

Episode-of-Care Payments

Cost Containment Strategy and Logic

Episode-based payments are at an early stage of development and use, but interest in them is growing. In contrast to traditional fee-for-service reimbursement where providers are paid separately for each service, an episode-of-care payment covers all the care a patient receives in the course of treatment for a specific illness, condition or medical event. Examples of episodes of care for which a single, bundled payment can be made include all physician, inpatient and outpatient care for a knee or hip replacement, pregnancy and delivery, or heart attack. Savings can be realized in three ways: 1) by negotiating a payment so the total cost will be less than fee-for-service; 2) by agreeing with providers that any savings that arise because total expenditures under episode-of-care payment are less than they would have been under fee-for-service will be shared between the payer and providers; and/or 3) from savings that arise because no additional payments will be made for the cost of treating complications of care, as would normally be the case under fee-for-service.

Episode-of-care payments also are known as case rates, evidence-based case rates, condition-specific capitation and episode-based bundled payments.

Episode-based payment creates an incentive for physicians, hospitals and other providers to work together to

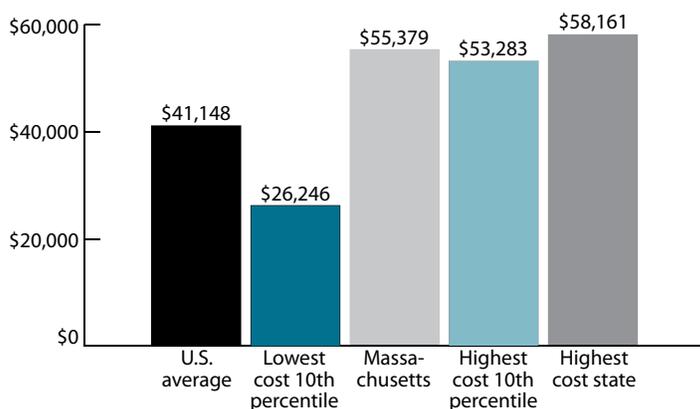
improve patient care related to an episode of illness or a chronic condition; providers do better financially when patient care is cost effective. Under episode-of-care reimbursement, for example, providers will have higher net income if they avoid unnecessary tests, reduce complications related to care, and shorten patients' hospital stay using better hospital discharge planning.

Research indicates cost savings for some conditions using episode-of-care payments, which are at an early stage of development.

Target of Cost Containment

Episode-of-care payments target unnecessary or duplicative care, avoidable hospitalizations, complications of care and inefficient care (e.g., providing high-cost care where less expensive care would be as effective). According to the Center for Healthcare Quality and Payment Reform, "An episode payment system reduces the incentive to overuse unnecessary services within the episode, and gives healthcare providers the flexibility to decide what services should be delivered, rather than being constrained by fee codes and amounts."¹ Episode-based payments are intended to strengthen incentives for providers to work together to offer more cost-effective care. Under the current fee-for-service system, no provider or group of providers is accountable for managing the quality and costs of a patient's care throughout the course of treatment for a condition or illness.

Figure 1. Massachusetts Annual Costs of Care for Medicare Beneficiaries with Three Chronic Conditions (Diabetes, Heart Failure and COPD), 2006



Source: Cathy Schoen, "Path to a High-Performance Health System: Improving Value and Achieving Savings," PowerPoint Presentation, Health Care Quality and Cost Council Annual Meeting, Boston, June 25, 2009; www.mass.gov/lhqcc/docs/meetings/2009_06_shoen_presentation.ppt.

Figure 1 uses Massachusetts data to illustrate the wide variation among the states in the annual cost to Medicare of providing care for three chronic conditions, reflecting various care practices and intensity of service. Episode-of-care payments are designed to reduce the average cost of these and other conditions and to reduce unwarranted variations in the cost of care.

Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 23, 2010, authorizes new Medicaid demonstration projects to test episode-of-care payments in up to eight states (section 2704). The payments are for integrated care for an episode of illness and must include a hospitalization. The effective date

for the demonstration projects is Jan. 1, 2012, through Dec. 31, 2016. The new legislation also establishes a national Medicare pilot program to develop and evaluate bundled payments for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge (section 3023). The Medicare pilot program will be effective Jan. 1, 2013.

State Examples

■ A Minnesota provision in comprehensive 2008 health reform legislation called for development of uniform definitions of at least seven “baskets of care” (e.g., asthma, low-back pain, obstetric care and total knee replacement).² These definitions are to form the basis for episode-based payments. Hospitals and providers will set a price for a package of care, allowing patients and payers to compare prices for bundles of care.

■ Massachusetts enacted legislation in 2008 concerning cost containment, transparency and efficiency in delivery of health care.³ After the legislation was enacted, the Massachusetts Division of Health Care Finance and Policy contracted with the RAND Corporation to assess a comprehensive menu of cost containment options. RAND estimated that cumulative savings from the widespread adoption of episode-of-care payments would be \$685 million to \$39 billion (0.1 percent to 5.9 percent of total health expenditures) for the period from 2010 to 2020.⁴ Savings would result from using episode-of-care payments for four hospital conditions (e.g., knee and hip replacements) and six chronic conditions (e.g., diabetes and asthma).

■ The Maryland hospital rate-setting commission uses case rates (i.e., episode-of-care rates) for hospital services, ambulatory surgery, and clinic and emergency room services.

■ Many Medicaid programs pay for prenatal care and delivery using a single, risk-adjusted, bundled payment.

Non-State Examples

■ The Centers for Medicare and Medicaid Services (CMS) launched the Acute Care Episode (ACE) Demonstration in 2009. Under the demonstration, hospitals are paid a single fixed rate for all hospital, physician and ancillary services provided during an inpatient stay for orthopedic or cardiovascular procedures. The demonstration sites are in Albuquerque, Denver, Oklahoma City, San Antonio and Tulsa.⁵

■ UnitedHealth is testing use of episode-based payments to pay oncologists for several months of cancer care.

■ PROMETHEUS Payment Inc., a nonprofit corporation with board members from several national employers, is develop-

ing a payment system designed to cover all care delivered by a provider for a specific condition (e.g., heart failure, chronic obstructive pulmonary disease, hypertension). Called an evidence-informed case rate, this payment approach is being tested in Minneapolis, Philadelphia and Rockford, Ill.

Evidence of Effectiveness

Limited evidence is available concerning the effect of episode-of-care payments on overall health expenditures. Existing evidence indicates that, for some conditions, episode-of-care payments can improve efficiency and generate cost savings.⁶

Mathematica Inc. reviewed the available evidence on episode-of-care payments. It showed scant evidence of the effects of episode-based payment approaches on cost and quality, although some programs indicate decreased costs of care.⁷

Most evidence concerning the effect of episode-based payments comes from federal and private sector pilot programs. (Several examples are included below.) Research for this brief did not uncover any assessments of cost savings from state programs that use episode-of-care payments.

■ **Coronary artery bypass graft surgery (CABG).** In the early 1990s, Medicare sponsored the Participating Heart Bypass Center Demonstration. Under this program, Medicare paid a single, negotiated, risk-adjusted amount for inpatient CABG patients. The payment covered both inpatient hospital and physician charges and any related readmissions. Medicare spending through 90 days post-discharge was found to be 10 percent lower than for patients who were not in the demonstration. The average length of stay in pilot program hospitals declined by between 14 percent and 32 percent.⁸ In the private sector, the Geisinger Health Plan, a Pennsylvania-based, integrated health care delivery system, currently accepts risk-adjusted episode-of-care payment for all care related to CABGs. The single payment includes hospital care, hospital readmissions within 72 hours and care for the following 90 days. Geisinger reports that its average hospital length of stay for CABGs is down 16 percent, and mean costs have been reduced by 5.2 percent.⁹

■ **Bundled payment for hospital care based on diagnosis.** Since 1983, Medicare has paid hospitals a fixed-rate-per-hospitalization based on diagnosis at the time of discharge. This diagnosis-related group reimbursement covers only the hospital’s expenses; it does not cover physician care. Researchers have found this type of episode-based payment has resulted in a “substantial and sustained reduction in Medicare hospital spending”¹⁰ and “significant overall reduction in the rate of Medicare spending growth.”¹¹ Several Medicaid programs use a similar system for paying hospitals.

A Minnesota provision in comprehensive 2008 health reform legislation called for development of uniform definitions of at least seven “baskets of care” (e.g., asthma, low-back pain, obstetric care and total knee replacement) that will form the basis for episode-based payments.

■ **Arthroscopic surgery.** A two-year study of a program that used a bundled payment for knee and shoulder arthroscopic surgery indicated that the health maintenance organization that made the bundled payment saved in excess of \$125,000.¹² Savings came from less radiography and physical therapy, shorter hospital stays, and fewer complications and hospital readmissions.

Challenges

While episode-based payments can help control costs for certain acute illnesses and chronic conditions, several caveats should be noted. Some have suggested that, unless they are properly structured, episode-of-care payments may create an incentive for providers to provide more episodes or avoid patients with complicated diagnoses in order to maximize income. Defining the boundaries of an episode can be difficult. The effect of episode-based payments may be dampened if payers use different definitions of an episode of care. Episode-of-care payments may require providers to set up new care arrangements. Providers may encounter administrative complications as they develop joint arrangements for accepting and dividing episode-of-care payment among themselves. Despite these difficulties, the trend among payers is toward increased use of episode-based payments.

Complementary Strategies

Episode-of-care payments can be used with other cost containment strategies. Examples include disease management programs, medical homes and care coordination programs. Using episode-based pay in conjunction with these strategies (which are the subject of other briefs in this series), may offer a greater level of cost containment than could be achieved by implementing a single strategy.

For More Information

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NCSL has posted supplemental materials and 2010 updates on this topic online at <http://www.ncsl.org/?tabid=19930>.

Notes

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About this Project

NCSL's Health Cost Containment and Efficiency Series describes multiple alternative state policy approaches, with an emphasis on documented and fiscally calculated results. The project is housed at the NCSL Health Program in Denver, Colorado. It is led by Richard Cauchi, program director, and Martha King, group director, with Barbara Yondorf as lead researcher.

NCSL gratefully acknowledges the financial support for this publication series from The Colorado Health Foundation and Rose Community Foundation of Denver, Colorado.



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