IDC ANALYZE THE FUTURE

IDC ANALYST CONNECTION

Sponsored by: Change Healthcare

This IDC Analyst Connection discusses the defining analytic of value-based reimbursement: the episode of care (EOC). Challenges and complexities associated with development of and use of episodes of care are discussed, including the benefits to payer standard use, provider coordination, and member affordability.

How Episodes of Care Improve Value-Based Reimbursement

December 2020

Questions posed by: Change Healthcare

Answers by: Jeff Rivkin, Research Director, Payer IT Strategies

Q. What are "episodes of care"?

A. The concept of an "episode of care" (EOC) was conceived to better define and measure units of healthcare delivery with the goal of identifying best practices in the delivery of high-quality, cost-effective care. While the concept is mature and well acknowledged and has achieved some success, challenges persist in generating consensus on the detailed parameters of these episodes and coordinating longitudinal data across the continuum (PCPs and specialists). Lack of clarity in definitions at a granular level continues to be a barrier to progress in the downstream practical applications of the EOC concept.

The National Quality Forum (NQF) Episodes of Care Measurement Framework defines an episode as "a series of *temporally contiguous* healthcare services related to the *treatment of a given spell of illness* or provided in response to a *specific request by the patient or other relevant entity*... [T]hese healthcare services can be administered by *one or more providers* over the course of the episode." Analysis of episodes, most often through use of transactional claims data, includes multiple provider inputs linked across a longitudinal period of time for a defined chronic illness or procedure.

As an example, let's say that a contract allows for a physical therapy (PT) patient to have 10 "free" visits without a co-pay in a "knee replacement bundle." After the first 10 appointments, each visit up to a maximum of 20 requires a $20 co-pay. First, the PT provider and all other providers in this bundle need to be affiliated. Then, an active live contract (also known as a smart contract) must be built. This contract must include active decrementing operators so that a patient's current state (6 visits executed out of 10 free visits) is accessible at any time.

Payers can define their value-based reimbursement (VBR) program in many ways. The underlying details behind those definitions can make that same real-world knee replacement scenario into an analyzable event. After methodology selection, the payer (for most methodologies) should look at the:

- Episode window
  - How is the episode triggered?
  - How many days is the episode (pre, post, and during)?
  - Do I want to consider look-back periods for comorbidities?

- Inclusion or exclusion
  - What patients do I want to include or exclude in my analysis?
  - What services do I want to include or exclude in my analysis?
  - What providers do I want to include or exclude in my analysis?
  - Do I want to track leakage?
  - Do I want to consider narrowing networks?
- Prospective or retrospective methodologies
  - Who receives payment?
  - What is the process for budgeting or sharing savings?
  - What risk level do I want to execute (full, upside only, or upside/downside)?

Q. Why do episodes of care matter?

A. An episode-based approach to performance measurement enables services provided in different settings and by different providers — that is, services that previously might not have been considered together — to be linked in one episode.

In value-based reimbursement, a portion of the provider's total potential payment is tied to the provider's performance on cost efficiency and quality performance measures. While providers may still be paid a fee for service (FFS) for a portion of their payments, they may also be paid a bonus or have payments withheld.

Fees paid to providers may also be contingent on the providers engaging in practice transformation to adopt technology and processes that alter the way they deliver care. Goals include the following:

- Accountability to the patients
- Nurse navigators providing a concierge level of interaction with the patients
- Automated processes to address prevention and wellness

To effectively analyze performance based on an EOC-dependent model, the value-based reimbursement agreement must incorporate several defined groupers. The agreement must establish a baseline or benchmark for quality metrics, readmission rates, complications, and/or patient volume, and the variance off that baseline must be tracked, reported, and acted against with appropriate payment procedures.

As healthcare affordability, consumerism, and price transparency become mainstream issues that determine consumers' loyalty to providers and payers, episodes of care provide standard benchmarks for members to "shop." While no one shops for an MRI in a vacuum (it is always in the context of triage, care, and follow-up), a "consumable service," such as a knee replacement, resonates with the consumer community.

From a payer perspective, whereas paper contracts and inefficient amendment processes sufficed before, payers are now facing providers coming to the contract negotiation table armed with analytics, models, and proposals for a variety of payment models. Payers must be prepared. Over 75% of payers surveyed by IDC indicated that they are executing new, replacement, or improvement initiatives in the provider and contract management application areas. Instead of merely haggling with payers on FFS rate increases, providers are using value-based contracting to spur complicated discussions on determining lump-sum payments, quality metrics to be used for bonuses or penalties, and arrangements for how shared savings should be split, which will be the new payment bargaining chips.

It is in this way that the episode of care is analytic — a material, hard, accepted, indisputable definition from which apples-to-apples comparisons of healthcare cost and quality may be made.

Q. Why does "PROMETHEUS" matter?

A. A comprehensive definition of and context for PROMETHEUS is actually an acronym: Provider Payment Reform for Outcomes, Margins, Evidence, Transparency, Hassle Reduction, Excellence, Understandability, and Sustainability. It is an initiative sponsored by the Health Care Incentives Improvement Institute (HCI3) to design episodes of care. One goal of the PROMETHEUS project was to categorize as much of the medical spend as possible into an episode. To do this, they created different episode classes or types. For example, PROMETHEUS offers several procedural episodes, which involve a surgical procedure and windows of time around the procedure during which care is delivered. Similarly, acute episodes are related to a single event with windows of time around the event during which care is delivered, but these events do not include a surgery. Good examples are acute myocardial infarction (AMI) or pneumonia.

PROMETHEUS also has chronic disease episodes, which aim to capture costs of chronic care management that fall outside procedural or acute episodes. They recently released several cancer care episodes involving chemotherapy. The chronic care and cancer care episodes are examples that do not feature a single anchoring event with windows of time before and after but instead may have extended or annualized windows of time divided throughout the long duration of care. Finally, there are other episodes that do not neatly fit into these classes, such as pregnancy or preventive services like colonoscopies or vaccinations. The current version of PROMETHEUS has 97 distinct episodes, but many of these episodes are clinically similar and can be grouped as related care of the same disease.

As stated previously, a standardized definition of an episode of care — with agreed-upon syntax and semantics — is beneficial to all. PROMETHEUS provides that consistency. Used and applied consistently, the methodology allows networks, providers, and care to be analyzed without nuance and exception. This approach enables employers and members to realistically evaluate service excellence from their payers, providers, and networks. Ultimately, this approach allows the market to engage in equitable comparisons and consumers to choose the optimal mix of cost and quality over a defined time period.

Additionally, PROMETHEUS has standards for specialist procedures, which represent 80–90% of healthcare costs. This significant chunk allows for the identification of low-value healthcare (any services that are unnecessarily costly or not beneficial to patient health) such as the overuse of unneeded services, underuse of needed care, services used to treat potentially avoidable complications (PACs), and services with large price differences based on where they are performed.

From a member standpoint, affordability is greatly impacted when members can understand the common language and terminology of the specialist provider community — and make purchasing decisions based on that understanding. Using standard definitions allows transparency. Cost and quality transparency naturally impact consumer choice, and competition can lead to lower prices and affordability. Episode definition is hard and mostly nonintuitive to the average consumer. The comprehensive PROMETHEUS library gives members confidence that their healthcare dollars are optimized.

From a payer standpoint, PROMETHEUS provides for the organization of care into groupings that encourage the effective standardization and consumerization of services across the payer organization. Care management, medical management, utilization management, and wellness all benefit tangentially from the coordination of provider services enabled by the PROMETHEUS methodology. Using PROMETHEUS as a way of thinking about longitudinal member health is a transforming driver in a payer organization.

Q. What challenges are there in implementing episodes of care?

A. Many organizations do not quantify why they want to execute value-based reimbursement. It is important to recognize and quantify measures of success for whichever motivation applies.

Similarly, most organizations do not understand their long-term opportunity. Using metrics such as medical expense savings, readmission rates, and complication rates rationalizes episode management and allow integrations with HEDIS, STARS, payment integrity, and consumerism objectives.

Unfortunately, most payers are reactive. They wait for a mandate. While it is understandable that payers want to wait for a state Medicaid mandate or the actions of a large, self-insured employer or a major health system to usher them into value-based paradigms, this position puts them on the defensive. Defensive short-term approaches lead to an FFS-based system with manual workarounds that will not scale. Eventually, the drain on staffing resources will mandate automation to grow and expand.

Payers also underestimate all the internal organizations that need interfacing. Even if payers plan on outsourcing, they often do not ensure that the outsourcer can handle all interfacing organizations.

Q. Why shouldn't a payer organization itself implement value-based reimbursement? Why use a vendor?

A. Experienced vendors have invented the methodology and/or installed the software in other payers, so they bring both standardization and practical experience to the payer that is evolving from FFS or expanding its fee-for-value program to scale across multiple health systems. Vendors understand that identifying opportunities for network enhancement is just as important as running analytics on an existing value-based model. Vendors also understand that the value-based paradigm is a closed-loop system of many analytics and back-office processes. The closed-loop base is established with the provider profile data being maintained by the provider system of record as managed by a provider data management system. Data there is used as the demographic base for contracts. In those contracts, "live" terms of payment and

product are managed, and terms/fees are communicated to the claims engine and the reconciliation engine(s). When payers ask how to build "live" contract clauses and how to invent provider affiliations for a contract, vendors have back-office answers.

Once the back office has implemented a solid, quality data environment that accurately defines providers and networks, and the contract management environment is ready to be flexible, the following operational questions must be answered:

- Where are my opportunities for savings and better care?
- Which episode methodology do I want to use?
- Do I have episode modeling software?
- Which episodes do I want to support?
- How am I going to price claims in dual (FFS/VBR) ways?
- How strong is my workflow architecture?
- Are my product/benefit plans able to be configured flexibly?
- How will I adjust claims and rating workflows?
- What prospective and retrospective VBR claims pricing engines do I buy or build?
- How do I reconcile FFS and VBR claims once I price them?
- What episode reconciliation operational software and processes do I use?
- How am I going to prove results and pay providers?
- How do I adjust prices and the risk pool next year?

About the Analyst

Jeff Rivkin, *Research Director, Payer IT Strategies*

Jeff Rivkin is Research Director of Payer IT Strategies for IDC Health Insights. In that role, he is responsible for research coverage on payer business and technology priorities; constituent and consumer engagement strategies; technology and business implications for consumer engagement; front-, middle-, and back-office functions; value-based reimbursement; risk; and quality-based payment and incentive programs, among other trends and technologies important to the payer community.

MESSAGE FROM THE SPONSOR

About Change Healthcare

Change Healthcare is a leading independent healthcare technology company focused on insights, innovation, and accelerating the transformation of the healthcare system through the power of the Change Healthcare platform. We provide data and analytics-driven solutions to improve clinical, financial, administrative, and patient engagement outcomes in the U.S. healthcare system.

Our comprehensive suite of software, analytics, technology-enabled services and network solutions drive improved results in the complex workflows of healthcare system payers and providers. Our Intelligent Healthcare Network is one of the largest clinical and financial healthcare networks in the U.S., facilitating over 15 billion transactions and approximately $1.5 trillion in adjudicated claims, or more than one-third of all U.S. healthcare expenditures. Our customer base includes approximately 2,400 government and commercial payer connections, 1,000,000 physicians, 125,000 dentists, 39,000 pharmacies, 6,000 hospitals and 700 laboratories.

IDC Custom Solutions

IDC Research, Inc.

5 Speen Street
Framingham, MA 01701, USA

T 508.872.8200

F 508.935.4015

Twitter @IDC

idc-insights-community.com

www.idc.com

This publication was produced by IDC Custom Solutions. The opinion, analysis, and research results presented herein are drawn from more detailed research and analysis independently conducted and published by IDC, unless specific vendor sponsorship is noted. IDC Custom Solutions makes IDC content available in a wide range of formats for distribution by various companies. A license to distribute IDC content does not imply endorsement of or opinion about the licensee.

External Publication of IDC Information and Data — Any IDC information that is to be used in advertising, press releases, or promotional materials requires prior written approval from the appropriate IDC Vice President or Country Manager. A draft of the proposed document should accompany any such request. IDC reserves the right to deny approval of external usage for any reason.

Copyright 2020 IDC. Reproduction without written permission is completely forbidden.