IHA Conference

February 14th, 2007

www.prometheuspayment.org

Agenda

8:30 – 9:15 – General Overview

9:15 – 10:00 – Evidence-informed Case Rates

10:00 – 10:15 – Break

10:15 – 11:15 – Scorecard and Incentives

11:15 – 11:30 – Pilots and Implementation

11:30 – Noon – Q&A

Presenters

Alice G. Gosfield, JD

Francois de Brantes, MS, MBA

Michael Pine, MD, MBA

Linda Bosserman, MD, FACP

Meredith Rosenthal, PhD

Beth McGlynn, PhD

General Overview

Alice Gosfield

Francois de Brantes

We're piloting a new payment model that, if successful, will…

- Remove the current barriers to the realization of high levels of professionalism in medicine, restoring autonomy with full public accountability
- Significantly improve the coordination of care in a fragmented delivery system, and the quality of care for patients
- Reduce unwarranted variation and moderate medical cost inflation
- Create true pricing information for all, and a way to measure output

We know some things work

Past and present CMS demos show that significant savings can be achieved when using “global” episodes:

- Centers of Excellence demo resulted in significantly reduced LOS, better patient outcomes and overall lower case costs….and higher margins for physicians
- PGP demo shows that reengineered practices are better at managing patients with chronic conditions and that incentives lead to reduced hospitalizations and lower overall costs

Performance reporting leads to performance improvement (think Apgar score)

Financial incentives impact behavior (think delivery case rates)

And we've known them for a while

The IOM's Crossing the Quality Chasm indicated that 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, right from the start – It starts with Evidence-informed Case Rates (ECRs) that are adjusted to reflect patient severity. High performers can make more than 100% of the Case Rate – 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 downstream providers.

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

Key Definition: An Evidence-informed Case Rate

A PROMETHEUS 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 Case Rates if the conditions are unrelated clinically, and all Case Rates have specific rules on what triggers them, breaks them, bounds them.

Patients with chronic conditions have an Anchor Case Rate which can be modified depending on the nature and severity of the condition and associated complications.

ECRs are not “grouped claims”

Built with specific diagnostic triggers and have specific end points	Constructed with claims triggers and end in “clean” claims period
Include an “incompressible” bundle of services	Can be compressed to zero
Distinguish services needed at onset and during maintenance	Consider all medical events to be equal
Have modifiers that trigger the need for higher intensity of resources (e.g. diabetes with two co-morbid conditions requires 3x services)	Are mostly linear and don’t distinguish resource needs by health status (i.e. no stages in cancer episodes)
Look forward	Look back

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
- 'Managing Physicians' (not gatekeepers, not necessarily primary) drive downstream referrals
- Parsable and unparsable pieces – a consultant who just does a consult and nothing more isn't bidding for a chunk

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

PROMETHEUS

Provider Payment Reform for Outcomes, Margins, Evidence, Transparency, Hassle-reduction, Excellence, Understandability and Sustainability

Potential benefits to Providers

- Clinically relevant payment
- Sustainable as a business model
- They do not take insurance risk; only medical management risk
- 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 post-payment 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

Hospitals can clinically integrate with physicians and not hold their money. Provides a better grounding to work together

Additional benefits to providers

Data is managed in separate service bureaus

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

Appeals go to the party making the decision

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 is a vehicle for Payers and Purchasers 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-informed and cost-efficient care by creating a basis for a negotiated price for providers to deliver good care

There are important benefits to payers & purchasers

- Case rates create greater predictability in the cost of care – variation in case rates should be due mainly to provider-payer negotiations
- PROMETHEUS encourages cooperation between all providers and explicitly discourages fragmentation by forcing downstream dependency
- Providers who achieve results at lower costs do better – they get to keep the difference between budget and actual – but cost avoidance alone is not rewarded
- Case Rates and their associated scorecard give payers new, more sophisticated tools for capturing provider "output" in a patient-centric way
- Case rates become *ex ante* prices for all: especially for enrollees in Consumer-directed Health Plans

Evidence-informed Case Rates

Linda Bosserman

Michael Pine

Evidence-informed Case Rates are built from the ground up

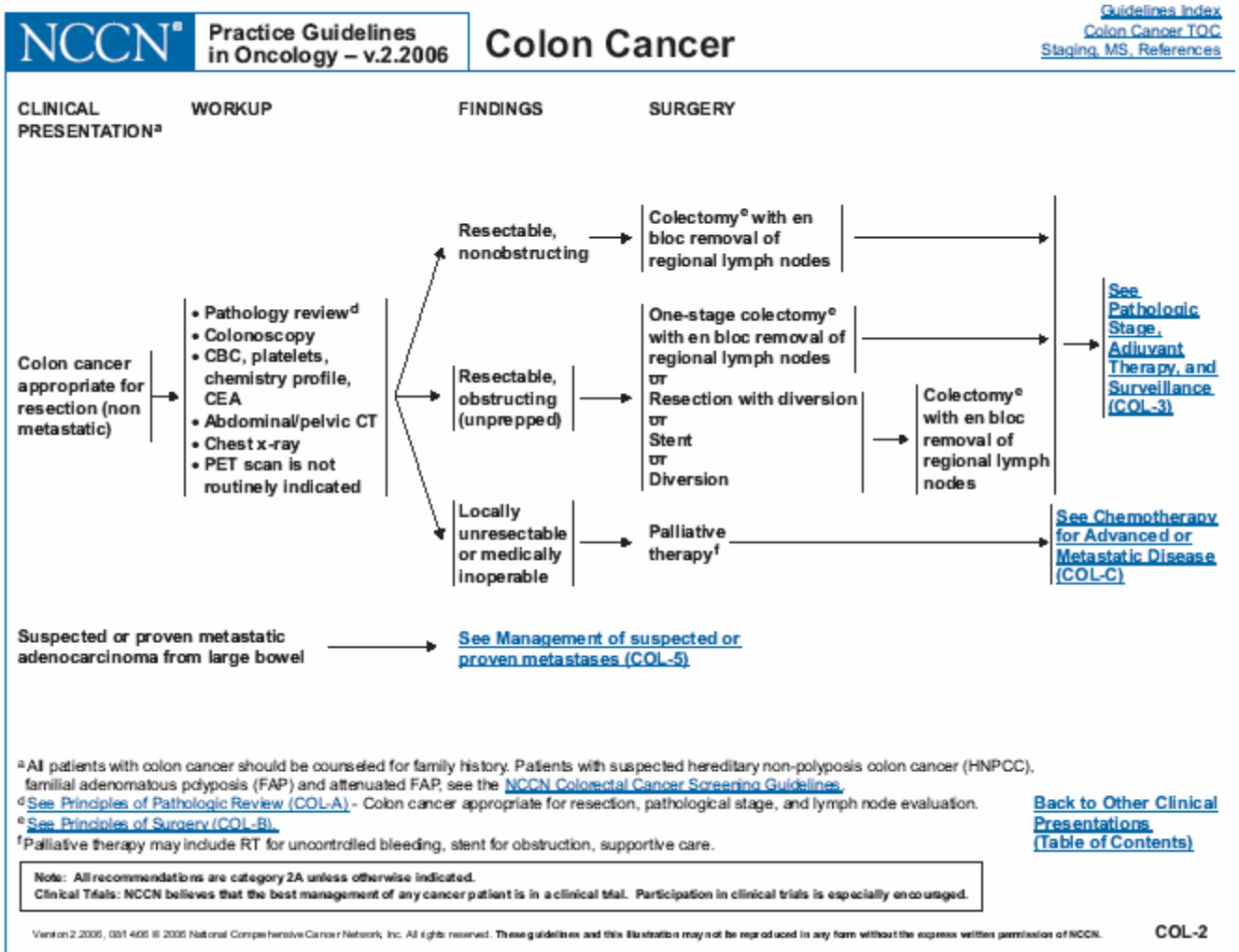
Starts with understanding what constitutes good care, consistent with available guidelines

Then guidelines are used to determine the core set of services that will be needed to care for the patient

Further analyses determine the triggers that signal a need for increased resources (ex ante patient factors)

Finally, empirical analyses try to parse out warranted and unwarranted variation. Unwarranted variation is variation caused by errors and bad care

Start with the guidelines….



NCCN® Practice Guidelines in Oncology – v.2.2006

Colon Cancer

Guidelines Index
Colon Cancer TOC
Staging, MS, References

CLINICAL PRESENTATION[a]	WORKUP	FINDINGS	SURGERY
Colon cancer appropriate for resection (non metastatic)	• Pathology review[d] • Colonoscopy • CBC, platelets, chemistry profile, CEA • Abdominal/pelvic CT • Chest x-ray • PET scan is not routinely indicated	Resectable, nonobstructing	Colectomy[e] with en bloc removal of regional lymph nodes
		Resectable, obstructing (unprepped)	One-stage colectomy[e] with en bloc removal of regional lymph nodes or Resection with diversion or Stent or Diversion → Colectomy[e] with en bloc removal of regional lymph nodes
		Locally unresectable or medically inoperable	Palliative therapy[f]

→ See Pathologic Stage, Adjuvant Therapy, and Surveillance (COL-3)

→ See Chemotherapy for Advanced or Metastatic Disease (COL-C)

Suspected or proven metastatic adenocarcinoma from large bowel → See Management of suspected or proven metastases (COL-5)

[a] All patients with colon cancer should be counseled for family history. Patients with suspected hereditary non-polyposis colon cancer (HNPCC), familial adenomatous polyposis (FAP) and attenuated FAP, see the NCCN Colorectal Cancer Screening Guidelines.
[d] See Principles of Pathologic Review (COL-A) - Colon cancer appropriate for resection, pathological stage, and lymph node evaluation.
[e] See Principles of Surgery (COL-B).
[f] Palliative therapy may include RT for uncontrolled bleeding, stent for obstruction, supportive care.

Back to Other Clinical Presentations (Table of Contents)

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

COL-2

Determine factors that might trigger higher costs….

Stage II Colon Cancer, but not rectal cancer
Clinical description of a typical patient covered by the core evidence-based case rate:
55 year-old male
Standard work-up required to diagnose and characterize the condition / establish the appropriateness and scope of the procedure covered by the evidence-based case rate:
See NCCN guideline for standard w/u with colonoscopy
Elderly/comorbid may need cardiac w/u or clearance; occasional patients with poor renal, cardiac or pulmonary function need more testing
Criteria that must be met for a typical patient to be eligible for coverage by the core evidence-based case rate:
Diagnosis of colon cancer following colonoscopy
Criteria for successful completion of care for a typical patient covered by the core evidence-based case rate:
no recurrence after three years of routine follow-up and surveillance
Ex ante factors (e.g., comorbidities, clinical status, disease progression) that increase required services beyond those covered by the core evidence-based case rate:
Elderly/comorbid may need cardiac w/u or clearance; occasional patients with poor renal, cardiac or pulmonary function need more testing
Complications associated with the covered condition and/or procedure or with its diagnosis and/or treatment that increase required services beyond those covered by the core evidence-based case rate:
See above. In addition, the recurrence rate is about 20%

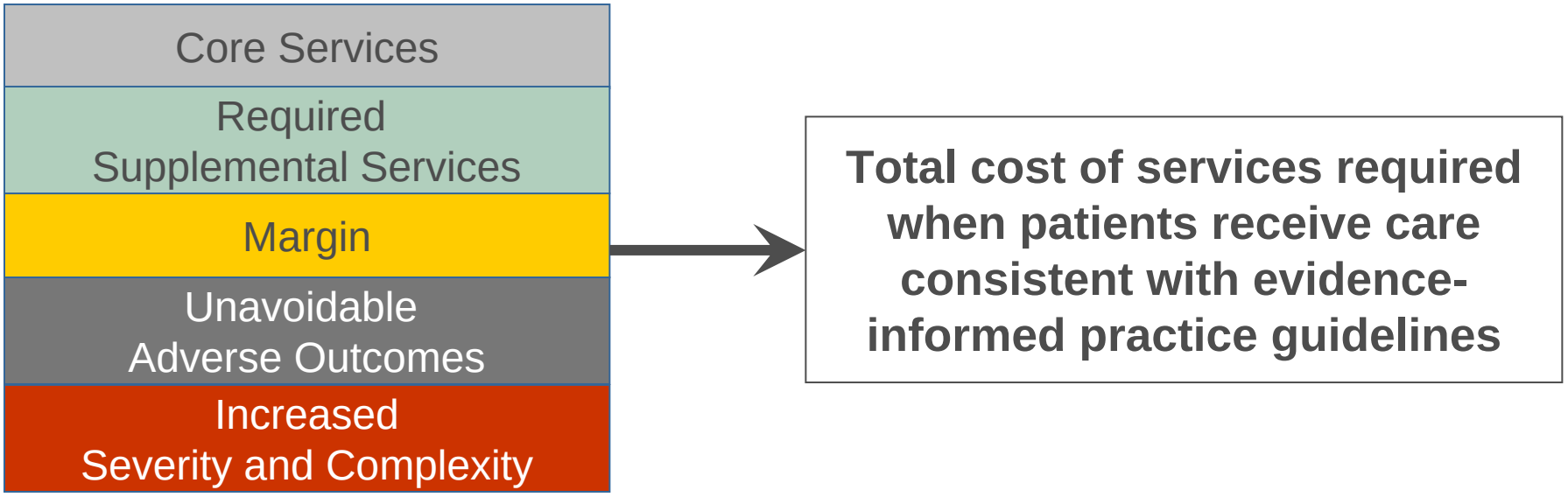
Identify discrete events in the care pathway….

Standard Component of Stage II Colon cancer	Definitions of the component	Detail of the component	Common Modifiers+	Common complications	Duration of the component
Surgical resection	Stage II is rarely obstructing or perforating so those complications are not considered	3 - 5 day stay; some get colostomy with teaching, most do not; occasional prolonged stay with ileus; occasional post op leaks, infections and DVT	Very few reasons NOT to get surgery	Ileus, post-op leaks, pneumonia, dvt	Hospitalization plus 2 - 4 week recovery
Chemotherapy	Some patients with St II will get chemo depending on risk factors. This varies from place to place	Those that get chemo will get FOLFOX usually, unless on a clinical trial. Most (75% or so) are observed; chemo requires up to 12 visits, pump charges, drug charges, CBC/chemistries every visit, doctor or NP charge every other visit	NCCN guidelines state: <12 nodes (increases); T4/perforation/lymphvasc/poorly diff (all increases); short life expectance and comorbidity (decreases)	Dose delays increase numbers of visits; many patients do NOT get all 12 doses because of neuropathy; oxaliplatin allergies in 5% or so; 5 - 10% hospitalized for 3 - 10 days with diarrhea (mostly elderly);	24 - 28 weeks
Workup	See NCCN guideline w/u minus colonoscopy and path	CBC/chemistries, CEA, CT of Ab and pelvis, chest CT,	No obvious modifiers	Elderly/comorbid may need cardiac w/u or clearance; occasional patients with poor renal, cardiac or pulmonary function need more testing	2 - 3 weeks
Surveillance	See guidelines:	Visit every 3 - 6 mo; CEA every 3 - 6 mo; CT scans of C,A,P every 1 yr x 3 for the higher risk patient	No scans for short life expectancy or comorbidity	Observation patients may have extra tests provoked by false positive surveillance tests	Variable; could define this any length but at least 3 yr.

Define a core set of services….

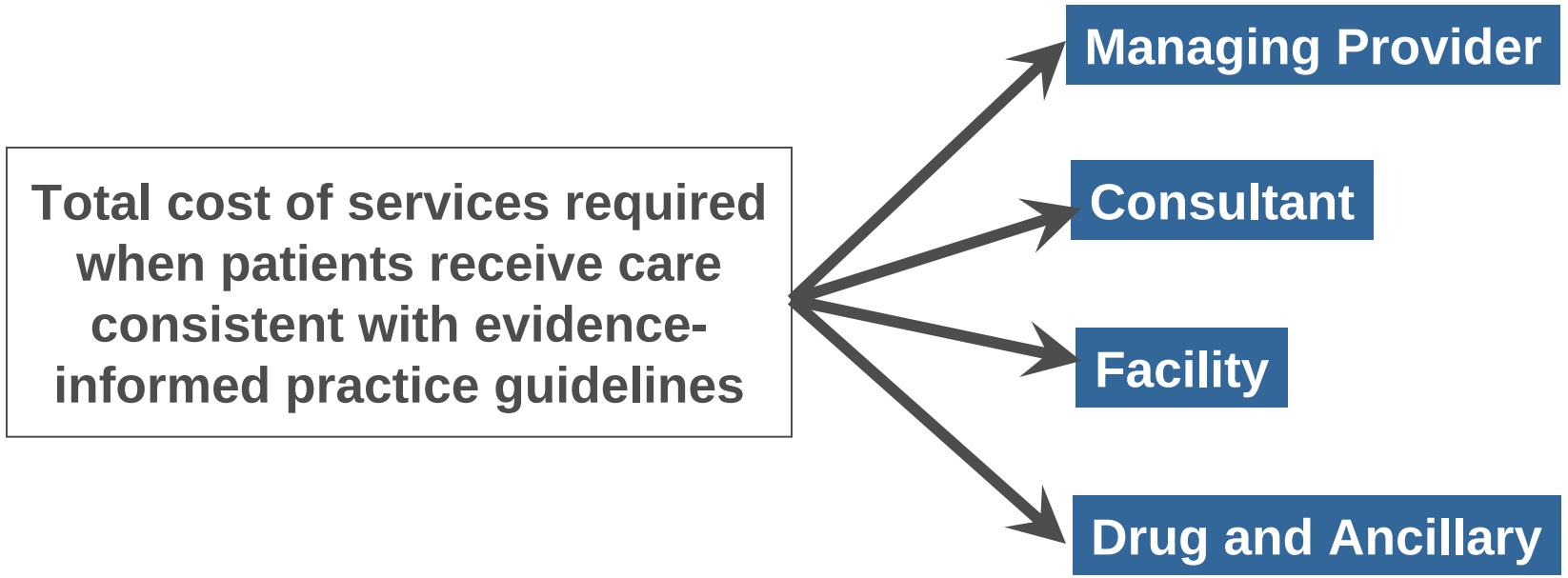
Time line of visits*		
Activity	**Frequency**	**Person**
Disease and case management	On-going	Medical oncologist and/or PCP
colonoscopy	Initial diagnosis and in Year 2, 5	Gastroenterologist + PCP to counsel
		about need for colonoscopy
visit to review biopsy	1	gastroenterologist
appointment regarding surgery	1	surgeon
hospital stay and surgery	3 to 5 days	surgeon
review data for stage II disease	1	medical oncologist
visit social worker	1 (this is uncommon in most places)	social worker
visit chemo nurse for teaching	1	chemotherapy nurse
decide on Rx	1	medical oncologist
lab for pre-chemo CBC, CMP, liver, CEA	1	lab
meet with clinical trial staff re protocol	1 (not common)	trial staff
chemotherapy and follow-up visit every 2 weeks	12 + 12	medical oncologist, chemo nurse
potential problems: nausea, diarrhea, fever, pain, etc.	3	medical oncologist, nurse
one month post therapy: review Rx and survivorship	1	medical oncologist
follow-up visit every 3 months	2 visits first year, 3 visits second year	medical oncologist
About 20% will recur incurring greater costs		
A minority of patients get chemotherapy with Stage II cancer, most will be observed		
*Most frequencies are year 1 unless specified		

Components of a PROMETHEUS Case Rate

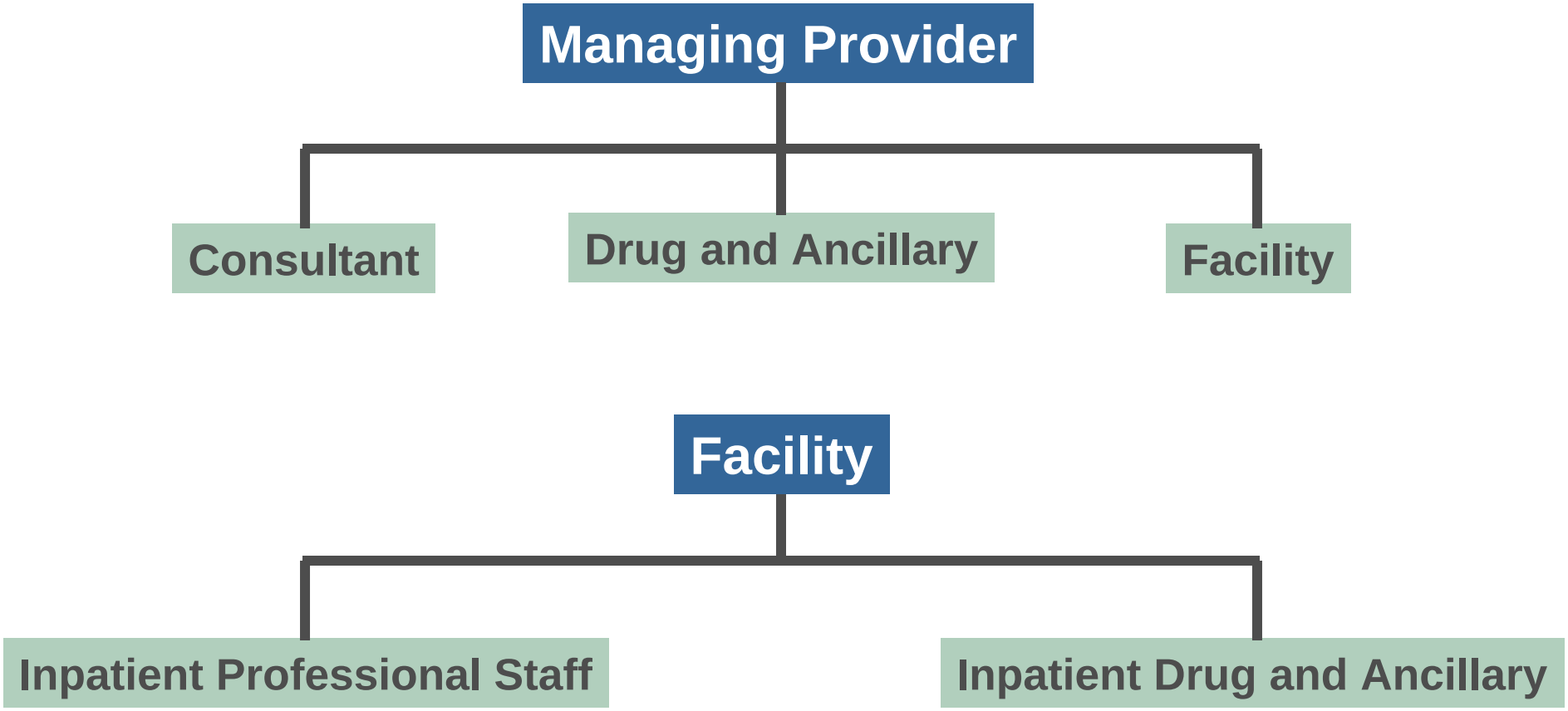


Warranted variation in cost for a patient receiving care consistent with “best” evidence-informed practice

Distribution of a PROMETHEUS Case Rate

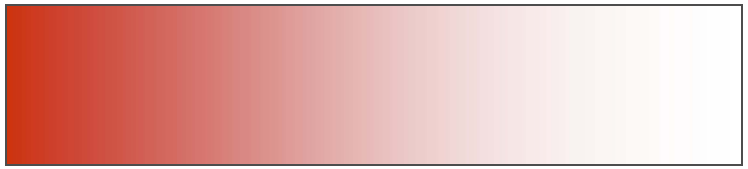


Responsibility for a PROMETHEUS Case Rate



Acute and Chronic Case Rates

Acute Case Rate for Self-Limited Conditions or Interventions
Examples: Pneumonia; Elective Cholecystectomy



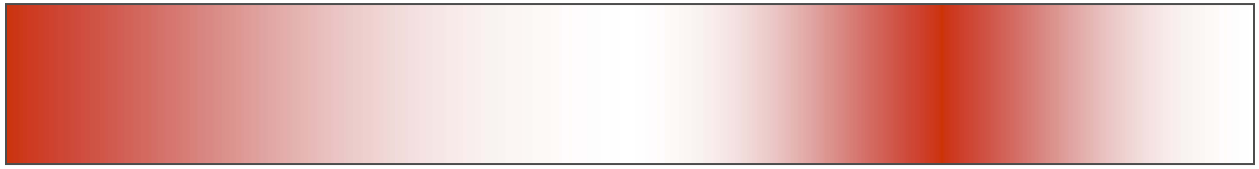
Beginning and end of Case Rate are defined by condition

Chronic Case Rate for Conditions Requiring Continuing Management
Examples: Diabetes, Colonic Cancer

Case Rate Covers a pre-defined period of care
and accounts for onset v. maintenance

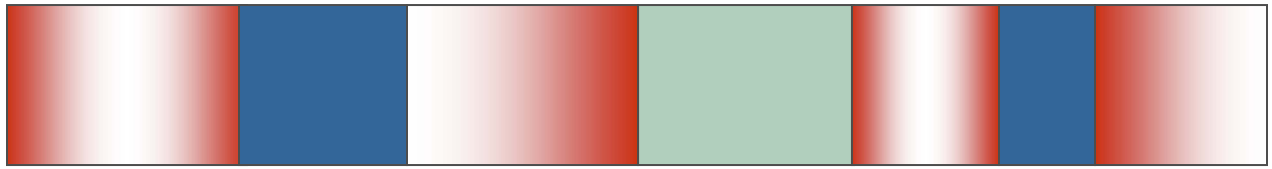
Two types of Chronic Case Rates

Case Rates for conditions managed by a single Managing Physician.
Example: Diabetes



Consultants, facilities, drugs and ancillaries are used as needed.

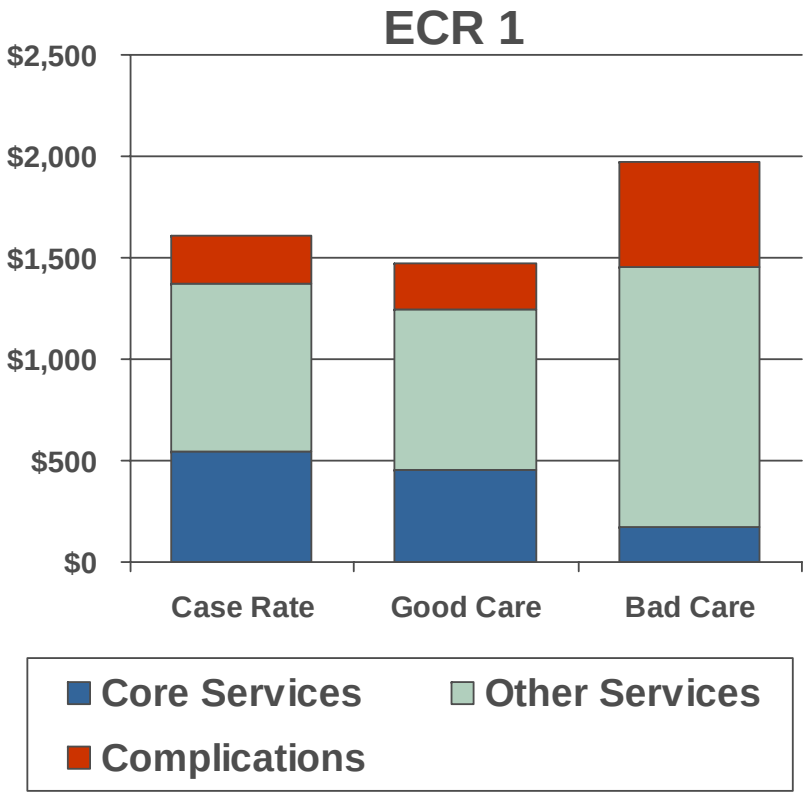
Case Rates for conditions with clearly defined subsections requiring different Managing physicians with separate Case Rates
Example: Colon Cancer

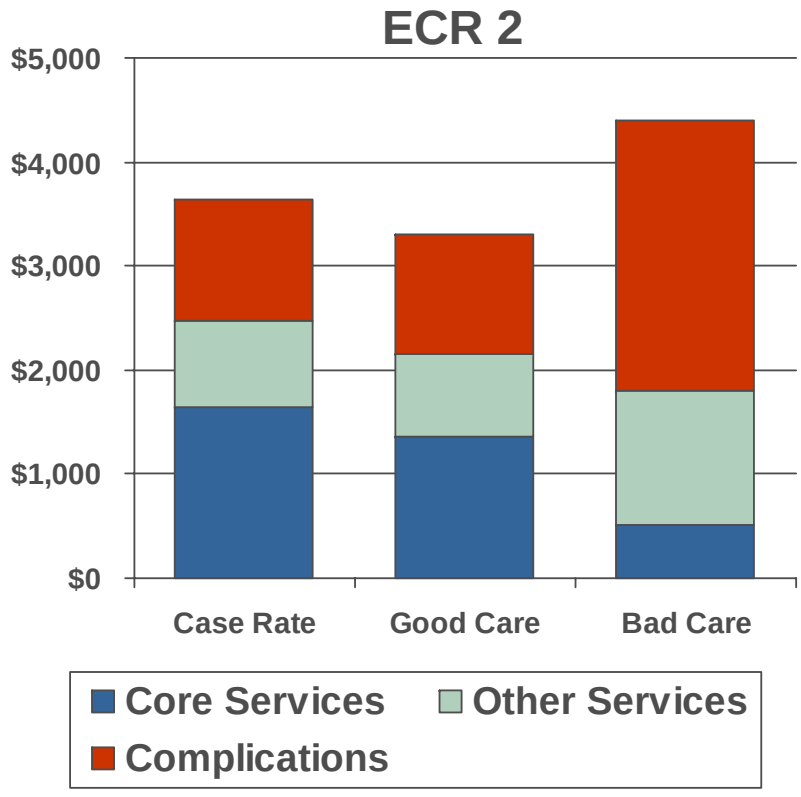


The principal Managing Physician (e.g., oncologist) turns over responsibility for the patient to other physicians (e.g., surgeon , radiotherapist) who serve as Managing Physicians for an embedded segment of care. Consultants, facilities, drugs and ancillaries are used as needed.

PROMETHEUS is designed to eliminate unwarranted variation

Bad Care is characterized by failure to perform evidence-informed core services, increased use of supplementary services, and high rates of complications.





Scorecard and Incentives

Meredith Rosenthal

Beth McGlynn

Colon Cancer Illustrates Involvement of Multiple Players in Health Care System

Provider	Screening	Diagnosis	Surgery	Adjuvant Therapy	Surveillance/ Management
Primary Care	☑				☑
Procedure Specialist		☑			
Surgical Specialist			☑		
Hospital			☑		
Medical Oncologist				☑	
Other					☑

Sample Areas for Assessment

Continuum	Technical Excellence	Interpersonal Excellence
Prevention	Risk factor reduction	Ease of scheduling; respect
Screening	Periodicity & choice of screening method; + findings referred for dx	Ease of scheduling; respect
Diagnosis	Polyp removal offered; document size, location; initial staging	Understand results & options; care coordination
Surgery	Negative margins, no spillage, no complications; staging accurate	Treated with respect; understand results; care coordination
Adjuvant therapy	Timely initiation, appropriate regimen; side effects mgmt	Choice of oncologist; scheduling appropriate
Follow-up	Periodicity of surveillance	Care coordination

Data Implications of Assessment Areas

Aspect of Care	Data Requirements
Prevention	Risk factor profile; interventions to reduce modifiable risks (diet, exercise, NSAIDs)
Screening	Method, results
Diagnosis	Surgical findings, procedures
Surgery	Surgical notes, staging, complications, risk factors
Adjuvant therapy	Type, regimen, completion
Surveillance	Periodicity, results
Patient experience	Ratings, reports (patient survey -- triggered by steps in process)

Putting the Pieces Together

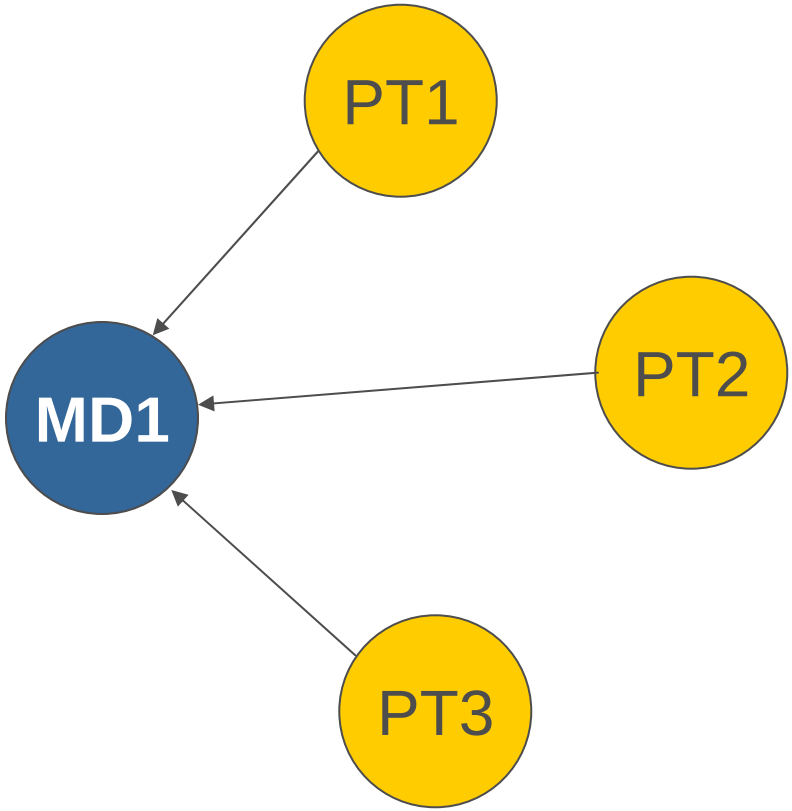
Technical Excellence	+	Interpersonal Excellence	=	Patient Score
% of recommended processes rec'd		Average score (score 0-100 scale)		

Equal weights, differential weights possible within and across categories

Scoring Primary Care Physician: 80% Direct Responsibility; 20% Team

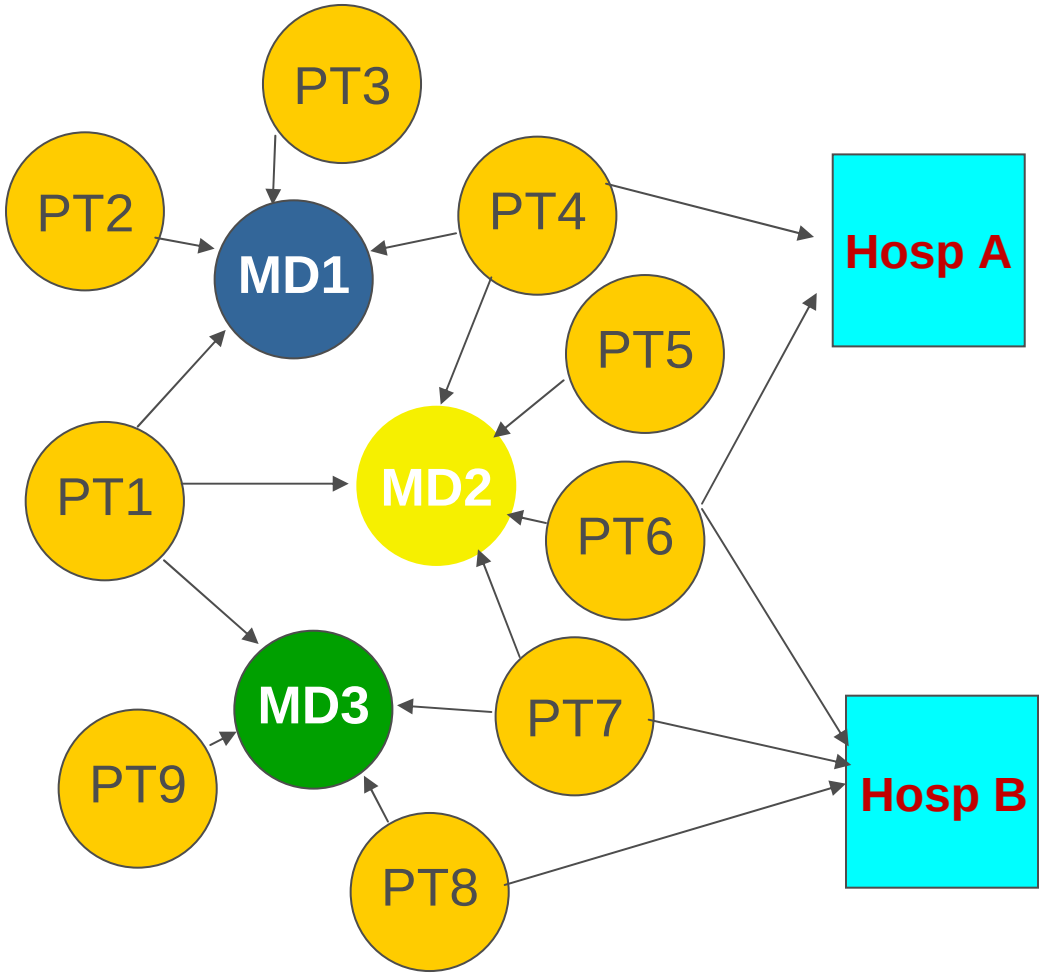
Provider	Screening	Diagnosis	Surgery	Adjuvant Therapy	Surveillance/ Management
Primary Care	☑				☑
Procedure Specialist		☑			
Surgical Specialist			☑		
Hospital			☑		
Medical Oncologist				☑	
Other					☑

Physicians See Multiple Patients



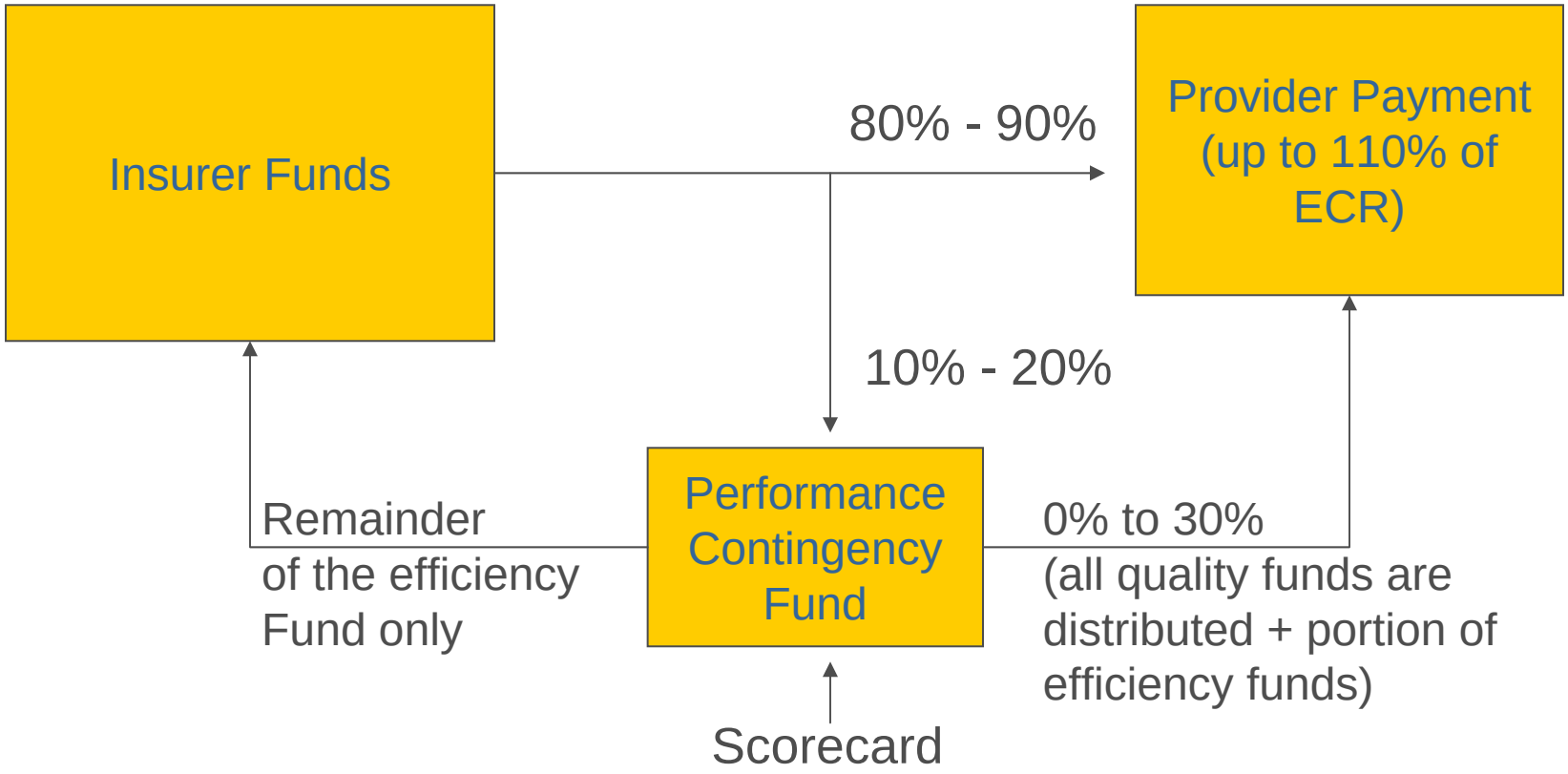
So, the physician's direct score reflects the panel seen

Patients See Multiple Providers

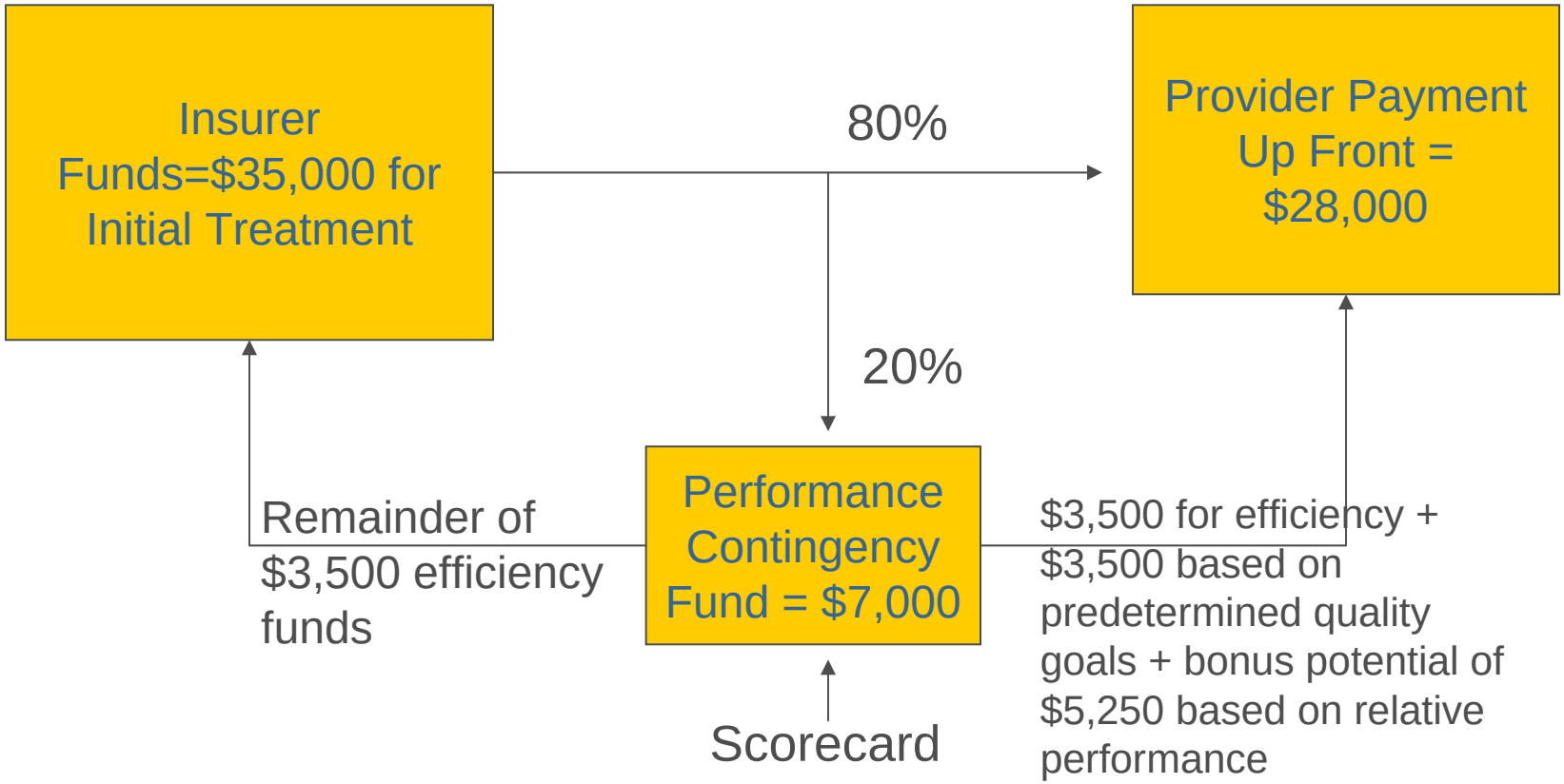


So, the physician's "team" score depends on the patients' networks

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



Example: Cancer Center Accepts ECR for Colorectal Cancer with 20% Performance Contingency



How Are the Contingency Funds Returned?

Suppose there is a single, comprehensive quality score for colon cancer treatment and $3,500 quality withhold

The score ranges from 0 to 1 (a population rate of performance)

Minimum acceptable score is 50%; maximum anticipated score is 90% (these will vary by measure)

Payment proportional to performance in the eligible range: e.g., a score of 70% is half-way between minimum and maximum scores so half the contingency is returned = $1,750

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

Pilots and Implementation

Francois de Brantes

We have a lot on our plate for the next six months

- Development of Evidence-informed Case Rates (ECRs) in cancer, chronic and preventive care, interventional cardiology, joint replacements
  - Working groups have worked on a starter set
  - Large claims databases have been secured and are being used to validate model
- Creation of an ECR Tracker to help plans implement
- Creation of an ECR Scorecard to evaluate clinical quality, efficiency, and patient satisfaction will be developed to govern return of withholds and the distribution of bonuses.
- Pilot site selection and preparation – up to four pilot sites will be selected by PROMETHEUS Payment Inc

We developed a number of criteria for pilot sites

Ranked 1	Ranked 2	Ranked 3
Willingness of Local Provider Leaders	Large Concentrated Medically Diverse Population	Stable Patient Population
Large Market Share of Willing Plans	Familiarity With Capitation	Current Prevalence of Case Rates
Existence of Integrated Delivery Systems	Other Major Healthcare Market Initiatives	Dominant Stake Holder/Provider
Experience of Market In Performance Measurement/ Reporting	Large, Active Employers/ Coalition	Presence of local business groups on health

We have some candidates

Chicago (IL), Brockton and/or Newburyport (MA), Memphis (TN), Philadelphia (PA), Seattle (WA), Cincinnati (OH), San Francisco (CA), and around a health system in FL

The goal is to start working the field/implementing in 2007

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 patient non-compliance be accounted for? *By calibrating measures*
- Withholds are a scam…*they were*

Q & A

Resources (Most Recent First)
www.gosfield.com/publications

Gosfield, “The PROMETHEUS Payment™ Program: A Legal Blueprint”, HEALTH LAW HANDBOOK (January, 2007) 36pp

Gosfield, “PROMETHEUS Payment: Better Quality and A Better Business Case” JNCCN (Nov. 2006) 3pp

Gosfield, “PROMETHEUS Payment: Getting Beyond P4P,” Grp Prct J (Oct. 2006) 5pp

Gosfield and Reinertsen, "In Common Cause for Quality Part 1: New Hospital-Physician Collaborations," Hospitals and Health Networks Online, October 10, 2006 Gosfield, "In Common Cause for Quality Part 2: PROMETHEUS Payment™ and Principles of Engagement", Hospitals and Health Networks Online, October 17, 2006

Gosfield, “PROMETHEUS Payment™: Better for Patients, Better for Physicians.” Journal of Medical Practice Management (September/October 2006) 5pp