Episodes Are More Than Payment Models: They're Key to Improving Care

written by Theresa Hush | July 20, 2020

For many health systems and groups, episodes are esoteric. Providers often think of them only in context of risk-based payment models like bundled payments and capitation. Navigating Value-Based Health Care contracts, providers analyze and model performance under Fee-for-Service and episode-based payments to decide their course of action. Or, if already in Value-Based reimbursement, they use them as targets for costs to pinpoint physicians who exceed the targets.

These strategies are shortsighted and limited. Even at best, they do nothing to address what is actually driving cost of care. By using payer-constructed episode specifications, such strategies potentially obscure valuable clinical and cost information from evaluation. These are lost opportunities for providers to direct their own clinically driven cost control

initiatives. Analyses of patient care episodes are tailor-made for providers to conduct inquiries of costs and cost drivers, resource use, patient outcomes, and inequities in health care. But to do that, we need to look at them differently than payers do.

Episodes Were Created by Payers as Risk Vehicles

Episodes are a methodology based on capturing all costs, resources used, outcomes, and other data for a given patient-capsule of health services. Typically, that capsule is defined by a patient, timeframe, and services specific to a type of care. Here's the hidden benefit: Capturing data in this way allows for comparison of costs, outcomes, and other metrics of health care for defined populations of patients—for example, those having certain procedures or those with conditions and risks.

But episode-based *payments* were designed to eliminate volume-based incentives for delivering more services and to establish fixed fees. Fixed health care fees, like capitation and episode-based reimbursements, are moving into the mainstream. Value-Based payment models are using more aggressive risk models than shared savings. Medicare signaled the shift from shared savings to fixed fees when incorporating global or partial capitation in its Direct Contracting program. In specialty services, procedural or treatment-focused episodes of care are forming the basis for cost measures—and for bundled payment reimbursements to specialists and other providers.

Episodes in Payment Models Can Be Artificial and Arbitrary

Building payment models based on episodes introduces other factors designed to make the payment more palatable to providers or easier for payers to administer. For example, Medicare and other payers will narrowly define a capsule of specialty care, so that diagnoses or factors that could lead to outlier costs are excluded from the episode altogether. That makes it more acceptable to physicians.

However, to make a single bundled payment work across a larger group of procedures, such as multiple spinal procedures, related procedures are combined. The episode that determines a bundled payment—constructed with multiple exclusions yet accumulated across multiple procedures and approaches—is no longer related to clinical care or outcomes in the same way.

Capitation Is an Episode-Based Reimbursement, but More Broadly Defined

Some might argue that capitation is not episodic because all care is included. But capitation is simply a person-episode with the episode time frame set to a year (and then paid out monthly). The same methodology of data capture exists in both capitation and episodic payments to specialists. The time span of the episode and types of services to be included have simply been lifted in capitation to make it more inclusive.

Capitation may also have variations in the capsule of services to appeal to providers, just as specialty episodes have these features. Providers may be able to choose global or partial capitation, respectively including everything or limiting fees

(and risk) to professional services. Medicare's Direct Contracting model allows providers to elect either global or partial capitation. Capitation may also be risk adjusted, or age-adjusted.

Three Huge Benefits of Episode Analysis

Despite the financial disasters experienced by providers during the pandemic, Medicare and health plans have given no indication that they will let up on plans to expand financial risk in health care. In fact, it's quite the reverse. Medicare is clearly proceeding with plans for Direct Contracting and Medicare Advantage plans to continue moving toward the most aggressive vehicles of Risk, prospective risk-based payment. At least one health plan has offered recovery payments to primary care physicians with the stipulation that they accept capitation in the future and remain independent.

To live under fixed fees, small progress in achieving savings and cuts in "elective" services won't be enough. That's where episodes can help:

1. Episodes can illuminate costs by revealing patient stories of care for given diagnoses, and resulting costs and outcomes.

Populations organized by higher risk or serious conditions can form the basis for special episode analyses, to facilitate reviews of potentially higher risk patients. Likewise, higher cost patients can be used as a unique population to explore common factors.

2. In a physician-driven environment where physicians have latitude to create clinically-relevant episodes rather than artificial constructs, they can more enthusiastically engage in evaluating cases and patient stories.

While coaching may be used to introduce the data and analytical approaches, it is essential that physicians see their own data and visual results. They are much more likely to be interested in contributing to the environment if there are clinical practice benefits and exchanges with other physicians.

3. Evaluating symptoms, diagnoses, and treatment results across conditions or patient attributes can also help to reveal a variety of other important aspects of care.

Inequities from racial, gender, or cultural bias for further study. These are topics that will be important for providers to address for ethical, consumer, and cost reasons.
Unexpected events, particularly following procedures. Including complications as well as problems or costs in post-acute care, unexpected events can be more clearly and fairly evaluated in the context of the episode as part of a learning process.
Evaluation of treatment modalities and areas where better patient information or shared decision making processes are indicated.

Episodes create a real opportunity to put the focus on value of health care. While it is not easy to construct episodes of care with data, making the effort will give providers a crucial advantage—to better understand how their decisions and services translate into costs, and how data reveals the clinical process from beginning to end.

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