

PROMETHEUS Payment: Better for Patients, Better for Physicians

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Although pay for performance is a positive development in the history of quality improvement in this country, it is generally accepted that most pay-for-performance programs do not offer a sustainable business model. PROMETHEUS Payment is a new approach to provider payment that is predicated on paying for the resources to be brought to bear to treat a patient for a condition in accordance with good clinical practice guidelines.

It is explicitly designed to reduce the administrative burden on physicians in favor of improved care coordination and collaboration among providers without requiring them to financially integrate or take insurance risk.

Key words: Clinical practice guidelines; administrative burden; transparency; negotiation; clinical integration; efficiency; payment; quality.

Dissatisfaction with current payment systems has been voiced by all quarters of healthcare, and for good reason. Although quality of care demonstrably lags ideal levels,¹ the physician payment system, in particular, is a real barrier to optimal quality results and steals time from the doctor-patient relationship.² Saddled with irrelevant administrative burdens, absurd coding conventions, idiosyncratic bundling rules, black box payment policies, and more, it is no wonder physicians believe they are not paid the right amount to do the right thing for patients. Pay-for-performance programs are a good first step, but are generally believed to be only transitional at best.^{3,4}

What is necessary for real improvement in both the amount paid and what it takes to get that money is a new payment system with specific goals to: (1) improve quality; (2) reduce administrative burden; (3) enhance transparency; and (4) support a patient-centric and consumer-driven environment, all while facilitating better clinical coordination throughout healthcare. Daunting as that may seem, beginning in December 2004, a group of experts in quality, research, economics, healthcare financing, law, and medicine came together to tackle this challenge. The result is PROMETHEUS Payment—Provider payment Reform for

Outcomes Margins Evidence Transparency Hassle-reduction Excellence Understandability and Sustainability.⁵

WHAT IT IS

PROMETHEUS payment is designed to pay what it costs providers to deliver what science says is appropriate care for the patient with a specified condition. From a clinical practice guideline (CPG), an evidence-based case rate (ECR) is constructed to take into account all of the care by all the providers who will interact with the patient for that condition. The physician practice bargains for that part of the CPG that it can and wants to deliver. As the patient develops comorbidities—a diabetic patient develops hypertension, congestive heart failure, and atherosclerosis—the base rate of payment is increased by risk adjusters to account for the additional services that will be necessary. Payment is made at the rate of 90 percent of the practice's bargained-for rate for chronic care and 80 percent of the full amount for acute care. The rest is held in a performance contingency fund that is later paid in accordance with the results of a comprehensive scorecard.

The scorecard takes into account whether the salient elements of the CPG were delivered, the clinical and financial outcomes of care, and the patient's experience of the care. Seventy percent of the score reflects the provider's own performance. Thirty percent of the score,

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though, includes the performance of the other providers treating the patient. This explicitly encourages otherwise-independent providers to work together clinically. Clinical collaboration can improve financial results. The scores are reported at the level of the contracting entity. This might be a solo practitioner, a single group practice, one hospital, or a fully integrated delivery system.

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From the performance contingency fund, one-half of the monies are paid for quality performance, and one-half are allocated to efficiency. First, the provider must meet a quality threshold to get the quality payment. Then these monies are paid pro rata in accordance with the scores for quality. Because it is likely that all providers will not score 100 percent, there will be quality fund remainders. These monies are pooled into another fund that is available to pay additional bonuses to really stellar performers.

The efficiency component will not be paid to a provider who does not meet the quality threshold. Then the efficiency component is applied only outside of a fully integrated system, which takes its own inherent risk for efficiency. These monies are also paid pro rata but because the total ECR determines the total available payments, providers earn both for their own good scores as well as for the efficiency of others treating the patient. On the other hand, efficiency fund remainders are not paid to the providers because, by definition, the plan incurs expenses for inefficient care delivery.

Some might be concerned that if the amount paid starts at 80 percent or 90 percent of the cost to deliver the full scope of the bargained-for care, then the practice is at risk to lose money when the scores are calculated. This is not true, however, because if the reason the provider's scores are not 100 percent is because services are not provided that should have been, then the practice did not incur the expense of providing those services and lost nothing.

WHAT MAKES IT DIFFERENT

Unlike capitation, PROMETHEUS does not pay one amount for all patients. It accounts explicitly for the cost of the services necessary to treat a specific patient for his or her condition and its complexity. By basing payment on the services that are included in CPGs, PROMETHEUS is unlike prior case-rate models, which, at best, have turned on hospital cost-accounting or historical charge patterns, neither of which has anything to do with what patients need clinically.

PROMETHEUS does not expose physicians to insurance risk, but only financial risk for their ability to manage clinical care effectively, efficiently, and in a way that maximizes the patient's satisfaction with the experience of care. These are legitimate measures of physician performance because they reflect matters in the control of the physician practice.

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Transparency is the bedrock of PROMETHEUS payment. There are no black boxes. The CPGs, ECRs, provider scores, and payment rules—when an ECR begins, how it is risk adjusted, when it ends, and what “breaks” it—are known by all participants. Still further, no one holds the money of any other participant unless that participant chooses to be paid that way. Although there is a benefit in independent providers working together to deliver care, even if they bid together they can be paid separately.

The program is flexible. It can work for a wide range of providers—hospitals, home health agencies, physicians, pharmacies, physical therapy providers, durable medical equipment suppliers, and more. It can accommodate all levels of physician aggregations from solo practitioners to the largest multi-specialty groups. The payment is focused around what the provider wants to deliver of the ECR and the clinical needs of the patient.

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Finally, PROMETHEUS explicitly contemplates voluntary participation and provider negotiation with the plan regarding the price for the portion of the ECR to be delivered. In this model, there is no “take it or leave it” contracting, pricing, and negotiation.

POTENTIAL BENEFITS

One of the primary benefits for the physician practice will be administrative burden reduction. The use of CPGs as the basis for payment eliminates the need for prior authorizations, concurrent review, certificates of medical necessity, and all forms of documentation of medical necessity for patients whose care is paid for under PROMETHEUS. Although a 1500 claim form is submitted to track which provider is delivering which components of the full CPG, the need to document the medical necessity of those services is no longer necessary. Not only that, but because payment occurs outside of the plan's normal claims processing mechanisms, payment will be faster and more certain. Still further, the critical

data management aspects of the program—when an ECR is triggered, who provides what care within the ECR, reports to providers that track performance along the way, and the calculation and reporting of the scores—are all conducted by independent service bureaus, not the plans that pay the claims. This makes that process more credible and likely faster than if the plans did it themselves.

Because the scorecard is the mechanism that determines whether the physicians provided what they bargained to deliver, there is no need for post-payment claims review and therefore no need for the documentation that physicians have to create solely to satisfy post-payment auditors. Prime among these is the documentation of evaluation and management (E&M) bullet points. PROMETHEUS payment is indifferent to the level of visit that was provided. The practice bargains for how it expects to deliver the CPG and is responsible on its own to ask for the payment that will cover its care. Some may choose to continue to document E&M bullet points rather than have different documentation approaches for patients of different payors, but that is the practices' choice, and such documentation is not necessary under PROMETHEUS payment.

PROMETHEUS is intended to permit practices considerable autonomy in how they deliver the care in the CPG. Whether the practice uses physician extenders, e-mail interchanges with patients, open-access scheduling, group visits, or any other approach to rendering care is irrelevant to the payment model. PROMETHEUS payment is indifferent to the use of nurse practitioners or physicians to take a history, give a drug, perform a test, supervise a test, or perform any other aspect of care delivery as long as it complies with state law. As a result, it is expected that a practice has a better incentive to focus on efficiency of care delivery and improving its own margins while its primary goal is to provide the patient with safe, timely, effective, efficient, equitable, and patient-centered care on which it will be measured.

Because all the providers treating a patient are included in the scores that drive final payment, PROMETHEUS also encourages clinical integration and collaboration, without requiring new organizational or legal structures for providers to work together. Providers can come together in whatever combinations make sense for them. Hospitals and physicians might bid together to treat a condition, like hip replacement, without running the risk of getting mired in the payment morasses of all the failed physician-hospital organizations of the late 1990s. With PROMETHEUS, both will do better if they collaborate in delivering care both for quality and efficiency. In addition, the values of PROMETHEUS are such that the program can further motivate hospitals and physicians to work together in more creative ways in common cause for improved quality.⁶

Primary care physicians and their consultants might work together and bid together, understanding clearly

which cases are appropriately retained by the primaries and which are better referred to the consultants. Physicians can join with other ancillary providers, if it makes sense to do so. For example, orthopaedists might join with physical therapists who are not part of their practice, and cardiologists might join with home health agencies to deliver care.

Even physicians of the same specialty—like oncologists or rheumatologists—who might come together to standardize their care get economies of scale in buying electronic health records, benchmark themselves, monitor their activities to improve, and otherwise meet the standards for clinical integration under the antitrust rules.⁷ They could bid to be paid the same way. This means that solo practitioners, who might be fearful of managing in this kind of setting, can join with like-minded clinicians to help each other do better in quality terms that will translate into doing better in financial terms. Or solo practitioners might clinically integrate with larger groups without having to sell or merge.

THE TWO WAYS TO BE PAID: PROS AND CONS

Some might think that PROMETHEUS payment is designed for big integrated entities. From the pilot projects, we may well learn whether the integrated systems in fact do better in this type of model or whether their own self-imposed bureaucracies do not serve them as well as might be imagined. But PROMETHEUS is not designed only for them. It is designed to motivate clinical collaboration regardless of practice form. Because the scorecard takes into account all providers, it does create a kind of virtual integration, even when providers do not explicitly collaborate.

The primary mode for provider payment is a monthly portion of the 80 percent or 90 percent of the provider's negotiated price, with the rest paid in accordance with the scores. Some physician groups might be fearful to take payment in this manner; so PROMETHEUS does offer the option of being paid fee for service, with a reconciliation at the end to see if the quality and efficiency portions of the ECR price can be paid. There are pros and cons to the modes of payment. Both offer the same clinical incentives and the same opportunity to be paid the full bargained-for portion of the ECR.

That said, virtually the only benefits to the fee-for-service payment as opposed to prospective payment is the familiarity with the payment approach and the fact that it will not disrupt the administrative processes of the office. It does, however, carry with it all the traditional problems of traditional claims payment—lost claims, questioned claims, delayed payment, and the need to document to support the claims. In addition, the fees are reduced by

10 percent or 20 percent for the performance contingency funds, so cash flow is uneven.

By taking PROMETHEUS payment at a fixed monthly rate, the payment will be quicker because there is no claims processing. There is more even cash flow month to month. There are no claims to be filed, nor documentation required for them because all of that is handled in the CPG itself and the scorecard. On the other hand, the real requirements of implementation are unknown. This is part of the realism that will be necessary in making PROMETHEUS work.

BEING REALISTIC

In the design of this new model, certain tenets were taken as immutable and critical: payment should reflect the cost of delivering what science says is the right thing to do; transparency applies to everything; no one holds the money of anyone else unless that entity chooses to bargain that way; and administrative burden should be reduced as much as possible. Still, though, for the model actually to be implemented it would have to entail some compromises from all quarters in the interests of broad participation by important stakeholders.

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Plans would not adopt PROMETHEUS if it were not easy to deploy. The design team made this as “plug and play” for the plans as possible, but this meant that there could not be major dislocation of existing systems nor new ones required. Therefore, claim forms will be filed, but not for claims payment unless the provider is being paid fee for service. It is the 1500 form that provides the basis to determine who is rendering what care and when the ECR is triggered.

In PROMETHEUS, the critical determinant of payment ought to be literally what it costs the provider to deliver that care. Yet, there is no information available anywhere that accurately reflects what it costs a good physician practice to deliver CPG-based care to a patient for a condition. For that reason, at least initially, payment will have to be based on a calculation that reflects what national claims databases tell us plans currently pay for high-quality care, with an extra margin added on top to reflect perversities in current payment rules and normal clinical variation. Over time, if physicians do this effectively, they should be able to generate data that more accurately speak to this issue. Physician practices ought to move in that direction now.

Transition itself will present challenges because not all payors in a market will shift to PROMETHEUS immediately. Physician practices will continue to have to respond to the old incentives while they struggle to develop new techniques to succeed in the new system. Even in the fullness of time, the complexities of PROMETHEUS are such that it will be appropriate only for about half of care delivery; so the old systems will remain in place no matter what, because PROMETHEUS is not intended as a wholesale substitute for the entire system. And Medicare, although interested in the development of PROMETHEUS, has not adopted this model.

HOW WILL PHYSICIANS SUCCEED

The most critical issue for physician practices will be what it costs to deliver evidence-based care in a CPG. Of course, whether PROMETHEUS is the payment model or not, this is critical information that physician practices have not yet developed; and they should. Collaboration with upstream and downstream providers explicitly for efficiency and quality is also a new challenge; but it, too, ought to be part of a well-functioning practice.

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Focusing on how to improve margins in a fixed-rate-payment environment means that efforts to be more clinically and administratively efficient will translate into improved results. But this also is an aspect of practice management that has gotten short shrift in the struggles around shrinking reimbursement, increasing malpractice premiums, difficulties in recruiting new physicians, and relating to the hospital. All of these practice management challenges will be called into play, but the beauty of PROMETHEUS is that it provides a very clear foundation upon which all of these decisions can be based.⁸

WHY CARE NOW?

Pilot markets will be selected. Five clinical areas will be addressed in the first implementation of PROMETHEUS: cancer; orthopaedics; chronic and preventive care; and interventional cardiology. The critical features of the “engine” that drives the inner workings of PROMETHEUS will be in place before the launch in early 2007. Much will be learned from the contributions of the participating providers and plans; and undoubtedly some of the concepts will have to be refined and adjusted.

For all of the uncertainty, there are no other options available for a meaningful, alternate payment model that will create what providers, plans, payors, and patients

need. The behaviors that PROMETHEUS motivates and rewards are useful and valuable no matter what the payment model. The promise of PROMETHEUS is significant. Savvy practices will adopt the principles that drive it no matter when it arrives at their local theater. ■

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