



Theory, Results and Implementation

NRHI Summit
July 31, 2008

Francois de Brantes
National Coordinator



About PROMETHEUS Payment

- Not for profit with independent BOD made up of employers, plans, providers, health care services experts
- Funded in 2006 by CMWF to develop and model Evidence-informed Case Rates
- Funded in 2007 by RWJF to develop implementation plan
- Funded in 2008 by RWJF to support pilot implementations

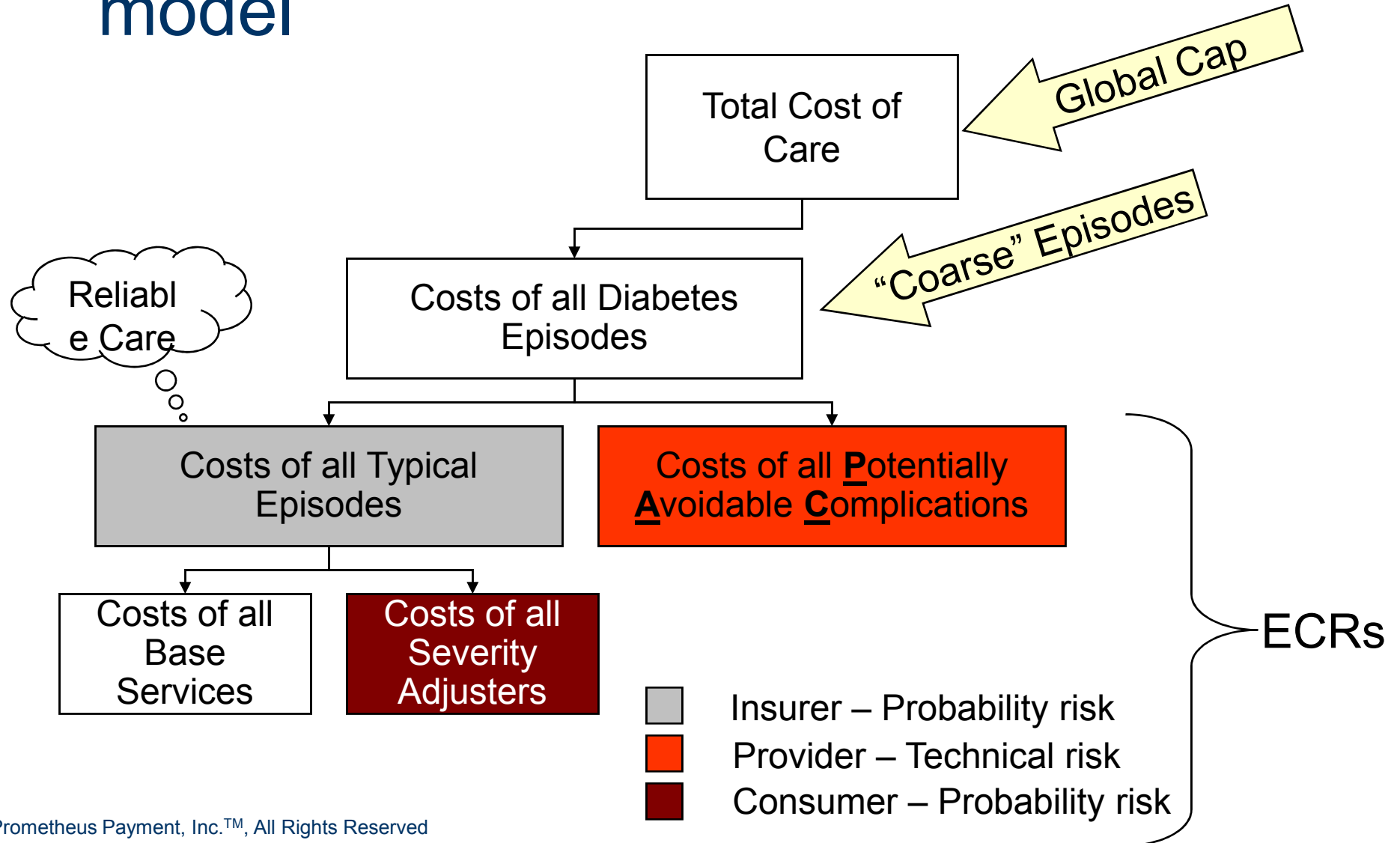


Core Concepts of Prometheus

- The price of an episode of medical care is specific to any patient-provider-payer triad
- The price has to include all the services recommended by evidence or expert opinion
- Episodes can be priced for chronic care, procedural care, or acute care
- There is no need for legal or financial integration of providers, just clinical integration



Risk bifurcation in the PROMETHEUS model





An Evidence-informed Case Rate... for each patient-provider-payer combination

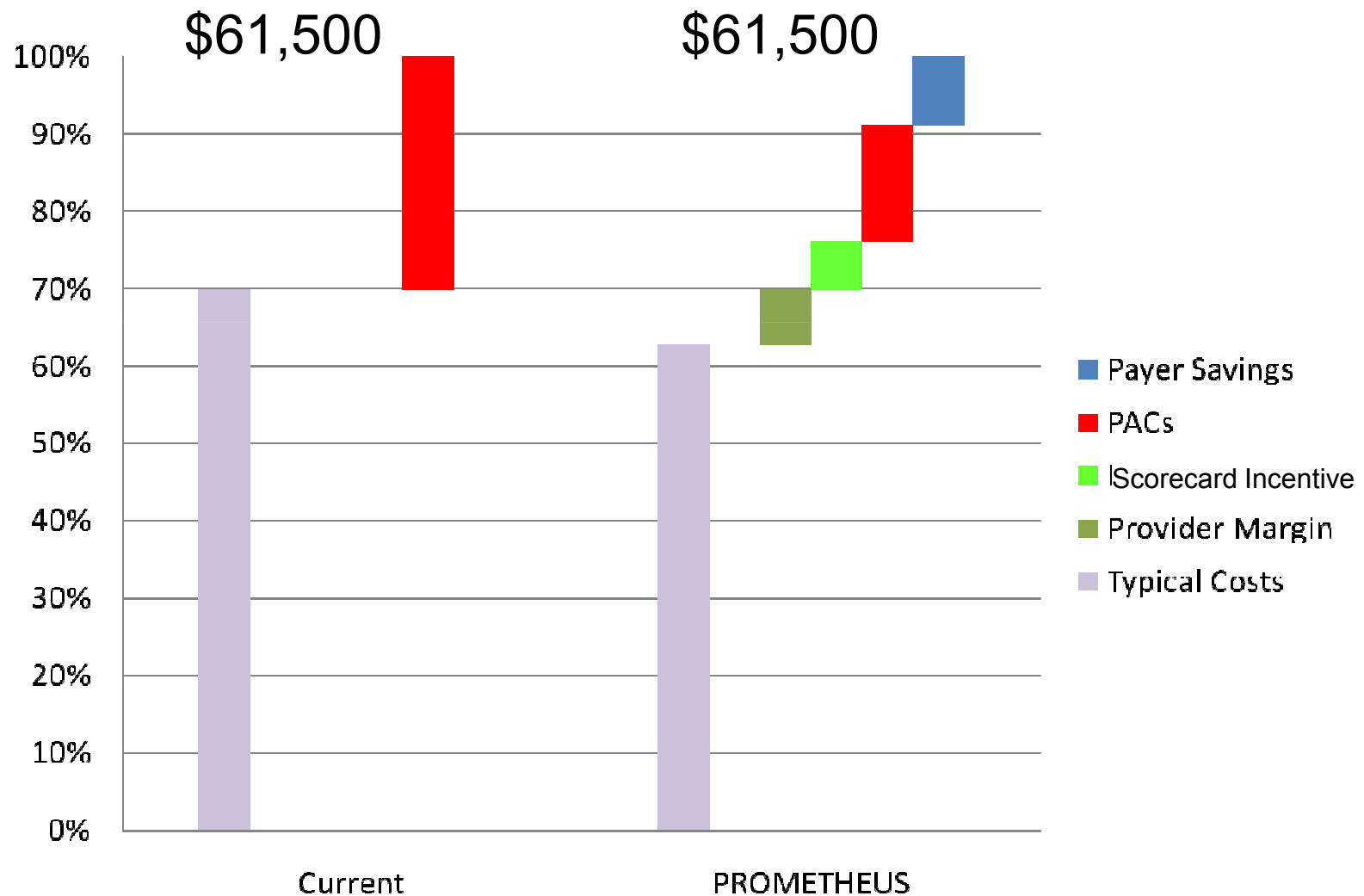
Total ECR price = Type of services * Frequency * Price per service

Based on 50% of current defect rate	Allowance for Potentially Avoidable Complications Margin
Currently based at 10%	Severity-adjustment caused by known patient health status
Arrived at through step-wise multi-variable regression model	“Normal” variation reflecting practice patterns
Adjusts ECR for local patterns	Core services that are recommended by best practice or evidence
Informed by guidelines and empirical data analysis	

The ECR explicitly removes excess cost of care caused by errors and creates a strong incentive to eliminate defects and improve quality.

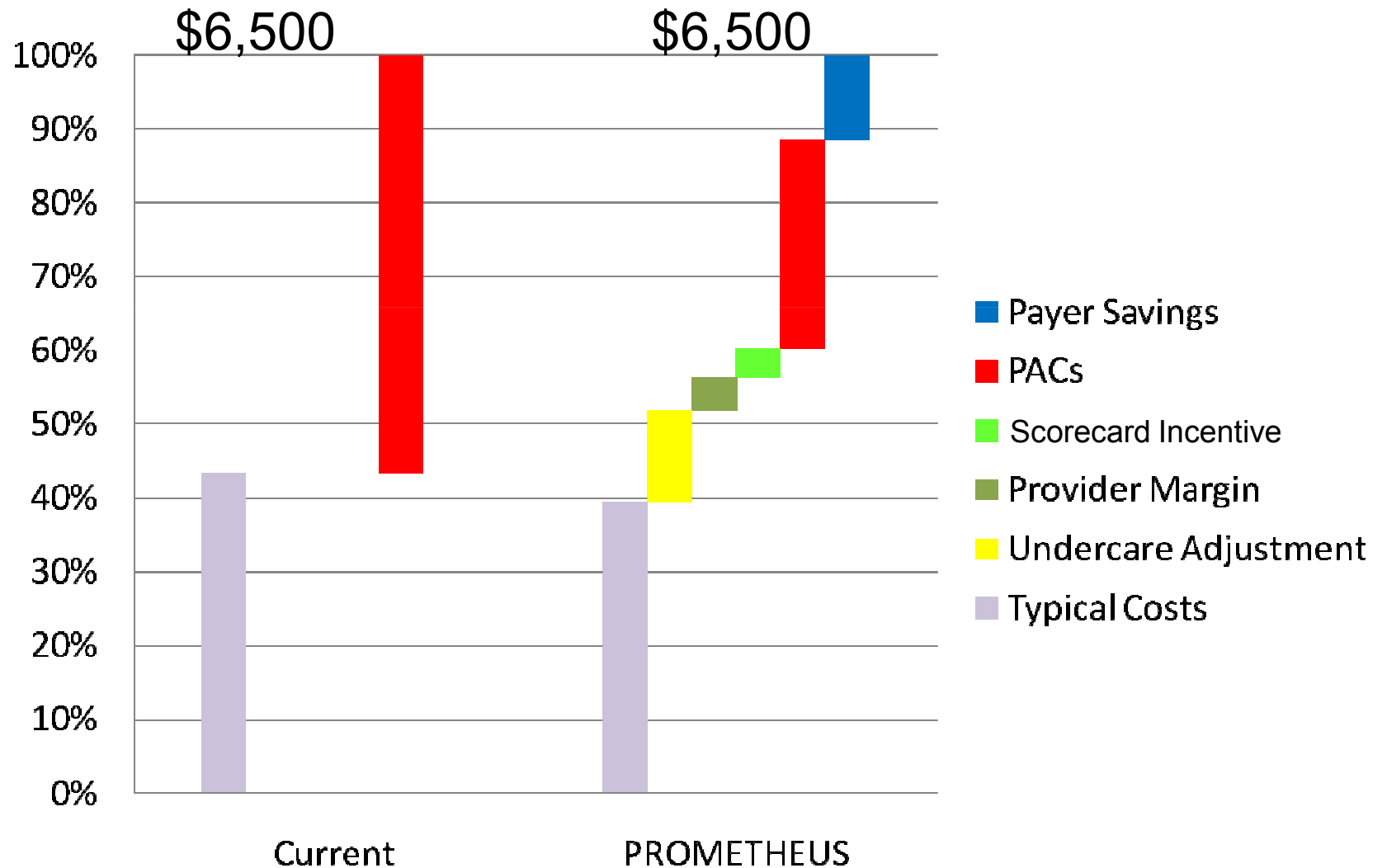


Results of AMI Model – Patient A



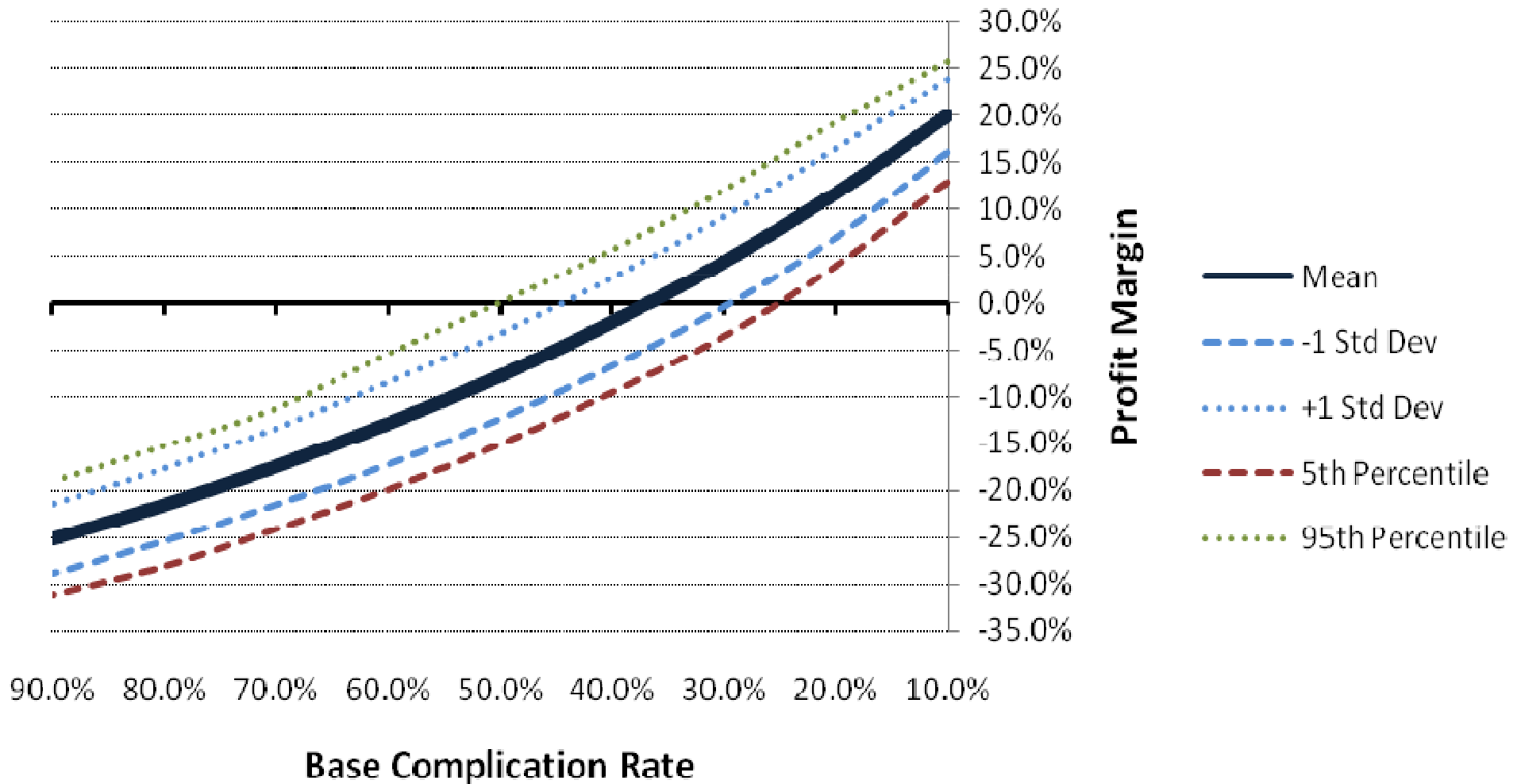


Results of Diabetes Model – Patient B





Total margin relative to Potentially Avoidable Complication Rate





Principles of implementation¹

- “virtual” ECRs fed through normal FFS claims streams – no need for prospective payment or complex contracting
- Upside only – no provider financial risk in first 18 to 24 months so that we can fully beta test all ECRs, severity algorithms, and provide information on upside and downside to providers
- Anyone can play – no need for IDNs, PHOs or other integrated organizations.
- It’s only complicated in the back rooms, not the physician office or the plan’s core processes

1. See “Making it Real” at www.prometheuspayers.org



Necessary pilot site characteristics

- Willing payer(s)
- Willing providers

....it takes guts!



Reactions so far...

- Nervous but favorable to concept – everyone agrees that reducing defects is a good thing, but everyone is nervous about the implications of change
- More complicated than off the shelf solutions – that’s because the off-the-shelf solutions aren’t working. The easy going has gotten us into this mess so it’s time to face into some hard realities/”inconvenient truths”
- Catalyst for having lots of other long overdue conversations – impact of benefit design on patient compliance, role of payer in managing risk pool, need to activate consumers to VBP