
Principles for Clinical Episode and Population-Based Payment Overlap

Health Care Transformation Task Force
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Who we are: Our mission to achieve results in value-based care



The Health Care Transformation Task Force is an industry consortium that brings together patients, payers, providers, and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. We are committed to rapid, measurable change, both for ourselves and our country.

We aspire to have 75% of our respective businesses operating under value-based payment arrangements by 2020.



Defining clinical episode and population-based payment

Clinical episode payments (CEPs) are based on defined episodes of care, usually beginning with a hospital admission and extending across multiple care settings. CEPs are considered a type of alternative payment model. Examples of episodic payment models include Medicare's Bundled Payments for Care Initiative (BPCI) and Comprehensive Care for Joint Replacement (CJR) models.

In **Population-based payments (PBPs)**, providers accept accountability for patients across a defined time period and across the spectrum of care. PBPs often encourage providers to take on financial risk for the populations they serve. Medicare Accountable Care Organizations are examples of PBPs.

Why addressing overlap between the two models is critical

The Challenge

While both episode-based and population-based payments present opportunities for improvement in quality and care, they are not always in alignment. The recent implementation of Medicare-focused alternative payment models has resulted in instances of overlap, where multiple providers may be responsible for the same patient under different payment models. While this does not create a problem by itself, it can create inefficiencies and challenges that are ultimately at odds with the end goal of delivering higher quality and more integrated care.

The Goal

In order to encourage better coordination of payment programs, the needs of individual patients should be the focal point of the discussion. **Payers, providers, purchasers, and policymakers should encourage solutions that allow the market to innovate and compete to deliver the best care for patients at the lowest price wherever possible.**

The Principles

The Task Force has developed a set of guiding principles to govern the development of best practices in public and private payer models. These principles will hopefully serve as a foundation for future policy recommendations.

Task Force principles on value-based payment overlap

Principle #1: Encourage market-based solutions that ensure patients receive high-quality care that improves outcomes and experience while lowering costs by **allowing all health care organizations committed to value-based care to collaborate in innovative ways** that make it easier and less costly for each organization to better serve patients.

Principle #2: Value-based payment model **participants should strive to find mutually agreeable solutions to manage model overlap** based on community and patient needs, marketplace dynamics, and their collaborative relationships.

Principle #3: Payment model methodologies (including all components of those methodologies) **should be transparent to the greatest extent reasonably possible** to all health care providers, payers, purchasers, and patients involved in an episode- or population-based payment model.

Task Force principles on value-based payment overlap

Principle #4: Approaches to addressing model overlap should: (1) **do no harm to value-based payment providers** by seeking a mutually beneficial solution whenever possible; (2) **seek to reduce administrative burden for providers, payers and patients**; and, (3) **include a fair and appropriate reflection of resource use and relative contribution to value creation** in setting target prices and savings allocations. This approach will encourage competition on quality and price.

Principle #5: In the short term, **innovative models should be allowed to run their course to develop necessary experience for model evaluation purposes**, which may require setting precedence rules (such as exclusions) in some cases. Such precedence rules should strike a balance that recognizes the relative importance of total cost of care models, while also creating a landscape that encourages parties to find market-based solutions. *Broad exclusion of providers and patients from participation in both a clinical episode model and a population-based model should not be a long-term strategy for achieving sustainable value-based payment and care delivery.*

Next steps

- The Task Force will use these principles to develop a set of practical strategies that can be used in policy recommendations and private sector guidance. More details will be issued in the near future.
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