

Care Episodes & Bundled Payment: Building and Automating Your Strategy

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As healthcare reform seeks better clinical outcomes and lower costs, there is widespread belief that changing the way providers are reimbursed can align incentives to produce better results. The strategy of bundling reimbursements for health care services into a single lump sum payment has attracted a lot of attention. Payment of a lump sum to all providers (physicians, hospitals, and others) involved in a pre-defined care episode is one strategy being tried. The intent of bundling payment by episode is to create strong incentives for hospitals and doctors to work together toward a single goal of more streamlined and coordinated care, while eliminating preventable complications and unnecessary services.

Reports from highly structured health-care systems (e.g. Geisinger Health System and the Kaiser HMO) show that this approach can achieve the desired results. But healthcare throughout most of the US is not organized in such self-contained, integrated delivery systems or staff model HMOs. The challenge now is to achieve similar results in less structured systems. Payers and providers are working on the frameworks for new collaborative entities (such as Accountable Care Organizations) to manage clinical, financial and legal challenges of aligned incentives. Whatever shape these arrangements take, bundling payments for care

episodes requires a foundation of flexible technology tools with four core competencies:

- *Episode Definition and Initiation*
- *Episode Resolution and Financial Management*
- *Clinical Care Management and Process Improvement*
- *Analytics for Action*

Before addressing these four areas, let's first look at the steps an organization must take – and the technology needed – to define a “care episode.”

Getting started in creating a Care Episode payment model

The set-up phase of care episode payment includes defining key components shown in *Figure 1*, with specifics to address:

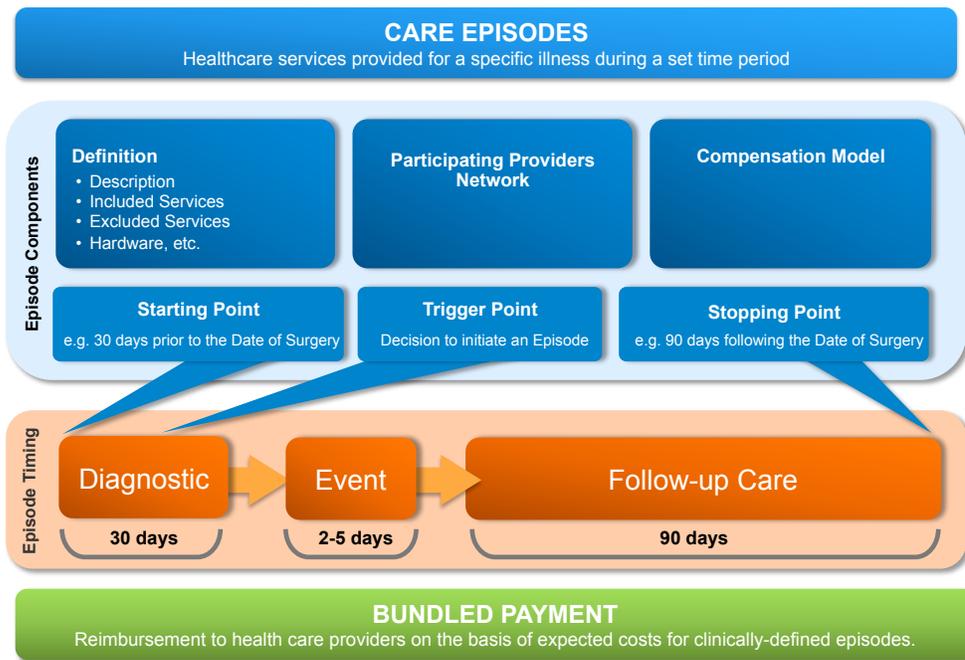


Figure 1: Definition of a Care Episode

Starting and stopping points.

The beginning and end of an episode must be clear, so that the claims payment process can recognize that an episode is underway. Urgent procedures may have little or no pre-intervention period (e.g. cardiac catheterization to evaluate new chest pain). In contrast, elective surgeries (e.g. total knee replacement), must have a 'trigger point' when the decision for surgery is made even if the actual surgery is set for a later date.

Care of chronic medical conditions (cancer, chronic heart failure, COPD) may involve fixed intervals of as long as 12 months.

Included and excluded services.

Correctly defining this category may be the single most important determi-

Participating provider network.

Defining 'who's in' and 'who's out' is just beginning to get the required attention. It's been relatively easy to launch pilot programs by approaching large physicians groups and/or hospitals (with established expertise in the targeted procedure) to create protocols for quality improvement and bundled payment. However, bringing a program to full scale that includes lower-volume or rural provider, may challenge core program premises if these providers aren't reimbursed enough to participate.

Compensation Model.

The goal is to create a single payment for an entire episode. This may be a lump sum paid before or after the episode, or a reconciliation process that aggregates claims for all included services into a total cost figure that is compared to the targeted goal. Some networks may start with a modified fee-for-service payment before implementing a lump sum strategy. Models for episodic bundling have been created by Prometheus, Integrated Healthcare Associates (IHA, California), 3M, Symmetry ETGs, and others. As payers add episodes, they may choose to use different models. An organization may find that the while one pay model is working well for a surgical episode (knee replacement), they may find compelling evidence to use another model for a diagnostic procedure (colonoscopy), and even create their own hybrid model.

Any technology solution must be able to meet varied compensation models. Yet the core competencies that an organization needs for bundled payments will be the same. McKesson is engaged in several pilots that execute varied payment models and care episodes.

Four core competencies for Care Episodes

Once a particular episode is defined, the key stakeholders must determine how to manage the clinical and financial aspects of the episode. An initial pilot of 10 to 30 patients may be handled through a manual process of claims processing and reconciliation of bundled payment, but any larger program requires automation. When bringing bundled payments to scale, automation ensures consistency, enables documentation of services according to the episode definition, and drives the feedback loops that enable the communication across stakeholders for process improvement.

The four core competencies required are shown in *Figure 2*.

- **Episode Definition & Initiation ('Front-end')**

A mechanism must be established for recognizing that an episode is underway, or will start at some future time – a challenge for many systems considering the range of possibilities. A key consideration is identifying the beginning of the impending episode (preferably during the pre-authorization process or during an episode registration process). In addition, electronic notifications by the health plan to key stakeholders are used to bundle claims and by the provider network to proactively employ the proper care pathways.

- **Episode Resolution & Financial Management ('Back-end')**

Once an episode is underway, most health systems will use the claims submission process to track resources used during care. 'Included' services may be payable as a fee-for-service, a modified fee-for-service, or a lump

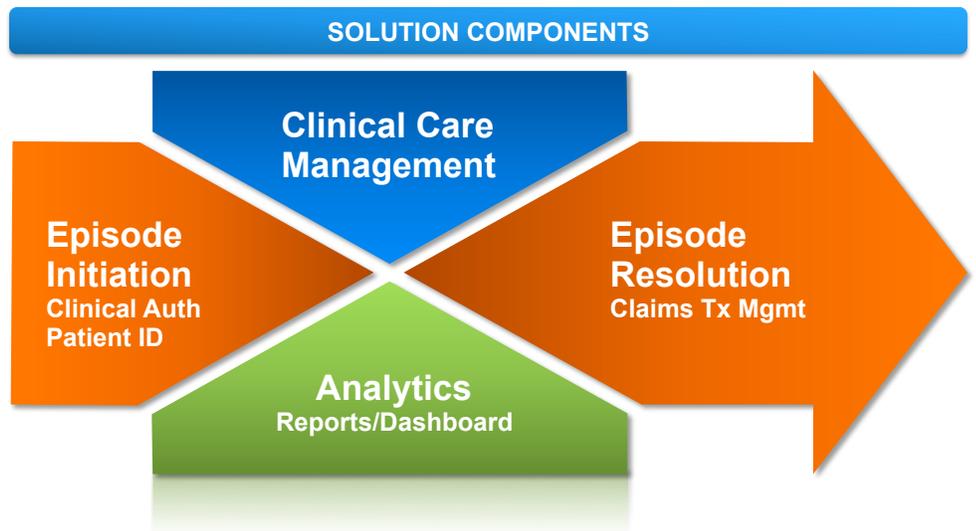


Figure 2: Care Episode Core Competencies

sum amount, depending on the episode definition and compensation model. 'Excluded' services, which will continue to be fee-for-service payments in most networks, are passed back to the primary claims processing system for conventional processing. McKesson's ClaimsXten logic engine implements episode payment rules in customer-hosted and McKesson-hosted processing environments. To apply this proven technology to the specific needs of care episodes, configuration and performance requirements are being refined in ongoing McKesson pilots.

- **Clinical Care Management – The Key to Improvement**

If a Care Episode program is not moving the needle towards best clinical practices – along with efficient use of resources and prevention of avoidable complications – the program is not achieving its goals. Automated assistance for clinical care management is essential across sites of service. We've learned that when the episode

definition used for financial management is mapped to the front-end logic, it creates a prospective process for entering a new episode correctly. This creates an important bonus for care management: Ideally, the same process can subsequently be used to generate alerts and reminders upfront to keep the patient on track. Automating clinical care guidelines (such as InterQual®) and patient clinical status indicators will be cornerstones of care continuity, along with electronic patient records. Combining these tools will make it possible to reduce complications and bring efficiency to care processes.

- **Analytics for Action**

Performance metrics for both clinical and financial measures are essential to providing useful feedback to the key stakeholders managing an episode. Some reports will be standardized; others will be unique to specific episodes. Timely feedback can help correct variances from best practice, even while an episode is underway.

In a self-optimizing system, claims data is retained in the episode logic engine for use in the reporting and analytics process. As the episode proceeds, an integrated analytics accumulate appropriate patient status indicators, which then trigger an update and/or alert to providers. Dashboards may also identify variations in care that indicate opportunities for improvement. Whether payment is tied specifically to the services used by a particular patient or determined by the average payment, it is still important to know what resources were used for that patient's care. Such analytics create the feedback loop that drives continual improvement. In the end, a provider performance tool used as the foundation for episode analytics should provide flexible, scalable on-demand analytics, and actionable data to optimize clinical and financial decision-making.

A word about ACOs

There is legitimate concern, though, that if a health plan aggregates conventional payments into a lump sum so that a second entity can disaggregate that sum without improving care and efficiency, the entire undertaking may become more expensive but no better! Accountable Care Organizations (ACOs) are important new entities that create a framework for providers to work together to manage the clinical, financial and legal challenges of building an episode of care and bundled payment program. The ACO structure and function are geared toward introducing and perpetuating behavioral changes for better use of health resources. This may be the critical success factor for improving clinical outcomes and reducing costs with a Care Episode strategy.

Summary

Dozens, or even hundreds, of initiatives for care episodes are already underway in the U.S., relying on myriad combinations of provider types, legacy systems, and techniques. No single system on the market has the perfect solution across all areas.

McKesson is piloting programs with several payers that will automate all of the major care process components. The pilots encompass episode identification and definition as well as payment determination and timing. We continue to apply our deep clinical knowledge to the need for analytics and clinical care management solutions to drive the true value of a care episodes program. Bundling payments holds great promise for reducing the cost of care by significantly reducing what are often redundant, duplicative services, refocusing practice on collaboration across providers and rewarding quality outcomes.

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