



New pricing approaches for bundled payments: Leveraging clinical standards and regional variations to target avoidable utilization



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ABSTRACT

Objectives: Develop pricing models for bundled payments that draw inputs from clinician-defined best practice standards and benchmarks set from regional variations in utilization. **Data:** Health care utilization and claims data for a cohort of incident Ontario ischemic and hemorrhagic stroke episodes. Episodes of care are created by linking incident stroke hospitalizations with subsequent health service utilization across multiple datasets.

Study design: Costs are estimated for episodes of care and constituent service components using setting-specific case mix methodologies and provincial fee schedules. Costs are estimated for five areas of potentially avoidable utilization, derived from best practice standards set by an expert panel of stroke clinicians. Alternative approaches for setting normative prices for stroke episodes are developed using measures of potentially avoidable utilization and benchmarks established by the best performing regions.

Principal findings: There are wide regional variations in the utilization of different health services within episodes of stroke care. Reconciling the best practice standards with regional utilization identifies significant amounts of potentially avoidable utilization. Normative pricing models for stroke episodes result in increasingly aggressive redistributions of funding. **Conclusions:** Bundled payment pilots to date have been based on the costs of historical service patterns, which effectively 'bake in' unwarranted and inefficient variations in utilization. This study demonstrates the feasibility of novel clinically informed episode pricing approaches that leverage these variations to target reductions in potentially avoidable utilization.

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1. Introduction

While health care payment systems based on case mix-adjusted activity—such as Diagnosis-Related Groups—continue to serve as policy mainstays in most industrialized health systems [1], payers have increasingly found these systems wanting on two important fronts.

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First, these systems are often cited as perpetuating fragmented health care delivery systems by paying à la carte for discrete services furnished by individual provider entities, offering few incentives for improving coordination of care [2,3]. Second, the prices set for services under these systems are typically based on the average historical costs of providing the service, regardless of whether the care was provided efficiently or effectively. This retrospective pricing approach can potentially perpetuate wasteful patterns of historical utilization by “baking in” the costs of suboptimal care into the pricing model [4–6].

In the hopes of overcoming the aforementioned first issue of fragmented care, governments and insurers in several countries have begun to experiment with varieties of bundled payment, where a single payment is issued for a patient’s complete episode of care over a pre-defined period of time. The reimbursed episode can span multiple entities such as hospitals, physicians and post-acute care providers, offering shared incentives for delivering coordinated and efficient care across the entire course of treatment [7–9]. While the empirical evidence supporting bundled payments is still emerging, demonstration projects have shown promising results in reducing costs and improving coordination of care [10–13]. In the US, the Medicare system has put bundled payments on centre stage by launching a new series of pilots through the Bundled Payment for Care Improvement (BPCI) initiative legislated under the Affordable Care and Patient Protection Act [14]. The BPCI gives providers the flexibility to select from a set of eligible health conditions and to choose a 30, 60 or 90 day post-discharge time window for the reimbursed episode of care.

While bundled payment models such as Medicare’s BPCI initiative show promise for bridging fragmented payment systems, pilot programs to date have done little to address the second limitation of traditional payment models: pricing models driven by historical average costs. The BPCI program sets prices for episodes based on the discounted sum of historical payments for services previously provided within the episode, without consideration for whether such services were necessary or effective [15]. With a growing body of research demonstrating wide regional variations in the costs of episodes of care driven by unwarranted variations in utilization of discretionary or potentially avoidable services [16,17], payers that continue to rely on historical costs for pricing bundled payments run the risk of perpetuating patterns of suboptimal utilization.

To date, payers seeking to experiment with more innovative pricing approaches for bundled payments have had little in the way of guidance from the health services literature. One notable exception is the PROMETHEUS Payment pilots, which reimburse episodes of care with pricing adjustments for potentially avoidable complications such as unplanned hospital admissions [18,19]. While these elements are promising, the PROMETHEUS methodology does not address unwarranted historical variations between providers in the way they utilize different health care settings—a key driver of avoidable variations in costs [20].

This study addresses this gap in the literature by developing a set of alternative models for pricing episodes of

stroke care. Stroke is one of the most devastating and costly conditions included under Medicare’s BCPI program, and has been suggested as a good candidate condition for bundled payment reforms. We capitalize on payment reforms underway in the Canadian province of Ontario, where an expert panel of clinicians has provided clinical parameters for defining best practice episodes of stroke care, including identifying areas of potentially avoidable utilization [21]. Using linked administrative data spanning hospitals, physicians and post-acute care providers, episodes of care are constructed for incident ischemic and hemorrhagic strokes. Based on the panel’s recommended best practice standards, costs are estimated for five clinically defined areas of potentially avoidable utilization. Finally, the study examines how regional variations in these areas of utilization can be exploited to establish best practice benchmarks for pricing bundled payments.

The pricing strategies explored in this study are pertinent to payers and policymakers seeking to move beyond traditional activity-based payment models toward paying for efficient, high quality care across providers and settings. Moving forward, bundled payments may provide a powerful platform to tackle unwarranted practice variations through use of pricing models that expressly target potentially avoidable utilization defined through evidence-based clinical standards. The findings in this study will also be of interest to providers of stroke care and to students of regional variations in health service utilization.

1.1. Payment reform in Ontario

In 2012, the Canadian province of Ontario, home to 13.2 million residents, began implementing a new activity-based payment model for hospital-based services. While resembling a conventional DRG-like hospital payment system in its current form, the Ontario government has announced two ambitious policy directions for the payment model’s evolution. First, payments will eventually reimburse the entire episode of care for a health condition, potentially spanning multiple providers and settings [22]. Second, prices under the new model will be based on the expected costs of best practice care, excluding the costs of services that are ineffective or the result of quality problems [23].

Well aware of the perils of administrators attempting to define clinical best practice, the Ontario government has commissioned expert panels of leading clinicians to develop best practice standards for a set of high volume conditions funded under the new model. Lessons learned from the PROMETHEUS pilots have reinforced the importance of engaging clinicians early on in new payment reforms in order to provide input into the methodology and build buy-in for the reforms among their communities of practice [20].

1.2. Defining best practices for a stroke payment model

As with Medicare’s BCPI program, stroke has been selected by the Ontario government as an early adopter for payment reform. Prior studies have noted that stroke is well-suited to bundled payment [24], with an episode of

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