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3M Health Information Systems

Bundling payment for episodes of care

Balancing the financial risk of health care

Part 1:
Overview

Why bundled payment?

Trigger, window, scope, sequence. The vocabulary of health care sometimes sounds like high speed motion photography. But the conversation is about bundled payment.

Bundled payment is one of several value-based purchasing initiatives focusing on cost effective health care. A bundled payment is a fixed amount paid for an episode of care or a group of services provided within a period. But it is more than just an inventory of services over time. A bundled payment captures the treatments, costs and resource utilization associated with different medical conditions throughout an episode and among multiple care providers.

This eguide will further define an episode of care—and concepts such as trigger events, windows, scope of service and sequence—in terms that are useful for designing bundled payment models.

The evolution of health care payment

Bundled payment isn't a new concept for inpatient services. Since 1983, Medicare has been successfully bundling all inpatient acute care services into a single per case payment using diagnosis related groups (DRGs).

The DRG payment bundle shifted some of the financial risk associated with a hospital stay from Medicare to the hospital.

This incentive for efficiency can be extended to services before and after hospital care, leveraging the same proven DRG methodology.

Part 2:
Balancing risk
The shift in risk with bundled payment

With cost-based reimbursement and fee for service, payers reimburse for each service delivered to a patient. Payers bear the burden of controlling costs, usually by defining which services they will or will not reimburse. Per-diem and per-case payment shifts some responsibility for efficiency to care providers, but only for services during a single patient visit or hospital admission.

The risk is more equitable with a bundled payment for an episode of care. Unlike fee for service, bundled payment discourages unnecessary care and encourages providers to coordinate care for the patients they jointly serve. Unlike capitation, in which providers are paid a lump sum per patient regardless of how many services the patient receives, an appropriately risk-adjusted bundled payment does not hold providers responsible for the onset and prevalence of disease.

Payers

Cost   Fee for service   Per diem   Per case   Episode   Capitation
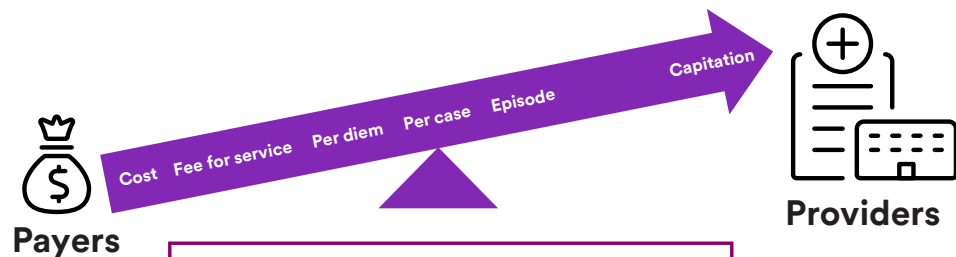
Providers

As payment models progress away from a cost basis and fee for service, some of the financial risk shifts from payers to providers. The burden of risk reaches a balance point with bundled payment for episodes of care.

Improving the cost *and* quality of care

Bundled payment makes providers accountable for the inpatient, outpatient and physician services associated with the treatment of a heath care problem over a specified period of time. The provider is financially responsible for how efficiently services are delivered.

The incentive in bundled payment is not just to reduce the cost of care. Hospitals involved in early bundled payment initiatives report improvements in the quality of care, particularly reductions in complications and readmissions.

According to the Medicare Payment Advisory Commission, an episode bundled payment creates the incentive for providers to deliver "the right mix of services at the right time." There are many different ways to define an episode of care—and to identify the right mix of services at the right time.

"The incentive in bundled payment is not just to reduce the cost of care. It's to deliver the "right mix of services at the right time."

-MPAC

Part 3:
Defining episodes
The challenges in defining an episode

In concept, an episode is a series of health care services related to a treatment of a particular illness or complaint. It may include inpatient, outpatient, ancillary and physician services as well as prescription drugs and medical devices.

In practice, the definition of an episode is more challenging.

An episode could be defined as treatment related to a **disease** or **medical condition** (e.g., pneumonia or pregnancy). That could work well enough for a discrete episode of acute care. But the definition doesn't account for treatment of a chronic condition over a period of time.

Furthermore, it can be difficult to attribute **services** for a patient with co-morbid medical conditions. All of the conditions can simultaneously affect the patient's care. For example, a patient may have congestive heart failure, diabetes and renal failure. Because these conditions affect each other, it would be difficult to attribute some services solely to uncontrolled diabetes.

An episode could be defined by the **services** delivered. However, patients who receive similar services may have different underlying medical conditions.

Alternatively, an episode could be defined by the **sequence** or **timing** of services. Without administrative rules, though, many episodes would never end. For example, many chronic conditions are progressive and, by definition, continue indefinitely.

Elements of a patient-centered episode

A single rule isn't enough to define an episode. There are several interrelated factors that define a patient-centered episode:

- **Trigger:** Hospitalization, same-day surgery, outpatient procedure, treatment in a clinic or physician's office
- **Window:** The number of days before and after the trigger event that the episode encompasses
- **Service scope:** The types of services that are included in the episode
- **Risk-adjusted chronic disease burden:** The patient's health status, determined using the diagnoses and procedures present during and prior to the trigger event

An episode encompasses services delivered during the window around the trigger event. During an episode of care, the expected level of resources consumed during treatment depends on the patient's acuity and chronic disease burden.

Disease-centered

- Focus on the resources needed to treat a specific disease
- Must separate services into those related and those unrelated to the disease

Patient-centered

- Focus on the individual patient's total disease burden
- No need to associate services with specific diseases

Treating the whole patient

The patient-centered definition of an episode signals a different approach to health care. Rather than focusing on the resources needed to treat a specific disease, it takes into account all of a patient's health issues and their interactions, not just the one disease that triggers an episode. From a treatment standpoint, this distinction can be profound. It supports providers in treating the whole patient through a complete health episode, such as a patient who has heart failure and diabetes considered together, rather than as one heart failure episode and another diabetes episode.

Only a single, patient-focused episode is assigned to a patient for a given time period, eliminating the need to assign certain procedures or services to different episodes. This approach, which can be used for both payment and provider profiling, reveals the true burden of illness and the impact it has on patient outcomes.

Collecting the data

The information that defines episodes exists on claims from the billable activities related to the patient's care. Aggregated, the claims data provide the essential diagnosis codes, procedure and/or revenue codes, start and end dates, service payments and patient characteristics.

Claims data used to define episodes

The claims data used to define episodes include a variety of care settings and services.

- Inpatient hospital (IP)
- Skilled nursing facility (SNF)
- Outpatient surgery (OSC)
- Pharmacy (RX)
- Radiology (RD)
- Outpatient hospital (OP)
- Extended care facility (ECF)
- Home health (HH)
- Durable medical equipment (DME)
- Hospice (HS)
- Emergency outpatient (EOD)
- Professional services (PS)
- Laboratory (LAB)

The role of risk adjustment

Clinicians consider a number of factors in treating patients, including multiple underlying health conditions. Performance and payment metrics need to consider them too. Risk adjustment provides a way to understand variations in patient outcomes and resource consumption, taking into consideration the patient's health status.

Risk adjustment is known by many names, including severity adjustment and case mix adjustment. It is used to understand variations in health care costs, resource utilization and outcomes within a patient population over a period of time, such as a month or a year.

Because of this, it provides a basis for calculating the expected health care costs of an individual patient, or a population, and for setting payment rates. It is a key element of reform initiatives that link financial incentives to clinical outcomes.

Part 4:
Bundled payment models

Designing a bundled payment model*

Payment systems are complex and sophisticated. Although the process is anything but simplistic, here is a basic outline of how a bundled payment model can be designed:

1. Group administrative claims into episodes of medical treatment

2. Assign costs to each episode, taking into account historical spending

3. Calculate the actual cost (by patient and episode)

4. Calculate the actual cost (by patient and episode)

5. Compare actual and expected episode cost

6. Define efficiency scores reflecting the providers' performance compared to their peers (measure performance based on outcomes)

*Curious how a bundled payment model gets developed? Members of the 3M clinical and economic research team provided a technical explanation of how 3M calculates an episode in an article entitled, "Developing A Prospective Payment System Based on Episodes of Care," which appeared in the *Journal of Ambulatory Care Management* (Vol. 32, No. 3, pp. 241–251).

Software tools for bundled payment

The 3M™ Patient-focused Episodes (PFE) Software uses standard claims data to assign patients and services into a single, mutually exclusive episode group. Based on proven methodologies, it is already used by payers and providers to group episodes of care. The software:

- Captures chronic disease, diagnoses and/or procedures, severity of illness and risk of mortality
- Predicts the level of expected resource use and cost (prospective)
- Explains past utilization and cost over a period of time (retrospective)

Part 5:
Clinically relevant results

The 3M PFE methodology is clinically relevant. It captures practices and payment in a logical framework for interpreting results. It identifies:

- How many patients received a particular treatment
- Changes over time in the severity of a cohort of patients with the same disease
- Why one patient is more expensive to treat than another
- Differences in outcomes of patients treated for the same condition

In addition to payment, episode groups could also be used to track disease prevention, public health and wellness programs.

Improving outcomes and efficiency

The 3M grouping logic supports the premise that effective coordination of care can improve patient outcomes and efficiency.

This is because:

- Clinical test models have been validated by physicians as consistent with clinical practice and treatment protocols, demonstrating a stable, reliable approach to episode grouping
- Relative weights are assigned to each episode, allowing payment to be calculated, independent of the clinical model
- Patient groups link the clinical and financial elements of an episode, supporting analysis of how changes in care delivery affect both costs and outcomes
- Risk adjustment provides a fair basis for measuring patient outcomes
- With more than 500 episodes representing inpatient and outpatient encounters as well as chronic and acute diseases, 3M PFE encompasses a broad spectrum of care
- The patient-centered model accounts for all co-morbidities that contribute to an episode, allowing a holistic, preventive approach to caring for patients with multiple conditions

Rely on proven methodologies

3M software is already used by clients nationwide to classify patients into clinically similar groups. These proven 3M methodologies help payers and providers adjust to payment reform with tools for episode grouping, bundled payment, risk adjustment and measuring potentially preventable events.

For more information on how 3M software and services can assist your organization, contact your 3M sales representative, call us toll-free at **800-367-2447**, or visit us online at **3M.com/HIS**.

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