



Transitioning to Value PROMETHEUS Payment Pilot Lessons

As the healthcare system begins to transition from volume-based to value-based payment, industry stakeholders are experimenting with payment models that can effectively align incentives to generate high-quality outcomes while reducing the cost of care. Participants in a pilot of the PROMETHEUS Payment® project have been preparing for implementation of a new payment model over the past year. Their experiences demonstrate both the opportunities and challenges providers will face in transitioning to a value-based system.

HFMA has convened a series of meetings with some of the providers participating in PROMETHEUS Payment pilots to explore three main issues:

- How will transitioning to a value-based system affect hospitals and health systems with respect to volume, capacity, and reimbursement, and what will be the hospital's role in a system that puts greater emphasis on chronic disease management through primary care physicians?
- How should hospitals work with physicians and other clinical staff on clinical care redesign efforts that improve quality and value, and how should cost savings generated from these efforts be shared among the providers?
- How does the current payment system create obstacles to reform?

These conversations are providing a forum for first-in-industry peer learning and informing HFMA of potential shifts in providers' needs during transitions to value-based care delivery and payment systems. For further resources on value-driving activities and research, including comprehensive thought leadership from HFMA's Value Project, see www.hfma.org/valueproject.

The following report will examine how the PROMETHEUS Payment pilot works and focus specifically on lessons learned

from pilot participants with respect to effects on hospital volume and reimbursement, chief physician concerns, and challenges and opportunities associated with implementing the project given current market dynamics.

How the Pilot Works

Payments for care under the PROMETHEUS Payment model are based on evidence-informed case rates (ECRs). An ECR is a budget for an entire care episode that includes all covered services bundled across all providers (including hospital, physician, laboratory, pharmacy, rehabilitation facility, etc.) that would typically treat a patient for a single condition or procedure. ECRs are patient-specific, in that they are adjusted for the severity and complexity of each patient's condition.

The ECR budget has four components. The foundation is *covered services*, clinically indicated costs of treating a condition or procedure, adjusted to reflect local practice patterns for providers. The costs of clinically indicated care are normative: They are costs of care that should be provided for a procedure or condition, and may well seem higher than costs under a fee-for-service payment model. When measured longitudinally, however, total costs of clinically indicated care should be lower.

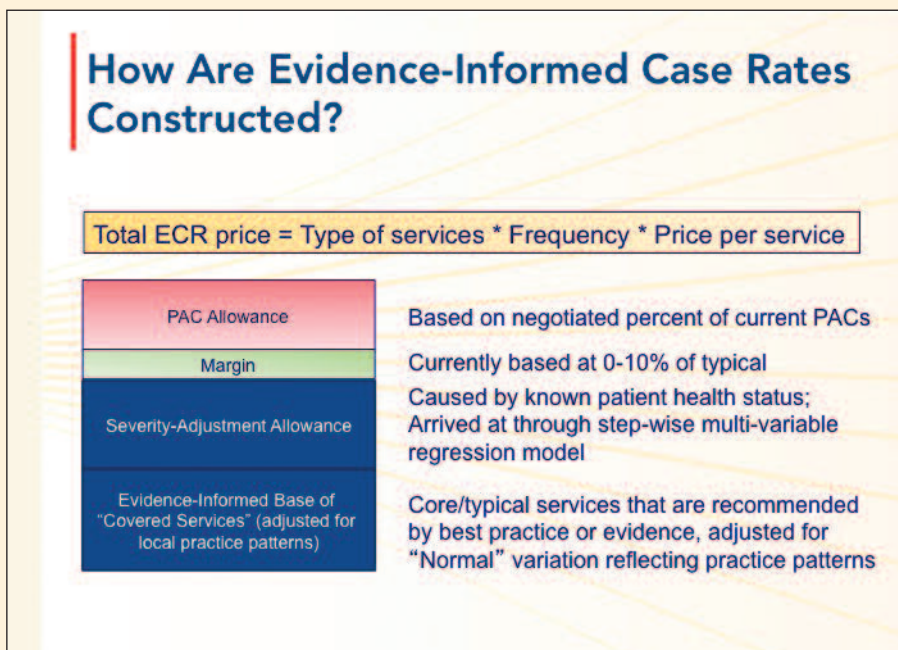
The second is an *adjustment for severity* based on both patient and provider characteristics. This adjustment takes multiple factors into account, including patient demographics and comorbidities, geographic location, and provider specialty.

The third component is an *allowance for potentially avoidable costs (PACs)*. PACs are deficiencies in care that cause harm to the patient and might have been prevented with more effective treatment. PAC occurrence is analogous to the defect rate in industrial manufacturing, arising from such factors as variability in clinical processes, errors, inefficiencies, or waste in the provision of care. The PAC allowance is a redistribution into the ECR of a negotiated portion of the locally observed rate of deficiencies. When PACs occur, such as complications that could have been avoided through proactive care, then the PAC allowance is used to offset the costs of associated treatment. If providers are able to reduce PACs below the negotiated rate that was redistributed, then the unused portion of the PAC allowance is distributed among the providers as a bonus.

The fourth and final component of the ECR budget factors in a *margin to account for return on capital assets and reinvestment in business operations*.

As of March 2011, the PROMETHEUS project has developed ECRs for seven chronic conditions, three acute medical conditions, five inpatient procedures, and six outpatient procedures. The time span covered by the ECR varies according to the condition. ECRs for chronic conditions, such as diabetes, span a full payment year. An ECR for an acute condition, such as acute myocardial infarction, spans 30 days.

For each year, providers set a budget (which may reflect a goal of, for example, a 10 percent reduction in PAC-related costs) and a quality threshold. The quality threshold is calculated through a combination of the percentage of patients with a given condition who meet quality measures for that condition and the quality of care provided at the hospitals to which physicians refer their patients. If providers meet the quality threshold for the year and they manage to perform better than the budget for their ECRs (both in terms of the costs expended for clinically indicated care and the costs expended on PACs), then they are eligible to share in the bonus pool created by the difference between the budgeted ECR amount and the actual ECR amount. Providers participating in the payment program agree in advance on an algorithm for sharing the bonus pool among the participants.



Lessons Learned

PROMETHEUS Payment pilots are implemented over a three-year period. In the first year, a team comprising providers and at least one payer is created; health plan data are submitted to PROMETHEUS representatives, who then create a historical price for each ECR. The provider/payer team then selects the conditions that will be the focus of their pilot. Often, the team will choose a condition based on high incidence or a high PAC rate that provides significant opportunity for cost reductions. The team also works on a financial model for distribution of payments and shared savings. The payment model for the selected conditions is then implemented in the second and third years of the pilot, with the expectation that efforts at PAC reduction will intensify from the second to the third year.

Most of the participants interviewed for this report are at or near the end of the pilot's first year. Their work to prepare for implementation of the PROMETHEUS Payment model has focused attention on three significant issues: effects on hospital volume, capacity, and reimbursement; physician concerns with PACs; and the problem of unintended windfalls for payers not participating in the pilot.

Effects on Hospital Volume, Capacity, and Reimbursement

The effects of PROMETHEUS Payment on hospital volumes, capacity, and reimbursement are in part tied to the conditions that participants have addressed in their pilots. In the instance of inpatient or outpatient procedure-based conditions, providers do not anticipate significant impact. Here, the biggest effect would be on readmissions, and hospitals are already working to reduce readmissions to avoid possible penalties under the Centers for Medicare and Medicaid Services' (CMS) value-based purchasing initiative.

Providers working to reduce PACs related to chronic conditions may experience more significant effects in volume, capacity, and reimbursement. A primary goal of chronic care management is to keep patients healthy and out of the hospital. Thus, for chronic conditions, admission of a patient to a hospital is itself a PAC—a cost that could have been potentially avoided through more effective chronic care management.

ABOUT PROMETHEUS PAYMENT

PROMETHEUS Payment is a project of the Health Care Incentives Improvement Institute (HCII), a not-for-profit organization dedicated to improvement of the healthcare system through outcome measurement, reduction of care defects, realignment of payment incentives, and promotion of a team approach to patient care. The project was supported by a grant from the Robert Wood Johnson Foundation.

In markets with tight capacity or with expected growth in service lines that accommodate the needs of aging baby boomers, the reduced volumes from better managed chronic care patients might help free up capacity for other patients. Notably, however, most of the providers interviewed for this paper do not have capacity issues and do not foresee significant future demand for additional capacity. Instead, they recognize the likely financial challenges of declining volumes resulting from improved chronic care management.

That said, many see the PROMETHEUS pilot as an opportunity to prepare for inevitable changes that are coming in health care.

“Participation in the PROMETHEUS pilot gained traction in our organization because our leadership realized that the world has changed in a way that reducing the total cost of care is paramount,” says Elizabeth Jaekle, vice president of business development, Crozer Keystone. “Our focus is now on improving the value proposition to those who receive our care and pay our bills. Ultimately, this means eliminating unnecessary care or redistributing expensive care and related revenues while maintaining or improving the quality of care delivered. It also means producing improved margins on a different but market-sustainable portfolio of business.”

Pilot participants see in the PROMETHEUS Payment model a viable option for transitioning to a value-based system because PROMETHEUS changes the payment model to encourage better coordination of care across the provider continuum and shares the savings realized by these efforts among the system

PROMETHEUS PAYMENT AND ACOS: A COMPARISON

A unique characteristic of the PROMETHEUS Payment model is its use of a bundled episode-of-care payment system combined with a potential shared bonus pool to encourage voluntary aggregations of providers that want to collaborate to provide improved patient care. In this respect—encouraging the creation of a multiple-provider network to improve the quality and cost of patient care—PROMETHEUS Payment has similarities to accountable care organizations (ACOs). Both employ a model of shared savings to promote structural changes in the delivery of care, especially coordination of care across the continuum of care providers. Indeed, several of the providers in the PROMETHEUS pilot already are integrated care delivery systems that could easily be described as ACOs.

The shared savings concept used by both PROMETHEUS Payment and ACOs also encourages a focus on driving waste out of the system, increasing the efficiency and effectiveness of care delivery. For organizations considering participation in an ACO, PROMETHEUS Payment, with its focus on reduction of PACs, can help providers understand practice pattern variations and system inefficiencies that will need to be reduced or eliminated. These competencies will

become particularly important for members of ACOs if, as anticipated, ACOs are asked to gradually assume financial risk for a managed population.

To the extent that ACOs are asked to assume population risk under a per-patient-per-month payment model, however, PROMETHEUS Payment is distinct. Its episode-based payment model and patient-specific weighting of ECRs do not require providers to assume the risk that their population may be less healthy than average. François de Brantes, executive director of HCI3, relates a conversation he had with a CEO of a health system considering participation in an ACO. “I’m not willing to accept the risk that a patient will have congestive heart failure,” said the CEO. “However, I am willing to accept the risk of managing that patient once he has CHF.”

Absent the ability to truly control a population—by restricting access to care outside a coordinated care network, for example—a bundled payment system like PROMETHEUS Payment that structures payment around a service that providers control may very well be more amenable to providers than a payment system that asks them to assume such population risk.

stakeholders. Hospitals should, for example, be compensated for effective patient education and services that smooth the transition of discharged patients to post-acute care. Similarly, they should share in the cost savings of improved readmissions.

Under the current system, efforts to penalize hospitals for readmissions that occur up to 30 days beyond a patient’s hospital stay without providing resources to promote the continuity of care beyond the hospital’s walls offer only an incentive to minimize losses from events that may be outside of the hospital’s control. Changes to the delivery of care, in

other words, cannot be sustained without changes to a payment system that does not consistently compensate for evidence-informed care and does little to reduce the fragmentation of care among providers.

Physician Concerns with PACs

Hospital finance executives participating in the pilot have learned that their understanding of potential to avoid cost through a model based on PACs is very different from that of

their physician partners. In particular, physicians are likely to challenge two concepts.

Viewing PACs in financial terms. Under the PROMETHEUS Payment system, PACs are expressed in dollar amounts and the significance of a PAC depends on the cost of treating the event that gives rise to the PAC.

Physicians are used to thinking in terms of events, not costs. As such, financial executives often face the burden of developing a way to translate the financial dynamics of PACs into terms that are meaningful to physicians and can enable productive discussions. Finance leaders may want to work with a small group of physicians on the right language before engaging with a broader clinical audience.

“Words matter,” says Ralph Rogers, MD, vice president of medical affairs and chief medical officer for Spectrum Health Hospital Group. “A term such as ‘potentially avoidable’ will require a complex discussion with physicians, and a non-clinician should be aware of the issues and potential sensitivities before beginning this discussion.”

Physicians may also show skepticism during discussions of clinically indicated costs for treating a condition or performing a procedure if they are not convinced of the accuracy of the information used as the basis. Many hospitals face the problem of fragmented information.

“Three similarly defined reports, run from different systems, can produce three different data sets,” says Crozer Keystone’s Elizabeth Jaekle. “It’s our responsibility, as leadership, to be accountable for the accuracy of the data we share with our physicians. This is difficult enough within our own expanding enterprise, but we are now working across an entire episode of care that requires data feeds we don’t internally source or reconcile.”

One way some pilot hospitals are fostering physician trust in applying the model is to set a zero percent PAC reduction target for the first payment year. “With no money attached, the emphasis is on simply doing the right thing in reducing complications,” says David Stenerson, vice president and CFO, OSF Saint Anthony Medical Center. “As you gain buy-in on the possibility of reducing PACs, you can move down the path to where the financial impacts of PAC reductions are more acceptable to an engaged audience.”

Other forces in the healthcare market are making cost-of-care discussions easier. More physicians are hearing their patients say that they simply can’t afford care, notes Eddie Bell, director of risk and reimbursement, Providence Health Plan. As a result, they have become increasingly willing to volunteer for programs that are looking for ways to make health care less expensive and more accessible for their patients.

Viewing PACs in quality terms. Some physicians may perceive a focus on PAC rates as indicating that quality isn’t being reached. When finance executives present physicians with a list of PACs, the physicians may believe they are being given a list of failings, rather than—as finance executives perceive—a list of opportunities to bend the cost curve. Also, it’s easy for physicians to overlook the notion of “potential” during discussions of cost avoidance, meaning there truly may not be opportunity for them to lower occurrence in some instances. As such, physicians may show particular concern about being held accountable for PACs that they see as outside their immediate control, whether that lack of control is an issue of cost allocated for treatment of the PAC or an issue of outcomes that depend on patient adherence to care protocols.

Physicians are more comfortable with metrics based on process than outcomes (for example, early administration of aspirin to patients at risk of heart attack versus 30-day mortality of patients after heart attack) because such metrics are clearly within the provider’s control. But health care is the midst of a transition as agencies such as CMS and the National Quality Forum change their focus from process-based quality measures to outcomes-based quality measures that extend well beyond the patient’s stay within the hospital.

The PACs defined by the PROMETHEUS Payment project are outcome-based measures and have been endorsed by the National Quality Forum for the chronic care and acute medical ECRs. PACs are divided into three categories.

- Type 1 PACs are condition-related, such as respiratory failure or insufficiency during a congestive heart failure hospitalization
- Type 2 PACs are for comorbid conditions, such as pneumonia or asthma
- Type 3 PACs are related to patient safety failures, such as adverse effects of drugs

Physicians have few problems with efforts to reduce Type 3, safety-related PACs. Types 1 and 2 aren't as readily accepted.

Comorbidities seen with Type 2 comprise a broad category over which physicians are likely to feel they have the least amount of control. Type 1 PACs—those that are specifically condition-related—also cause concern in that it includes complications that might occur years into a condition. “It may be difficult for a physician to prevent the manifestation of a complication during the particular year being measured for the PAC if this complication has been developing for many years prior,” says Carole Montgomery, MD, vice president of access and coordination of care, Spectrum Health.

Montgomery also notes that, for many conditions and complications, there is not always an evidence-based answer. “The challenge is that even if every physician follows evidence-based care protocols, we can't always be sure of the impact.”

Should providers be held accountable for outcomes they do not fully control? Most participants say probably so, at least in part. “We need to get away from the idea that non-compliance with a care protocol is a patient attribute,” says Montgomery. “It is another problem in our current care delivery models, and we need to create a culture change in health care to figure out what we're doing wrong.”

Moreover, all “budget-based” payment models—whether PROMETHEUS or accountable care organization-type gain-sharing—will hold organizations accountable for all costs, including many that physicians and hospitals are not accountable for today. The key aspect of PACs is that they are potentially avoidable: They are areas where providers should work on reduction of incidents, but where providers may well be unable to achieve total elimination. A PAC for admission of a patient having a diabetic emergency is a means to get providers focused on how they can better improve patient education and patient adherence to care protocols. Realistically, total elimination of diabetic emergencies is an unattainable goal. But getting the number of diabetic emergencies down by just 10 or 20 percent would have a big impact on pulling costs out of the system.

Hospitals are taking a variety of approaches to increase physicians' comfort level with PACs. OSF Saint Anthony Medical Center first engaged the leadership of the primary

care group in discussions to ensure credibility with the medical staff. Then, rather than trying to “boil the ocean,” the hospital worked with the physicians to prioritize high instance, high volume PACs. “We've decided to work methodically on the items with the most value rather than overwhelm everyone with the full list of PACs,” says Saint Anthony's David Stenerson. “Our first focus will be on getting solid implementation of these prioritized PACs across the board.”

Other providers find it more effective to shift the focus from PACs to internal systems when identifying opportunities for improving quality and reducing costs. “Because PACs are expressed as dollars and not actual events, physicians may feel that PACs are good at identifying general areas of focus but are not where the heavy lifting occurs,” says Crozer Keystone's Elizabeth Jaekle. “An internal focus on specific clinical behavior producing the PACs really requires a review of process and systems, with the ultimate improvement in PAC rates rolling up from there.”

Hospitals are also experimenting with methods that encourage patient compliance with care protocols. Providence Health & Services in Oregon is testing a program that gives physicians \$100 for each patient who completes an online education and evaluation program related to the patient's condition. The Integrated Physician Network in Colorado, working through both member primary-care practices and local employers, is trying to create relationships with family members who can help encourage patient compliance and improve outcomes. The organization also is introducing care coordinator roles that will contact patients between physician office visits.

Regardless of the difficulty in pursuing chronic care costs, pilot participants agree that it is here where greatest opportunity for efficiencies lies. As Providence's Eddie Bell notes, “We have been working within the hospital to bring down costs on procedures and supplies for some time. Chronic diseases are the only places where we see big opportunities for further cost reductions.” And this, again, is the significance of PACs: They are not intended as a line-item review of failures in clinical care, but as a menu of opportunities for reducing costs or reducing the rate of cost increase within the system, bending the cost curve in a way that will improve the affordability and quality of care.

ORGANIZATIONS INTERVIEWED FOR THIS REPORT

To compile the material for this report, HFMA convened meetings with representatives of the following organizations that are participating in PROMETHEUS Payment pilots.



Crozer Keystone Health System is an integrated delivery system located in Delaware County, Pa., part of the Philadelphia metropolitan area. The system operates 774 inpatient beds across five hospital campuses, multiple ambulatory centers, a network of approximately 320 employed physicians (including 120 primary care physicians), and comprehensive home care and hospice services. It participates in multiple risk-based payer contracts today.



Integrated Physicians Network and Centura Health, based in the North Denver/Boulder area, is a PROMETHEUS Payment pilot that involves collaboration between an independent practice association that combines more than 160 providers across 30 practice sites through a network linked by a common electronic medical record with embedded evidence-based care protocols and Centura Health, a health system that includes 12 hospitals, seven senior living communities, and home care and hospice services.



SAINT ANTHONY MEDICAL CENTER

OSF Saint Anthony Medical Center, part of the OSF HealthCare system, is a 254-bed tertiary care hospital located in Rockford, Ill. It is affiliated with OSF Medical Group - Rockford. OSF Saint Anthony is participating in a PROMETHEUS Payment pilot that also includes SwedishAmerican Health System, Rockford Health System, and the Employers' Coalition on Health (ECOH), a not-for-profit organization that contracts directly with providers, representing 130 Rockford-area companies and 50,000 covered lives.



Providence Health & Services – Oregon Region, based in Portland, is a not-for-profit, integrated network of hospitals, health plans, physicians, clinics, home health services, and affiliated health services.



Spectrum Health is an integrated health system based in Grand Rapids, Mich. It includes a medical center, regional community hospitals, a dedicated children's hospital, a multispecialty medical group with more than 500 physicians, and a health plan (Priority Health) with more than 600,000 members.

Unintended Windfalls to Nonparticipating Payers

Collaboration between providers and payers is a cornerstone of the PROMETHEUS Payment model. However, a major concern to participants in the pilot is that improvements in care generated by efforts to reduce PACs will create an unintended financial windfall for payers that are not participating.

As physicians work to improve care, they will not differentiate between patients who are in the population covered by a payer participating in PROMETHEUS Payment and those covered by nonparticipating payers. Hospitals understand that these improvements will likely hurt volumes and revenue, as discussed earlier, but with respect to PROMETHEUS patients, expect that at least some of these losses will be offset by the hospital's share of the bonus pool created by savings associated with PAC reductions. Revenue lost from patients covered by nonparticipating payers will have no such offset.

The problem is further complicated for providers in that payers who have agreed to participate in the PROMETHEUS Payment pilot—and have invested the necessary resources—are unlikely to agree to a sharing of the model that results from this investment and that may create for them a competitive advantage against other payers in the market.

Pilot participants are taking on the unintended windfall issue by approaching nonparticipating private payers and trying to negotiate a shared savings model with them, independent of the PROMETHEUS Payment structure. This approach provides some opportunity to rein in benefits seen by those payers not participating in the formal pilot. However, there will still be a significant percentage of Medicare and Medicaid patients who benefit from PROMETHEUS delivery reforms and reduced costs, with no mitigation of the losses sustained by the pilot participants.

These problems will, of course, attach to any effort to redesign care delivery with payment structures that do not mandate the participation of all payers in the market. Yet the importance shouldn't be dismissed. Such obstacles are significant within the current payment system and seriously impede provider efforts to better coordinate care. "It feels like we're walking through a dark room to a place we know we

want to get to, but we have no idea about what we might bump into on the way," says Joseph Fifer, vice president of hospital finance, Spectrum Health.

Until a critical mass of payers is on board for payment and care delivery reform, providers would be courting financial disaster with widespread implementation of a program that produces savings in which they do not share. It may well be time for the major payers—including CMS and the major health plans—to begin aggressively partnering to find solutions to the problems in the payment system that impede reforms designed to improve care and reduce costs.

Even if most payers come on board with delivery reform, however, they will likely favor different models with different incentives. Provider CFOs will need the competency to generate as much commonality as possible among different payers.

Transitioning to Value-Based Systems

Through their involvement with the PROMETHEUS Payment project, the providers interviewed for this report have come to more fully understand the challenges involved in transitioning to a healthcare system that rewards value over volume. Key issues industry stakeholders will have to address include the need to:

- Focus on chronic disease management and right-size the system as necessary, while sustaining the viability of providers to offer access to care
- Establish new collaborative relationships between hospital administrators and clinicians that focus equally on improving quality and reducing the avoidable costs of care
- Ensure that participants in improvement efforts are not penalized to the benefit of those who are reluctant to change

Although value-based transitions aren't going to be easy, pilot participants repeatedly expressed affirmation in the belief that this is the direction the system must take. The current system is costly and ineffective, often resulting in fragmented, less than optimal care.

The opportunities of change outweigh its challenges. To succeed, system stakeholders need to find ways to bend the cost curve of health care to a sustainable rate while improving the efficiency and outcomes of care. ■