcome metrics, patient-reported outcome and functional status measures, and some process measures related to procedures. Use quality scorecards to track performance on quality and inform decisions related to payment. Use quality information and other supports to communicate with, and engage patients and other stakeholders.

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