



PROMETHEUS: New Payment System, New Keys to Success

By Alice G. Gosfield

Criticism of the predominate payment systems in the United States is rampant. From the Institute of Medicine's call for payment reform in order to improve quality, to physician dissatisfaction with administrative burdens, to employer concerns about escalating costs, no one is very happy. The advent of pay for performance has been an effort to stimulate at least some aspects of the payment environment to directly improve quality. However, most of these efforts have been regarded as transitional at best.

The dissatisfactions with payment do not come only from providers. The consumer driven healthcare model, increasingly favored by health plans and employers, is one that emphasizes transparency and consumer choice based upon pricing. To date, there has been little available to satisfy any of these concerns. The challenge of change has seemed insurmountably daunting. Yet, there is general agreement that without some innovation in payment, the ultimate goal of improved quality results will languish.

Beginning in December 2004, a group of experts in quality, research, economics, healthcare financing, law, and medicine came together to tackle these issues. The result is PROMETHEUS Payment—Provider payment Reform for Outcomes Margins Evidence Transparency Hassle-reduction Excellence Understandability and Sustainability.¹ This proposal, which is not intended to supplant all of the current payment system, but rather to substitute for it where appropriate, is intended to (1) improve quality, (2) lower administrative burden, (3) enhance

transparency, and (4) support a patient-centric and consumer-driven environment. This article describes how PROMETHEUS payment works, the skills and knowledge required to succeed within it, and how it might change internal audit activities.

PROMETHEUS

The essence of PROMETHEUS Payment is that it models a price to deliver a full continuum of services as called for in a good Clinical Practice Guideline (CPG) for a condition. Determining all of the resources that science tells us ought to be brought to bear to treat a patient for a specific condition, an Evidence-based Case Rate (ECR) is established, condition-by-condition. The overall case rate incorporates the care of all the providers that will interact with the patient for that condition—physicians, hospitals, rehabilitation providers, pharmacies, laboratories, and more. Providers who seek this type of payment will negotiate a price for that portion of the CPG services they will render.

The primary mode of PROMETHEUS payment is prospective, with a pro rata monthly portion of the negotiated segment of the ECR paid for the duration of the time of care incorporated in the ECR. (It is possible to use the PROMETHEUS mechanisms in a fee for service environment with an after the fact reconciliation against the targeted case rate. That option is available for physicians who do not want prospective payment.) For chronic care, the duration of the rate might be a year, but for certain orthopedic therapies, for example, it might be four months. ECRs will be risk

adjusted to reflect co-morbid conditions that typically arise, with additive payments for the increased complexity of care. At some point, though, the ECR will be "broken" because the services are no longer oriented around the original clinical condition. For example, if a patient who has diabetes develops coronary artery disease and hypertension and then hyperlipidemia, each of those factors would represent an increased risk with additional payment. If the patient later has a heart attack, the ECR would be broken because the principal care is no longer the treatment of the chronic diabetes. Payment for care outside an ECR follows traditional models.

For chronic conditions, 10 percent of the total payment and for acute conditions, 20 percent will be held back in a provider Performance Contingency Fund as a hedge to determine whether the provider delivered what it bargained to render to the patient. This assessment will be made on the basis of a Comprehensive Scorecard that takes into account whether the salient features of the CPG were delivered, the patient's experience of care, the outcomes of care, and, in non-integrated delivery settings, the efficiency of the care. Seventy percent of a provider's score turns on what that provider does itself, but 30 percent of the score turns on the performance of the other providers also treating the patient. By this mechanism, providers are encouraged to do their own work well and also to select the clinicians and facilities to which they refer based on their ability to perform successfully, too. This drives toward explicit clinical collaboration.

¹ To review a full exposition of the model see: "PROMETHEUS: Provider Payment for High Quality Care," (May 2006), www.prometheuspayers.org.

Half the Contingency Fund is allocated to quality and half is allocated to efficiency. After meeting a minimum threshold, quality payments are made pro-rata from the 10 percent or 20 percent holdback. Where a provider delivers most of the elements of the CPG but not all, or delivers all the elements of the CPG but the patient is dissatisfied with the experience in some way, the requisite quality portion of the Performance Contingency Fund will be paid to reflect the results in the Scorecard. Remainder amounts that are not fully paid for quality will be available to establish an additional bonus pool for those providers whose performance is most exemplary. They will receive additional money beyond their full portion of the ECR.

There is no efficiency payment to a provider from the Contingency Funds if that provider has not met the quality payment threshold. Efficiency is measured both by the extent to which the expense of the provider's services remains within the ECR limits, and also the extent to which the expenses of the other providers to whom he refers remain within the ECR limits. Excess revenues not paid as efficiency bonuses are retained by the plan because the plan incurs additional expenses when providers are not efficient.

Because the impact of the Scorecard reflects the behavior of all the providers, groups of providers might choose to bid together to work together clinically. Integrated delivery systems might negotiate to deliver the full continuum of care. Stand-alone hospitals could bargain to render in-patient care only, or they could join with physicians or other downstream providers to negotiate together to deliver a broader continuum of services. Primary care physicians might choose to bid with their consultants or with other downstream providers like physical therapy clinics or pathology laboratories; or physicians of the same specialty who are not financially integrated might bid to be paid the same way for the same portion of the CPG.

Even with collaborative bidding, under no circumstances does anyone hold the payments for another entity unless the parties choose to be paid that way. There is no requirement that providers financially integrate, accept insurance risk, or create other complex reorganization of the delivery system. The model is designed to be implemented

within current organizational structures. It is documented in simple contract amendments to existing provider agreements.

Transparency is a bedrock principle of PROMETHEUS Payment—transparency of pricing, scores, CPGs, and all the payment rules. Providers will be given actionable reports as they deliver care, so they know how well they are doing with regard to their bargained-for rates. In addition, to make the collaboration among independent providers meaningful, providers will not be scored on the performance of their downstream referral providers (and potentially upstream relationships) until there is sufficient data accumulated to provide them with reports about the performance of the entities to which they would refer.

Potential Benefits

Because the payment is based primarily on the cost of what science tells us is the right way to deliver care for a condition, the mechanism is far more clinically relevant than fee for service, per diems, DRGs, capitation, contact capitation, or any other preexisting model of which the design team is aware. The model offers certainty in the payment amount both to payers and providers. Prices, the negotiated ECR portion, can be shared with consumers who are choosing their providers. Providers who standardize their processes and know what it costs to treat patients for a condition will do well under PROMETHEUS.

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PROMETHEUS Payment should reduce administrative burden from the outset. It eliminates the need for (1) prior authorizations for admissions or high-cost services, (2) concurrent review; (3) post payment claims audits, and potentially (4) even drug formularies. The CPGs incorporate all of these issues and the Scorecard measures whether the CPG was provided. PROMETHEUS Payment can be expected to reduce malpractice liability for participating providers since liability always turns on whether the provider rendered the standard of care. Here, payment is based on explicitly

delivering the standard of care. For hospitals, the Scorecard might well include patient safety concerns such as whether the six planks of "The 100,000 Lives Campaign" are in place at the facility. While the advent of "The 100,000 Lives Campaign" has raised the stakes on malpractice liability for hospitals, PROMETHEUS is another enhancement to patient safety, which can contribute to preventing needless deaths.

PROMETHEUS fosters clinical integration in antitrust terms among providers, including between hospitals and physicians. It tracks directly to the values set forth in "Crossing the Quality Chasm," that care should be safe, timely, efficient, effective, equitable, and patient centered. In the last analysis, this model gives providers significant freedom to exercise clinical judgment and operational efficiency to provide evidence-based care.

Implementation

While the basic concept, paying for what science says is the cost of delivering excellent care for a condition, is simple, the infrastructure to make this program work is complex. There will have to be an "engine" to drive essential features including (1) an ECR Translator to construct payment amounts from a CPG, (2) an ECR Budget Estimator to establish the overall payment amount, (3) an ECR Tracker to take data from encounter reports and allocate it to the appropriate providers in accordance with the pieces of the CPG they are delivering, (4) an ECR Reporter to inform providers along the way and to determine how much should be paid at the end of the case rate, and (5) the Comprehensive Scorecard.

To make implementation as close to "plug and play" as possible for health plans, the engine will be developed by independent certified vendors who can claim to be offering the PROMETHEUS brand of infrastructure. Data management will go on at service bureaus that are independent of the health plans, which pay claims. An outside vendor has been engaged to create the core elements of the engine by the end of 2006. Pilot markets will launch in the first quarter of 2007. The initial pilots will be oriented around five general categories of clinical conditions: cancer, chronic care, cardiology, preventive care, and orthopedics. Working groups of practicing clinicians with methodology experts and medical advisory specialty committees to provide input have been created around each of these conditions.

Keys to Success

To effectively negotiate a good payment rate around science-based delivery of care, the most critical information needed is what it costs a hospital or other provider to render that care. Traditionally, this is not where hospitals and most providers have excelled. The performance of regular or at least periodic internal audits to substantiate these costs will be an important success factor for providers. Efficiencies of care through standardized clinical and administrative processes, proper flow of patients, avoidance of errors, and good patient care experience will enhance scores and therefore payment amounts. Here again the performance of regularly scheduled operational internal audits will be of significant importance. Since PROMETHEUS explicitly contemplates negotiations between providers and plans, hospital clarity regarding true costs of quality care will be vital.

The scoring that reflects the performance of other providers treating the patient, makes real the value in close clinical collaboration among providers. This will be true for hospitals and their physicians. The need to find better ways for each to help the other with their business case is an ongoing imperative. PROMETHEUS Payment offers an opportunity to work across the continuum of care from office to hospital and beyond, based on common clinical goals. Success in collaboration will produce better payment and financial margins while avoiding the pitfalls of the many failed physician hospital organizations of the 1990s.

Auditors focusing on financial performance and compliance will face new challenges in PROMETHEUS. The

most critical issue on which auditor input is invaluable is what it costs a provider, literally, to deliver CPG-based care for a specific condition. In addition, the design team expects a variety of techniques could be used to 'game' the system. On one hand, providers might claim diagnoses the patient does not have in order to trigger an ECR or generate risk adjustment add-ons. On the other hand, they might also claim that patient preference or contraindications to the care in the CPG motivates them not to follow the CPG. Whether claims are legitimate will turn on what is documented in the medical record.

On the other hand, most of the key data functions, which generate payment, are conducted by independent service bureaus that do not pay claims. Monitoring the data which (1) triggers the ECR, (2) determines which provider has rendered which portion of the ECR, (3) allows risk adjusters to be added to the base payment; (4) breaks the ECR, or (5) means the ECR is concluded will be other places in the process where careful auditor attention will be important. Still further, the intersection of the service bureaus that generate data on which payment is made with the plans, which actually pay claims, will also be a potential point for audit.

Because the model is intended to motivate changed behavior, providers and plans both will have to create some new internal processes to meet the demands of PROMETHEUS. But even at its widest implementation, PROMETHEUS Payment likely only

makes sense for about 75 percent of health care delivery. The rest of the payment system will still apply for the rest of care, so parallel audit paths will likely emerge, but they will focus on very different issues.

Conclusion

PROMETHEUS Payment offers the opportunity for providers to be paid fairly for the best science we have available to meet patient needs with respect to a large portion of America's health care expenditures. Implementation will be incremental and careful.

An enormous amount will be learned from the PROMETHEUS Payment pilot projects. To make PROMETHEUS real will depend on the willing commitment of well-motivated plans and providers to try something new and unproven. As a practical matter, though, the values, skills, and techniques that will determine success under PROMETHEUS are those, which will create better quality, more efficient care anyway. PROMETHEUS offers the potential for the right payment to do the right thing. **NP**

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Providers receive payment for rendering best science available.

Additional Resources

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