

PROMETHEUS Payment ECR Contracting Strategies



Fair, Evidence-based Solutions. Real and Lasting Change.

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Doug Emery, M.S.
Implementation Leader, Western Region

Agenda

- **Myth Busting**
- **Prospective vs. Retrospective Payment**
- **CFO's Dilemma**
- **Changing the Unit of Account**
- **Health Plan as Financial Integrator**
- **ACOs and Medical Homes**
- **Negotiating Risk Corridors**
- **Product Development**

Three Most Popular Myths about EOC Payment

- **Myth #1: Episode or bundled payment requires an ACO or ACO-like provider organization because it can only be done with prospective payment**
 - ACOs, PHOs and IDSs are helpful but such organizations are rare and few can process a prospective payment anyway
 - The plan can act as financial integrator in a retrospective payment environment; almost none can pay prospectively

Three Most Popular Myths about EOC Payment

- **Myth #2: Episode pricing must be an average or one-size-fits-all payment**
 - Episodes must be severity-adjusted to avoid gaming
 - ECR risk adjustment, focusing on technical risk, enjoy very high R-Squares and are clinically defensible
 - Risk-adjusted pricing must also function as a feedback loop to physicians

Three Most Popular Myths about EOC Payment

- **Myth #3: Episode payment only works for acute inpatient care**
 - ECRs have not only been modeled for acute episodes but chronic episodes as well (fulfilling Professor Solon's original concept)
 - Chronic ECRs consistently represent the greatest opportunity for PAC rate reduction and achieving accountable care (especially when joined with PCMH)
 - Chronic ECRs are the most accurate way to model Medical Village

Prospective Payment: Problems (assuming integration)

1. Is the price right?
2. How do you risk-adjust based solely on Index Stay?
3. What about patient "leakage"?
4. Enduring problem of double-billing (#3 and #4 create a subrogation nightmare)
5. Benefits redesign and accumulator difficulties
6. Factoring outcomes measures into payment

Retrospective Payment: Pros and Cons

Cons:

- Hard to arrive at a prospective price for beneficiaries
- Physician attribution and PAC dollar disbursements not easy to determine
- Has limited potential to induce provider integration
- Hard to apply technical risk downside (need FFS withholds)

Pros:

- Will not disrupt current billing and claims adjudication systems
- Scalable
- Risk corridors easy to determine including no-downside arrangements
- Full ACO or IDS structures not necessary (but helpful)
- It is a more “forgiving” strategy
- Allows multiple plans to coalesce to solve “CFO’s Dilemma”

CFO's Dilemma

- Accountable care (volume to results) is a laudable goal

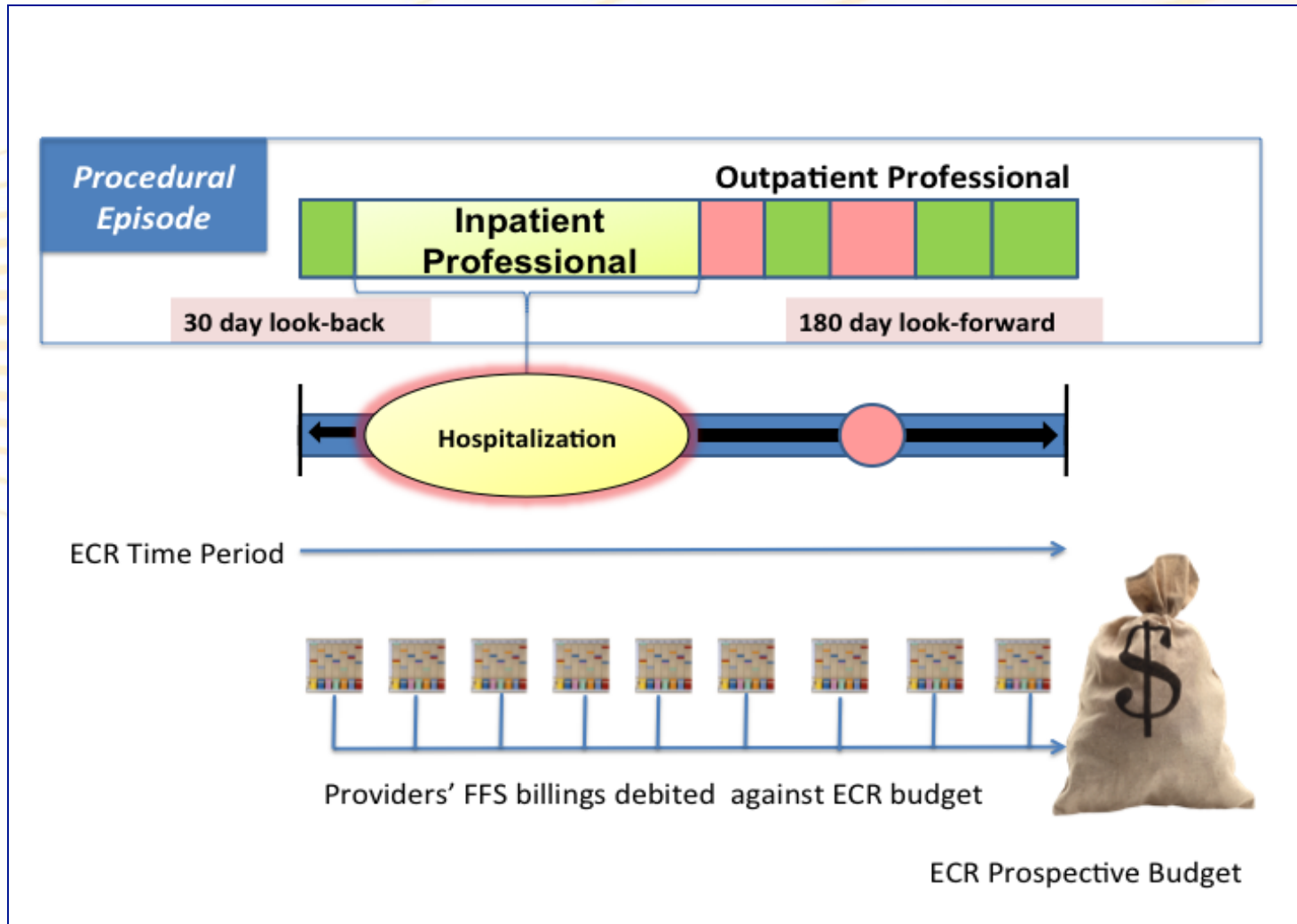
BUT:

- Most delivery systems' current book of business is 90 – 100 percent FFS
- Care process reengineering is costly, painful, time consuming and risky
- One progressive plan may only make up a minor fraction of total payment

THEREFORE,

- Is it worth it?
- Corollary Question: What is the critical mass?

Retrospective Payment: Changing the Unit of Account



An Example: Total Hip

- Contracting ECR Unit of Account: Total Hip
- Contracting Providers: Orthopedic Group, Rehab Therapists, and Hospital
- PAC Analysis Result: 235 patients, 9% PAC Trend, \$5,875,000 Total Dollars (9% PAC dollars = \$528,750)
- PAC Reduction Target: 50% or PAC Rate Deflection to 4.5%
- ECR Risk: No Downside Year 1

Year 1 Results:

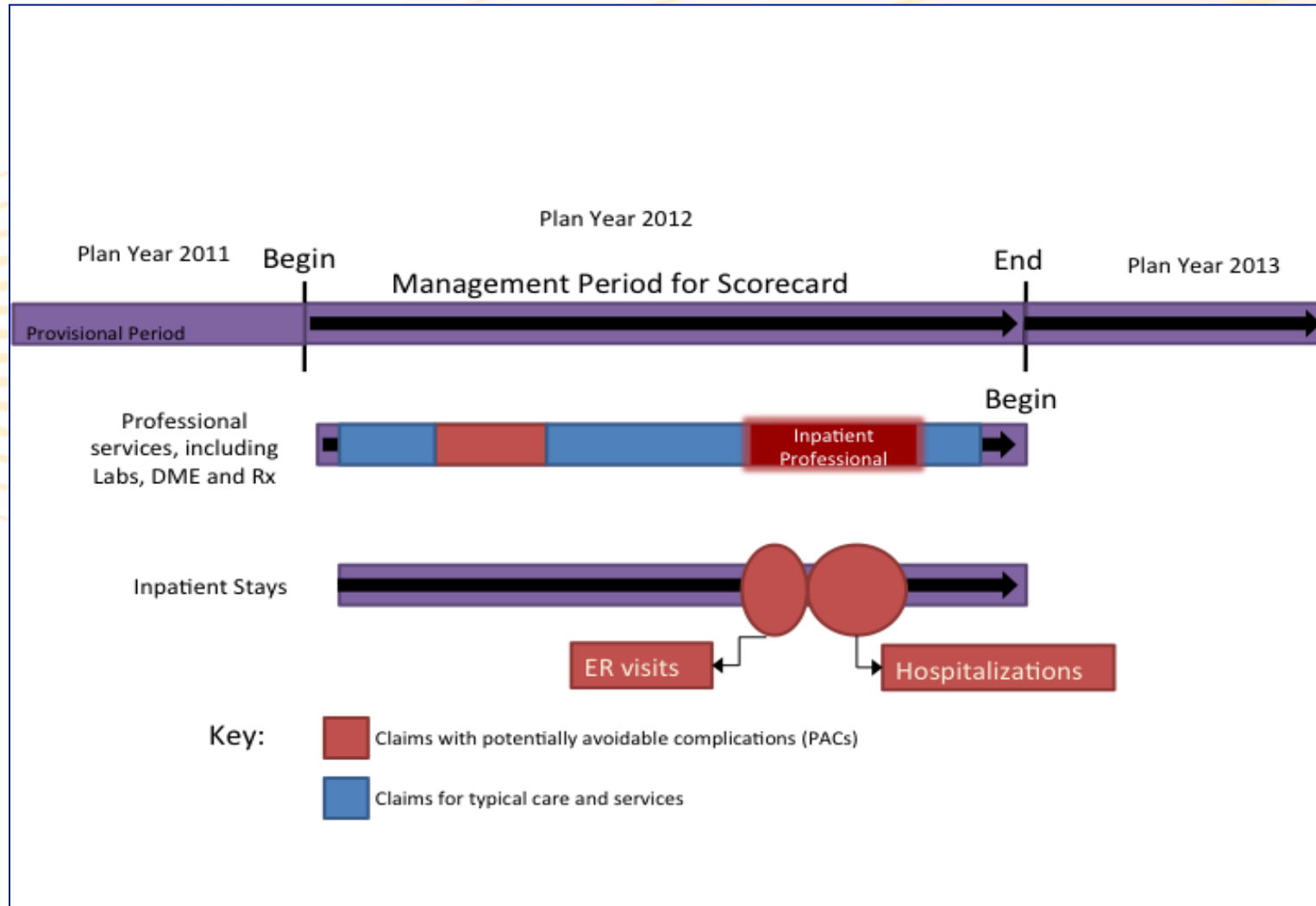
- 241 patients
- Actual (PAC Allowance + Severity Adjusted Typical) = \$5,543,000
- Actual PAC Reduction = 39% (about \$300,000 in savings)

Year 2 Go-Forward Strategy:

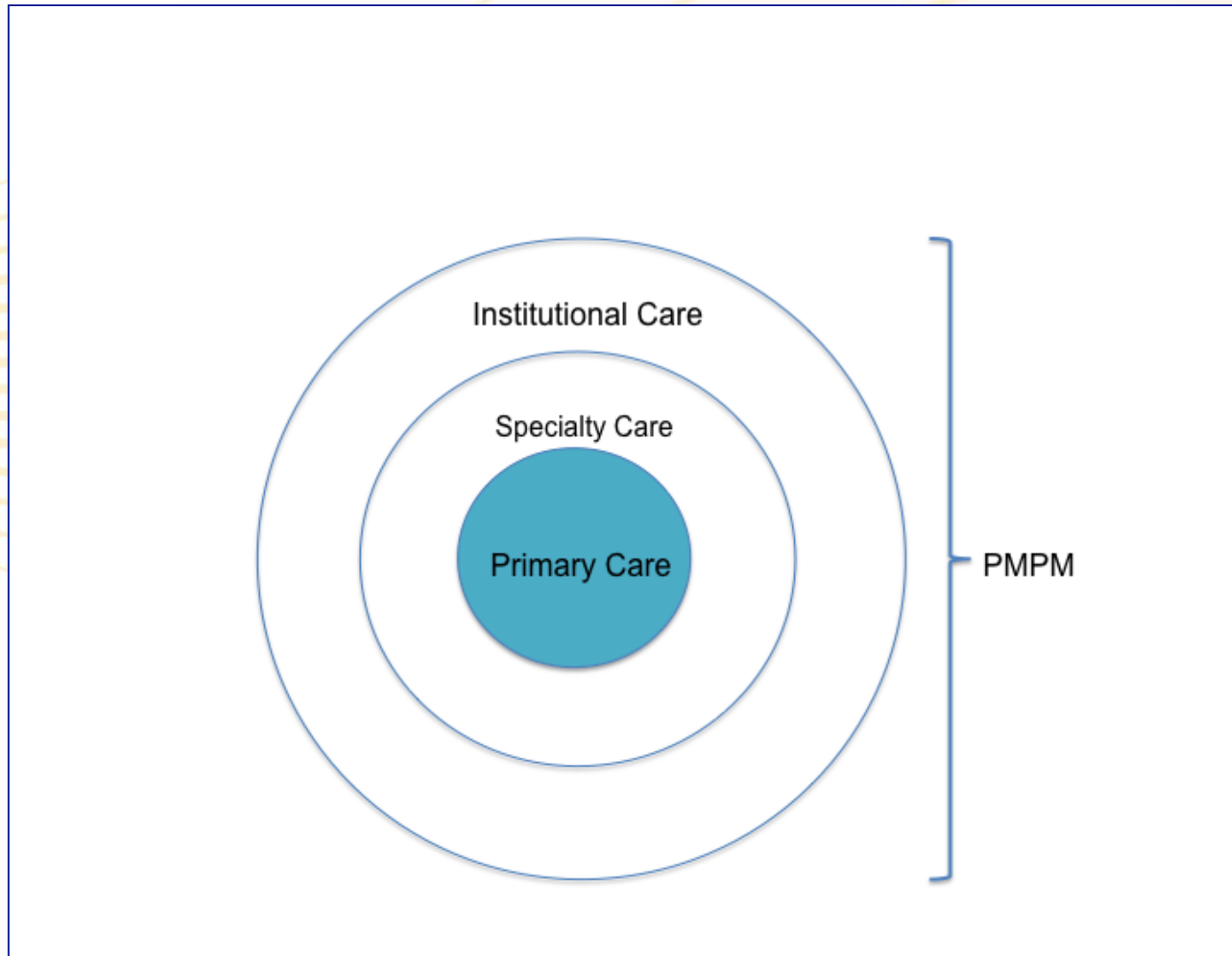
- Keep 50% PAC Rate Reduction target
- Go to Downside risk with 20% withholds on FFS billings

Years 3 or 4: Full Prospective Payment

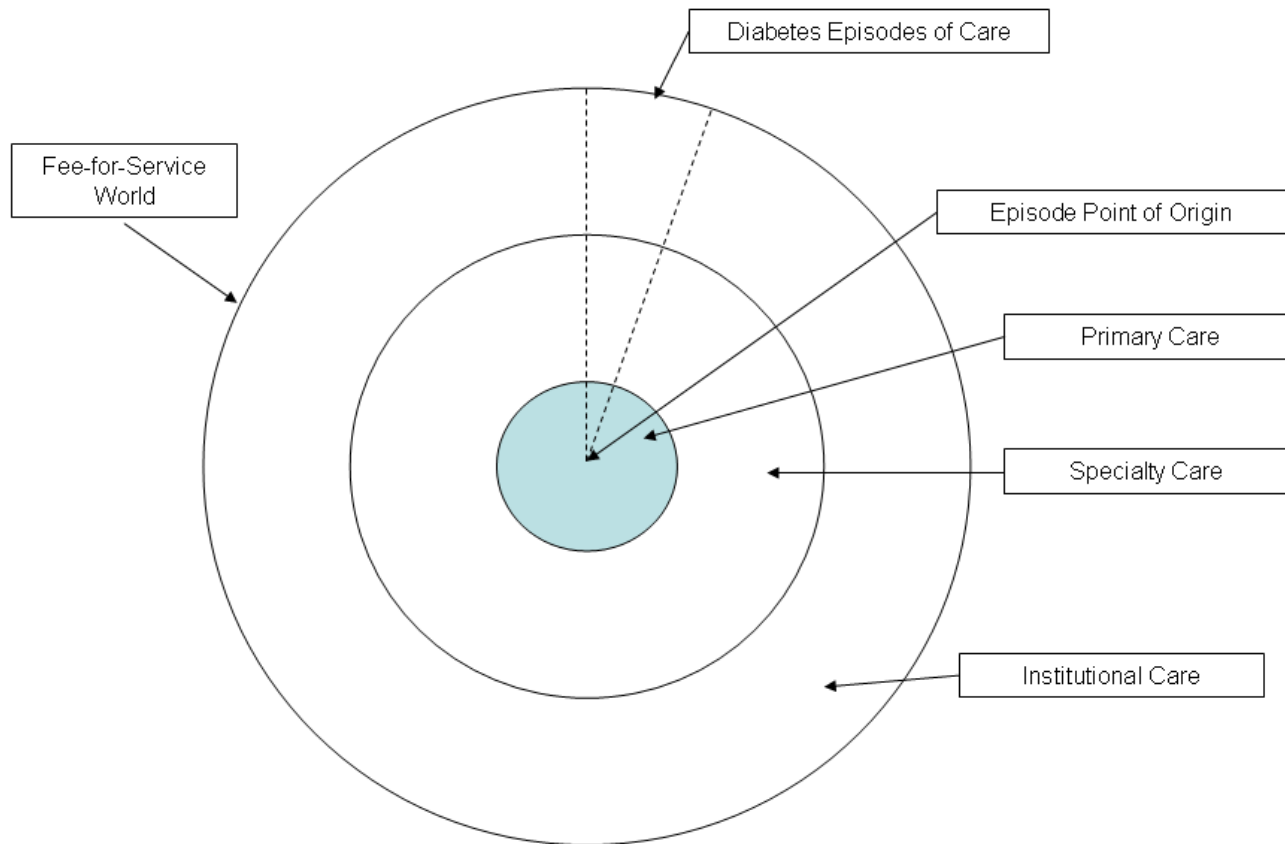
Chronic ECR Retrospective Payment



ACOs and Medical Homes



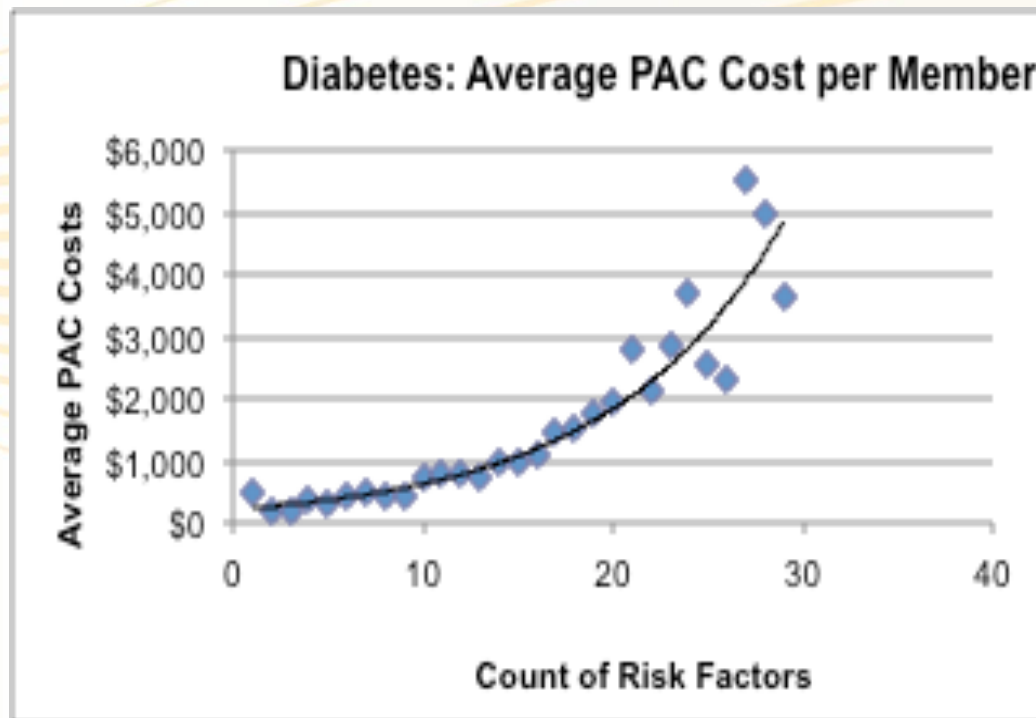
The Medical Neighborhood



Total Dollar Continuity Over the Longitudinal Path of Care

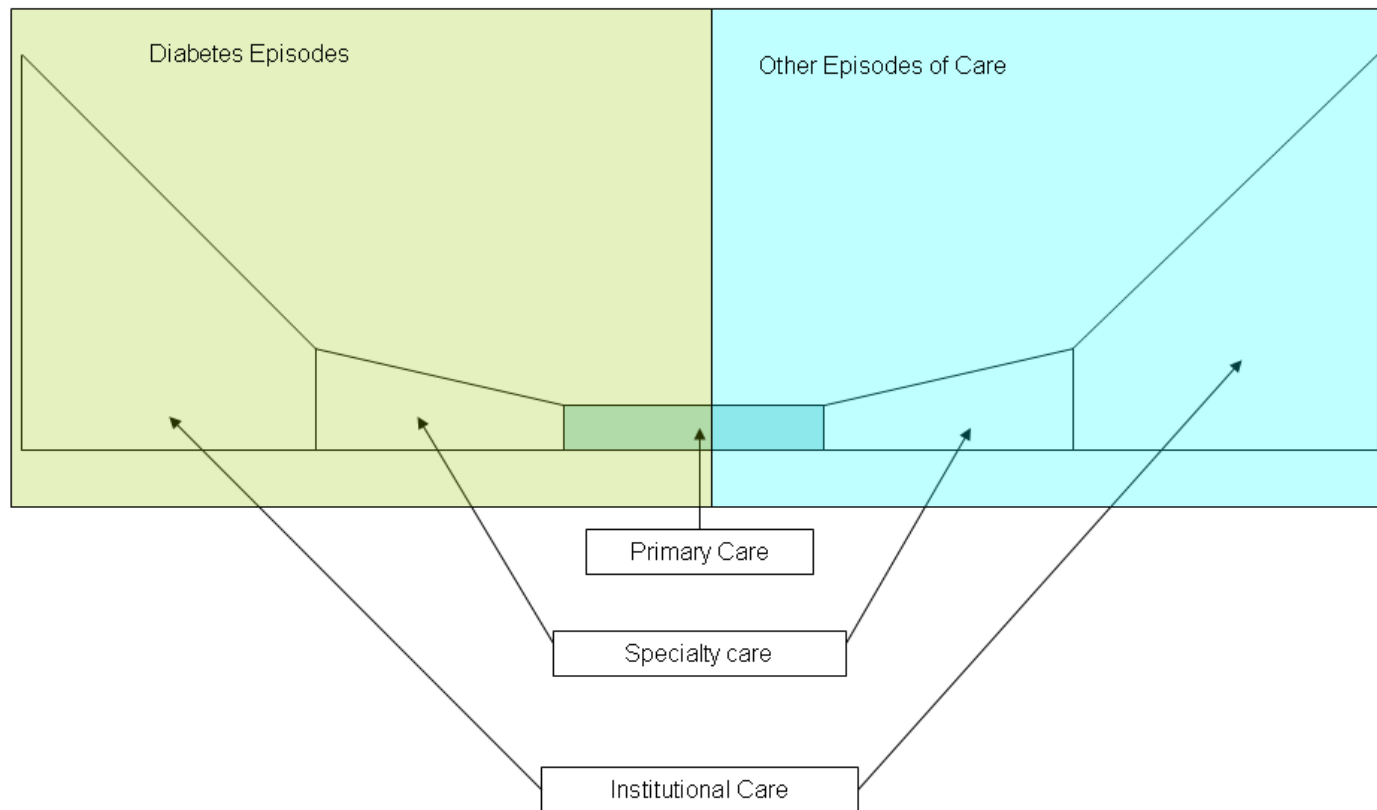
Source: *Sustaining the Medical Home: How Prometheus Payment Can Revitalize Primary Care*, RWJ publication

Risk and Complexity in the Medical Neighborhood



Correlation = .97

Amplitude of Cost Along the Care Continuum



Source: *Sustaining the Medical Home: How Prometheus Payment Can Revitalize Primary Care*, RWJ publication

What Does This Tell us About Contracting ECRs?

- Complex patients with progressive diseases are coming into contact with multiple providers who are loosely coordinated
- Disease management programs need to be better organized throughout the entire sequence of care
- Transitions in care are poorly communicated

Thus,

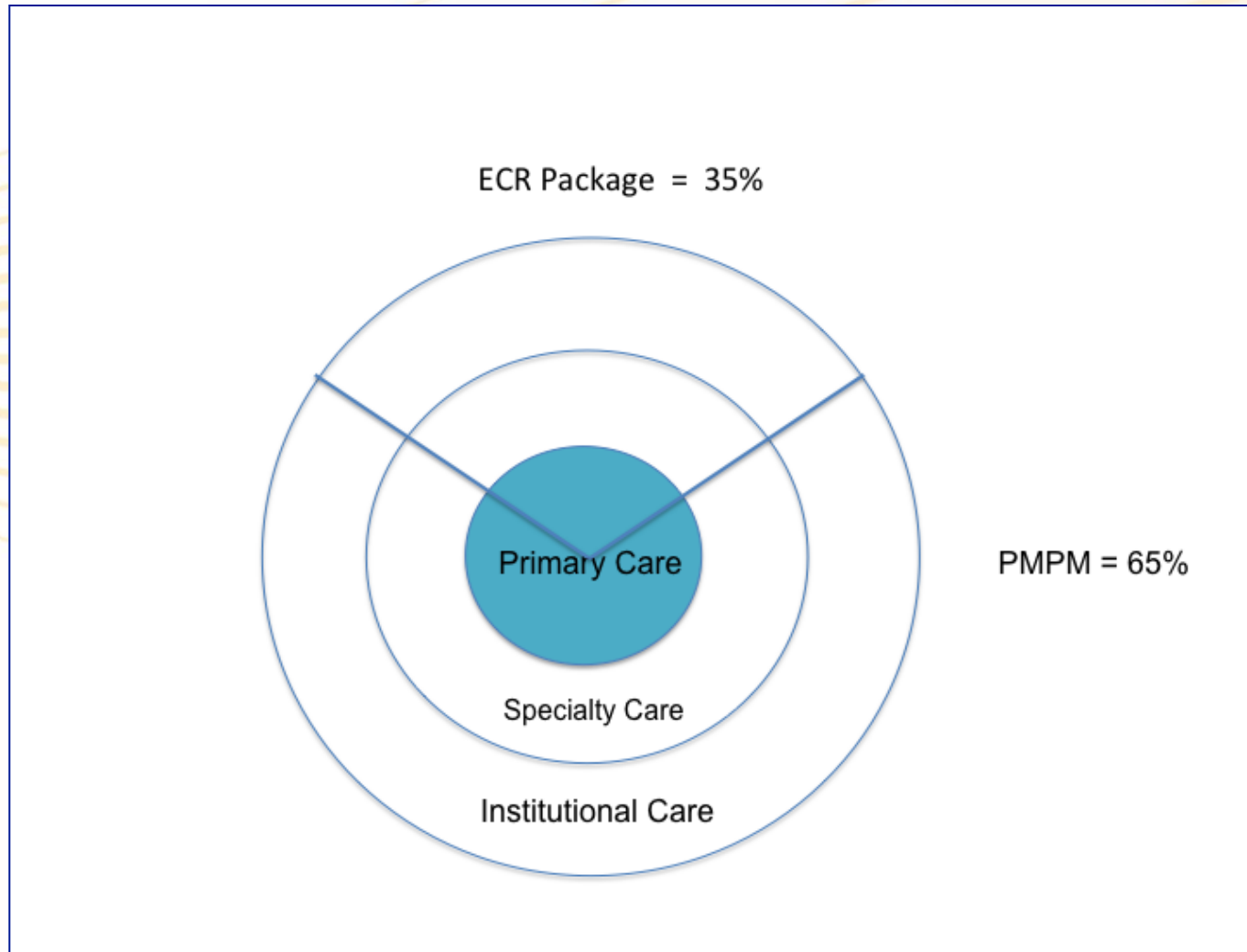
- The contracting Unit of Account (ECR) must function both as a better incentive structure and a continuous feedback loop.
- *Acting as a financial integrator, a plan can improve its network value proposition by changing the Unit of Account and the Unit of Analysis through episode of care contracting*

The Prometheus ECR Inventory:

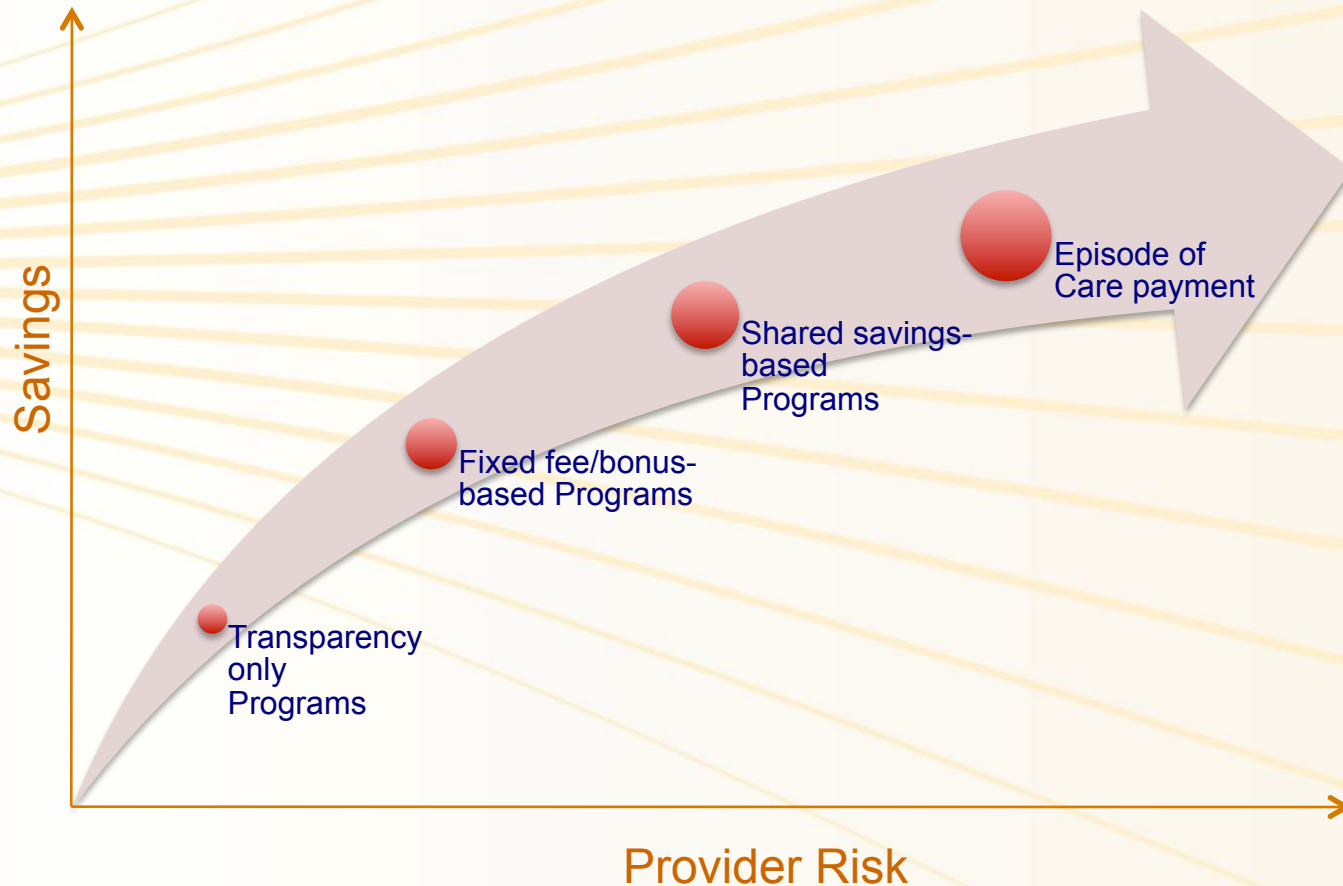
New Units of Account

Type of ECR	Time Window	ECRs
Chronic Medical	One year from trigger	Diabetes, CHF, COPD, Asthma, CAD, HTN, GERD
Acute Medical	0-day look-back; 30-day look-forward	AMI, Stroke, Pneumonia
Inpatient Procedural	30-day look-back; 180-day look-forward	Hip Repl /Knee Repl, CABG, Bariatric Surgery, Colon Resection
Outpatient Procedural	30-day look-back; 180-day look-forward	Angioplasty (PCI), Knee arthroscopy, Hysterectomy, Cholecystectomy
	7-day, 30-day	Colonoscopy
	9 months, 2 months	Pregn & Delivery

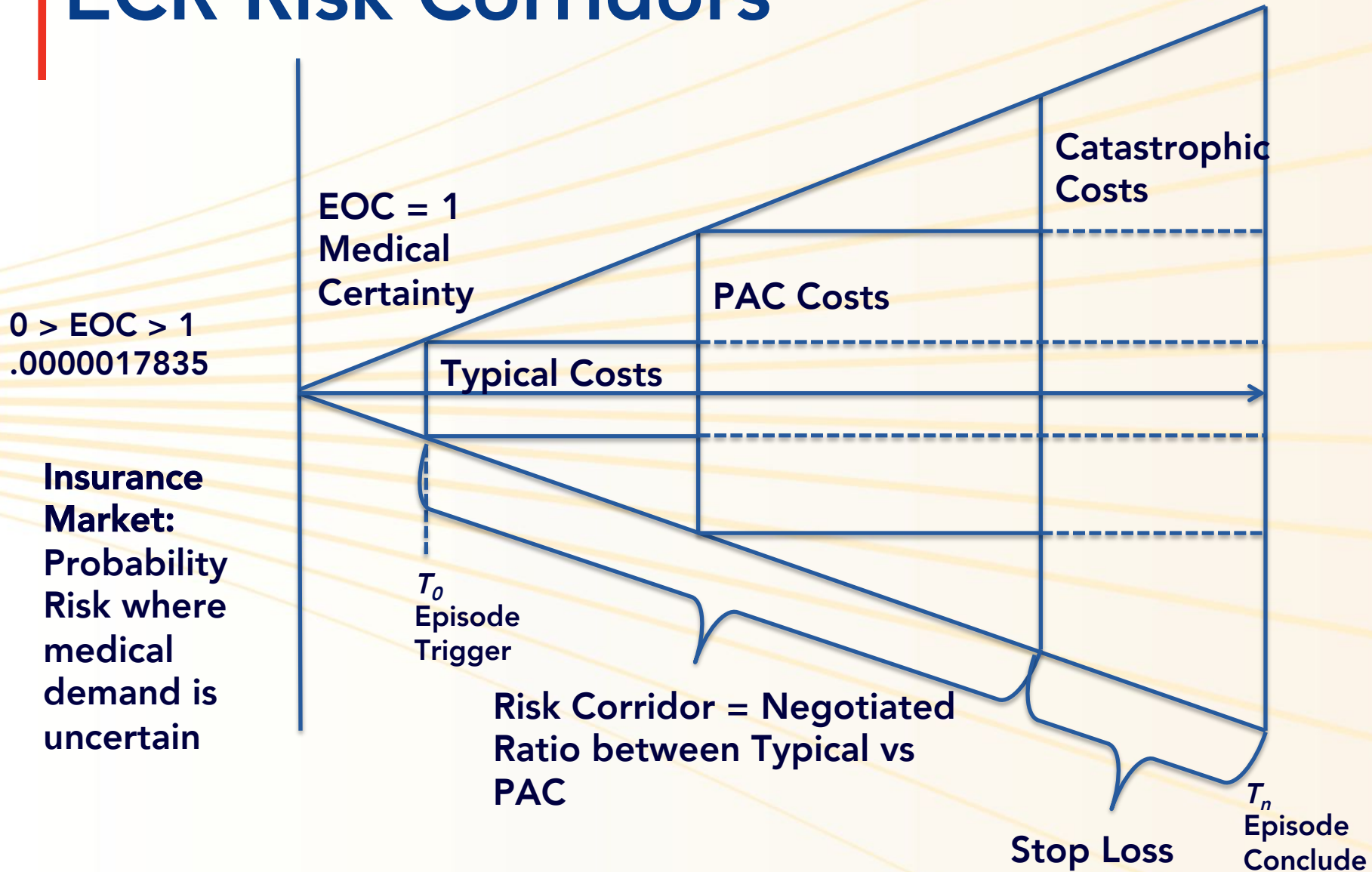
Retrospective Hybrid Models: Mixes of PMPM, ECRs and FFS



The Pathway from Retrospective to Prospective Payment



ECR Risk Corridors



Tunable Parameters: Negotiating ECR Risk Corridors

The PAC Allowance:



CHF Prospective Budget @ 50%

Patient 1 = \$4,112

Patient 2 = \$15,549

Patient 3 = \$34,629

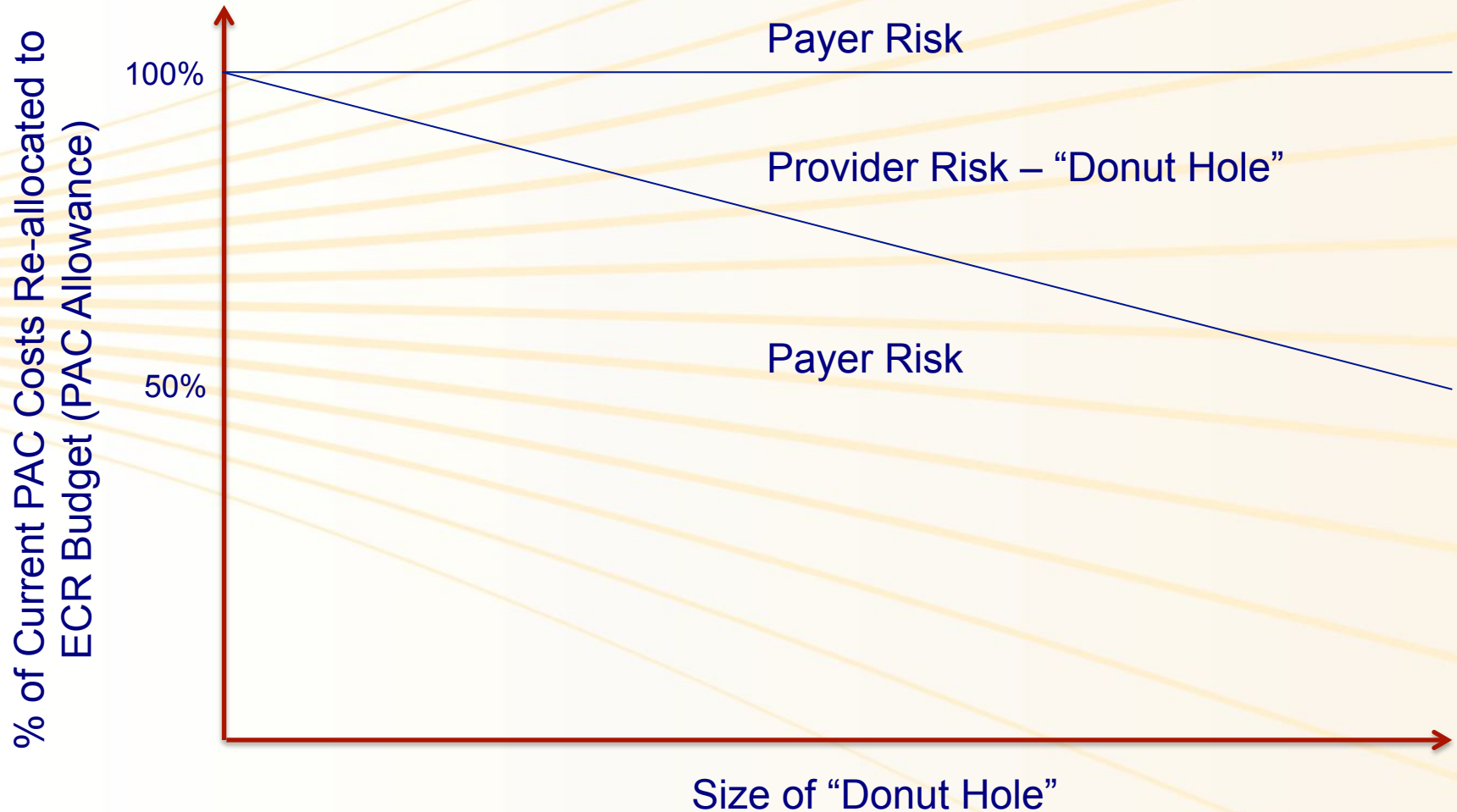
CHF Prospective Budget @ 75%

Patient 1 = \$5,348

Patient 2 = \$18,714

Patient 3 = \$41,013

Tunable Parameters: The Donut Hole

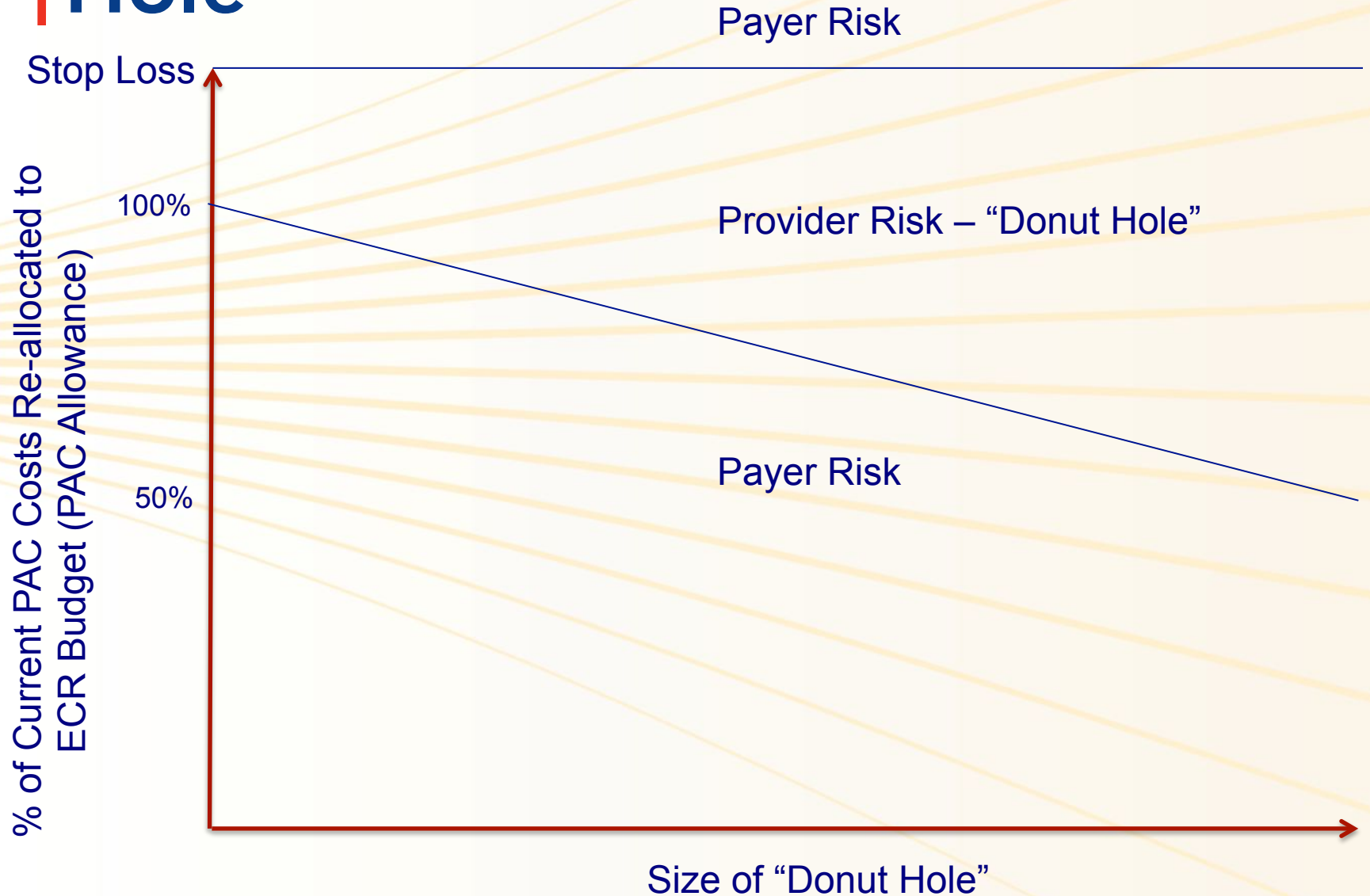


Tunable Parameters: Negotiating ECR Risk Corridors

Stop-loss:

- For a Chronic ECR, a Stop-loss is defined as being equal to 2 times the standard deviation of the PAC allowed amount;
- For an acute ECR, a Stop-loss is defined as being equal to 3 times the standard deviation of the PAC allowed amount.

Tunable Parameters: The Donut Hole



PAC Rates and BTE Measures

ECR Contract Price is a function of two simple variables:

$$f = (x,y)$$

Where x is the negotiated PAC Allowance and y is the negotiated Min / Max of baseline clinical performance measures

If a physician can score between 0 and 100 points at, say, y



Then the magnitude of X can be altered by adjusting the min/max bars according to the agreed upon starting values of plans and providers. We recommend that the Max be no higher than 90.

Product Development and Due Diligence

- 1. Define episode services**
 - Inclusions/Exclusions (Prometheus Playbooks)
 - Time, Trigger, Conclude, Provisional/Management ECRs (Operational Rules)
 - ECR Precedence (Hierarchical Rules)
 - Outcomes Measures (Prometheus / BTE Scorecard)
- 2. Determine Clinical Components**
 - Inpatient, Outpatient and Ambulatory
 - Identify Principle Physicians vs Consulting Physicians (Care Teams)
 - Identify Ancillary Care and Downstream Providers
 - EMRs, Patient Registries, Clinical Decision Support
 - Accreditation and Recognition Programs
- 3. Contract Negotiations**
 - PAC Rate Analysis
 - Technical Risk Corridors and Stop Loss
 - ECR Contract Templates
- 4. Benefits Design**

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