PROMETHEUS NEWSLETTER: ISSUE 4 September, 2009

Robert Wood Johnson Foundation

From the Board Chair

Dear Readers:

Reading through Senator Finance Committee Chairman Max Baucus' (D-MT) Health Reform Bill, it is starting to sound like the PROMETHEUS Payment team's wish list for effective payment reform are becoming a tangible reality in Washington.

> *"… the Secretary would test alternative payment methodologies, which would include bundled payments or arrangements in which providers continue to receive reimbursement under current payment systems, but are held jointly accountable for the quality and cost of care provided to Medicare patients.*
>
> *Payments would be adjusted for patient severity of illness and other patient characteristics, including having a major diagnosis of substance abuse or mental illness, resources needed to provide care as well as adjustments for differences in hospital average hourly wages, physician work, practice expense, malpractice expense, and geographic adjustment factors.*
>
> *The pilot program's payment methodology would also take into account the provision of services such as care coordination, medication reconciliation, discharge planning and transitional care services and other patient-centered activities as defined appropriate by the Secretary."*

While nothing is final, and things are certain to change over the next few months as the bill goes through the hearing and markup process, the initial 223 pages are a fantastic start.

There is so much exciting news for us to report. In this quarter's newsletter, you will find updates on several new and informative products that are available from the program, such as a 2-page brief that clearly explains the Evidence-informed Case Rate (ECR®) concept; updates on the latest progress from our active pilot sites (including a few new ones that recently joined us); and a comprehensive case study on budgets under PROMETHEUS Payment compared to traditional fee-for-service arrangements.

Every day I wake up and remember that while the barriers to effective health reform seem daunting if you listen to the cable news shows, in the real world the progress being made is clear: the forces at play are igniting payment reform like never before.

Sincerely,

Alice G. Gosfield, Esq.
Chairman of the Board
PROMETHEUS Payment, Inc.

Pilot Site Updates

Over the last few months, we have seen a lot of developments in the PROMETHEUS Payment pilot sites. With four Robert Wood Johnson Foundation-sponsored pilot sites officially active, and more in the works, there is an exciting future ahead for this project.

Rockford, IL

After two years of hard work and community-wide coalition building, the team at the Employers Coalition on Health (ECOH) are ready to officially light the PROMETHEUS fire. Earlier this month, the Rockford team held a successful summit with all of the major community stakeholders to talk over the details of PROMETHEUS Payment and prepare to go live on January 1, 2010. All together, the pilot site will involve 140 employers, three of the area health systems and cover more than 50,000 lives.

Minnesota

The pilot team in Minnesota continues to shine in the PROMETHEUS Payment project, taking the model and turning it into reality. Since January of this year, HealthPartners, one of the major regional insurers, has been actively paying providers under the PROMETHEUS ECR model for Acute Myocardial Infarction (AMI). Meanwhile, Medica, another local insurer, is currently running ECRs for measuring provider performance in their pilot sites and is seriously considering ways to expand their participation in the project by 2011.

Philadelphia, PA

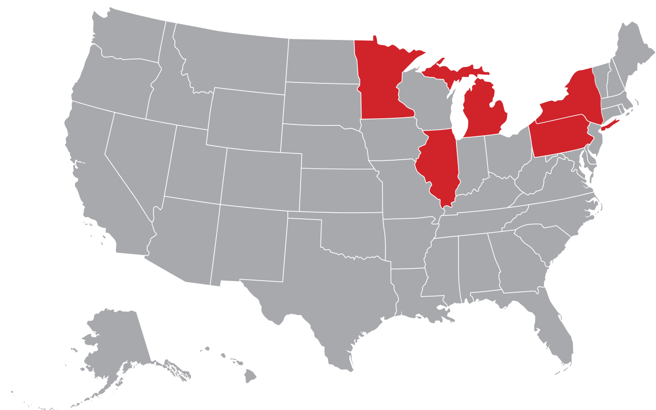
The pilot site at Crozer-Keystone Health System in Philadelphia grows stronger every day. Building on the fundamental PROMETHEUS Payment goal of intense collaboration with the disparate local health care stakeholders, the Crozer-Keystone team is in final meetings to run through the numbers and strengthen physician buy-in for going live with the ECRs applicable to hip and knee replacement surgery. The goal is that by January 2010, two local plans—Independence Blue Cross and Aetna—will be participating.

Grand Rapids, MI

That's right, we have a new pilot site! The team at Priority Health in Grand Rapids has officially joined PROMETHEUS Payment. Focusing primarily on Northwest Michigan, this pilot site has the potential to cover 250,000 (or 500,000?) lives. While just in the beginning stages of setting up a plan for implementing the project and determining the scope of work, the future of health care payment looks a bit brighter in Grand Rapids.

New York State

Some exciting news from the New York State Health Foundation (NYSHealth) as two pilot sites prepare to launch in the state. Right now the teams from PROMETHEUS Payment and the NYSHealth are just getting started—preparing for the new sites and determining who will be participating and collaborating with us on the ground—but stay tuned for more great news from New York.



The Latest From PROMETHEUS Payment

NEJM Perspectives "Building a Bridge from Fragmentation to Accountability"

A critical part of restructuring the health care delivery system is the need to develop an effective payment formula that rewards professionals for delivering high-quality, coordinated and efficient care.

Many argue that the current fee-for-service and per-patient (capitation)-style payment models have led to a fragmented U.S. health care system beset by poor performance and dysfunction. Rather than encouraging value-driven health care, these reimbursement models reward volume-driven care—where providers are paid for "doing things" (often too many or not enough), rather than working together to deliver quality services that are proven to keep people healthy, reduce errors and help avoid unnecessary care.

In a Perspectives article published online in the *New England Journal of Medicine* in September, authors François de Brantes, Meredith Rosenthal and Michael Painter discuss how episode-based payments—and specifically the RWJF-funded PROMETHEUS Payment® model—might be the bridge that brings integration and accountability to America's fragmented health care system.

Read the article: http://www.rwjf.org/qualityequality/product.jsp?id=47429

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

SEPTEMBER 10, 2009

Building a Bridge from Fragmentation to Accountability — The Prometheus Payment Model

François de Brantes, M.S., M.B.A., Meredith B. Rosenthal, Ph.D., and Michael Painter, J.D., M.D.

In the current debate over health care reform, many observers are proposing new delivery structures to move U.S. health care away from fragmentation, poor performance, and dysfunction

Q: What Are Evidence-informed Case Rates (ECRs®)?

A: Pre-designed budgets that are bundled to cover comprehensive, evidence-based personalized care in treating a given condition.

The PROMETHEUS Payment® model seeks to ignite a transformation in health care payment by moving away from unit-of-service payment to episode-of-care payment. This new two-page brief explains Evidence-informed Case Rates® (ECRs), the core element of the PROMETHEUS Payment model.

Payment packages centered around a comprehensive episode of medical care, ECRs are bundled patient-specific budgets that cover all treatments related to a single illness or condition. They offer a comprehensive solution to bundling provider payment that can effectively account for the unique variables in each patient's care.

To date, for pilot purposes, PROMETHEUS Payment has developed ECRs for a number of acute, chronic and inpatient procedures, including heart attacks, hip and knee replacement, diabetes, asthma, congestive heart failure and hypertension. These existing ECRs can potentially impact payment for almost 30 percent of the entire insured adult population and represent a significant amount of dollars spent by employers and health plans.

To read the brief visit: http://www.rwjf.org/pr/product.jsp?id=48088

Building an Evidence-informed Case Rate (ECR): Knee Replacement

All Core Services:
- Lab tests
- Office visits
- Pharmacy costs
- Rehabilitation therapy

+

Margins for:
- Geographic practice variations
- Risk adjustment
- Potentially Avoidable Complications (PACs)

"Waste In U.S. Health Care Spending"—PROMETHEUS Slides Now Available through RWJF 'SlideBuilder'

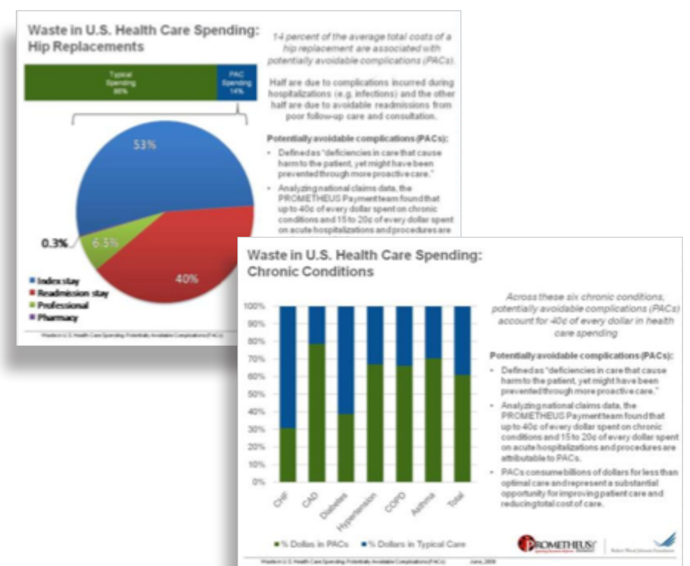
The PROMETHEUS Payment team is proud to announce that two interesting slides on waste in U.S. health care spending are now part of the RWJF SlideBuilder library and available for download and use in your presentations or to share with colleagues. These slides offer a compelling visual aid to describing the waste and inefficiencies present in across the U.S. health care system. They include:

Waste in U.S. Health Care Spending: Chronic Conditions

Potentially avoidable complications (PACs) account for up to 40 cents of every dollar in U.S. health care spending across six common chronic conditions. This chart demonstrates what percent of the spending for each condition is attributed to correct, typical care versus PACs.

Waste in U.S. Health Care Spending: Hip Replacements

PACs account for 14 percent of the average total cost of hip replacement in the U.S. This chart demonstrates where those PACs are found, with half due to complications incurred during hospitalizations (e.g. infections) and the other half due to avoidable readmissions from poor follow-up care and consultation.



To download the slides, visit: http://www.rwjf.org/pr/search.jsp?catid=28&isprod=1&src=pr&q=prometheus

PROMETHEUS Payment In Practice

Case Study with Clinical Scenario and Sample Budget: Charles

Clinical Scenario:

Charles, a 60-year-old man with known congestive heart failure was admitted to the hospital with shortness of breath via the emergency department.

On arrival in the emergency department (ED), his weight was up by 10 pounds and he reported having been a little careless with his salt and water intake. In fact, two nights before, he was at a friend's house where they had chicken barbecue and drinks in excess. His primary care physician did not have any openings to see him for another three days. In the meantime, he had stopped taking his water pill (diuretic) prescription since it had run out, and his doctor's appointment was scheduled in a couple of days anyway.

All of this resulted in his current visit to the emergency department. Since his primary care physician did not see patients in the hospital, Charles' care was directed by a hospitalist. After three days of intensive treatment in the hospital, his body weight was down to a baseline level and Charles was released.

Traditional Fee-for-Service Costs:

Under a fee-for-service payment system, Charles' ED visit, hospital stay and all of the laboratory tests and radiology exams associated with this episode cost a total of $11,228. Prior to this episode, he had recently been admitted to the ED once before due to shortness of breath, and the bill for that visit totaled $2,125.

Apart from the two ED incidents, Charles was being seen regularly by a primary care physician and was diligent about taking his medication. The total annual cost for this routine care is $9,000.

Assuming that from now until the end of the year Charles continues this routine care and avoids food and alcohol excess, the total health care bill for his condition is $22,353 ($13,353 in ER visit costs + $9,000 in routine care).

PROMETHEUS Payment Budget:

Under Charles' clinical scenario, the PROMETHEUS Payment model offers the potential for significant cost savings and increased quality of care.

To begin, the budget for treatment in the PROMETHEUS Payment model is calculated as an "Evidence-informed Case Rate" (ECR®) – patient-specific budgets for the treatment of a single illness or condition. As determined by tested, medically accepted, clinical practice guidelines, ECRs include all the covered services related to the care of the condition, bundled across all the providers who would treat the patient for it.

With the base costs established, the ECR budget is then risk-adjusted to account for the severity and complexity of the patient's condition. It is then bulked-up with an allowance for potentially avoidable complications (PACs). PACs are deficiencies in care that cause harm to the patient yet might have been prevented through more proactive care. Should complications occur, this portion of the budget offsets the costs of the corrective treatment. But if providers can reduce or eliminate the PACs, they can keep the entire allowance as a bonus and significantly improve their margins per patient.

For Charles' ECR budget, a detailed examination of his personal history finds that in addition to the CHF being treated, he also has coronary artery disease and gastro-esophageal reflux disease. For this, he is taking antacids in addition to the standard medicines for heart failure, including diuretics, ACE-inhibitors, and anti-platelet agents.

Considering the severity of his heart failure and the other medicines he is taking, the PROMETHEUS Payment model calculates a personalized, severity-adjusted yearly budget of $9,800 for routine CHF care for Charles plus an allowance for PACs of $10,300. This results in a total annual care budget of $20,750.

The purpose of the PROMETHEUS Payment model is not to encourage the physician to skimp on routine care to meet the budget, but on encouraging high-quality, efficient, patient-centered care while minimizing the amounts spent on PACs.

Key to this is providing incentives for physicians to monitor Charles' health between the routine office visits (such as calling to check on his health and ensure that he is taking his medication), better coordinate care with other providers and other important proactive steps that can be taken to avoid complications, emergency room visits or hospitalizations (such as a 24-hour nurse help line). Under the current fee-for-service model, his physician is paid for each office visit ($75 per visit) but not for these other services.

As a result, potentially avoidable hospitalizations occur at an alarming frequency and represent 70 percent of the total yearly cost for CHF for most patients in the United States. Most experts agree that these hospitalizations could easily be reduced by half if patients were better managed.

In Charles' case, if his physician had managed him more proactively, he would likely have only incurred the one emergency department visit for shortness of breath and the total annual bill for care of his CHF would have only been a total of $11,125 ($9,000 in routine care + $2,125 for the ED).

Against a budget of $20,750, the difference of $9,625 is the "bonus" that Charles' physician and any of their clinical collaborators would be eligible for.

And that's the goal: to provide a clear incentive to reduce avoidable complications. However, if avoidable complications do occur, then the hospital and physicians are at risk, in much the same way as any other organization in the country is at risk when they deliver a defective service or product.

Comparative Cost of Treatment

Under Fee-for-Service:	$22,353
Budget under PROMETHEUS Payment:	$20,750
Potential cost savings and bonuses:	$9,625

PROMETHEUS Payment®, Inc. is a not for profit corporation which has been created to steward the further development and implementation of the PROMETHEUS Payment model.

PROMETHEUS Payment is specifically designed to: (1) improve quality (2) lower administrative burden (3) enhance transparency and (4) support a patient-centric and consumer driven environment, all while facilitating better clinical coordination throughout health care.

By creating common clinical incentives for all parties, the likelihood of significant system reform is enhanced even though in the fullness of time PROMETHEUS Payment will not substitute for all fee for service and capitation. In the last analysis, PROMETHEUS Payment is intended to create
a payment environment where doing the right things for the patient helps providers and insurers do well for themselves.

For more information on the PROMETHEUS Payment system, visit **www.prometheuspayment.org.**