

PROMETHEUS Payment: Getting Beyond P4P

BY ALICE G. GOSFIELD, J.D.



The failure of existing payment systems to produce optimal quality has been decried far and wide,¹ perhaps most importantly by the Institute of Medicine, calling for a new payment system for the 21st century.² Pay for performance (P4P) programs have emerged over the last few years as one step on that pathway.³ But they are generally regarded as transitional at best and suffer from some inherent limitations.⁴ And then there is the ethical issue of why providers should be paid extra to do what they should anyway.

P4P Limitations

As to structure, most P4P programs are local and oriented

around chronic conditions (e.g., diabetes, asthma, congestive heart failure) to which the American healthcare system has admittedly not devoted much attention. These conditions are not only major financial drains but have become priorities for health policy focus.⁵ But P4P programs that address them are predominantly aimed solely at primary care physicians.

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Although Bridges to Excellence⁶ is a notable exception, the vast

majority of these programs take the class of providers who are playing and tier them comparatively to determine who will get the financial rewards, thereby making it uncertain as to whether any specific group will receive any money, let alone the amount. In addition, very few programs actually are documented in contracts. They are offered on a “take it or leave it” basis. There are significant questions as to whether these programs put new money on the table or simply shuffle the already limited pool from bucket to bucket, disadvantaging some physicians to the betterment of others.

As implemented, there is little quantification of the cost to groups to get this money. Yet, there is no question a group will incur some expenses, whether in staff time to gather and report data, monitor services rendered, and payments received or in additional practice expenses (e.g., drugs, equipment) to achieve the desired improved results. How P4P affects already thin margins is largely unknown.⁷

Two factors, however, most significantly doom the essentially positive development of P4P to a limited shelf-life: (1) If everyone moves up to the raised bar for payment for the current conditions addressed, then what happens? Is new money made available or is the money for the current programs redeployed in favor of other lagging conditions? (2) P4P mostly offers small incremental payments in fundamental payment models which have demonstrated their essential

toxicity to optimal quality. Those systems still impose undue administrative burdens, questionable compensation amounts, inadequate incentives to perform effectively, black boxes, and countless other absurdities which physicians know and lament. Is there another way?

Taking up the IOM's challenge, in December 2004 a group of experts (see sidebar, page 18) in healthcare financing, law, medicine, quality, research, and economics convened to develop a new provider payment model to (1) improve quality, (2) lower administrative burden, (3) enhance transparency, and (4) support a patient-centric environment, all while facilitating better clinical coordination throughout healthcare delivery. The result is PROMETHEUS Payment — Provider payment Reform for Outcomes Margins Evidence Transparency Hassle-reduction Excellence Understandability and Sustainability.⁸

How PROMETHEUS Works

PROMETHEUS Payment begins by taking a clinical practice guideline (CPG) for a condition and translating it into an Evidence-based Case Rate (ECR) by quantifying the cost of the resources incorporated in the CPG to provide optimal care to the patient in accordance with the best science we have available. The ECR takes into account all the care to be provided by all the providers who will interact with that patient for the condition—physicians, hospitals, pharmacies, ancillary service providers, and more. The initial conditions for pilot projects are cancer, interventional cardiology, joint replacement, preventive care, and chronic care.

Co-morbidities are addressed by increasing the base amount negotiated by the provider to account for the additional resources to be brought to bear to treat the patient.

For example, if a patient with diabetes develops hypertension and atherosclerosis, each of these additional diagnoses entails additional resources and services; and, so, the base amount is increased in a step-wise fashion which is made known when the provider and plan reach agreement. When the co-morbidities alter the basic reason for treatment though, the ECR may be broken and payment reverts to traditional processes. For example, if the same patient has a heart attack, then that becomes the primary reason for treatment and the diabetes ECR is either broken or the patient's care is paid for on two separate ECRs. Two ECRs might also be relevant if a chronic diabetic patient is treated for a hip fracture. The point is that the payment model is intended to capture the resources appropriate to treat the patient optimally for the relevant conditions.

THE PAYMENT MODEL IS INTENDED TO CAPTURE THE RESOURCES APPROPRIATE TO TREAT THE PATIENT OPTIMALLY FOR THE RELEVANT CONDITIONS.

From the price that the plan and provider negotiate—including the risk adjustment amounts—the provider is paid monthly for the duration of the ECR an amount which reflects 80 percent or 90 percent of the agreed-upon rate. (There is a mechanism to be paid fee for service with a reconciliation, but the design team does not expect this to be the typical mode; and certainly organized group practices would be better served by the prospective payment for reasons described below.) The holdbacks of 20 percent (acute care) and 10 percent (chronic care) of the agreed-on prices are retained in a Performance Contingency Fund which is paid to the provider based on the results in a Comprehensive Scorecard.

The Scorecard quantifies whether the salient elements of the CPG were provided, the patient's experience of the care, and the patient's outcomes. Perhaps most significantly, 70 percent of the scores are based on what the provider, himself, does, and 30 percent reflects what the other providers have done in treating the patient. This is intended explicitly to motivate more clinical collaboration among otherwise independent providers who will do better financially if they coordinate clinically with those to and from whom they accept and give referrals.

Half of the Performance Contingency Fund is paid based on quality results. First, the provider must meet a quality threshold and then is paid pro rata in accordance with its scores. Because not all providers will score 100 percent on quality, the remainders of those amounts are held in a separate pool of money which is used to pay to truly stellar performers bonuses on top of the bargained for portion of the ECR.

The other half of the Fund is paid based on efficiency results, except for integrated delivery systems which are scored on quality alone because they take inherent efficiency risk by bargaining to deliver the entire ECR. A provider who does not meet the quality threshold is not eligible for efficiency payments. Because the efficiency is also determined by the performance of all the providers, providers benefit further by coordinating care with other high-quality, efficient providers. The efficiency payments are made pro rata in accordance with the overall performance of the providers treating under the ECR. Because plans must pay out money when providers are inefficient, though, efficiency fund remainders are not paid to providers.

Providers that seek to be paid under PROMETHEUS come forward and bid voluntarily for the portion of the ECR they want to

deliver and the price they seek to be paid for what they expect to do for the patient. The model can work for solo physicians, group practices, standalone hospitals, networks of similar and competing physicians, all the way to integrated delivery systems. Providers can configure themselves into whatever aggregations make sense to them including ad hoc combinations for specific conditions—cardiologists might bid with hospitals and rehab providers for interventional procedures, but with primary care physicians and pharmacies for chronic care. Scores are calculated at the point of contracting—whether a group, a network, a physician, a hospital, or a system. Even so, no matter how providers come together clinically, no one holds the money of another party unless they choose to be paid that way. In other words, providers can bid together to coordinate care and still be paid directly by the plan and separately from each other.

Distinguishing Features and Benefits

Global rates and case rates have existed in varying forms in the American healthcare system for years. To the knowledge of the design team, only PROMETHEUS begins with what is clinically appropriate for the patient in accordance with science as the foundation for the case rate.

There are several core principles embedded in PROMETHEUS which respond to the aims of the IOM. Transparency is a bedrock. The CPGs, the ECRs, the risk adjusters, and the scores are all made known to all participants—providers, plans, employers, consumers, and patients. There are no black boxes.

The model seeks to reduce administrative burden throughout. With PROMETHEUS Payment there is no need to document the necessity for diagnostic tests, drugs, or anything contemplated in the CPG. There is no

need for prior authorizations, concurrent review, post-payment claims audits, certificates of medical necessity, or any of the host of administrative nightmares physicians must waste time on daily in the current systems. There is not even a need to document the evaluation and management code bullet points because PROMETHEUS is indifferent to the level of visit rendered. All of these issues are addressed in the CPG, the delivery of which is measured in the Scorecard. PROMETHEUS holds the potential of eliminating formularies and fostering a wide range of efficient yet patient-centric delivery modes. The use of ancillary personnel to save physicians for their highest and best use and encourage team treatment, group medical visits, telemedicine, Web-based care, and e-mail communication are all within the choice of the bidding providers, who can take these approaches into account in determining their price for their portion of the ECR.

ONLY PROMETHEUS BEGINS WITH WHAT IS CLINICALLY APPROPRIATE FOR THE PATIENT IN ACCORDANCE WITH SCIENCE AS THE FOUNDATION FOR THE CASE RATE.

Group practices that accept prospective payment can expect faster payment since they will be paid outside the plan's standard claims payment process. The data elements which drive the core features of payment are managed by independent service bureaus and not the plans that pay claims, thereby both making the process "plug and play" for the plans and removing any potential conflict between paying claims and managing the data which drives the total payment amount.

Group Practice Nexus

PROMETHEUS Payment is intended to foster clinical collaboration and flexibility in how care is

provided, so long as the salient elements of the CPG are present. Whatever their progress to date, group practices are much further along on this than most physicians who have not formed groups. The infrastructure to succeed under PROMETHEUS is more likely to be present in group practices, which are already coping with performance measurement, electronic health records, pay for performance, and other transitional steps which should prepare them well for PROMETHEUS.

Because of the emphasis on clinical collaboration without financial integration, though, PROMETHEUS also offers the opportunity for group practices to improve relationships with solo physicians and smaller groups, from whom and to whom they refer. Similarly because all providers in the ECR do better financially when they improve quality, PROMETHEUS encourages collaboration with the hospitals to which organized groups are almost always a significant other.⁹

Limitations

PROMETHEUS represents a major opportunity to foster better quality and more equitable payment. Ideally it would reflect the actual cost to the group of providing care in accordance with a specific CPG. Even the most sophisticated group practices, though, rarely have developed any such data. As a result, to begin the process of developing ECRs, PROMETHEUS must start with national claims data which demonstrates what plans pay for CPG-conforming care. This information will be adjusted upward to account for both clinical variation among patients treated on a CPG and some of the downward perversities in traditional payment and fee schedules. This approach enhances the potential for a group to realize improved financial margins for good care. Still, though, even in the absence of

PROMETHEUS Payment, organized groups would be well advised to do a far better job of developing data to make the case that links their true costs to the optimal patient care delivery for specific conditions.

Even in the fullness of time, PROMETHEUS will not supplant all payment models. It is too complex for simple conditions and cannot encompass truly extraordinary circumstances. There will never be an ECR for a paraplegic cancer patient who is caught in a house fire. The design team thinks that at its apogee PROMETHEUS Payment will address well more than half of the healthcare expenditures in this country; but wouldn't that be a major change?

Perspectives

The software engine to drive the data management is under construction. Pilot markets are being identified for launch in early 2007. Willing plans and providers who are fed up with the problems of the last 30 years of payment and who are willing to try something new will really change the system. There is still much to be learned from these experiments to refine the model.

Yet, the values that drive PROMETHEUS Payment stem from the IOM's aims. Groups that position themselves to succeed with PROMETHEUS Payment will improve their care, their data, and their financial margins even before they implement PROMETHEUS.¹⁰ P4P is not enough. PROMETHEUS is a more robust option, and group practices are ideally situated to take advantage of it.

PROMETHEUS Payment, Inc.

The Core Design Team

James Bentley, Senior Vice President,
Strategic Policy Planning
American Hospital Association
Chicago, Illinois

Francois de Brantes, National
Coordinator
Bridges to Excellence
Washington, D.C.

Douglas Emery, VP Reimbursement Policy
eHealth Initiative
Washington, D.C.

Alice G. Gosfield, J.D., Principal
Alice G. Gosfield and Associates, P.C.
Philadelphia, Pennsylvania

Sam Ho, M.D., Executive Vice President,
Chief Medical Officer
Pacificare
Cypress, California

Allan Korn, M.D., Senior Vice President,
Clinical Affairs Chief Medical Officer
Blue Cross Blue Shield Association
Chicago, Illinois

Jeffrey Levin-Scherz, M.D., M.B.A.,
Chief Medical Officer
Partners Community Health Care, Inc.
Boston, Massachusetts

Elizabeth McGlynn, Ph.D., Associate
Director
RAND Health
Santa Monica, California

Toni Mills, Managing Director
Blue Cross Blue Shield Association
Chicago, Illinois

Joseph O'Connor, CEO
IHCIS/ Ingenix
Minneapolis, Minnesota

Michael Pine, M.D., M.B.A.
Michael Pine and Assoc.
Chicago, Illinois

Daniel Roble, J.D., Partner
Ropes & Gray
Boston, Massachusetts

Meredith Rosenthal, Ph.D., Associate
Professor
Harvard School of Public Health
Boston, Massachusetts

Richard Salmon, M.D., Senior National
Medical Director
CIGNA
Bloomfield, Connecticut

Craig Schneider, Project Officer
CMS Regional Office
Boston, Massachusetts

The Board of Directors

John E. Brush, Jr., M.D., F.A.C.C
Cardiology Consultants
Norfolk, Virginia

Suzanne F. Delbanco, Ph.D., CEO
The Leapfrog Group
Washington, D.C.

Alice G. Gosfield, J.D., Principal
Alice G. Gosfield and Associates, P.C.
Philadelphia, Pennsylvania

Allan Korn, M.D., Senior Vice President,
Clinical Affairs Chief Medical Officer
Blue Cross Blue Shield Association
Chicago, Illinois

Thomas H. Lee, M.D.
Partners Healthcare System
Boston, Massachusetts

Elizabeth McGlynn, Ph.D., Associate
Director
RAND Health
Santa Monica, California

Keith Michl, M.D., Internist
Manchester Center, Vermont

Meredith Rosenthal, Ph.D., Associate
Professor
Harvard School of Public Health
Boston, Massachusetts

Andrew Webber, President & CEO
National Business Coalition on Health
Washington, D.C.

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Alice G. Gosfield, J.D., is the first Chairman of the Board of PROMETHEUS Payment, Inc. a not-for-profit, national, multi-stakeholder project to develop a new provider payment model (PROMETHEUS Payment) that will base provider payment on the cost of delivering guideline-based care as measured in a comprehensive scorecard. The model is designed for and expected to lower administrative burdens in the system over time, while improving the quality of care by paying for what science says patients should be treated with for their condition.