

In Common Cause for Quality Part 2: PROMETHEUS Payment® and Principles of Engagement

10.17.2006 By, Alice G. Gosfield, Esq.

A new reimbursement model, Prometheus Payment, outlines a method for payment based on good clinical practice.

Editor's note: *This is the second part of a two-part presentation on physician engagement in quality. In part 1, the authors offered 13 strategies for quality-driven hospital-physician collaboration. This week, in part 2, the presentation describes Prometheus Payment--a model that provides a new option to propel quality and collaboration--and concludes with some principles of engagement to enhance all of these strategies.*

Quality demands alone ought to motivate hospitals to seek ways to collaborate more effectively with physicians. But the most significant lever to better hospital-physician relationships might be a different payment system. Pay for performance, while a positive development, is generally seen as transitional at best. What is needed is a payment system explicitly designed to improve quality, lower administrative burden, enhance transparency, and support a patient-centric and consumer-driven environment, while making consistent the clinical incentives for hospitals and physicians.

Beginning in December 2004, a group of experts concerned about current reimbursement models--experts in quality, research, economics, health care financing, law and medicine--began a series of meetings to tackle these issues. The result is Prometheus Payment (Provider payment Reform for Outcomes, Margins, Evidence, Transparency, Hassle-reduction, Excellence, Understandability and Sustainability). Under Prometheus, hospitals and physicians will do better financially if they do better in quality. The behaviors Prometheus motivates are the right thing to do even if no payment change occurs. Prometheus, however, offers the opportunity for the right payment for the right care.

Distinctions

Prometheus Payment encompasses the cost of delivering a full continuum of services according to a good clinical practice guideline (CPG). Reflecting the cost to deliver those services, an evidence-based cased rate (ECR) is established condition by condition, incorporating the care of all the providers who will interact with the patient for that condition.

The primary mode of Prometheus Payment is prospective with a pro rata monthly portion of the provider's negotiated segment of the ECR paid for the time frame incorporated in the ECR. For chronic care this might be a year, but for acute and procedure-based care, it might be over a period of a few months. ECRs will be risk adjusted to reflect typical co-morbid conditions with incrementally higher payments for increased complexity of care.

The difference between Prometheus ECRs and other case rates is that never before has a payment system started with what the patient ought to receive in clinical terms and what that costs the provider to deliver, rather than historical charges, fee schedules, resource consumption or expenditures. Prometheus is different from capitation because it is not based on actuarial principles or insurance risk. Nor does Prometheus set one payment amount for all patients.

Payment Amounts

Providers bargain with the plan for a price for that segment of the CPG within the ECR that they want to deliver. For an integrated delivery system this might be the entire CPG. For a stand-alone hospital it might be only the hospitalization for a knee replacement and the physical therapy that follows. Hospitals might join with physicians or ancillary providers to bid for a broader continuum within the CPG. Even if providers bid together, they may be paid separately for their specific portion of the CPG.

For chronic conditions, 10 percent of the bargained-for payment is held back to be paid in full when it is clear that the provider delivered what it bargained to provide to the patient. For acute services, the holdback is 20 percent. These dollars are held in a Performance Contingency Fund that is allocated one-half to quality and one-half to efficiency.

Whether the provider receives all or part of the contingency fund depends on its scores in the Prometheus Payment Comprehensive Scorecard. The scores take into account whether the salient features of the CPG were delivered, the patient's experience of care and patient outcomes. The bulk of the score (70 percent) turns on the provider's own performance, but 30 percent takes into account the performance of the other providers treating the patient for the same condition. This explicitly motivates independent providers to work together clinically.

The Performance Contingency Fund is paid first, based on whether the provider meets a quality threshold. Then, depending on the score, a pro rata portion of the holdback is paid. No efficiency money is paid to a provider unless the quality threshold has been exceeded. Providers are scored on efficiency only when there is data made available to them that identifies the performance of other providers, whether in the Prometheus system or not, so they can choose good clinical partners.

Potential Benefits

Paying for the cost to deliver what science says is the right treatment is a major change to improve quality. Paying for what science says is the appropriate care for a patient prevents the misuse, overuse and underuse that stem from perverse financial incentives.

Because the CPG establishes the medical necessity of care the provider bargains to render, there is a significantly smaller administrative burden. Prior authorizations, concurrent review, documentation of the medical necessity of care, certificates of medical necessity for ancillary services, and post-payment claims review are all unnecessary because they are either incorporated in the CPG or taken into account in the scorecard. Prometheus has the potential to eliminate health plan formularies.

Prometheus gives providers significant autonomy to decide how to deliver care within their portion of the ECR. It provides certainty in the payment amount to each provider per patient, as well as certainty in cash flow because there are no claims processing issues. The critical data mechanism is managed by independent data service bureaus that track the beginning and end of the ECR, assess which providers rendered which portions of the ECR and calculate the scores that drive the payment from the contingency funds. This entire process takes place outside the normal plan claims payment processes, likely making provider payment faster as well.

Because providers can configure themselves into any combination they want, or none, and all have the opportunity to negotiate their rates, the days of “take or leave it” contracting will be over. No one holds the money of any other provider unless they choose to negotiate that way. The rules of payment, the CPGs, the ECRs and the scores are all transparent. There are no black boxes.

Care delivered under Prometheus may reduce malpractice liability risk because the explicit bargain is to deliver the standard of care. For hospitals, where the six planks of the 100,000 Lives Campaign are part of the scorecard, Prometheus will help prevent needless deaths and injuries and the lawsuits associated with them.

Collaboration Opportunities

ECRs address the full continuum of care. Hospitals and physicians will both do better when they coordinate care for quality and efficiency and facilitate each other’s quality scores. The collaboration strategies presented in part 1 of this article all will contribute to success in Prometheus, which will translate into both financial and quality benefits.

Prometheus Payment motivates clinical integration--by physicians with hospitals, by primary physicians with consultants and even by otherwise competing physicians with each other for profiling, benchmarking and improvement. Prometheus Payment stimulates better clinical collaboration without unnecessary financial integration or insurance risk.

What Will Make It Happen

The initiation of Prometheus Payment requires the development of a software “engine” to (1) translate guidelines into ECRs; (2) establish an ECR budget and track the inception, process of care, “breaking” and termination of each ECR; (3) allocate portions of the ECR to the providers who bargained to render them; (4) provide ongoing reports to providers along the way; and (5) calculate the scores. This is unquestionably complex. But vendors are already engaged to create this before pilots will be implemented. For plans, the program will be as “plug and play” as possible.

Pilot markets are being identified to launch in early 2007. Five clinical areas will be the focus of the pilots: oncology, chronic care, preventive care, interventional cardiology and joint replacement.

Why should hospitals care now? Because the issues Prometheus Payment addresses are the key to improved quality and financial results. Even in the fullness of time, Prometheus Payment will apply only to about 50 percent of health care. Hospitals and physicians are still bound together in common cause for the rest.

Limitations

Prometheus Payment will not substitute for all fee for service, capitation, DRGs or any other form of payment. Implementing Prometheus Payment requires the willing collaboration of plans and providers. There will be transition costs. Ideally the payment amount will reflect a real estimate of the cost of the resources needed to deliver science-based care. But since there is virtually no such accurate data available, the payment amount will begin with national claims data regarding good care delivery and will

add increases to account both for clinical variations and downward distortions in existing payment systems. It will also add margins for providers.

Still, the potential to change large parts of payment to this model is tantalizing and fits well with the collaboration strategies described in part 1 of this article. How can hospitals and physicians move forward?

Principles of Engagement

For hospitals to win the hearts and minds of physicians, the cardinal rule is to involve them at the earliest stage of conceptualization, design and implementation. Physicians will be suspect of hospital proposals if they think their only role is to bless something already decided. Their involvement should be transparent to other physicians and widely publicized. Making it clear that the physician perspective has been taken into account is essential for endorsement by other physicians.

The individual physicians whose engagement is important need not be chosen by the medical staff, but they must be perceived by other physicians as leaders in the medical staff culture. Sometimes the true cultural leaders are not the individuals holding a medical staff title. True leaders in the physician culture can act as champions and bring others along. They enjoy peer respect for their clinical care, have demonstrated integrity and selflessness in acting as physician representatives, function well as a communication conduit to and from other physicians, and are open to learning new information.

Believable consistency requires open, frequent and candid communication, including sharing raw data underlying the hospital's position and needs. Consistency also is demonstrated by consistent attendance at appropriate meetings. Hospital representatives who do not participate actively with the physicians in scheduled meetings send a message that they do not value the undertaking. An often-cited challenge to better relationships is loss of trust, which is best repaired by believable, consistent actions.

A Common Goal of Quality

Hospitals need--and will need more in the future--the passionate engagement of their physicians in quality improvement. Most physicians are deeply committed to the quality of their patients' care and the safety of the environment to which they bring them. The common goal of improved quality is what should be the basis for the hospital-physician bond.

It is time to focus more on the positive opportunities to help each other, with the ultimate benefit of better care for patients. The strategies and principles presented here will advance that common goal.

Alice G. Gosfield, Esq., is an attorney in private practice with Alice G. Gosfield and Associates, PC, in Philadelphia. She is also the first chairman of the board of Prometheus Payment Inc.

For more information about Prometheus Payment, please visit www.prometheuspayment.org.

The opinions expressed by authors do not necessarily reflect the policy of Health Forum Inc. or the American Hospital Association