



Top 5 Myths of Episode Payment

IHA P4P Conference

Payment Reform Mini Summit

March 10 2009



Myth #0 – it can't work because...

- It's too complicated
- It's too disruptive
- It's too....

Yeah, whatever.



Prometheus in MN & IL

MN

- Working with HealthPartners on AMI ECRs
- Working with Medica on the Chronic Care ECRs
- Continuously informing the MN Hosp Association about our progress
- Informing the State and Commissions on Lessons Learned from our work
 - Avoid “one price fits all”
 - Create appropriate severity adjustments
 - Allow for continued innovation and evolution of the models

■ ECOH

- Rockford, IL
- 160 member companies with 26,000 employees
- Covers large area between IL and WI state line
- Pilot Partners include HDMS and IRP
- 6 Chronic Medical ECRs
 - Diabetes
 - CHF
 - COPD
 - CAD
 - Asthma
 - HTN



Prometheus in IL and PA

Utah

- Working with Public Employee Health Plan
- Collaborating in a statewide initiative to reform the payment and delivery of care
 - Collaborators include: IHC, HealthInsight, the UT Chartered Value Exchange, UHIN, Regence BCBS

Crozer-Keystone

- Springfield, PA
- Population covered represents almost a million people
- Dominant provider in Delaware County, Pennsylvania, northern Delaware, and part of western New Jersey
- Pilot partners include IBC, Aetna, and IRP
- Inpatient Procedural ECRs
 - Total Hip
 - Total Knee



Prometheus Elsewhere

- Normalizing ECRs in Maine for a potential statewide initiative
- Working with the MA Payment Reform Commission and, separately, with Partners Health Care
- Normalizing ECRs for large State employee benefit plan to implement bariatric surgery ECRs and estimate opportunity for better care of patients with Diabetes and CAD
- Working with a couple of regional plans and one national plan on normalizing the ECRs through their claims database

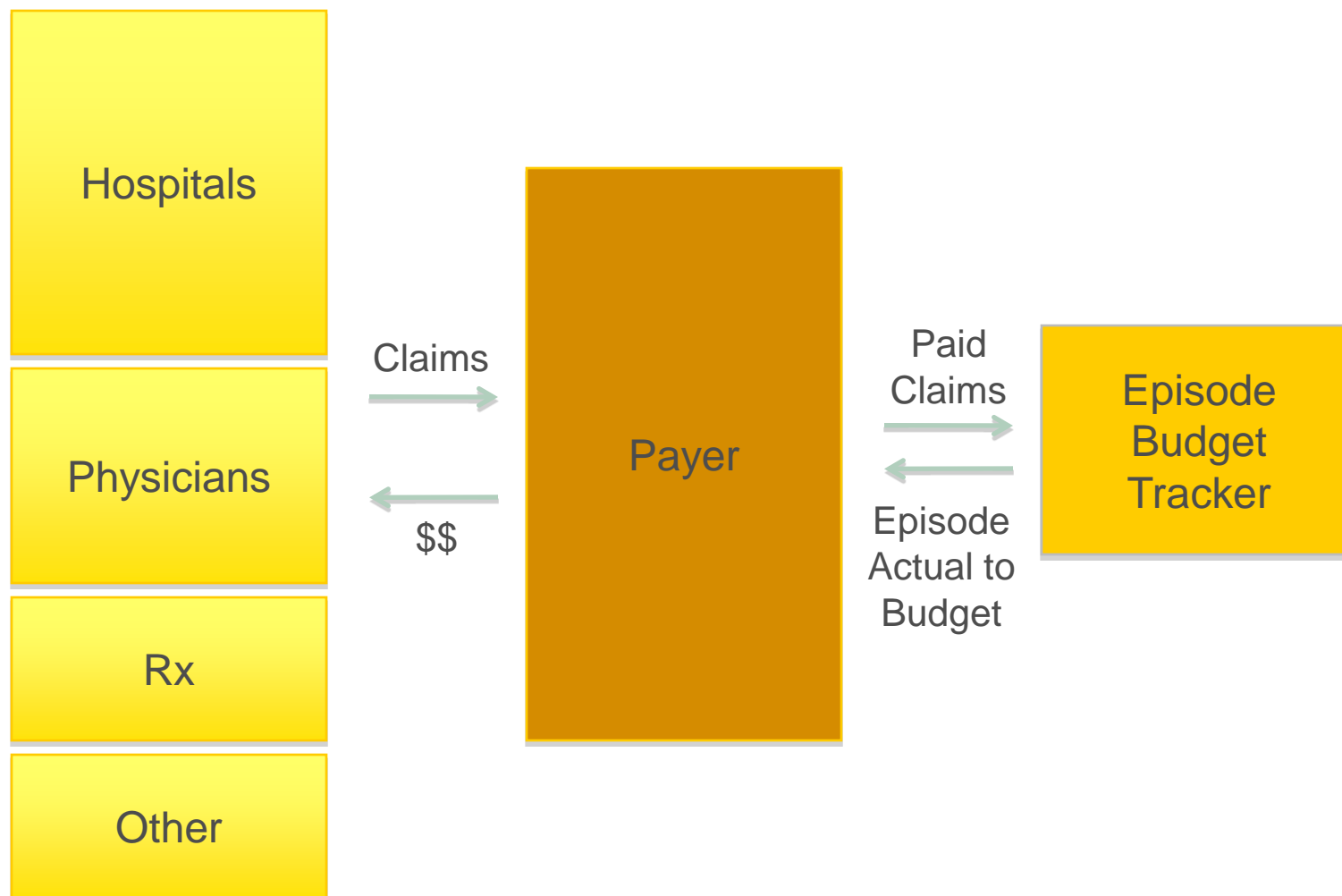


1. You need an “Accountable Care Organization”

- You only need an ACO if you prospectively pay the episode (or care package or bundle)
- You don’t need any organization to “buy” the patient if you prospectively budget and retrospectively reward/penalize
- And while we’re at it, we can let payment reform shape the delivery system as opposed to letting the current delivery system shape payment reform



Claims are paid same as today, and then get tagged against the episode budget





And you don't need complicated legal agreements to divvy up the money

	# of Patients	Overall Episode Price	Actual Spend Observed	Bonus Opportunity
COPD	25	\$34,423	\$27,827	\$6,596
Diabetes	50	\$201,300	\$176,358	\$24,942
CHF	10	\$87,977	\$73,723	\$14,254
Asthma	35	\$71,863	\$60,745	\$11,118
CAD	70	\$176,623	\$154,547	\$22,076
HTN	310	\$600,329	\$529,127	\$71,202
Overall	500	\$1,244,378	\$1,022,327	\$150,188

All claims hit the episode accumulator by patient and tracks the providers that cared for the patient

Barring a formal agreement between the treating physicians on how to share the bonus potential, the split is based on % of E&M

	% of total E&M claims	Share of Bonus
Dr. Tooker – Internist	40%	\$60,075
Dr. Lee – Cardiologist	30%	\$45,056
Dr. Stoller – Pulmonologist	15%	\$22,528
Dr. Rastogi -- Nephrologist	15%	\$22,528



#2. Episodes are priced the same for all patients with the same episode type

- Only if you want to encourage cherry picking of patients
- Episodes can be severity adjusted and priced/budgeted at the patient level – especially if you're not prospectively paying the episode.



Pricing an Episode of CHF

Predictor	Coefficient on Ln Scale	Hypothetical Patient Scenarios		
		Patient 1	Patient 2	Patient 3
Intercept	7.3049	1	1	1
Heart valve disorders	0.1463	0	1	1
Coronary atherosclerosis and other heart disease	0.2072	0	1	1
Carditis, Cardiomyopathy	0.1294	0	1	1
Conduction disorders	0.2003	0	1	1
Statins and other anti-lipid agents	0.2161	0	1	1
Bronchodilators and other antiasthmatics	0.2345	0	0	1
Antiarrhythmic agents	0.2274	0	0	1
Inhalers and respiratory agents	0.2061	0	1	1
Antacids and drugs for other oral and GI problems	0.2915	0	1	1
Diuretics	0.2469	0	1	1
Other cardiovascular agents	0.1697	0	0	1
Beta-Blockers	0.2322	0	0	1
ACEI, ARB, anti-renin drugs	0.1672	0	1	1
Calcium channel blocking agents	0.1672	0	0	1
Antiplatelet agents, thrombin inhibitors	0.2214	0	1	1
Antidepressants	0.194	0	0	1
Severity-adjusted Price of base services		\$1,488	\$27,418	\$93,341



#3. Episodes can only be used for procedures or acute events

- Episodes can cover acute, procedural or chronic care
- And you can also bundle chronic care episodes to create a practice-based global fee – which is NOT capitation, but simply a sum of severity-adjusted patient-centered episodes



This practice stands to make a “bundle” if they reduce avoidable complications

	# of Patients	Overall Episode Price	Typical Spend Observed	Allowance for “defects” and Bonus Opportunity
COPD	25	\$34,423	\$27,827	\$6,596
Diabetes	50	\$201,300	\$146,358	\$54,942
CHF	10	\$87,977	\$53,723	\$34,254
Asthma	35	\$71,863	\$40,745	\$31,117
CAD	70	\$176,623	\$154,547	\$22,077
HTN	310	\$600,329	\$499,127	\$101,202
Overall	500	\$1,244,378	\$922,327	\$322,051

The \$322K is contingent upon the actual dollars spent by the payer on potentially avoidable complications, AND on the practice’s quality scores



#4. Episodes encourage underuse of needed services and overuse of unneeded episodes

- Yes if you are simply looking at historic averages of costs of care and not monitoring /1000 rates of procedures.
- Episodes done right – like the Prometheus Payment Evidence-informed Case Rates – right-size the base typical services and tie margins to reductions in avoidable complications.
- And clinical triggers (not claims triggers) should launch episodes



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

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

Based on 50% of current defect rate	\$3,000 -- \$16,500	CHF ECR Range** \$7,000 -- \$41,400
Currently based at 10% of typical	\$360 -- \$2,260	
Arrived at through step-wise multi-variable regression model	\$3,600 -- \$22,600*	
Adjusts ECR for local patterns		
Informed by guidelines and empirical data analysis		

* \$2,300 was added to the base set of claims-based/observed services to create a right-sized evidence-informed set of services.

** The upper range can be greater than the amount stated depending on the severity of the patient



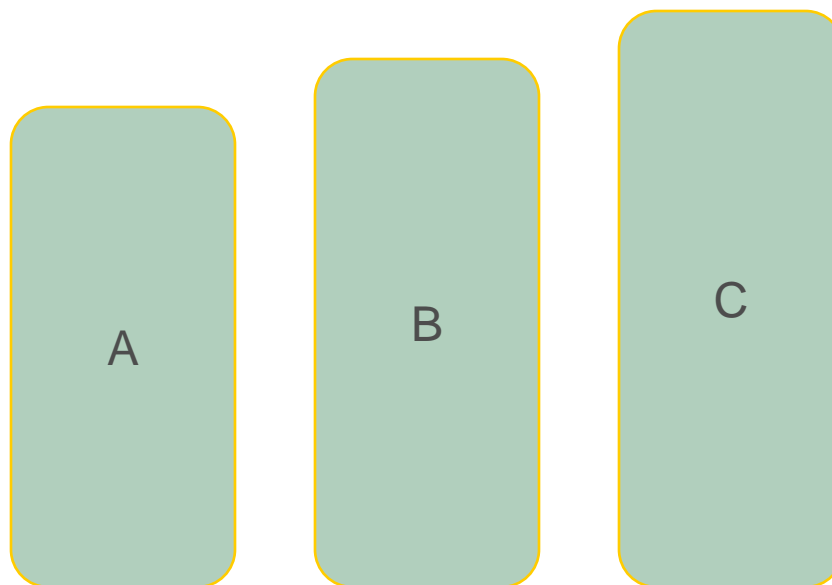
#5. You can't tier a network using episodes

- You can't do a blunt institutional tiering, but
- You can do a service line “tiering” – true patient arbitraging of product value as opposed to plan-directed arbitrage of institutional cost



Who's afraid of the consumer/patient?

Episode of CHF



Each “team” can improve by (1) increasing their quality score, (2) decreasing their episode price – provided they meet the min Q score of 80

Episode Cost	\$25,500	\$27,500	\$30,000
Quality Score	82	90	92
Value Index	311	305	326
Co-pay	\$560	\$0	\$1,700

Value Index = Episode Price / Quality Score
 Co-pay A = (311-305) * 90
 Co-pay C = (326-305) * 90