

Prometheus Pilot: Policy Decisions

As the pilot site moves closer to implementation, a progressive “glide path” has emerged to take provider reimbursement from the current fee-for-service mode to bundled payment or case rate reimbursement for patient-centered episodes of care. Part of the initial implementation steps for year 1 includes several key decision points for pilot site partners. This document provides an overview of the policy decisions all involved parties need to consider as part of the Prometheus pilot.

Policy Decision #1: PAC Allowance

One aspect of a local Prometheus implementation that is flexible in accordance with the decisions collaboratively made by the participating pilot site partners is the extent to which the dollars identified by the ECR® Analytics as falling into the Potentially Avoidable Complications funds (PAC allowances) are allocated to the ECR® Budget for each condition. In the original enunciation of the Prometheus model fifty percent (50%) of the PAC monies was allocated to Providers in the ECR Budget. The intention is of the 50% PAC allowance is to provide a cushion for providers that will offset the actual cost of complications when they do occur and provide an additional margin for those providers who reduce or eliminate them. In implementing the model pilot site partners may choose to allocate a different percentage of PACs. However, Prometheus does not recommend decreasing the PAC Allowance below 50%.

Policy Decision #2: PAC Reduction Target

Another component of a Prometheus pilot is setting a PAC reduction target for year 1. Pilot site partners agree to target an X% reduction in the dollars spent on potentially avoidable complications. The pilot site can make the distribution of rewards contingent upon achieving this particular PAC percentage reduction. However, it is critical to note that the decision regarding where to set the PAC Allowance impacts where to set the PAC reduction target. If the PAC Allowance is set at 50%, the pilot site partners agree to build 50% of PACs into the ECR Budget. In doing so, they are also agreeing to reduce PACs by 50%. Introducing an additional PAC reduction target could be daunting for the delivery system in the first year of the pilot. The question remains, what criteria need to be in place in order for rewards to be triggered? Will rewards be paid out after the very first dollar is saved or does the pilot site want to make rewards contingent upon an X% reduction below the ECR budgets? Rewards distribution is also contingent upon providers meeting the minimum quality threshold, which is described in more detail below.

Policy Decision #3: Quality Threshold Designation

Another flexible element in Prometheus is the quality threshold above which Providers become eligible to be paid monies remaining in their PAC funds after claims have been paid. In the initial design of the program, seventy percent (70%) of the Provider’s score depends on what that Provider does, thirty percent (30%) depends on what everyone else treating the patient for the ECR condition does; and there must be a minimum of a score of fifty (50) for the Provider to be eligible for any allocation of remainders in the PAC Pools. These percentages and thresholds may vary. The collection of baseline quality data can help to inform where to set the minimum quality threshold.

Policy Decision #4: Margin

Prometheus currently sets the margin at 10% of the predictive typical costs to account for depressed fee schedules, acknowledge the elimination of overuse and underuse in the model and permit provider entities to operate and continue to invest in infrastructure and improvement. However, the margin can be adjusted to meet the needs of the implementation site. A different margin percentage could be used, or the margin could be set to 0%.

Policy Decision #5: Distribution of Rewards

Prometheus employs one-to-many provider attribution logic in which any provider who has the opportunity to impact a particular patient's care is attributed to that patient. Prometheus recommends that rewards are distributed among providers based on percentage of office visits (e.g. % of E&M codes). Please see the table below for an example.

	# of Patients	Total ECR Budgets	Actual Spend Observed	Bonus Opportunity
Diabetes	50	\$201,300	\$176,358	\$24,942
CAD	70	\$176,623	\$154,547	\$22,076
HTN	310	\$600,329	\$529,127	\$71,202
Overall	500	\$978,252	\$860,032	\$118,220

Doctor	E&M %	Provider Score (70%)	Hospital Score (30%)	Total Score	% Eligibility Based on Min/Max	Bonus Share
	A	B	C	$D = (B * .7) + (C * .3)$	$E = (D - 50) / (90 - 50)$	$\$118,220 * A * E$
Dr. Jones - Internist	40%	83.30	61	76.61	66.50%	\$31,458
Dr. Lee - Cardiologist	30%	64.32	61	63.32	33.31%	\$11,814
Dr. Baker - Pulmonologist	15%	58.94	61	59.56	23.90%	\$4,237
Dr. Rastogi - Nephrologist	15%	72.57	61	69.10	47.75%	\$8,467

For the inpatient medical and inpatient procedural ECRs, Prometheus recommends a 50-50 split between the physician group and the hospital.

Policy Decision #6: Distribution of Remaining ECR Funds

Not all funds in ECR Budgets will be paid to treating Providers because the bonus opportunity is contingent upon the quality score. Prometheus recommends that any remaining funds in ECR Budgets are to be paid in some measure to some proportion of top performing Providers. In the initial design, the top twenty-five percent (25%) of Providers would be paid this bonus. In local implementation, a different percentile could be used, or none. In the table above, there is a difference of \$62,224 between the overall bonus opportunity and the bonus share the four physicians above have been paid. The remaining \$62,224 could be paid to providers performing in the top 25% proportionally to the number of patients or ECRs the managed or proportionally to the base bonuses.