



MEDIA ADVISORY

For Immediate Release

January 14, 2010

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Episode-Based Payments: Charting a Course for Health Care Payment Reform

Policy Analysis Explores Key Considerations in Moving Away from Fee-for-Service Payment

WASHINGTON, D.C.—As consensus grows that true reform of the U.S. health care system requires a move away from fee-for-service payments, designing alternative payment methods, including episode-based payments, has emerged as a high priority for policy makers, according to a new Policy Analysis from the National Institute for Health Care Reform.

Written by researchers at the Center for Studying Health System Change (HSC) and Mathematica Policy Research, the analysis identifies key policy considerations involved in designing and implementing an episode-based payment system that would essentially bundle payment for some or all services delivered to a patient for an episode of care for a specific condition over a defined period.

For example, a typical episode might focus on a heart attack, beginning with the onset of a patient's chest pain, continuing with urgent care by a physician or emergency services provider, followed by hospitalization services and any procedures performed, and lastly post-acute and rehabilitation services during a recovery stage. For chronic conditions, such as congestive heart failure, an episode could be defined as a period—a month or a year—of management of the condition, including physician services, the services of other personnel and, in some cases, hospital stays.

Ideally, a well-designed episode-based payment system would encourage providers to improve efficiency and quality of care, according to the analysis. Careful consideration of how to design and implement episode-based payments, however, will set the stage for success or failure. Key policy considerations include:

- how to define episodes of care;
- how to establish episode-based payment rates;
- how to identify which providers should receive episode-based payments;
- how to ensure compatibility with other proposed payment reforms; and
- how to stage implementation to focus on a narrow set of priority conditions, patients and providers.

Written by HSC's Hoangmai H. Pham, M.D., M.P.H.; and Paul B. Ginsburg, Ph.D.; and Mathematica's Timothy K. Lake, Ph.D.; and Myles M. Maxfield, Ph.D.; the new Policy Analysis—*Episode-Based Payments: Charting a Course for Health Care Payment Reform*—is available online at <http://www.nihcr.org/publications/EpisodeBasedPayments.html>.

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Although the broader health reform debate has sidestepped in-depth discussion of provider payment reform, most health policy experts agree that fee-for-service payments contribute to the overuse of well-reimbursed services and the underuse of less-lucrative services; a medical culture that places little value on such activities as care coordination that are not explicitly reimbursed; and a fragmented delivery system that patients and providers find increasingly difficult to navigate.

At the other end of the spectrum, capitated payments—fixed per-enrollee, per-month payments—provide strong incentives for care coordination to maximize efficiency and could motivate quality improvement if accompanied by quality-based bonuses. However, full capitation, where the provider is at risk for all care required by a group of patients, exposes providers to financial risk that few are capable of managing well given current market and practice structures. Moreover, while fee-for-service payment raises concerns about incentives for providers to deliver unnecessary care, full capitation raises the opposite concern—that providers might withhold needed services to maximize profits.

In today's fragmented delivery system and payment environment, individual providers have little financial incentive to step out of their silos to coordinate care across a patient's conditions and care settings and limited ability to influence other providers' behavior. The quandary for policy makers is how to motivate providers to reconfigure their practice arrangements and care processes to produce more efficient and coordinated care without setting many of them up for failure with a rapid transition to full capitation. Between the two extremes of fee-for-service and capitation lie intermediate models, such as episode-based payments, which pay providers based on a set of related services delivered to a given patient.

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The National Institute for Health Care Reform contracts with the Washington, D.C.-based Center for Studying Health System Change to conduct high-quality, objective research and policy analyses of the organization, financing and delivery of health care in the United States. The nonprofit, nonpartisan Institute was created by the International Union, UAW; Chrysler Group LLC; Ford Motor Company; and General Motors to help inform policy makers and other decision-makers about options to expand access to high-quality, affordable health care to all Americans.

The Center for Studying Health System Change is a nonpartisan policy research organization committed to providing objective and timely research on the nation's changing health system to help inform policy makers and contribute to better health care policy. HSC, based in Washington, D.C., is funded in part by the Robert Wood Johnson Foundation and is affiliated with Mathematica Policy Research.