

# PROMETHEUS

*Igniting Payment Reform*

Primary Care Forum  
June 22 2006

Francois de Brantes  
National Coordinator

## Crossing the Quality Chasm – page 18

**Recommendation 10: Private and public purchasers should examine their current payment methods to remove barriers that currently impede quality improvement, and to build in stronger incentives for quality enhancement.**

Payment methods should:

- Provide fair payment for good clinical management of the types of patients seen. Clinicians should be adequately compensated for taking good care of all types of patients, neither gaining nor losing financially for caring for sicker patients or those with more complicated conditions. The risk of random incidence of disease in the population should reside with a larger risk pool, whether that be large groups of providers, health plans, or insurance companies.
- Provide an opportunity for providers to share in the benefits of quality improvement. Rewards should be located close to the level at which the reengineering and process redesign needed to improve quality are likely to take place.
- Provide the opportunity for consumers and purchasers to recognize quality differences in health care and direct their decisions accordingly. In particular, consumers need to have good information on quality and the ability to use that information as they see fit to meet their needs.
- Align financial incentives with the implementation of care processes based on best practices and the achievement of better patient outcomes. Substantial improvements in quality are most likely to be obtained when providers are highly motivated and rewarded for carefully designing and fine-tuning care processes to achieve increasingly higher levels of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.
- Reduce fragmentation of care. Payment methods should not pose a barrier to providers' ability to coordinate care for patients across settings and over time.

Prometheus Payment, Inc. Proprietary & Confidential Page 2

## PROMETHEUS answers the Chasm challenge

**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.

Prometheus Payment, Inc. Proprietary & Confidential Page 3

## Key Definition: An ECR

An Evidence-based 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:

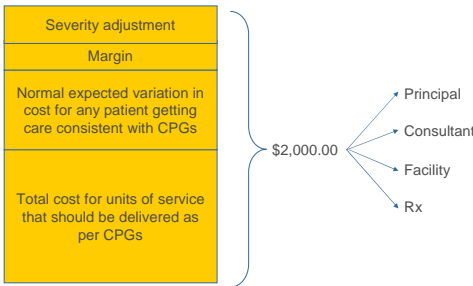
1. Guidelines, where they exist and are suitable for this purpose
2. Evidence or expert consensus on what constitutes good care
3. Empirical evidence of the total cost of care incurred when patients are cared for by "good" providers

A patient can have multiple ECRs if the conditions are unrelated clinically, and all ECRs have specific rules on what triggers them, breaks them, bounds them.

ECRs are severity-adjusted

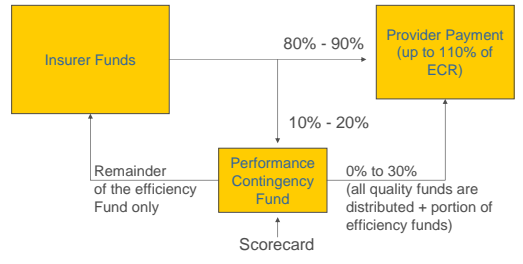
Prometheus Payment, Inc. Proprietary & Confidential Page 4

## An Example of an Evidence-based Case Rate



Prometheus Payment, Inc. Proprietary & Confidential Page 5

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



Prometheus Payment, Inc. Proprietary & Confidential Page 6

## 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

## Family practice and internal medicine can win with Prometheus

- Case rates include all the care associated to a patient. As such, managing the patient appropriately in the “medical home” will enable the primary physician to keep a significant amount of the difference between the ECR and the actual total cost of care – similar to CMS's PGP demo
- Prometheus frees physicians to allocate their resources as best they see to deliver the best possible result for the patient
- Prometheus encourages cooperation between treating physicians and explicitly discourages fragmentation

## Important points to emphasize

Initially, the ECRs will be estimated using national averages and then regionally adjusted leveraging the CMS regional price adjusters. These estimates will be provided to all providers as a basis for the negotiation

In the first year, the providers will only be judged on their performance, but the performance of others will be shared to help them make better decisions in future years

Best estimates of the financial cost for physicians to reengineer their practices is about \$20K per physician, \$50K for a practice of three

We will have an independent “service bureau” adjudicate Prometheus

For the most part, we will be substituting the complexity of payment justification with performance justification

## Several concerns have been uniformly raised

It's complex.

It requires a lot of IT infrastructure.

It favors big integrated entities.

Most CPGs don't reflect evidence.

Patients don't fit neatly to a CPG.

Plans are not trustworthy.

The engines could be black boxes.

And on the implementation front:

- A problem if only one plan plays.
- Transition will not ease administrative burden because this doesn't replace what exists.
- How will we be scored for patient compliance?
- Withholds are a scam.
- What is appealable?

## Questions/Discussion

What are the biggest challenges you see with this from your end?

Are we missing anything critical?

What will it take to convince providers that this is worth taking a swing at?

What will it take to convince plans and employers that this is worth taking a swing at?