



WHAT IS PROMETHEUS PAYMENT®?

AN EVIDENCE-INFORMED MODEL FOR PAYMENT REFORM

Ideas about how to pay providers to improve quality and reduce costs are ground zero for many current discussions about national health reform. A variety of solutions are being touted to correct the widespread deficiencies and increase value in our health care system – with concepts like “Accountable Care Organizations” and “medical homes” getting a lot of attention. Another is the PROMETHEUS Payment® approach – a promising model for measuring and paying for care that could be especially valuable for health care leaders and policy-makers as they are faced with the challenges of health care costs in this economy. The consumer-centered PROMETHEUS approach is currently being tested in real communities.

Most experts agree that a fundamental problem of the nation’s health system is that both the current fee-for-service and the per-patient (capitation)-style models of reimbursing providers encourage *volume-driven* health care rather than *value-driven* health care. Providers are rewarded for “doing things” (often too many or not enough), rather than delivering quality services that are proven to keep people healthy, reduce errors and help avoid unnecessary care.

The PROMETHEUS Payment model seeks to ignite a transformation in health care payment by challenging the way providers and insurers conduct business – moving away from unit-of-service payment to episode-of-care payment. Launched in 2006 and now with four pilots across the country through the support of the Robert Wood Johnson Foundation, PROMETHEUS Payment steps beyond “pay for performance” models of change to test paying for individual, patient-centered treatment plans that fairly reward providers for coordinating and providing high-quality and efficient care.

Episodes Of Care

At its core, the PROMETHEUS Payment model centers on packaging payment around a comprehensive episode of medical care that covers *all* patient services related to a single illness or condition. Covered services are determined by commonly accepted clinical guidelines or expert opinion that lay out the tested, medically accepted method for best treating the condition from beginning to end.

The costs of treatments are calculated into what is called an “Evidence-informed Case Rate” (ECR®), which creates a patient-specific budget for the entire care episode. ECRs include all the covered services related to the care of a single condition – bundled across all the providers who would treat a given patient for the given condition (such as a hospital, a physician, laboratory, pharmacy, rehabilitation facility, etc.). The ECR is adjusted to take into account the severity and complexity of the individual patient’s condition.

To date, for pilot purposes PROMETHEUS Payment has developed ECRs for a significant number of acute, chronic and inpatient procedures, including heart attacks (AMI), hip and knee replacement, diabetes, asthma, congestive heart failure and hypertension. These existing ECRs can potentially impact payment for almost 30 percent of the entire insured adult population and represent a significant amount of dollars spent by employers and plans.

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What really makes PROMETHEUS Payment different from other health care payment systems and typical pay-for-performance models is its strong incentive for clinical collaboration to ensure positive patient outcomes. In addition to earning the base ECR payments, providers are given the opportunity to earn bonuses through a comprehensive quality “scorecard” tied to the reduction of potentially avoidable complications (PACs).

Comprehensive Quality Scorecard

The PROMETHEUS Payment comprehensive quality scorecard contains a variety of metrics that track and evaluate care across the entire scope of treatment. These include scores for a range of items – each provider’s performance in meeting the clinical practice guidelines which define the ECR, positive patient

outcomes, the avoidance of preventable complications and the patient's satisfaction with care received.

When ECRs are paid, a portion of the budget is withheld and then paid out depending on the scores that the providers and their clinical collaborators earn. To create a very clear incentive for clinical collaboration, the final scores depend 70 percent on what the individual provider does and 30 percent on what every other provider treating that patient for that condition has done. PROMETHEUS experts say the value of coordination across settings is critical, particularly in the management of chronic conditions. For example, one study found that up to 50 percent of congestive heart failure hospitalizations could be avoided with better care coordination.

Potentially Avoidable Complications

Coordinating care and avoiding complications are defining features of the PROMETHEUS Payment model and form the basis for unique incentives that reward providers for improving care and reducing potentially avoidable complications (PACs).

PACs are usually deficiencies in care that cause harm to the patient, yet might have been prevented through more proactive care – for example, when a patient with diabetes ends up getting an amputation because of uncontrolled blood sugar.

Unfortunately, PACs remain all too common in the U.S. health care system. In analyzing large sets of national claims data, the PROMETHEUS Payment team found that up to 40 cents of every dollar spent on chronic conditions and 15 to 20 cents of every dollar spent on acute hospitalization and procedures are attributable to PACs. All told, PACs amount to hundreds of billions of dollars for less than optimal care and represent a substantial opportunity for improving patient care and reducing total cost of care.

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Under PROMETHEUS Payment, the incentive for providers to act on and reduce PACs comes directly from the savings found in reducing them. A PAC allowance is calculated for and included in each ECR. This amounts to 50 percent of dollars spent today on these conditions. Should complications occur, this portion of the budget serves to offset the actual costs of the corrective treatment. But if providers can reduce or eliminate PACs, they can keep the entire allowance as a bonus and significantly improve their margins per patient.

Conclusion

All together, the PROMETHEUS Payment model offers a realistic, rational and sustainable blueprint for a new health care payment system. It effectively promotes and rewards high-quality, efficient, patient-centered care, providing common performance incentives for all parties and creating an environment where doing the right things for patients also allows providers and insurers to do well financially. Perhaps most importantly, it does this without introducing new costs or administrative burdens and without changing the way patients access care today.

And it saves money. Even with a considerable increase in payment tied to PROMETHEUS Payment's scorecard, because of the enormous amount of money that is paid today for poor quality care and deficiencies, there would still be significant savings seen across the system.

As the nation explores ways to increase health care value and usher in meaningful changes in the way care is paid for, the PROMETHEUS Payment model offers a viable option for a future with better patient outcomes and greater cost effectiveness.

The Essential Elements Of Prometheus Payment

1. Evidence-informed Case Rate (ECR)

- A comprehensive packaged budget for the treatment of an illness or condition that includes all covered services related to the care for that condition, as determined by tested, medically accepted, clinical practice guidelines.
- Covers payment for all the providers across all settings who would treat the patient for that condition (such as a hospital, a physician, laboratory, pharmacy and a rehabilitation facility).
- Is adjusted to take into account the severity and complexity of the individual patient's condition.

2. Provider quality scorecard

- A portion of the ECR payments is withheld and paid depending on the scores that providers and their clinical collaborators earn on individual quality scorecards.
- Includes a comprehensive mix of quality care metrics, such as: provider's performance in meeting clinical guidelines, positive patient outcomes, the avoidance of complications and the patient satisfaction.
- Incentivizes clinical collaboration by making 30 percent of the score dependent on what others treating that patient for that condition have done.

3. Potentially avoidable complications (PAC) pool

- Potentially preventable deficiencies that occur in inpatient or outpatient care which cause harm yet could have been prevented through proactive care.
- Represent up to 40 cents of every dollar spent on chronic conditions, and up to 30 cents of every dollar spent on hospitalizations.
- A PAC allowance is calculated based on the ECR – it is paid out either to offset the costs when complications do occur or as bonuses to providers for avoiding them.