As healthcare reformers are seeking 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 healthcare 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 healthcare systems (e.g., Geisinger Health System and the Kaiser HMO) show that this approach can achieve the desired results. However, healthcare throughout most of the United States is not organized in such self-contained, integrated delivery systems or staff model HMOs. The continuing challenge 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 the 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 five core competencies:

- Episode definition and initiation
- Episode resolution and financial management
- Clinical care management and process improvement
- Analytics for action
- Physician and hospital network development and management

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

### Creating a Care Episode Payment Model

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

#### 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 under way. 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, chronic obstructive pulmonary disease) may involve fixed intervals of as long as 12 months.

#### Included and excluded services. Correctly defining this category may be the single most important determinant of success in the entire episode definition process. This is where the typical components of every procedure (e.g., clinical laboratory, imaging, anesthesia services) are itemized. Preventable complications that will be included in the bundled price also must be identified. Full transparency at this step is a critical success factor. All stakeholders must understand their risk from the outset if the program is to succeed.

#### 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 providers 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 payment before or after the episode, or a bundled reconciliation process that aggregates claims for all included services into a total cost figure that is compared to the targeted goal. Many networks may wish to 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), 3M, Symmetry ETGs and others. As payers add episodes, they may choose to use different models. An organization may find that the while one payment model is working well for a surgical episode (knee replacement), there may be compelling evidence to use another model for a diagnostic procedure (colonoscopy) or medical episode — or even to create their own hybrid model.

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

**Five 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 useful growth of the 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 communication across stakeholders for process improvement.

The five core competencies required are shown in Figure 2.

- **Episode definition and initiation.** A mechanism must be established for recognizing that an episode is under way 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 and financial management.** Once an episode is under way, 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, modified fee-for-service or a lump 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 and process improvement.** If a care episode program is not moving toward 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 up-front to keep the patient on track. Automating clinical care guidelines (such as InterQual®) and patient clinical status indicators will be the cornerstone 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 under way. 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, 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.

• **Physician and hospital network development and management.** Most pilots are being launched in focused, well-defined provider environments with manual support for claims processing, payment distribution according to predetermined formulas, and reconciliation with clinical and financial targets. Scaling up this process will require provider credentialing, performance and new reimbursement tools. Network management capabilities include the definition of narrow networks of providers that have contracted for an episode of care and bundled payment program. The ability to steer patients toward this narrow network of providers is critical to prevent issues associated with members receiving services outside of the program, often referred to as leakage. The network management capability also has linkages to the payment system. The ability to automate the selection of the appropriate fee schedule based on the provider and member criteria on the claim will become critically important as value-based reimbursement programs mature, including bundled payments programs.

A Word about Accountable Care Organizations

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), now in the implementation stage, 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 functions are intended to introduce and perpetuate 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 under way in the United States, 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 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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