Prometheus Payment – Making it Real

Health Industry Forum

April 29th 2009

Prometheus Payment, Inc.

- Not-for-profit, founded in 2007
- Funded by RWJF and the Commonwealth Fund
- All work is transparent….methods are freely available and open to comment on web site
- Multi-stakeholder Board
- More information at www.prometheuspayment.org

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Some core principles and objectives

- Let payment and incentives drive delivery system reform, not the other way around
- Tie effectiveness to efficiency – focus on “defect” reductions
- Solve the “Brent James Dilemma” – make it worthwhile to engage in continuous value improvement and delivery system innovation
- Get providers to act as a team even if they’re not integrated
- Don’t cause significant disruptions to current operations

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Clarifying accountability for cost variation

Total Cost of Care

Global Cap
BCBS MA

Costs of all AMI Episodes

"Coarse" Episodes
CMS – ACE

Reliable Care

Costs of all Typical Episodes

Costs of all Potentially Avoidable Complications
(and other provider-specific variation)

Costs of all Base Services

Costs of all Severity Adjusters

Evidence-informed Case Rates (ECR)

- Insurer – Probability risk
- Provider – Technical risk
- Consumer – Probability risk

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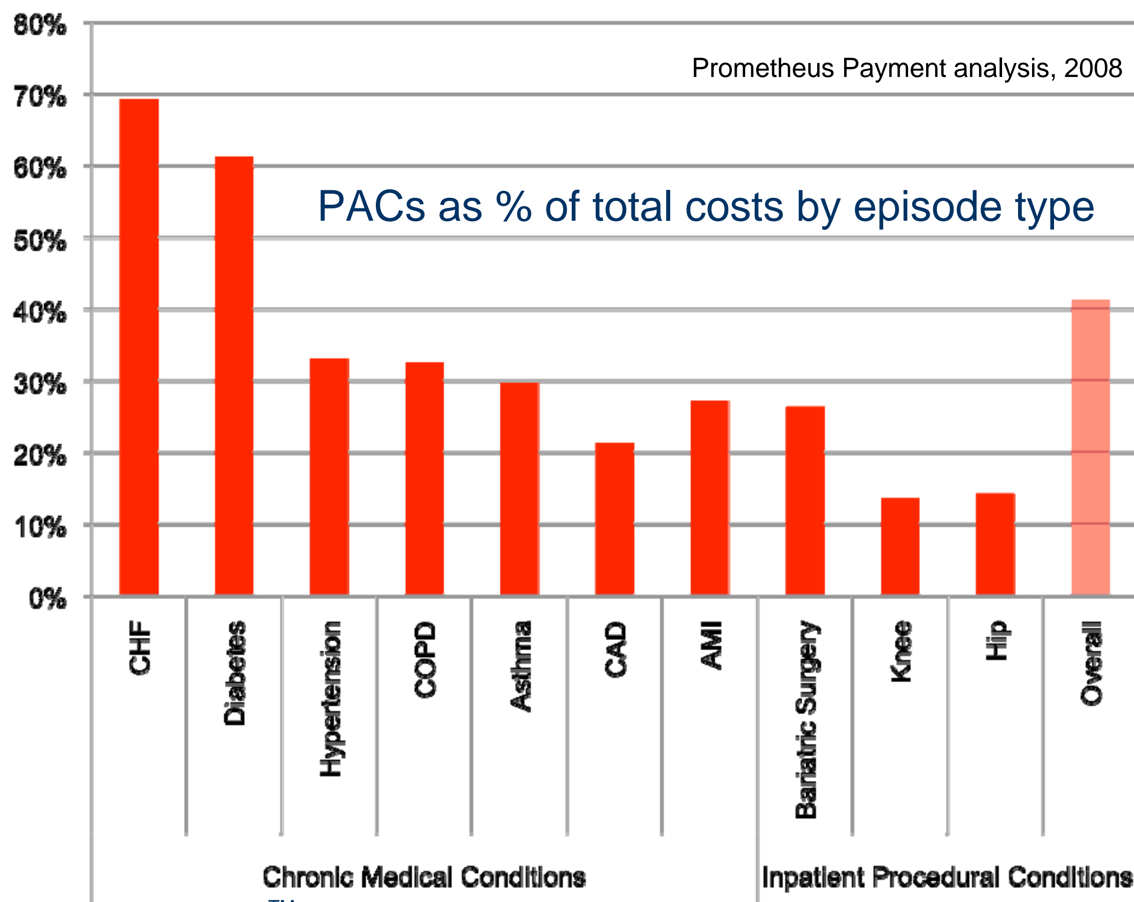
Potentially Avoidable Complications = bad things happening to patients = care defects



Reducing the red bar reduces the costs of the episode and harm to the patient.
If we got to zero defects on all of these episodes everywhere in the country, we'd save $500B and many many lives.

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Myth # 1: You need an “Accountable Care Organization”

- You only need an ACO if you prospectively ***pay*** the episode (or care package or bundle)
- You don’t need any organization to “buy” the patient if you prospectively ***budget*** and retrospectively reward/penalize

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Claims are paid same as today, and tagged against the episode budget

Hospitals

Physicians

Rx

Other

Claims →

← $$

Payer

Paid Claims →

← ECR Actual to Budget

ECR Budget Tracker

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And you don't need complicated legal agreements to divvy up the money

	# of Patients	Overall Episode Price	Actual Spend Observed	Bonus Opportunity
COPD	25	$34,423	$27,827	$6,596
Diabetes	50	$201,300	$176,358	$24,942
CHF	10	$87,977	$73,723	$14,254
Asthma	35	$71,863	$60,745	$11,118
CAD	70	$176,623	$154,547	$22,076
HTN	310	$600,329	$529,127	$71,202
Overall	**500**	**$1,172,515**	**$1,022,327**	**$150,188**

All claims hit the episode accumulator by patient and it tracks the providers that cared for the patient

Barring a formal agreement between the treating physicians on how to share the bonus potential, the split is based on % of E&M

	% of total E&M claims	Share of Bonus
Dr. Tooker – Internist	40%	$60,075
Dr. Lee – Cardiologist	30%	$45,056
Dr. Stoller – Pulmonologist	15%	$22,528
Dr. Rastogi -- Nephrologist	15%	$22,528

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Myth #2: Episodes can only be used for procedures or acute events

- Episodes can cover acute, procedural or chronic care
- And you can also bundle chronic care episodes to create a practice-based global fee – which is NOT capitation, but simply a sum of severity-adjusted patient-centered episodes

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Types of Evidence-informed Case Rates (ECRs)

Type of ECR	Trigger	Time Window	Examples
Chronic Medical	Outpatient Professional	One year from trigger	Diabetes, CHF, COPD, Asthma, CAD, HTN
Acute Medical	Inpatient Facility	3-day look-back; 30-day look-forward	AMI, Stroke, Pneumonia
Inpatient Procedural	Inpatient Facility	30-day look-back; 180-day look-forward	Hip/Knee Replacement, Bariatric Surgery, CABG
Outpatient Procedural	Outpatient Facility/ Professional	30-day look-back; 180-day look-forward	PCI, Hernia, Knee repair, Ligaments

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Myth #3: Episodes have to be priced the same for all patients

- Only if you want to encourage cherry picking
- Episodes can be severity adjusted and priced/budgeted at the patient level

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Pricing an Episode of CHF

		Hypothetical Patient Scenarios		
Predictor	**Coefficient on Ln Scale**	**Patient 1**	**Patient 2**	**Patient 3**
Intercept	7.3049	**1**	**1**	**1**
Heart valve disorders	0.1463	0	**1**	**1**
Coronary atherosclerosis and other heart disease	0.2072	0	**1**	**1**
Carditis, Cardiomyopathy	0.1294	0	**1**	**1**
Conduction disorders	0.2003	0	**1**	**1**
Statins and other anti-lipid agents	0.2161	0	**1**	**1**
Bronchodilators and other antiasthmatics	0.2345	0	0	**1**
Antiarrhythmic agents	0.2274	0	0	**1**
Inhalers and respiratory agents	0.2061	0	**1**	**1**
Antacids and drugs for other oral and GI problems	0.2915	0	**1**	**1**
Diuretics	0.2469	0	**1**	**1**
Other cardiovascular agents	0.1697	0	0	**1**
Beta-Blockers	0.2322	0	0	**1**
ACEI, ARB, anti-renin drugs	0.1672	0	**1**	**1**
Calcium channel blocking agents	0.1672	0	0	**1**
Antiplatelet agents, thrombin inhibitors	0.2214	0	**1**	**1**
Antidepressants	0.194	0	0	**1**
Severity-adjusted Price of base services		**$1,488**	**$27,418**	**$93,341**

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An ECR… for each patient-provider-payer combination

Total ECR price = Type of services x Frequency x Price per service

Component	Description	Range
PAC Allowance	Based on 50% of current defect rate	$3,000 -- $16,500
Margin	Currently based at 10% of typical	$360 -- $2,260
Severity-adjusted Core	Arrived at through step-wise multi-variable regression model Adjusts ECR for local patterns Informed by guidelines and empirical data analysis	$3,600 -- $22,600*

CHF ECR Range**
$7,000 -- $41,400

* $2,300 was added to the base set of claims-based/observed services to create a right-sized evidence-informed set of services.
** The upper range can be greater than the amount stated depending on the severity of the patient

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Take-aways

- Payment for episodes of care can and is being done, and not just for procedures or acute events
- It doesn't have to be a prospective payment system
- PACs are so significant that they create a huge opportunity to fund improvements – call it "gain-sharing" if you want

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