The Promise and Challenges of Clinical Integration in an Episode of Medical Care Payment Environment

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BTE’s Mission

*Bridges to Excellence* is a not-for-profit organization developed by employers, physicians, health care services researchers, and other industry experts with a mission to create significant leaps in the quality of care by recognizing and rewarding health care providers who demonstrate that they have implemented comprehensive solutions in the management of patients and deliver safe, timely, effective, efficient, equitable and patient-centered care.

BTE is also the operational arm of PROMETHEUS Payment, Inc, a separate 501-c-3 organization.
BTE is currently the largest P4P effort in the country
Are we succeeding?

YES:

Large and small employers (public and private) as well as insurers are participating across the country

Thousands of physicians have become recognized and are better managing their patients

We have concrete evidence that “reengineered” practices deliver better care at a lower cost

A strong signal (credible performance assessments and meaningful rewards) gets practices to change behavior

BUT:

Ultimately we’re fighting an impossible head wind (toxic payment systems) that we have to convert to a tail wind through more fundamental payment reform
What is being paid for today?

Payment structures send powerful signals about type of care purchasers want delivered

- Physicians are professionals—but they also respond to incentives

Current signals

- Want more units of care
- “High-tech” care is most highly valued
- Want less primary care
- Coordination is not valued
  - Each physician should do their own thing
  - Redundant services not a problem
- Quality not important
  - Payment same for low quality care
  - Mistakes yield more payment

Paul Ginsburg, Jan 2007
PROMETHEUS Payment brings these concepts together

Create the right framework for pricing care by starting with a base set of services informed by evidence/best practices

Further split technical risk into the component attributable to the patient (severity/health status) and the component attributable to the provider

Hold providers strictly accountable for their portion of technical risk across the care continuum

Create a solid business case for doing right through (a) the allowances for Potentially Avoidable Complications, and (b) the scorecard
Risk bifurcation in the PROMETHEUS model

- Total Cost of Care
  - Costs of all AMI Episodes
    - Costs of all Typical Episodes
      - Costs of all Base Services
      - Costs of all Severity Adjusters
    - Costs of all Potentially Avoidable Complications

- Global Cap
- “Coarse” Episodes

- Reliable Care

- Insurer – Probability risk
- Provider – Technical risk
- Consumer – Probability risk

Evidence-informed Case Rate
Huge amounts can be saved by reducing Potentially Avoidable Complications

AMI Relevant Services $743 million

- Stays $542 Million
- Professional $201 Million

Potentially Avoidable Complications: $207 million

- All PACs from AMI
- All professional services during stays
- All claims with “PAC” diagnosis codes
- All claims with “PAC” procedure codes
- Drugs used to treat PACs
- All related readmits

Professional + Re-admissions $148 Million

Typical claims and services: $536 million

- Claims that do not have a “PAC” code

Stays $482 Million
Professional $54 Million
And even more so in chronic care where PACs are rampant

**Diabetes Relevant Services**

- Medical: $595 Million
- Pharmacy: $732 Million

**Typical claims and services:**

- Medical: $108 Million
- Pharmacy: $407 Million

**Potentially Avoidable Complications:** $813 million

- All diabetes-related inpatient stays
- All professional services during stays
- All claims with “PAC” diagnosis codes
- All claims with “PAC” procedure codes
- Drugs used to treat PACs

- Claims that do not have a “PAC” code

**Relevant Services**

- Medical: $488 Million
- Pharmacy: $325 Million

**$1.32 billion**
A new payment system means new organizations

Real clinical integration is a necessary condition to win in an episode of care payment system

But the emphasis on reducing hospitalizations means the integration has to have a significant outpatient focus, not an inpatient one

Evidence-informed Case Rates become ex ante prices that can be used by consumers to differentiate provider organizations, introducing real competition on real value

Winners will integrate with best in class in a reformed and reshaped supply chain
MARCET STRUCTURE OF AN EOC PARADIGM

Insurers Organizing Payment Around Acute and Chronic Paradigm

Health Plans

Health Insurance Market

Total Care of Complex Populations (Global Capitation)

Episodic Care (Global Fees)

Chronic Care (Management Fees)

Medical Delivery Market

- Total Delivery
- High-Risk Delivery
- Hysterectomy
- Cataract

Plan and Provision of Care are Integrated

- Frail Elderly
- AIDS
- Some Cancer
- Rural Areas
- Natural Monopolies

- CHF
- Diabetes
- High-Risk OB
- Rare Disease

- Hlp Replacement
- Knee Replacement
- Breast Cancer
- Lung Cancer
- Peptic Ulcer

- Gallstones
- Gallbladder Removal
- Colorectal Cancer
- PTCA
- Severe Coronary Syndrome

- CABG
- End-Stage Renal Disease
- Prostate Cancer
- Urinary Stones
- Chemical Dependency

- Acute Mental Health
- Outpatient Mental Health
- Stroke
- Cartoid Endarterectomy
Evolutionary View of System Reform

- **1970**: Uniformed Open Choice FFS Profession Dominated
- **1980**: Compressed Choice Capitation HMO dominated
- **2000**: Informed Open Choice Global Fees Consumer Dominated
- **2030**: Open-System Managed Care