Health Policy, Health Reform, and Performance Improvement

Evidence-Informed Case Rates: A New Health Care Payment Model

April 17, 2007 | Volume 57

Authors: François de Brantes, M.S., M.B.A., and Joseph A. Camillus, M.B.A., M.P.H.
Editor(s): Deborah Lorber

Overview

As a way to address the flaws of traditional payment methods, like fee-for-service and capitation, the authors of this report suggest a new payment model, based on evidence-informed case rates (ECRs). Under this system, providers are paid a single, risk-adjusted payment across inpatient and outpatient settings to care for a patient diagnosed with a specific condition. Working with experts in the health care field, the authors selected 10 conditions for ECR development, examining issues like diagnosis, services covered by the ECR, and criteria for successful completion of care. This new model, say the authors, can improve health care quality, lower administrative burden, enhance transparency, and support a patient-centered, consumer-driven environment. To further promote quality care, the ECR model calls for a portion of the payment to be withheld and re-distributed based on provider performance on measures of clinical process, outcomes of care, and patient experiences.

Executive Summary

The flaws of the traditional fee-for-service and capitation systems are well known. The former—which involves separate payments for each service—has been closely associated with the rapid rise of health insurance premiums, while the latter—which provides a flat fee per patient—can put providers at risk by providing insufficient funds to cover the cost of services rendered. In the United States, both systems have failed to promote coordination among providers or high-quality outcomes for patients.

A new payment model, based on evidence-informed case rates (ECRs), attempts to address these failings. An ECR is a single, risk-adjusted, prospective (or retrospective) payment given to providers across inpatient and outpatient settings to care for a patient diagnosed with a specific condition. Payment amounts are based on the resources required to provide care as recommended in well-accepted clinical guidelines. The ECR model was developed by Prometheus Payment, a nonprofit corporation focused on developing a new health care payment model designed to improve health care quality, lower administrative burden, enhance transparency, and support a patient-centered, consumer-driven environment. To further promote quality care, the Prometheus ECR model calls for a portion of the payment to be withheld and re-distributed based on provider performance on measures of clinical process, outcomes of care, and patient experience with care received.

To model ECRs in a way that would be credible, realistic, and accurately reflect the clinical delivery of care, Prometheus gathered experts in the field and convened

five working groups, consisting of medical professionals, health care researchers, and data modeling experts. The working groups selected 10 conditions for ECR development, looking at criteria like prevalence, costs, treatment variation, coordination, and reimbursement, among others. Then, they developed the scope of each ECR, by examining issues like the standard work-up required to diagnose the condition, the services covered by the ECR, and criteria for successful completion of care.

To develop an estimate of the base ECR payment, the groups walked a typical patient step-by-step through the relevant clinical practice guidelines, using the following four questions to match costs with guidelines:

1. What are the actual resources (e.g., equipment, facilities, supplies) used to provide the recommended care?
2. Who is most likely to use those resources?
3. Where might this care happen most often?
4. How long will it take (using surrogates of evaluation and management visits for time)?

Table ES-1. Visits Required to Treat Stage III Colorectal Cancer

Activity	Frequency*	Person
Colonoscopy	1	Gastroenterologist and primary care provider counseling on need for colonoscopy
Visit to review biopsy	1	Gastroenterologist
Appointment regarding surgery	1	Surgeon
Hospital stay and surgery	3 to 5 days	Surgeon and hospital staff
Review data for stage III disease	1	Medical oncologist
Visit social worker	1	Social worker
Visit chemo nurse for teaching	1	Chemotherapy nurse
Decide on drug therapy	1	Medical oncologist
Lab for pre-chemo CBC, CMP, liver, CEA	1	Lab

Meet with clinical trial staff regarding protocol	1	Trial staff
Chemotherapy and follow-up visit every two weeks	24	Medical oncologist, chemo nurse
Potential problems: nausea, diarrhea, fever, etc.	3	Medical oncologist, nurse
One month post therapy: review drug therapy and survivorship likelihood	1	Medical oncologist
Follow-up visit every 3 months	4	Medical oncologist
Disease and case management	Ongoing	Medical oncologist and/or primary care provider

*Frequency refers to visits unless bed days are specified for hospital stays.
Source: Authors' analysis.

For each condition, the working groups also identified a set of common complications that will change the services required. Future data modeling efforts will determine how the identified complications change the total cost of care. As complications develop, both the scorecard and the price paid for services rendered will change accordingly.

An essential component of the ECR is the performance withhold. Provider performance will be tracked using two methods: 1) the Prometheus scorecard, which is currently being designed, will include measures of care process, outcomes, and patient experience and 2) normal claims activity. Tracking claims can play an important a role in assessing provider performance—as much as the scorecard—because appropriate performance on a condition can potentially only be known by looking at what services were delivered (or not delivered) to the patient. For example, measuring the right care for back pain is effectively accomplished by using claims data to identify services that should (and, more important, should not) have been provided. Conversely, depression typically has very few encounters, which provide limited detail on whether the patient's status has changed. In this case, a patient's status using a standardized clinical assessment tool is necessary.

Next steps in developing and implementing ECRs include data modeling activities; determining which conditions merit development of new ECRs, based on availability of guidelines and potential impact on the payment system; and determining how best to keep ECRs updated as clinical guidelines change. In 2007, Prometheus will select up to four pilot sites and work with local stakeholders to prepare each site for implementation. Current candidates include Brockton, Mass.; Chicago; Memphis, Tenn.; Philadelphia; and San Francisco. Prometheus also expects to develop an additional 50 to 60 ECRs during the next three years to increase the scope of the pilots and cover an increasing portion of the total care delivered in any community.

Citation

F. de Brantes and J. A. Camillus, Evidence-Informed Case Rates: A New Health Care Payment Model, The Commonwealth Fund, April 2007

The Commonwealth Fund 1 East 75th Street, New York, NY 10021 Phone: 212.606.3800 Fax: 212.606.3500 E-mail: cmwf@cmwf.org