



HCDP Meeting

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## What we know about P4P

Incentives work and can lead to practice reengineering, but practices need help to reengineer

Better quality can cost less, but you need to focus on the right measures

Self-assessment of performance leads to focused quality improvement, but it's resource-intensive to pull charts

Employers banding together can create enough critical mass to impact physician behavior, but you need the plans to really make it work (or CMS)



## **We still need a better output measure for all the dollars spent in the system**

Studies of health care productivity have been hampered by output measurement

Visits, RVUs imply objective is health *care* (e.g. volume of services), not health

Looking at episodes (e.g., defined by index event plus time) results in opposite problem – “best” provider delivers no services – because basic episodes can be compressed down to \$0

And we need to better delineate and apportion the different types of risk



# Current payment modes compress risk at either end

*Risk-bearer*

Risk Type	Explanation	Purchaser- Employer- Plan Sponsor	Employee- Patient	Provider
Probability Risk	Risk that an adverse health event will occur	80%	TBD	80%
Provider Technical Risk	Risk that the care provider will not be competent or qualified to produce a favorable outcome for the health event	80%	TBD	80%
Choice-Utility Risk	Risk that the value of the services provided is far less than the loss sustained from getting it	80%	TBD	80%

FFS

Capitation



# Risk can be apportioned appropriately

*Risk-bearer*

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Probability Risk	Risk that an adverse health event will occur	80%	10%	10%
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# There are strategies to get there

## Risk-bearer

Risk Type	Explanation	Purchaser- Employer-Plan Sponsor	Employee- Patient	Provider
Probability Risk	Risk that an adverse health event will occur	<ul style="list-style-type: none"> <li>▪ <i>Few Plan designs</i></li> <li>▪ <i>Self-insured plans</i></li> <li>▪ <i>One Pool</i></li> </ul>	<ul style="list-style-type: none"> <li>▪ <i>Forced enrollment &amp; contributions</i></li> </ul>	<ul style="list-style-type: none"> <li>▪ <i>Population-based outcomes measures</i></li> </ul>
Provider Technical Risk	Risk that the care provider will not be competent or qualified to produce a favorable outcome for the health event	<ul style="list-style-type: none"> <li>▪ <i>Measure and reward quality</i></li> <li>▪ <i>Increase consumer understanding and value of quality</i></li> </ul>	<ul style="list-style-type: none"> <li>▪ <i>Create incentives for patients to seek higher quality providers</i></li> </ul>	<ul style="list-style-type: none"> <li>▪ <i>Severity adjusted bundled payments</i></li> </ul>
Choice-Utility Risk	Risk that the value of the services provided is far less than the loss sustained from getting it	<ul style="list-style-type: none"> <li>▪ <i>Incentives for “good behavior” and adherence to care guidelines</i></li> </ul>	<ul style="list-style-type: none"> <li>▪ <i>Create cost transparency</i></li> <li>▪ <i>Increase consumer sensitivity to price of services through co-insurance</i></li> </ul>	<ul style="list-style-type: none"> <li>▪ <i>Prospectively and retrospectively adjust bundles</i></li> </ul>



## Private and public sector efforts are trying to address these issues

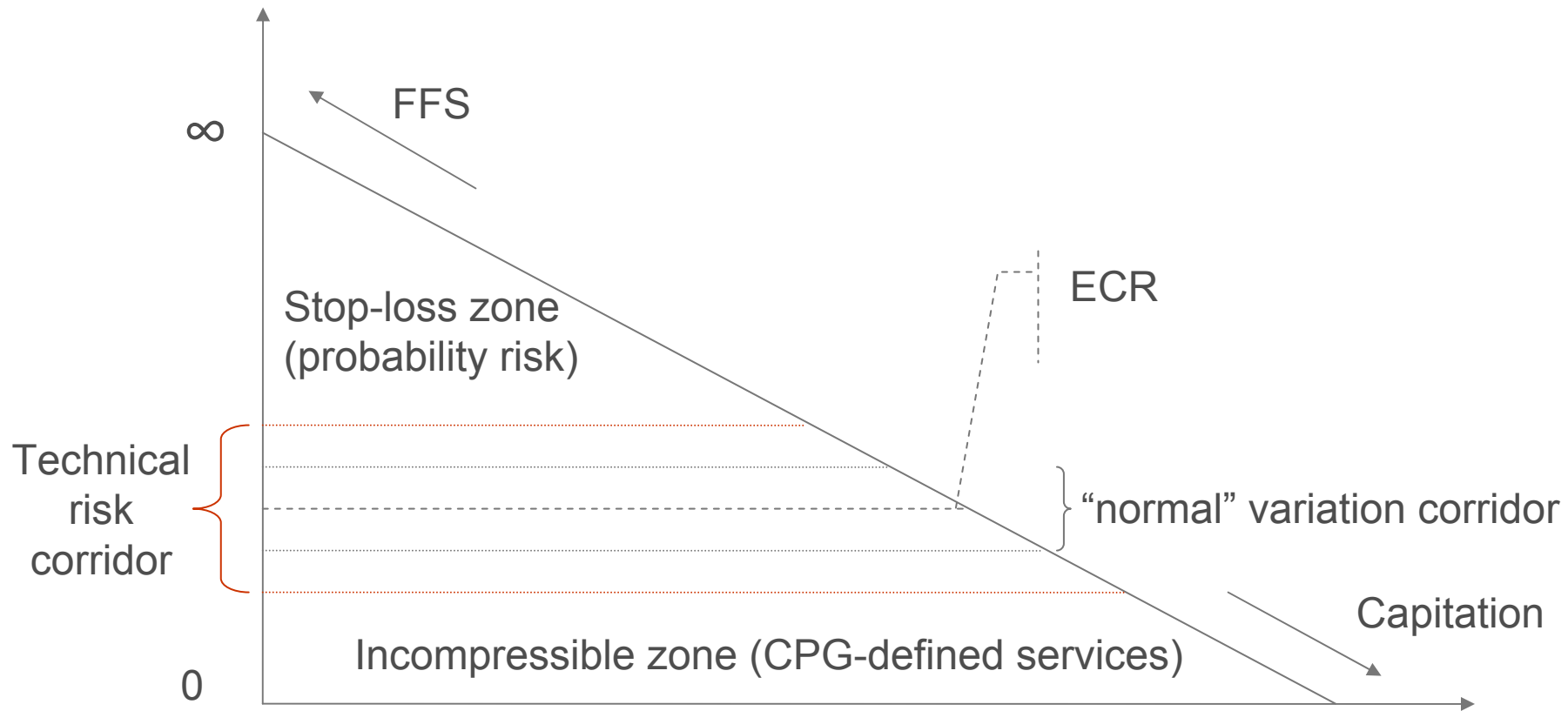
Transparency – Leapfrog, HQA/AQA/BQI, AHIC’s Working Group on price transparency, President’s EO on health care, Health Information Exchanges

Performance-based rewards – Bridges To Excellence, Care Focused Purchasing, High-performance Networks

Consumer engagement – CDHPs, Disease management, differential co-pays/co-insurance, “Stay healthy” programs



# Evidence-based Case Rates help to apportion technical and probability risks and create a more robust output measure





# PROMETHEUS creates the right mechanisms to apportion risk between providers and payers

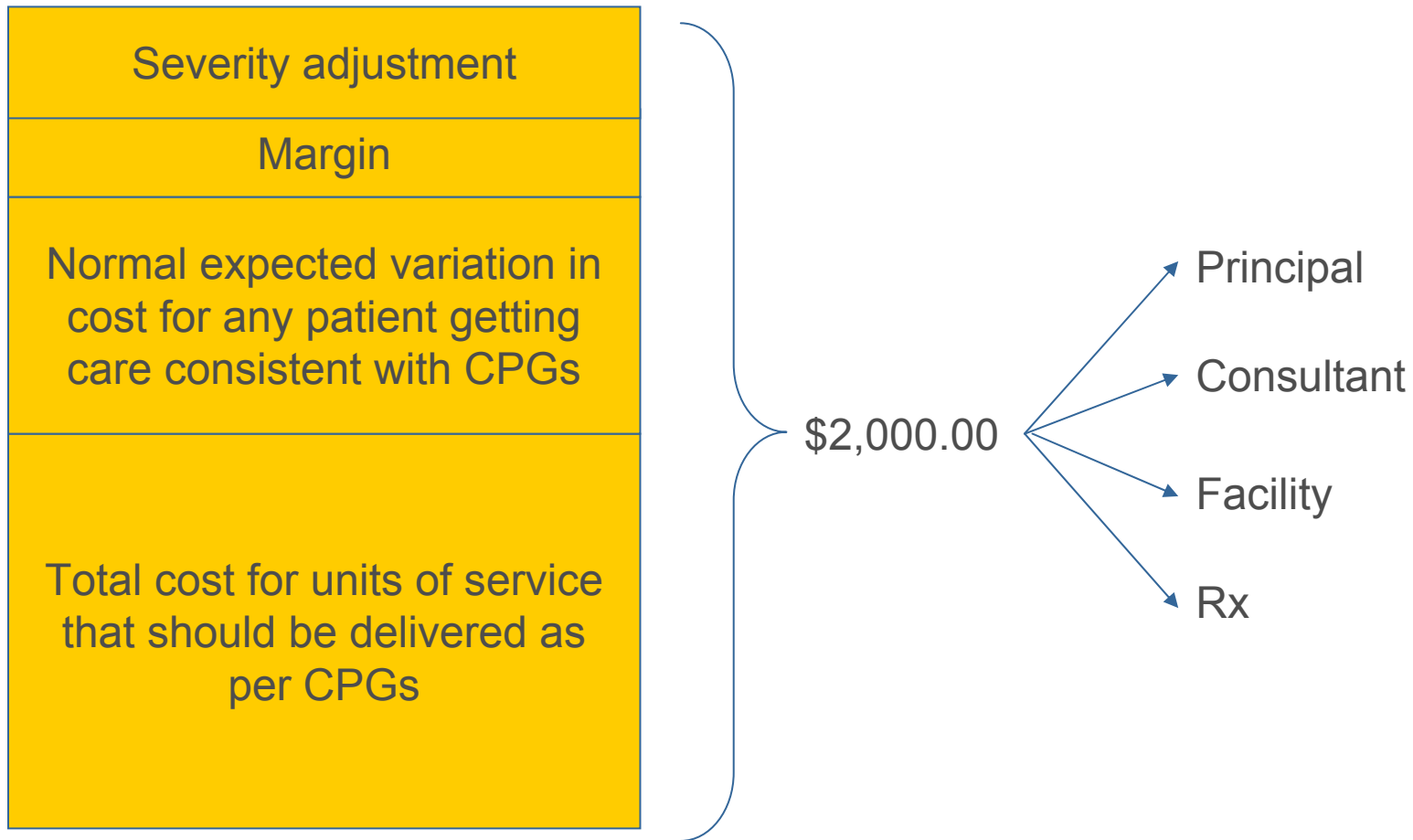
**Pay right up-front** – It starts with Evidence-based Case Rates (ECRs) that are adjusted to reflect patient severity. High performers can make more than 100% of the ECR – doing well while doing right. Low performers will make less.

**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.

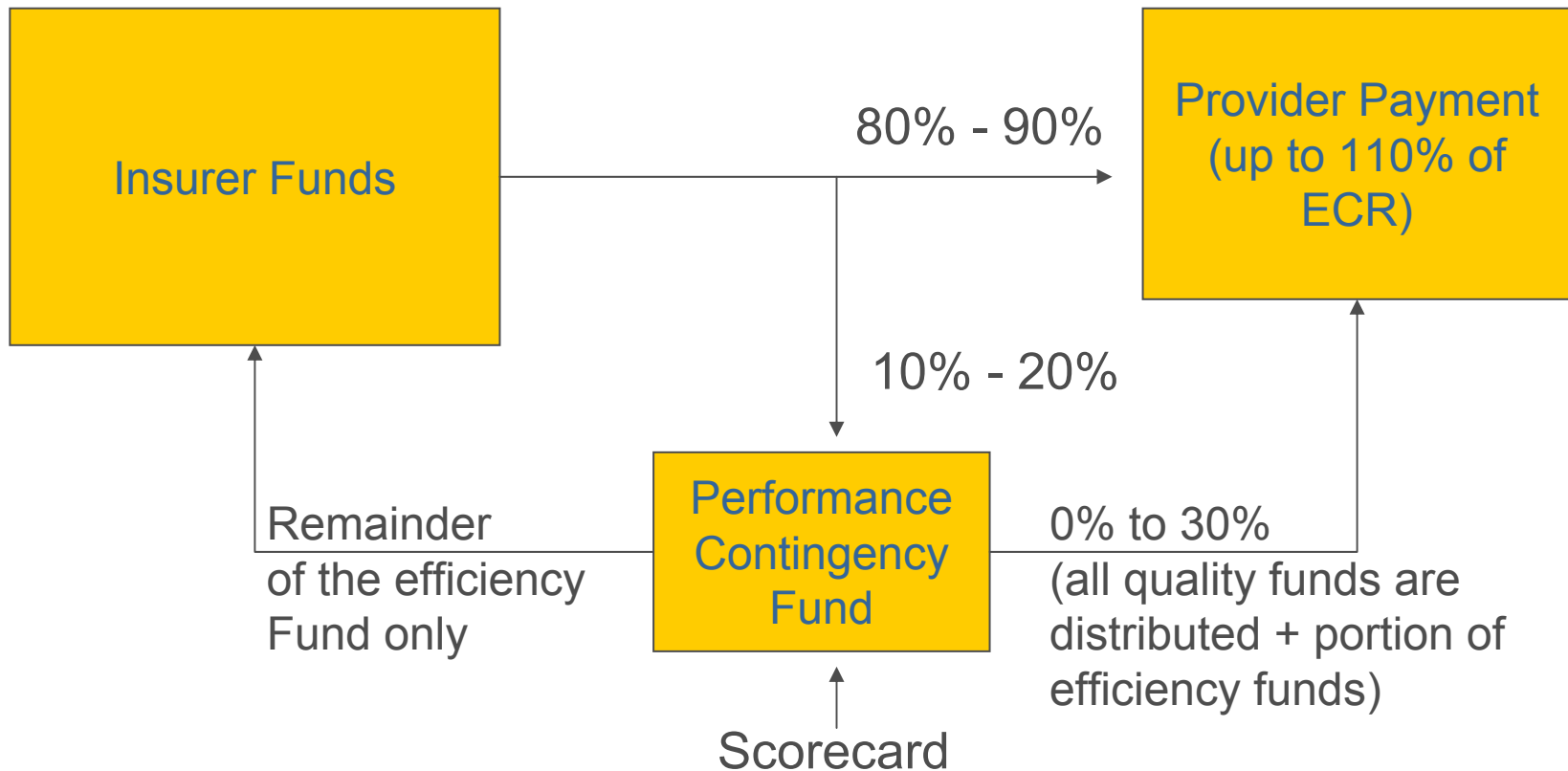


# An Example of an Evidence-based Case Rate





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





## 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



# Payers, providers and patients can win with Prometheus

- Case rates include all the care associated to a patient, assigning a fair global fee to a patient's episode of care
- Prometheus frees physicians to allocate their resources as they see fit to deliver the best possible result for the patient, but makes them accountable for the total financial cost and the quality of treating that patient
- Prometheus encourages cooperation between treating physicians and explicitly discourages fragmentation
- Case rates become ex ante prices for all CDHPs