IHA Pay for Performance Summit

Alice G. Gosfield, Esq.

February 15th, 2007

www.prometheuspayment.org

Alice G. Gosfield, J.D.

Alice G. Gosfield and Associates, PC

2309 Delancey Place

Philadelphia, PA 19103

(215) 735-2384

Agosfield@gosfield.com

www.gosfield.com

www.uft-a.com

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

The Design Team

Jim Bentley, AHA

Francois de Brantes, BTE

Doug Emery, eHI

Michael Pine, Michael Pine & Associates

Alice Gosfield, Alice G. Gosfield & Associates

Jeff Levin-Scherz, Partners Health Care

Beth McGlynn, RAND

Toni Mills, BCBS Association

Mike Taylor, TowersPerrin

Dan Roble, Ropes & Gray

Meredith Rosenthal, Harvard School of Public Health

Craig Schneider, MA Health Data Consortium

Purposes

Get beyond P4P which is not sustainable as a payment reform model

Deal with the toxicities of FFS and capitation

Reduce administrative burden -- to physicians and plans

Pay to deliver the right combination of services according to science

Track to the IOM STEEEP values

Basic Concepts

Amount of payment is derived from assessment of projected resources to deliver care in a good CPG

Negotiated base payment takes into account severity and complexity of patient's condition

Bulk of it is paid prospectively, monthly; although FFS option is available

More

Evidence-informed case rate (ECR) encompasses all providers treating a patient for that condition and is allocated among them in accordance with that portion of the CPG they negotiate to deliver

Comprehensive scorecard measures process, outcomes, patient experience of care, relative efficiency (not in an IDS)

It is risk adjusted

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:

1. Guidelines, where they exist and are suitable for this purpose
2. Evidence or expert consensus on what constitutes good care
3. 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.

Still More

Performance Contingency holdback of 10% on chronic care 20% on acute care provides basis to pay remainder of ECR in accordance with scores

Better performing providers get better margins and potentially additional $

Voluntary, not total substitution, negotiated; FFS and capitation remain for other conditions

TRANSPARENCY OF EVERYTHING

Who plays?

Providers can configure their groupings, if any, any way they want – 1sy 2sies can play; single hospitals can play; competitors can bid together (e.g., multiple oncology groups in a market)

Not just for integrated systems

No one holds the money of someone else unless they negotiate for that

Potential Benefits

Clinically relevant

Sustainable as a business model

Offers certainty and predictability in payment amount

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)

Designed to be ‘plug and play’ for plans

More Benefits

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

Fosters clinical integration

Tracks to STEEEP values

Gives physicians more clinical control over what they do

Service bureaus, not plans, manage the data

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 become *ex ante* prices for all: especially for enrollees in Consumer-directed Health Plans

Infrastructure to be developed

ECR Translator --- to construct payment amounts from a CPG

ECR Budget Estimator – to establish the payment amount

ECR Tracker – to take data from ‘claims’ and allocate to appropriate providers the pieces of the CPG they delivered

ECR Reporter – to figure out how much is owed, if any, at the end of the CPG

Comprehensive Scorecard

Next Steps -- 2007

Vendor of the core Engine is engaged

ECR working groups engaged:

oncology – lung and colon cancer;
interventional cardiology – STEMI; non-ischemic CHF; mitral valve regurgitation,
chronic care – diabetes with and without hypertension; depression in primary care
preventive care
orthopedics – knee and hip replacement

Develop Scorecard

Identify pilot markets and contract for pilots

Launch pilots 2d half of 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*

Caveats

This will be complicated – mostly the infrastructure

There will be transitional costs especially given parallel systems

There are pitfalls

There is short term reality and long range potential

This will take work BUT

There will be no change without struggle

Pro·me·the·an (prə-mē'thē-ən)
adj. defiantly original; so boldly creative as to have a life-giving quality

"*Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has." --*
Margaret Mead

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