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Welcome! This toolkit is designed to provide the information you need to gain a solid understanding of the PROMETHEUS Payment model, consider the potential benefits of a pilot implementation and take action. It is meant for use by local health care cooperatives, employers, physicians or health plans interested in exploring the PROMETHEUS model.

In clear language, this toolkit explains the thinking behind this new payment approach and lays out the steps to implementation. It describes how to conduct your initial data analysis, build support among CEO leadership and other champions, engage your providers and payers, define your project scope and ultimately launch your pilot. It will also point you to additional resources to help you at each step.

The PROMETHEUS model was created by the Health Care Incentives Improvement Institute (HCI3), a non-profit organization guided by a Board of Directors that includes physicians, employers, health plans and others. Development has been supported primarily by a grant from the Robert Wood Johnson Foundation (RWJF).

Is your region a good candidate for PROMETHEUS Payment implementation?

A PROMETHEUS pilot can be a complex undertaking. Here are some questions to consider before venturing down this path. You don’t need to answer “yes” to all of them now; the details will all be explained later in this toolkit. But these questions will help you begin to understand some key factors before you decide to move forward.

- Is at least one payer and one provider organization willing (and eager) to participate?
- Is payment reform a priority for each participating organization?
- Can you count on the CEOs to be committed to this effort?
- Are you willing to devote substantial time, and financial and human resources, to the pilot?
- Does your staff include a skilled SAS programmer, strong analytics team and capable project manager? If not, can you get them on board?
- Do providers have an Electronic Medical Records (EMR) system in place? If not, can they implement one?
- Do payers have access to high quality claims data?
Will there be a sample of at least 30 patients—and preferably many more—in the areas you intend to focus your pilot on?

Is there a strong sense of urgency to overcome the obstacles that may arise?

*Again, the details behind each question will be explained as you move through the toolkit.* You don’t need to answer them now. But on a high level, you may already have a sense of whether your organization is a good candidate for a PROMETHEUS implementation.

*One more thing to keep in mind: You can employ the PROMETHEUS model for purposes other than explicit payment reform.*

Its data-driven approach has much to offer in helping your organization:

- Understand the factors driving its costs;
- Measure its quality of care against local and national benchmarks; and
- Identify the most critical areas on which to focus its cost and quality improvement efforts.

Even just running your claims data through PROMETHEUS’ online tools can yield a wealth of information you can put to work in many different ways.

Bottom line: if you are considering a payment reform pilot, or simply want to identify areas that offer the best quality improvement and cost saving opportunities, this toolkit can be an invaluable resource.

*Let’s get started!*
1A) PROMETHEUS Payment is a new compensation approach, based on medical episodes of care, now being piloted at three pilot sites across the country.

Funded by RWJF, the current pilot implementations are designed to test the validity of the PROMETHEUS model. Each pilot is unique, and based on the specific needs of each participating organization and its multiple stakeholders.

1B) What PROMETHEUS is: a promising path to effective payment reform

The PROMETHEUS model packages payment around a comprehensive episode of medical care that covers all patient services related to a single illness or condition. It is designed to bring economic incentives in line with the medical profession’s desire to improve patient health and create an environment where doing the right things for patients helps providers and insurers do well financially.
The designers believe it addresses the full range of issues necessary to create a payment system that is fairer and more accountable than the current fee-for-service system, without introducing new administrative burdens or changing the way patients access care. They believe it enables employers and health plans to increase efficiency and pay for the quality, not quantity, of care. And they believe it encourages physicians, hospitals, and health systems to work in teams to share information, take collective responsibility for a patient’s health, and improve treatment value and outcomes.

1C) What PROMETHEUS is not: proven over time in a wide range of settings

While early feedback and data are promising, a full and robust set of results has yet to be recorded and analyzed. To be sure, PROMETHEUS is no magic bullet. It is one of a number of innovative payment models designed to help transform today’s fragmented and inefficient health care system. It will not be the best solution for every organization, but it may be a good one for yours, based on the following criteria.

1D) Who should explore PROMETHEUS—and who shouldn’t?

A pilot site requires the active participation of at least one payer and at least one provider organization. Since a key goal is to encourage physicians and hospitals to work together, and overcome the organizational barriers of siloed fee-for-service medicine, ideal pilot sites include multiple provider organizations and other multi-stakeholder organizations (including health plans, employer groups, provider organizations, and hospitals).

Organizations should be motivated to explore the possibilities of new compensation models and ready to work through the kind of organizational change required. In other words, a site must have willing payers and providers, the enthusiastic involvement and support of the CEO and other high-level executives, and a sense of urgency within all participating organizations. As a practical matter, pilot sites should also have access to high-quality claims data at the member level. Ideally, EMR systems will already be in place. While not absolutely necessary, EMR systems are certainly helpful in implementing a data-driven model like PROMETHEUS, as is a well resourced IT and Quality Management team.

An organization with most or all of these attributes will be a good candidate for a successful PROMETHEUS pilot. In the next section we will review the fundamentals of how PROMETHEUS Payment works and the steps involved in piloting the model.

For a pilot implementation to succeed, there must be a strong sense of urgency to think proactively, overcome obstacles and avoid “analysis paralysis.” The effort must be a high priority of all participating organizations. This includes a willingness to devote time and resources to the implementation, whether that means allocating funds, reassigning existing staff, or hiring new data analysts or other professionals.

Tools and Resources
» PROMETHEUS Payment Brochure
» High-Level Case Studies: Diabetes, CHF, Knee Replacement, Bypass Surgery
» Sample Project Plan
The PROMETHEUS model uses medical records, claims data and other data to measure the quality of care delivered to patients. Measures are based on commonly accepted clinical guidelines or expert opinions that define the best methods for treating a given condition from beginning to end. The prices of all treatments are tallied to generate an Evidence-informed Case Rate™ (ECR), creating a budget for the entire care episode within a defined time period.

2A) What an Evidence-Informed Case Rate includes

An ECR includes all covered services, bundled across all providers that would typically treat a patient for the given condition (hospital, physicians, laboratory, pharmacy, rehabilitation facility, etc.). Each ECR is adjusted to accommodate the severity and complexity of the patient’s condition. Learn more in Evidence-Informed Case Rates: A New Health Care Payment Model.

PROMETHEUS currently has ECRs for 21 conditions, including:

<table>
<thead>
<tr>
<th>Category</th>
<th>Conditions Covered by a PROMETHEUS ECR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Medical</td>
<td>Asthma, CAD, CHF, COPD, Diabetes, GERD, HTN</td>
</tr>
<tr>
<td>Acute Medical</td>
<td>AMI, Pneumonia, Stroke</td>
</tr>
<tr>
<td>Inpatient Procedural</td>
<td>CABG, Colon Resection, Bariatric Surgery, Hip Replacement, Knee Replacement</td>
</tr>
<tr>
<td>Outpatient Procedural</td>
<td>Colonoscopy, Cholecystectomy, Hysterectomy, Knee Arthroscopy, PCI (Angioplasty), Pregnancy/Delivery</td>
</tr>
</tbody>
</table>

When providers hear about a global payment model like PROMETHEUS, they often assume it is just another version of the capitation models tried in the past. This is not the case. Capitation systems, which provide one flat fee for patient care, often fail to compensate providers fairly. But PROMETHEUS increases payment by adjusting for risk factors like patient demographics and severity of illness. Plus, it provides an allowance for PACs. As a result, it’s fairer to physicians—especially those who deliver the best outcomes.
Building an ECR: Congestive Heart Failure (CHF)

Charles is a 60-year-old man with CHF. A detailed examination of his personal history shows he also has coronary artery disease and gastro-esophageal reflux disease. Considering the severity of his heart failure and the other medicines he is taking, the PROMETHEUS Payment model calculates a personalized, severity-adjusted yearly budget of $9,800 for routine CHF care for Charles plus a PAC allowance of $10,300.

If providers help Charles avoid PACs like unnecessary readmissions, that allowance will be distributed back to them in the form of bonus payments.

2B) The importance of Potentially Avoidable Complications

To determine relevant costs of a specific episode, the model separates out two types of risk. Probability Risks are outside the provider’s control and therefore assumed by the insurer. Technical Risks are within a provider’s control and therefore assumed by the provider. Technical risks include Potentially Avoidable Complications (PACs) and other variations. PACs are deficiencies in care that cause harm to the patient, and might have been prevented with more effective treatment. Learn about the history of PAC Development.

PROMETHEUS PAC measures endorsed by NQF

In early 2011, the National Quality Forum (NQF) endorsed PAC measures for six chronic conditions (Asthma, CAD, CHF, COPD, Diabetes, Hypertension) and three acute care conditions (AMI, Pneumonia, Stroke) used in the PROMETHEUS model. These go beyond previous outcome measures to help move the U.S. health care sector to a new level of accountability—based on value instead of volume.

2C) How these elements tie together

Driving down PACs is the key to driving down costs. It is estimated that up to 40 cents of each dollar spent on chronic conditions, and up to 20 cents of each dollar spent on acute hospitalizations and procedures in the United States, are due to PACs. A substantial PAC allowance is calculated within each ECR. If complications occur, this allowance is used to offset costs of corrective treatment. But if providers reduce or eliminate PACs, they can potentially keep the entire allowance as a bonus.

To be more specific: Under PROMETHEUS, providers continue to get paid under their current negotiated fee schedules. Then, if they manage patients well and minimize PACs, they can potentially earn bonus payments as well. All claims are applied against the ECR for each patient, and any difference between the actual costs and the budgeted costs is distributed to providers.
In addition to tying bonus opportunities to PAC reductions, PROMETHEUS includes incentives to reward provider performance on clinical process, outcomes of care and patient experience. Based on these measures, payment is re-distributed and shared by all parties. In this way, providers are compensated for the quality of care they collectively deliver, not the number of tests or procedures they perform. PROMETHEUS also encourages collaboration and shared accountability because each provider's compensation is based, in part, on how well other caregivers perform. (Provider performance is measured through the use of scorecards, detailed in Section 5.)

**Building an ECR: Knee Replacement**

Karen had a routine knee replacement surgery followed by an uneventful recovery. She suffers from rheumatoid arthritis, obesity and sleep apnea and takes medicines for diabetes. Considering the severity of Karen’s knee, her overall health and the other medicines she is taking, the PROMETHEUS Payment model calculates a personalized, severity-adjusted budget of $24,500 for routine knee-replacement. This includes all the costs of surgery, follow-up physical therapy and rehab and other routine care, plus a PAC allowance of $3,500. If providers help Karen avoid PACs like infections, that allowance will be distributed back to them in the form of bonus payments.
SECTION 3:

Getting Started With Your Own Pilot: Conducting Initial Data Analysis

3A) Why this step is essential

Before implementing PROMETHEUS Payment, payers will need to perform an initial data analysis of the health plan's claims data. This is an essential step in determining the areas that offer the best opportunity to improve care quality and reduce costs. Before you dive in, this section will review a couple of points to consider.

While it should not be difficult to conduct this analysis, it does require a highly competent SAS programmer, and it may occupy a significant portion of the programmer's time. In fact, one may not be enough; some pilot sites report the need for an additional SAS programmer/data analyst.

In addition, payers must have “clean” and accurate claims data, formatted according to HCI3’s specifications. To help with compliance, HCI3 provides a checklist of specs, and an instruction manual on how to format data. Be sure to review these documents and check each data source before moving forward. If the data does not conform, it will produce erroneous results or no results at all. A simple example of “unclean” data would be a member ID that is not unique; in other words, it includes more than one person. If individual member identifiers or other information are missing from the data, the outputs will be certainly be compromised.

3B) You can conduct the initial data analysis yourself

If you have a highly competent SAS programmer who can devote substantial time to this effort, and a solid analytics team to interpret results, you can conduct your own analysis through the ECR Analysis Tool on the HCI3 website. Once you set up your profile and review the user agreement, you can download the freeware and run the application.
If you choose to run your claims data yourself, the data must first be mapped to a standard format. You will receive detailed instructions on how to execute the necessary steps. The tool allows you to input your organization type, population type and number of lives covered. It then analyzes your claims data to create a snapshot of your current health care spending across multiple conditions, so you can examine how efficiently health resources are being used relative to benchmarks.

By comparing your PAC rates against national and regional averages, you can calculate the overall impact PROMETHEUS can have on your organization. Potential pilot partners can review the initial outputs to determine the percentage of dollars spent on PACs across any of the 21 ECR conditions and procedures. You will also receive an Opportunity Report that highlights the savings you can achieve by reducing those PACs. This report is essential to helping you identify the ECRs that offer the greatest quality improvement and cost saving opportunities.

**Caution Point**

If you run the data in-house, you will have to license the full SAS ECR Analytic package by signing a license agreement. Again, a skilled SAS programmer will be needed for this. In addition, certain characteristics are required before you run your data.

For example:

- The file must consist of two years worth of incurred claims with a run-out period of 3-6 months.
- All costs must be reported as “Allowed Amounts” and reconciled to adjust for interim bills and negative dollars.
- A single “final” bill must be submitted for each claim.
- Inpatient Stay Claims must be rolled up to one claim per admission/discharge.
- Pharmacy claims must be reported with prescription dates, one NDC code per claim and associated costs.
- Professional, Outpatient Facility, Ancillary and Other Claims have NOT been rolled up, and have remained at the claim line level.

Of course, the PROMETHEUS team is available for consultation to help with these and other issues.
3C) Or contract with partner data analysis firms

For a more in-depth report, you can have your initial data analysis performed by PROMETHEUS data partners such as Masspro or MedAssets. You will need to sign a Data Use Agreement and Business Associates Agreement before any data transfer can take place. You can use the PROMETHEUS templates, or use your own standard agreements to expedite the agreement process. PROMETHEUS and its data partners are available to discuss the contents and format of the files prior to their submission for data analysis.

There is an advantage to running your data this way: the ECR analytic outputs are more detailed. In addition to a breakdown of the dollars spent on the chosen ECRs, you will receive provider-level outputs that can help you understand where the sources of variation are, in terms of both cost and quality. You will also receive a PAC drill-down report so you can see which specific PACs are occurring most often and are the most costly. Click here for a sample report that illustrates the level of in-depth information you can obtain if you choose this path.

3D) What the results will show

No matter how you choose to run your data, the results will show your PAC rates and identify the exact source of those PAC dollars. From there, you can determine the areas of your organization that offer the greatest potential to improve quality and reduce costs. With these findings in hand, you can make an informed decision about whether, and how, to move forward with PROMETHEUS.

Of course, the potential ROI and cost savings identified in your data analysis are not the only things you'll need to consider. Any decision to implement PROMETHEUS must take many factors into account. The organization must be truly motivated to improve health care quality and move away from fee for service payment. Providers and payers must make the pilot a priority, and be eager to work together for mutual success. On a purely practical level, participants must have the time and resources needed for implementation. And providers must have EMRs, and the ability to improve quality once the results are in (see Section 5.) It's important to understand this may not be easy. But of course, few things worth doing ever are.

Tools and Resources

» ECR Tool (Freeware to run your data if you have SAS capabilities)

» Sample Data Analysis Report from ECR Tool (Opportunity Report)

» Data Specifications for Payers (Checklist)

» ECR instruction book (explanation, how-to of data specifications)

» Sample Data Use Agreement and Business Associates Agreement

» Sample License Agreement

» Sample Deeper Analytics report
Building Support: CEO Leadership and Champions

4A) Senior-level support is essential

Once you decide to implement PROMETHEUS Payment, a key step is to obtain formal commitment from the CEOs of all participating payer and provider organizations. CEO support can be expressed through letters of commitment.

This is critical because a high-stakes payment initiative like PROMETHEUS will impact many areas of the organization. During the pilot, many diverse professionals—from the nurses and physicians who redesign care delivery to the finance and informatics people who update payment and accounting systems—will need to collaborate closely. They must know their efforts have the CEO’s full support, attention and enthusiasm.

While backing from another C-suite executive (such as the person in charge of fund allocation or discretionary spending) can have a powerful impact, it can’t compare to CEO-level support. The CEO is the ultimate decision-maker and is accountable for the organization’s success or failure. With final say over allocation of resources, only the CEO can send a message all the way down the reporting lines about corporate priorities.

As a result, the CEO’s full, public commitment through something like a letter is essential. If the signal from the top isn’t clear, mid-level managers will inevitably struggle with finding and maintaining the resources needed to implement such a complex project. At some point, a corporate priority that is clearly backed by the CEO will override all other considerations, and resources will be allocated accordingly. Having the CEO drive engagement tells everyone that this effort will be supported.
4B) What a CEO commitment letter should indicate

A CEO commitment letter should indicate that PROMETHEUS implementation is a priority for the organization, that it fits well within his/her vision and that it is urgently needed to improve quality and cost efficiency. The letter must also state that your organization has the resources in place to execute the implementation, or is willing to allocate resources as needed (for example, billing systems and contracts may have to change for the pilot to take place). The letter should spell out these requirements and explain that PROMETHEUS will be a priority for every member of the organization.

4C) A physician champion is important too

If possible, you should also have a physician champion on board to spread the message and build support. After all, this initiative represents a major shift in how physicians will be compensated and their skepticism and pushback are certainly to be expected. Having a physician who understands the program and is committed to its success will go a long way toward persuading other providers that PROMETHEUS will continue to compensate them at the current contracted amounts, while offering significant potential upside as well. The physician champion should focus on communicating the incentives for delivering better outcomes and explaining how PROMETHEUS rewards excellence by allowing top performers to earn more.

Tools and Resources

» Statement of Commitment from CEOs of Payers
» Statement of Commitment from CEOs of Providers
5A) Steps to encourage willing and enthusiastic participants

Without the buy-in of the CEO and other C-suite executives, there is little chance of success. But that essential top-down commitment is not enough. You need to engage providers and payers around this initiative as well. There must be clear efforts to organize teams and committees on both sides, and they cannot stop at merely getting everyone around the table for a meeting. There must be a strong bias toward action.

To build momentum, PROMETHEUS Payment recommends a formal kickoff meeting to present the initial data analysis, review the high-level concepts behind the model and foster a strong sense of urgency for improving quality and cost efficiency. Building clinical collaboration and a strong consensus behind the pilot will significantly improve your chances of success.

This meeting can be a high-level concept review of PROMETHEUS or it can be more granular and used as a forum to present the results of the initial data analysis. In either case, senior leaders and other representatives from all participating health plans, employer groups, provider organizations and hospitals should be in the room.

You may also need to provide more detailed education for providers and payers around key concepts like ECRs, PACs and scorecards. Providers must have a good understanding of the PROMETHEUS model and the clinical quality measures used. Payers should clearly understand the bundled payment concept and ECR model. Overall, both groups should understand why it is urgent for their organizations to undertake this initiative and work together to make it a success. Initial data results should be presented to both providers and payers in formats that resonate with each group, preferably with real examples from the initial data analysis.

For the pilot to succeed, payers and providers must make it an internal priority. To encourage this, some pilot site payers tie compensation directly to the success of the PROMETHEUS implementation. Some providers also tie their clinical re-engineering efforts to the pilot, focusing first on the targeted ECRs, then expanding their efforts to other areas of the practice. Generally speaking, integrating the pilot into the larger goals and aspirations of each participating organization can help make it a priority for all participants.
5B) Explaining scorecards and bonuses to providers

Clinicians will be expected to submit clinical data to an independent third party for scoring. With this data, a quality “scorecard” will be created. This is a performance assessment tool that provides continuous quality feedback to providers and serves as a measurement tool upon which any potential rewards or bonus opportunities will be contingent. The scorecards will measure provider performance through a mix of quality care metrics, such as meeting clinical guidelines, achieving positive patient outcomes, avoiding complications and improving patient satisfaction. See a sample scorecard here.

This model puts accountability for care where it belongs—in the hands of providers. And they are only held accountable for variables they can control. As previously discussed, providers will continue to get paid under their current negotiated fee schedules, with a substantial PAC allowance included in each budget. If complications occur, this allowance is used to offset costs of corrective treatment. If providers manage patients well and minimize PACs, they keep that allowance as a bonus. As a result, those who create the most value will earn the highest compensation under PROMETHEUS.

Most physicians today—particularly specialists—are facing reduced fee schedules. PROMETHEUS can relieve this pressure by tying bonus opportunities to PAC reductions and compensating physicians for the quality of care they collectively deliver, not the number of tests or procedures they perform. For these reasons, providers may also want to drill down into the details behind PACs and examine the top drivers of PACs within their patient populations.

5C) Explaining technical requirements to providers and payers

Generally, providers should have robust clinical information systems that provide “acceptable” EMRs. However, if the pilot focuses on a discrete ECR (such as diabetes), providers can organize a part of their practices to manage those patients without a significant investment in infrastructure or technology.

What constitutes “acceptable” records? The simple answer is that provider’s system should be recognized by the Bridges to Excellence (BTE) Physician Office Systems program. BTE, like PROMETHEUS, is part of HCI3.

This BTE Physician Office Systems program is designed to recognize practices that use information systems to enhance the quality of patient care. To obtain recognition, practices must demonstrate that they have implemented systematic office processes to reduce errors and increase quality. For example, this requires maintaining patient registries to identify and follow up with at-risk patients.
Another criterion is using electronic systems to maintain patient records, enter orders for prescriptions and lab tests and provide patient reminders. Ideally, a practice’s electronic systems should interconnect with other systems, use nationally accepted medical code sets and be able to integrate data such as lab results and medical histories from other organizations’ systems.

Providers must also make sure they have (or can obtain) the resources to improve care based on the scorecard results. For instance, this could involve a quality improvement department, infection control team, disease management program, or case management models. Improvements could be accomplished through enhanced processes and systems, patient care checklists, better population management and outreach and other means.

As for payers, they must have a certain level of cleanliness and accuracy in their data for the pilot to succeed, and high quality claims data at the member level is essential. (This was explained in detail in Section 3.) See data specifications here.

Remember, it is not necessary to contact HCI3 to launch your pilot implementation, although the PROMETHEUS team always available to provide advice and support.
Based on your initial data analysis, if you decide that proceeding with PROMETHEUS Payment makes sense for your organization, you can decide which ECRs to focus your pilot on.

6A) Four questions to answer before choosing your ECRs

The selection of ECRs is entirely up to the pilot site partners. The answers to these key questions will help you make an informed decision.

- Does the ECR represent a potential cost savings opportunity?
- Is this condition/procedure the best place to focus quality improvement efforts?
- Are quality improvement efforts already occurring around this condition or procedure—and, if so, how can those efforts be leveraged?
- Is this ECR consistent with our mission (such as becoming a destination center for a certain procedure, or becoming known for providing excellent chronic care management)?

Depending on your answers to these questions, the choice of ECRs for you to select should be clear.

6B) Choose your Care Recognition Programs

In addition to choosing your ECRs, you will need to select one or more of the Care Recognition Programs offered by BTE. The BTE Care Recognition Programs are designed to correspond with the various ECRs, and provide a mechanism to evaluate provider performance based on the clinical data they submit. (These programs underlie the provider scorecards discussed in the previous section.)

The BTE Care Recognition Programs include the following:

- Asthma Care
- Cardiac Care
- Cardiology Practice Recognition
- Congestive Heart Failure Care
- COPD Care
- Coronary Artery Disease Care

Provider incentives must be proportional to the effort required to earn them. If they are too low, it will diminish your chance of success. Incentives also work best if they are designed to increase over time, so doctors who continually improve their practices are rewarded in kind. The better they get, the more incentives they deserve—and the more patients should be encouraged to utilize them. Quality is a constant process, and the incentives must reflect that.
The specifications of each BTE Care Recognition Program should be carefully reviewed with the pilot site before the programs are selected. These specifications can be found in the Policies and Procedures manuals. (As discussed in Section 5, BTE also offers a Physician Office Systems recognition program, which lays out the criteria provider EMR systems must satisfy.)

BTE Recognition programs measure the quality of care delivered in physician practices, with a special emphasis on managing patients with chronic conditions, who are most at risk of incurring PACs. The programs are based on nationally recognized measures by organizations such as National Committee for Quality Assurance (NCQA) and the American Board of Internal Medicine. They are designed to reward providers who meet certain performance measures, based on care provided to a sample of individual patients and documented in the medical records of those patients. Clinicians and practices get a complete report on their measures from the clinical data submitted, with benchmarks on performance and peer comparisons.

6C) Creating an ECR Amendment and Building Consensus

Once the scope of the pilot is agreed upon, agreements must be made regarding which ECRs and measures will be implemented, and which providers, provider specialties and health systems to engage. These should all be spelled out in what is called an “ECR Amendment”—an addendum to current provider contracts that sets forth the terms and conditions by which the pilot partners agree to proceed.

The contract must specify the ECRs chosen for the pilot, the risk-sharing arrangement, the size of the PAC allowance built into the prospective budgets and the criteria upon which financial rewards are based (such as PAC reductions or minimum quality thresholds). In most sites, incentives are offered to providers and health systems in the form of bonuses. These are typically paid at the end of the year to those clinicians who come under their ECR PAC budgets by delivering quality care to patients.

To use one very simple example: let’s say you decide on a PAC allowance of 100 percent for a CHF ECR, with a PAC reduction rate goal of 6 percent. If the participating providers reduce PACs in a given CHF episode by 6 percent, they are collectively eligible to receive that entire PAC allowance as bonus payments, with the distributed amounts based on each provider’s level of participation in that episode.
Health plans using the PROMETHEUS Payment ECRs to contract with providers are faced with a number of unique issues. This section briefly discusses these issues and provides some suggestions for addressing them.

7A) Role of the Health Plan

The first issue to address is the role of the health plan in contracting for ECRs. Health plans may contract with existing provider organizations that decide to accept financial risk for complete ECRs or the plan may serve as a “virtual integrator” for providers not otherwise affiliated with each other but willing to participate together for ECR reimbursement.

Whether or not a health plan chooses to serve as a virtual integrator depends on the availability and willingness of existing provider organizations to accept the financial and clinical risk associated with ECRs and the resources of the plan to undertake the development of “virtual” provider organizations.

7B) Contracting with Existing Provider Organizations

Many types of provider organizations may desire to contract with a health plan for ECRs including Accountable Care Organizations (ACOs), Physician Organizations (POs), Integrated Delivery Systems (IDSs) or Physician Hospital Organizations (PHOs).

Before contracting with a health plan, these organizations, similar to the health plan, have likely conducted an analysis or assessment of opportunities for clinical and financial improvement utilizing ECRs—an ECR analysis or opportunity assessment. Ideally, the ECRs the health plan and provider organization would like to contract for overlap.

Once the plan and provider organization have agreed on a set of ECRs, they must negotiate and agree on the terms for pricing and administering the ECR contracts. Often plans and providers will develop pilot programs whereby they will “operate” the contracts for a specified pilot term (perhaps one-year) while limiting downside or upside risk to each other while they work out administrative and methodological issues associated with entering into contracts using the new payment units.
7C) Prospective or Retrospective Payment?

A fundamental question in contracting for an ECR with an existing provider organization is whether to make ECR payments prospectively or retrospectively.

Episode of care or ECR contracting have long been seen as a potentially effective way to transfer manageable financial risk to providers through a single (global) case rate. This “technical” or “performance” risk transfer enables a provider organization to recognize the financial reward for delivering a complete case for less than the negotiated price.

A common perception is that bundling payment along an episode of care requires calculating the total case fee or payment in advance and paying the total fee upfront or prospectively to the “integrated” provider. This allows the provider organization in turn to distribute the funds internally. While this prospective payment scenario may be ideal, there are a number of challenges associated with this approach.

7D) Digging deeper

As mentioned, health plans using the PROMETHEUS Payment ECRs to contract with providers are faced with a number of unique and very complex issues. We strongly suggest those in this situation read the in-depth reports from PROMETHEUS Evidence-informed Case Rate (ECR) Contracting Strategies and Guidelines for Health Plans on prospective and retrospective payment for more information and background.
After laying the groundwork for the PROMETHEUS Payment pilot in your organization—and developing a strong consensus to support it—you are now ready to launch your pilot site and begin work.

8A) Physicians will submit their clinical data

To get the pilot underway, clinicians will submit clinical data to a third party, such as a data intermediary or one of PROMETHEUS’ partner Performance Assessment Organizations (PAO) for scoring. Depending on the areas you wish to focus on, you may have several options available for submission. Providers must submit data from their medical records for performance assessment via an EMR or registry capable of collecting and reporting clinical data in a format suitable for the implementation, as outlined by the Policy and Procedures documents.

There are multiple paths available to clinicians, depending on the specific ECR. For example, clinicians or practices may submit data on outcome and process measures to NCQA for assessment. Those connected to an approved data aggregator (e.g., EMR vendor, Patient Registry vendor, Health Information Exchange) may have their data submitted on their behalf to an independent PAO for an automated evaluation. Clinicians or practices may also submit their data directly to IPRO through its Clinical Data Portal.

8B) Health Plans plug into the ECR Engine

Health Plans will plug into the PROMETHEUS ECR Engine, a claims tracking/financial accounting system. It combines all data elements into one system, allowing payers and providers to price, reimburse and track ECR-related claims.

The engine-specific processing is separated into Filter, Navigator and Accumulator modules:

- The Filter determines if a claim is part of an ECR.
- The Navigator steers claims to the appropriate decision categories, such as Exclude, Conclude, Terminate, PAC, or Typical.
- The Accumulator places claims into separate Typical and PAC buckets and calculates the dollars associated with each bucket to perform the reconciliation process for the financial analysis.

Upon the conclusion of running an ECR for your data, each ECR will produce an output report. This will tally actual costs and compare them to predicted costs for payment purposes.
Payers and providers will not have to modify their existing claims systems to accommodate implementation of the model. The Engine will work in the background tracking the ECRs and keeping payers and providers informed. Through ongoing data analysis, you can compare your performance to established industry baselines and make continuous quality and cost efficiency improvements.

**8C) Payments are distributed**

Payments are based on the negotiated contracts between providers and payers as well as a basket of quality measures embedded in the PROMETHEUS Payment scorecard.

During the pilot, providers and payers will bill and reimburse claims as they currently do via the fee-for-service system. Historical claims data allows for the accumulation of risk factors to build and provide severity-adjustment information to construct ECR budgets on a per patient basis.

PROMETHEUS prospectively *budgets* but does not prospectively *pay* episodes. In other words, the ECR budget is compared to the actual spending for that particular ECR. If all providers who manage the patient are able to do so within the ECR budget, they are potentially eligible for a bonus at the end of the year. The portion of the bonus depends on two factors: their quality score and their level of involvement in the episode.
Thank you for your interest in the PROMETHEUS payment model. If you choose to move forward, we wish you the best of luck with your pilot.

At the very least, we hope a PROMETHEUS pilot will generate critical information to spur continuous, measurable improvements in your organization. At best, we hope it provides the framework for a transition to a payment system that provides greater value and improved patient outcomes for your organization—and maybe one day across the entire health care system.

Again, it is not necessary to contact HCI3 to implement the model, but the PROMETHEUS team stands ready to provide the advice and support you need at any time. Even though PROMETHEUS is designed to help rein in costs, funding your pilot may be an issue in this era of tight budgets. If so, you might be eligible to receive financial support during your implementation. Contact HCI3 for details.

For additional information on any of the topics covered in this toolkit, please review the many tools and resources listed in each section, or visit www.prometheuspayment.org.