Audioconference

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Agenda for today

- Introductions
- Brief overview of Prometheus
- Benefits to Providers
- Benefits to Payers
- Discussion

Crossing the Quality Chasm – page 18

Recommendation 10: Private and public purchasers should examine their current payment methods to remove barriers that currently impede quality improvement, and to build in stronger incentives for quality enhancement.

Payment methods should:

- **Provide fair payment for good clinical management of the types of patients seen**.
- **Provide an opportunity for providers to share in the benefits of quality improvement**.
- **Provide the opportunity for consumers and purchasers to recognize quality differences**.
- **Align financial incentives with the implementation of care processes based on best practices and the achievement of better patient outcomes**.
- **Reduce fragmentation of care**.

PROMETHEUS answers the Chasm challenge

Pay right up-front – It starts with Evidence-based Case Rates (ECRs) that are adjusted to reflect patient severity. High performers can make more than 100% of the ECR – doing well while doing right. Low performers will make less.

Promote clinical integration and accountability across the board, and reward better quality – 10% to 20% of the payment is deposited in a performance contingency fund and tied to provider performance on process and outcomes of care, patient experience of care, and cost-efficiency. Providers are encouraged to be clinically integrated, even virtually, with 30% of their score dependent on the performance of providers they refer to.

Promote transparency – ECRs provide real and complete price transparency for consumers and providers, and the scorecard provides full transparency on quality.

PROMETHEUS picks up where others have left off

PROMETHEUS builds on past efforts with similar motivation: improve cost-efficiency, support quality

- CMS Heart Bypass Center Demonstration
- Utah's Designated Service Provider Program
- Anthem's Cardiac Services Network
- Oxford's Specialty Management Program

Key advantages of PROMETHEUS over prior attempts at global payment:

- Clinically relevant construction of case rates
- Linkage to scorecard with powerful incentives for quality
- Sophistication of risk adjustment

Key Definition: An ECR

An Evidence-based Case Rate is a global fee that encompasses all the appropriate level of services needed to care for a patient's condition.

Appropriate is informed by:

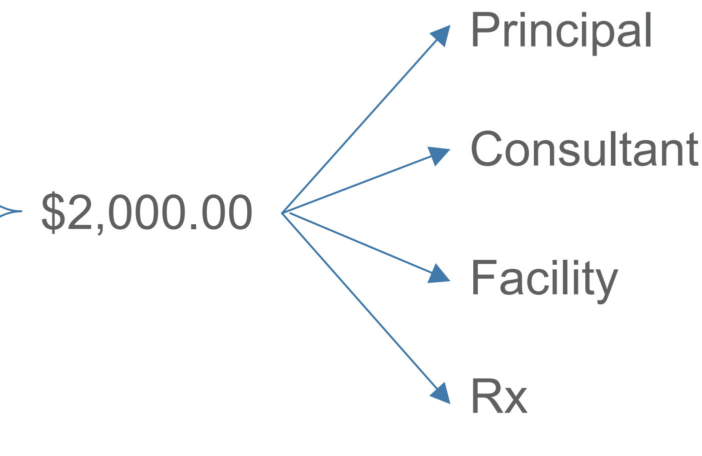
- Guidelines, where they exist and are suitable for this purpose
- Evidence or expert consensus on what constitutes good care
- Empirical evidence of the total cost of care incurred when patients are cared for by "good" providers

A patient can have multiple ECRs if the conditions are unrelated clinically, and all ECRs have specific rules on what triggers them, breaks them, bounds them.

ECRs are severity-adjusted

An Example of an Evidence-based Case Rate

Severity adjustment
Margin
Normal expected variation in cost for any patient getting care consistent with CPGs
Total cost for units of service that should be delivered as per CPGs



Providers are at risk for a small portion of their income, which is set aside for performance-based compensation

Insurer Funds

80% - 90%

Provider Payment (up to 110% of ECR)

10% - 20%

Remainder of the efficiency Fund only

Performance Contingency Fund

0% to 30% (all quality funds are distributed + portion of efficiency funds)

Scorecard

The PCF and Scorecard are the financial "regulators" of Prometheus

Providers are graded on a curve with a mean of B+ -- today's average score is C. To get any of the Performance Fund, you have to get at least the min score.

The formula encourages constant improvement from the treating physician and others

All undistributed Quality Funds are allocated to the Top Quartile quality performers, while all unearned Efficiency Funds are returned to the payer

What types of providers can participate?

IDS that manages the full ECR

Providers that take portions of the ECR:

- Providers can configure their groupings, if any, any way they want – 1sy 2sies can play; single hospitals can play
- No one holds the money of someone else unless they negotiate for that

Clinically integrated networks - competitors can bid together (e.g., multiple oncology groups in a market)

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Potential benefits to Providers

- Clinically relevant payment
- Sustainable as a business model
- Offers certainty in payment amount at maximums with a potential additional quality bonus
- Expects negotiation between providers and plans
- Should reduce admin burden (no E & M bullets, no prior auths, no concurrent review, no postpayment claims audits, maybe no formularies) over time

There is great opportunity for real clinical integration

Held out in every network settlement with the FTC to date

Elements: (1) protocols and
CPGs; (2) internal review and profiling; (3) investment in infrastructure; (4) corrective action; (5) data sharing with payors

Fee bargain must be ancillary to the real reason you are doing this

Additional benefits to providers

Data is managed in separate service bureaus

Carved out in simple amendments from contracts that otherwise remain in place

Will improve the quality of CPGs

Lowers fraud and abuse risks

Reduces malpractice liability

Tracks to STEEEP values

Gives physicians more control over what they do

Prometheus as a Vehicle for Payers to Target Value

Existing payment systems largely reward volume (fee-for-service) or cost avoidance (capitation, DRGs)

Pay-for-performance has begun to address the need to align payment more closely with value or cost-efficiency (in the true sense of cost per unit of output)

Prometheus takes the next step by organizing the entire payment system around the delivery of evidence-based and cost-efficient care

How is Prometheus Value-Based Payment?

ECR budgets reflect costs of providing evidence-based (high-value) care

Providers are financially rewarded for achieving high levels of process and outcome measures

Providers who achieve results at lower costs do better: cost avoidance alone is not rewarded

ECRs and scorecard give payers new, more sophisticated tools for capturing provider “output”

Example: Using ECRs for Cost-Efficiency Measurement and Benchmarking

Using evidence and consensus from Clinical Workgroups, process, outcome measures will be assigned weights (a function of strength of evidence, importance of contribution to outcomes, reliability of measure, etc.) and aggregated

Risk-adjustment derived from ECR development

All costs tracked in scorecard for relevant interval (rules about start/end ECR in place)

Cost-efficiency=costs/output

Additional benefits to payers

- Case rates include all the care associated with a patient, assigning a fair global fee to a patient's episode of care and creating greater predictability in the cost of care
- The program is designed to be administered using current underlying claims systems
- Prometheus encourages cooperation between all providers and explicitly discourages fragmentation
- Case rates become ex ante prices for all: including enrollees in Consumer-directed Health Plans

Several concerns have been uniformly raised

It's complex…*yes, but doable*

It requires a lot of IT infrastructure…*some*

It favors big integrated entities….*not really*

Most CPGs don't reflect evidence….*they mostly do*

Patients don't fit neatly into a CPG….*true, but that's ok*

Plans are not trustworthy….*it's a matter of opinion*

The engines could be black boxes….*but they won't*

And on the implementation front:

- A problem if only one plan plays….*yes unless it's a really big one*
- Transition will not ease administrative burden because this doesn't replace what exists….*true*
- How will we be scored for patient compliance? *By calibrating measures*
- Withholds are a scam…*they were*

Why should you care now?

PROMETHEUS Payment rewards what providers should be doing anyway

Bolsters a common orientation to quality

Provides an explicit basis on which hospitals and physicians in particular can work together in common cause

See Gosfield and Reinertsen: “In Common Cause for Quality”, October, 2006. http://www.hhnmag.com/hhnmag_app/hospitalconnect/search/article.jsp?dcrpath=HHNMAG/PubsNewsArticle/data/2006October/061010HHN_Online_Gosfield&domain=HHNMAG

Questions/Discussion

What are the biggest challenges you see with this from your end?

Are we missing anything critical?

What will it take to convince plans and employers that this is worth taking a swing at?

What will it take to convince providers that this is worth taking a swing at?