Executive Summary

This document provides background information about the AAN Model Episodes of Care resources. In this document, you will learn about the connection between episodes of care and bundled payments, the structural components of episodes of care, financial considerations, and how to use AAN episodes of care resources. AAN Model Episodes of Care for stroke, epilepsy, and dementia are available on the Episodes of Care page.

THE MOVE TO ALTERNATIVE PAYMENT SYSTEMS

The escalating cost of health care represents one of the greatest domestic challenges for the United States. While the growth in health care costs has slowed in the past year, the rate of change remains well above inflation. Currently, Medicare and Medicaid costs exceed 25 percent of the federal budget and health care costs in aggregate are approaching 20 percent of the GDP. The magnitude of these costs—nearly twice other nations with more comprehensive coverage—decreases the take-home pay of middle income wage earners. It also diverts states’ revenues from schools, infrastructure, and other programs, and is the major driver of the escalating federal deficit.

To address the cost of health care, the Centers for Medicare & Medicaid Services (CMS) tests alternatives to health care payments and even systems of delivery. While CMS is initiating pilot projects, many major insurance companies already are offering a range of alternative payment structures. The possible arrangements include bundled payments, patient centered medical homes, and Accountable Care Organizations (ACOs).


AAN EPISODES OF CARE: GUIDANCE FOR BUNDED PAYMENTS

An episode of care and its corresponding bundled payment must consider a population of patients rather than an individual patient. The population—while not homogeneous—encompasses predictable frequencies of different services.

The goal of AAN Model Episodes of Care is to identify clinical episodes and services appropriate for bundling, but not to price those services. Ultimately, the institution must define the population, services to be included, and duration of the payment window and then determine the contract amount. The AAN resources provide guidance in this process.

HOW TO USE AAN MODEL EPISODES OF CARE

Use the AAN Episodes of Care to learn more about the structure of an episode of care for a specific neurologic disease and to prepare for contract negotiations with payers. Each episode model includes a practical framework for a specific neurologic condition. The framework delineates the process of care delivery and presents the information along the moving parts of an episode of care.

• Define the episode of care
  A. Description: Services included vs. services excluded
  B. Define the episode in terms of time: Starting point and stopping point (e.g., 90 days following stroke)
• Identify all participating providers and define the role of a neurologist
• Determine when follow up care starts and clarify the complications and services that are going to be bundled into the follow up care
NOTE ABOUT EPISODE GROUPERS

Bundling claims and assigning compensation for participating providers are also important components of episodes of care but are not addressed in the AAN resources. Payers often use existing episode groupers, such as Episode Treatment Groups (ETG), Episode Risk Groups (ERG), and Diagnosis Related Groups (DRG).

Episode groupers create “episodes of care” by collecting all inpatient, outpatient, pharmacy, and ancillary service claims for patients over a defined period of time. These proprietary groupers identify all the codes associated with an episode of care and group patients into homogeneous categories and assign a severity level reflecting the complications and comorbidities that impact treatment and outcomes.

There are few neurology-focused episode groupers available. To design an episode of care from scratch using a data derived model could be quite expensive. Payers would need denominator specifics (detailed ICD-9 and ICD-10 codes), CPT-codes, and any applicable pharmaceutical and device specifications. The AAN episodes include a list of ICD-9 diagnosis codes that could be used to define an episode of care.
DIFFERENT POPULATIONS, DIFFERENT BUNDLES

Different bundled payments may be appropriate for the same disease depending on the characteristics of the population of patients. In addressing dementia, for example, it is suggested that two different episodes are appropriate: One for episodes around initial diagnosis and one for chronic management.

Table 1: Elements of an episode of care.

<table>
<thead>
<tr>
<th>Stroke</th>
<th>Epilepsy</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>New onset adult seizures</td>
<td>Uncontrolled seizures</td>
</tr>
<tr>
<td>Time</td>
<td>Pre-hospital EMT to rehabilitation</td>
<td>Initial assessment to follow-up</td>
</tr>
<tr>
<td>Population</td>
<td>Type of event, age, location</td>
<td>Type of seizure, age, location</td>
</tr>
<tr>
<td>Team</td>
<td>Stroke team</td>
<td>Not specified</td>
</tr>
<tr>
<td>Services</td>
<td>Depends on the phase</td>
<td>Depends on the phase</td>
</tr>
<tr>
<td>Settings</td>
<td>ER, Hospital, SNF</td>
<td>Hospital, SNF, home</td>
</tr>
<tr>
<td>Outcomes &amp; Measures</td>
<td>Prevention of complications</td>
<td>Not well defined</td>
</tr>
</tbody>
</table>
PAYMENT CONSIDERATIONS

Currently, there are two financial models for bundled payments. Private payers agree to a fixed amount for each patient on the basis of the expected costs for a defined episode of care. If the actual cost of services is less than the agreed upon payment, the provider of the service benefits. For CMS, the arrangement is more complex. Services are paid on a fee-for-service basis. At the end of the measurement period, an accounting is made of the actual costs versus the budgeted amount. If savings are achieved, CMS and the entity share in the amount. Overpayments are addressed in various ways depending on the contract.

BUNDLED PAYMENT ARRANGEMENTS AND QUALITY OF PROVIDED CARE

Concern is raised that alternative payment models may actually result in a decline of quality due to their inherent incentives to reduce the amount of provided care. Yet, the current fee-for-service payment model provides incentives to spend as little time as possible with patients and to perform unnecessary testing, both of which are shown to erode the quality of provided care. The thoughtful redesign of care delivery has the distinct potential to improve care, focusing on appropriate quality metrics and assuring appropriate care such as counseling, care coordination, and support provided by a team. In the move to alternative payment models, it is critical that the entire team is committed to providing high quality care.

QUESTIONS TO ASK BEFORE THINKING ABOUT A BUNDLED PAYMENT PILOT

- Are you planning to bundle payments with providers that you have worked well with in the past?
- Is there a central organization to administer payments and claims?
- Have you establish your baseline costs? To do that, you might want to meet with an actuary or discuss with a practice manager.

SUMMARY

Bundled payments are popular among payers because they reduce health care spending. A bundled payment represents a fixed payment for all services rendered during a specific period of time to treat an identified condition. The set of services rendered during a specific period of time is carefully assessed and constructed as a clinically defined episode of care. The development of an episode of care and its corresponding bundled payment must consider a population of patients rather than an individual patient. Use the AAN Model Episodes of Care to learn more about the structure of an episode of care for a specific neurologic disease and to prepare for contract negotiations with payers. AAN Model Episodes of Care are available on the Episodes of Care page. You also can access the AAN’s Payer Relations Toolkit to help establish productive relationships with payers, build the groundwork for successful appeals and save time.