

PROMETHEUS PAYMENT[®]: WHAT'S THE SCORE?¹

How Scores Determine Provider Payment



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The PROMETHEUS Payment[®] model is explicitly designed

to pay providers to deliver what science says patients should receive for their specific constellation of clinical problems associated with a condition. The maximum payment amount for a provider is based upon an Evidence-informed Case Rate[®] (ECR). Whether the provider will realize the full potential for payment depends on the scores that provider earns under the model's comprehensive scorecard. To create a very clear incentive for clinical collaboration, the final scores depend 70% on what the provider does and 30% on what every other provider treating that patient for that condition has done—whether under the ECR or not.² The scoring system is an essential element of what makes the PROMETHEUS Payment[®] model different from other payment systems as well as different from typical pay-for-performance models, even though it uses many of the same measures that pay-for-performance programs use today.

The workings of the PROMETHEUS[®] scorecard have not been fleshed out until relatively recently. Now it is time to explain the theory of the scoring and its development. This paper describes how we got to the current scoring approach, the principles of scoring, the sources of the measures, how scores are calculated, and the impact of the scores on payment. It should be noted, however, that as with much of the conceptual work on PROMETHEUS Payment[®], we expect that multiple aspects of the scoring will be refined as we implement the program in pilot sites and with other collaborators. Still further, it is beyond the scope of this first iteration to explain all the possible permutations in scoring. The purpose of this paper is to introduce and elucidate the basics of scoring. **So, let's get started.**

¹ This paper assumes a basic familiarity with the payment model. For information about the PROMETHEUS Payment[®] model and how case rates themselves are constructed, go to www.prometheuspayout.org to review the publications there as well as FAQs.

² If a patient receives care from a provider for the same condition, but that provider is not being paid under the PROMETHEUS Payment model, those monies will be subtracted from the budget available to pay all the providers.

The Conceptual Evolution

When the Design Team first confronted how to make the payment model attractive to plans, one of the considerations was providing for some way to assure that care which had been contracted for, was actually delivered—a score to demonstrate performance. The scores would also serve as a basis to report provider performance to patients, other providers, plans and anyone else with an interest, not only to fulfill the goal of transparency³, but also to provide actionable information on which providers could improve their care delivery and patients could choose good performing providers.

To attract providers, as well as plans, there was also the issue of administrative burden reduction. Since the clinical practice guidelines which form the basis for the ECR, encompass the rendering of a particular combination of services, it would no longer be necessary, in this model, to engage in post-service audits to assure that specific and discrete services were authorized in advance or had been rendered, or visits performed at specific levels.⁴ If we could develop a way to capture whether providers were producing proper outcomes for patients based on measured performance even if physicians still have to file claims, much of the administrative burdens for providers as well as plans would dissipate. In addition, the system would offer far greater flexibility to providers in the organization and delivery of care.

The payment amounts reflect what science dictates. If providers use innovative approaches to accomplish condition-specific improved outcomes, so much the better. In other words, with a clinical practice guideline as the foundation upon which payment is based, there would be no need to prior authorize services, engage in concurrent review, conduct post-payment audits, evaluate the level of visit which had been provided, review the medical necessity of the laboratory services ordered, or subject the drug prescriptions to pharmacy benefit review as in or out of formulary. The provider's scores would determine whether the care was good, even if the delivery was not explicitly what was set forth as the basis for the payment amount. As we will see in the discussion of the payment impacts, efficiency alone does not drive payment increases: clinical quality, including appropriate flexibility in delivering care, has more of an effect on the actual payment providers will receive.

That said, though, we expected it was also likely that not all providers would produce optimal performance. And some, despite their best efforts, might not achieve threshold levels of quality. To confront that dilemma, we needed a way to avoid rewarding

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³ For a list of the principal tenets of the PROMETHEUS Payment® model see <http://www.prometheuspayout.org/mission/tenets.htm>

⁴ For an elucidation of the many ways the PROMETHEUS Payment® model explicitly departs from the post-service inspection and audit model of Medicare, see Gosfield, "Getting The Team Paid: How Medicare Physician Payment Policies Impede Quality", HEALTH LAW HANDBOOK (2009 ed.) (in press) <http://gosfield.com/PDF/Gosfield.Getting%20the%20Team%20Paid.pdf>

inadequate care while assuring that there would be enough incentive to encourage the move to more science-based care. We initially thought that a 10% withhold on chronic care payment and a 20% withhold from the maximum amount an acute care provider might be paid would safeguard both against providers stinting on services, as well as against plans paying for services never rendered. As the design of the model evolved, though, while the withhold remained attractive, the differentiation between chronic and acute care proved unrealistic. We then posited that withholds of 10% for physicians and 20% for hospitals and other institutional providers might be a more workable approach. Once, however, we discovered the considerable funds available in the Potentially Avoidable Complications (PACs) Pools,⁵ it became obvious that these funds could serve as the incentive payment in the ECR, at least until care had been so improved that there was less money in the PAC Pools than our initially conceived withhold funds. Because providers would be paid as they rendered care, these PAC Pool funds would be available as a “bonus” payment once the provider demonstrated having achieved a minimal quality threshold, and then would be paid pro rata in accordance with the scores.

Principles of Scoring

In the same way that the Design Team would not be in the business of creating the guidelines as the foundation for the ECRs, the Design Team was not going to go into the business of creating new measures. There are already many measures in the system.⁶ Focusing on structure, process and outcomes, we would leverage existing measurement and reporting efforts such as for hospitals, from the Joint Commission ORYX program and Leapfrog measures, CMS measures for hospitals and physicians, and Bridges to Excellence (BTE) measures for physicians. Further, since we are using Evidence-informed Case Rates[®], we need to rely primarily on already validated measures which reflect that evidence. Patient experience of care (as well as patient assessment of functional health status, wherever possible) would be a critical component of scores, although that data would have to come from other sources still. We would utilize the already adopted principles of the Ambulatory Quality Alliance⁷ and Hospital Quality Alliance⁸.

Based on best practices in scorecard design⁹, the Design Team determined that the scorecard as applied should (1) reward both threshold performance as well as improvement from prior performance; (2) minimize the potential for cherry-picking patients to

⁵ For an understanding of how the PAC Pools are derived and applied, see Gosfield, “Making PROMETHEUS Payment Rates Real: Ya’ Gotta’ Start Somewhere”, (June 2008), <http://www.prometheuspayment.org/publications/pdf/MakingItReal-Final.pdf>

⁶ Gosfield, “The Performance Measures Ball: Too Many Tunes, Too Many Dancers?”, HEALTH LAW HANDBOOK, (2005 ed.) West, A Thomson Company, pp., 227-283 <http://gosfield.com/PDF/Ch4Gosfield.pdf>.

⁷ <http://www.aqaalliance.org/>

⁸ <http://www.hospitalqualityalliance.org>

⁹ Rosenthal and Dudley: “Pay-for-performance: A Decision Guide for Employers”, AHRQ, April 2006, <http://www.ahrq.gov/qual/p4pguide.htm>

enhance scores (by rejecting sicker patients); and (3) create stratified comparisons to provide appropriate comparisons for providers with disproportionate shares of un- or under-insured patients. This last principle became especially important when we understood that it would be both impossible at the outset, as well as unfair in the scoring, to take into account only those patients whose care was paid for by ECRs. Therefore, providers are scored on all their patients receiving care for the conditions at issue.

Similarly, we did not want the system to permit mediocre performance on one ECR where budgets were exceeded, with rewards still paid on others. The financial effect would have to be such that across ECRs the provider was in a positive financial position before any incentive would be paid. But the most critical issue was that no incentive payment would be made unless, across ECRs, the provider achieved a quality threshold; in other words a hospital could not do spectacularly well on a few hips and knees, and not perform to the threshold on acute myocardial infarction cases and expect to receive any payout from the PAC Pools. We will see below how these principles are implemented.

The PROMETHEUS® Engine takes CMS 1500s and UB-94s and allocates the services rendered to all providers treating patients under ECRs as being either typical or associated to a Potentially Avoidable Complication (PAC)¹⁰. That data is reported to BTE which manages the scorecard. Maintaining this function within the PROMETHEUS Payment® system has the dual effect of both lowering administrative burden to plans and enhancing the credibility of the data, since there is no advantage or disadvantage to the data manager from the scores themselves.¹¹

Measures

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In selecting measures that would track to the specific ECR conditions, the Design Team was mindful of the challenge to not contribute further to administrative burden. Therefore, measures would have to be those already in use by some other source, and the reporting of them would be limited and mostly self-reported. The dilemma of gleaning data directly from medical records, which is expensive, time consuming, burdensome to physicians and very difficult in an era when electronic records are not universally available, was the first challenge as to what would be useful as measures. The measures would have to be relatively easily reported by providers. It should be noted, as well though, that claims data—that data submitted to the PROMETHEUS Engine by all the providers working on the ECR—will provide the basis to judge efficiency, and who rendered what services. The number of patients treated by

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¹⁰ Again, for the construction of ECRs and PACs, see n5.

¹¹ Providers have long decried that plans manipulate performance data for their own financial ends.

each provider and paid under each ECR also weights the scores. As we show in Table 1 (page 8) that data feeds into the Scorecard calculations as well. The claims data also produces the complication rate determined in accordance with the characterization of the ‘potentially avoidable complications.’ This data will be taken into account in the scoring process, too.

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Because many of the chronic conditions addressed in the ECRs are being addressed by others as well, finding measures to score physicians on those conditions was not so difficult. Bridges to Excellence, already serving as the administrator of PROMETHEUS Payment[®], Inc., activities, was in the business of scoring physicians for performance on cardiac care and diabetes, among other conditions. For coronary artery disease, heart failure, asthma, and chronic obstructive pulmonary disease, the NCQA measures already in use for cardiac care were the beginning, with additions of condition-specific measures from CMS’s Physician Quality Reporting Initiative (PQRI), the American Medical Association Physician Consortium for Performance Improvement (PCPI), and well-established guidelines.

Among the measures selected are those addressing structure (e.g., health information technology infrastructure, use of registries), process (e.g. angiotensin converting enzyme inhibitor or angiotensin receptor blocker therapy (ACEI/ARB) in heart failure, lung function testing in asthma) and outcomes (e.g. LDL levels, oxygen saturation).¹² Some of the measures—like blood pressure, low density lipoprotein (LDL), use of diuretics, and smoking cessation—are relevant to multiple conditions, so they are, in effect, scored more than once, as relevant to each ECR separately.

There is no national program for the production or collection of physician patient satisfaction data or data on patient experience of physician care. As the program is implemented in local settings, there may well be regional or local programs that can provide such information. For example, in Massachusetts, there is a program in which patient experience of care is being systematically collected for all physician groups at the practice level.¹³

For hospitals, condition-specific inpatient measures were less available. For acute myocardial infarction and CABG, Leapfrog and CMS already had measures in use. For bariatric surgery there were limited Leapfrog measures. For knee and hip replacements, there was nothing condition-specific; but all of the care could be measured by hospital-wide scores on, for example, surgical infections, and other ORYX data as reported to the Joint Commission.

¹² For all the chronic care measures by ECR see www.prometheuspayment.org/scorecard/index.htm

¹³ see <http://www.mhqp.org/quality/pes/pesMASumm.asp?nav=031600>

By contrast, for data on hospital-based patient experience of care, there is the HCAHPS program. The federal government sponsors this survey of the patient assessment of care which is described as follows:

The HCAHPS survey is composed of 27 items: 18 substantive items that encompass critical aspects of the hospital experience (communication with doctors, communication with nurses, responsiveness of hospital staff, cleanliness and quietness of hospital environment, pain management, communication about medicines, discharge information, overall rating of hospital, and recommendation of hospital); four items to skip patients to appropriate questions; three items to adjust for the mix of patients across hospitals; and two items to support congressionally-mandated reports.¹⁴

These measures tend to demonstrate overall quality performance; although, over time, we would hope the industry would move toward the parsimonious addition of more specific, salient measures for each of the ECR conditions.

Weighting and Calculations

The weighting of the measures either tracks closely to the NCQA-BTE weighting, or has been created with input from physicians. For example, the COPD measure weights were developed by a panel of physician leaders from the Cleveland Clinic, Duke and National Jewish Hospital. Intermediate outcomes measures such as hemoglobin A1c tend to be weighted higher than process scores. Typically, the model assigns 60% or more of all potential points for a set of condition-specific measures to intermediate outcomes and the balance to process. This calculation is intended to give importance to what happens to the patient as opposed to checklists of fragmented processes. Since following good clinical practice guidelines will tend to produce the outcomes that are the evidence which support the guideline, the Design Team expects good concordance between the care called for in the guidelines driving the ECR budget and good outcomes. That is the whole point of the model. Still, if providers achieve good outcomes without providing every scintilla of what is in the guidelines, the design allows greater flexibility for providers if that flexibility produces good results for patients.

For each measurement set (e.g. Diabetes Care) each measure is assigned available point limits. The actual points awarded for that measure are calculated by counting the results of the physician's patients' compliance with that measure. The number of patients with the condition who meet the measure is the numerator. The denominator is the universe of patients with that condition for that provider during the scoring period.¹⁵ For measures

¹⁴ http://www.cms.hhs.gov/hospitalqualityinits/30_hospitalHCAHPS.asp

¹⁵ For these and all scoring purposes, "a provider" may be a single physician, a single specialty, a large multi-specialty group, a hospital, or a fully integrated delivery system, a PHO or whatever configurations providers present. The "providers" who negotiate for PROMETHEUS Payment[®] to be made by the plan are the locums for scoring as well. The level at which the provider is paid is the level for scoring.

of poor control, a low numerator is good and produces the obverse result. For example, if out of 100 diabetics only 10 have poor scores, the remaining 90% did well and determine the point value. The table below illustrates how the scoring works:

Table 1. **Measure Set Scoring**

Diabetes Care			
Clinical Measures	Points per Measure	Num/Den Result	Points Awarded <i>(points per measure x Num/Den result)</i>
Poor control measures			
HgBA1c Control	15	89.26%	13.39
Blood Pressure Control	15	79.87%	11.98
LDL Control	10	66.67%	6.67
Superior control measures			
HgBA1c Superior Control	10	23.08%	2.31
Blood Pressure Superior Control	10	41.03%	4.10
LDL Superior Control	10	61.54%	6.15
Process measures			
Ophthalmologic Exam	10	60.26%	6.03
Nephropathy Assessment	5	95.92%	4.80
Podiatry Exam	5	76.83%	3.84
Smoking Status and Cessation Advice and Treatment	10	95.35%	9.53
Total	100		68.80

By using a calculation of the numerator and denominator, per physician, per patient, per condition, per scoring period, physicians can increase their scores with every additional patient whose care is consistent with good standards. A practice is scored on all the condition-specific measure sets that correspond to the ECRs that they are managing. As the PROMETHEUS Payment[®] model is first implemented, physicians can be scored on up to six chronic care ECRs. Their total score across all those measures will determine their ultimate maximum payment. To avoid paying from the PAC Pools where the scores are widely disparate across ECRs, the number of patients treated under each ECR (in the table below stated as a percentage of the universe of patients treated under all the chronic ECRs) determines the weighted result. Weighting the results offers yet another protection against a provider neglecting one condition over others, but still gives credit for improvement without perfection. Then, all the weighted scores are added to determine if the baseline quality threshold has been met.

Table 2. **Quality Threshold Scoring**

	Possible Points	Actual Points	% of Patients	Weighted Score <i>(Actual points x % of patients)</i>
COPD Care	100	91.05	40.0%	36.42
Hypertension Care	100	68.65	15.0%	10.30
Cardiac Care	100	74.90	7.5%	5.62
Diabetes Care	100	68.80	15.0%	10.32
Heart Failure Care	100	59.71	2.5%	1.49
Asthma Care	100	33.79	20.0%	6.76
Total	600	396.90	100%	70.91

In Table 2, the simple unweighted sum of the scores for each clinical area is 396.90, which translates to a total score of 66.15 on a 100 scale ($396.90/600=66.15$). However, the patient volumes (stated as a percentage of all patients paid to that physician under ECRs) are weighted across the universe of all patients paid under ECRs, so the weighted “case-mix-adjusted” score is 70.91. This weighting is only used to determine if any PAC Pool Funds will be paid. The actual payments for each ECR are as set forth in Table 4.

Let’s now assume that the physician who scored a 70.91 on his chronic care ECRs refers his patients with CAD to a hospital which scored a 63 on CABG as detailed below in Table 3. The physician’s final quality scorecard threshold would therefore be: $70.91 \times 70\% + 63 \times 30\% = 68.54$.¹⁶

Table 3. **Hospital Scoring**

CABG Care			
	Points Per Measure	Score	Points Achieved
<i>Outcomes</i>			
Leapfrog Survey Result	20	50%	10
<i>Process</i>			
Leapfrog Survey Result	10	75%	7.5
CMS Hospital Compare	10	90%	9
<i>Volume</i>			
Leapfrog Survey Result	20	50%	10
<i>Patient Safety/Surgical Infections</i>			
Leapfrog Survey Result	10	75%	7.5
CMS Hospital Compare	10	90%	9
<i>Patient Experience of Care</i>			
CMS Hospital Compare	20	50%	10
Total	100		63

Because the physician's final score is greater than 50, our quality threshold, the physician will qualify for PAC Pool funds. The specific allocation of those funds is a simple award proportional to where the physician is situated on the scoring scale of 50 to 90 (above 90, the physician automatically gets 100% of the incentives because the clinical value to patients to get 100% might be low and the effort to attain that level high and potentially distracting from more beneficial efforts). Following our current example, the physician would earn 46.35% of the eligible CAD PAC Pool funds ($68.54 - 50 = 18.54$; $90 - 50 = 40$; $18.54 \div 40 = 46.35\%$).

While this formula would be applied to each ECR, taking into account the performance of the respective hospital to which the physician referred for specific conditions, for the purposes of this paper, we will assume that he refers to the same hospital all the time, when patients need admissions, and that the hospital's scores are the same for all the admissions. Since many of the measures for hospitals are systemwide at this time, that assumption is not necessarily wrong, either. But where physicians have choices among hospitals, and hospitals do better in some services than others, part of the point of the design is to encourage physicians to send their patients to those places where performance is better for what the patient needs. None of this can happen without actionable data being available, which won't be the case until the model has been in effect for at least a year. So we will apply the 46.35% rate across all of this physician's ECRs. Let us now look at what that means in actual dollar terms.

Table 4. **Payment Effects**

Type of ECR	Number of ECRs	Total Budget for Typical	Total Budget for PAC	Total Actual for Typical	Total Actual for PAC
COPD	25	34,102	4,115	37,512	12,567
DM	50	185,611	64,309	152,201	32,649
CHF	10	55,098	43,210	57,046	42,876
Asthma	35	21,862	10,508	21,643	1,506
CAD	70	154,166	25,224	137,208	22,598
HTN	310	844,898	39,470	735,061	25,432
Totals	500	\$1,295,736	\$186,837	\$1,140,670	\$137,628
Variance				\$155,066	\$49,209

Table 4 summarizes the results for the physician across each ECR. The first column represents how many of each patient he treated under that ECR. This hypothetical physician treats more patients with hypertension than anything else. The “total budget for typical”

¹⁶ In the fullness of time and implementation of the model, this 30% will also take into account the surgeons and other specialists treating the patient for the same condition; but the first iteration of the PROMETHEUS® Scorecard cannot do that yet.

is the payor's dollar amounts available to pay for an uncomplicated case. If a physician is more innovative and resourceful than most, he can make money here. This physician manages diabetes, coronary artery disease, and hypertension significantly better than the payor calculated from historical patterns, in accordance with the clinical practice guidelines and expert opinion. The physician may be using nurse practitioners to be involved with his patients more than others. He may have better educational programs to help patients comply with his prescribed regimens. He may use email interchanges or other health information technology to keep patients engaged but not in the office. None of these specific techniques will be visible in the data, but he will earn improved financial margins for those conditions from some kind of process improvement. That is the point of the incentives.

There may be other factors at work, too, though. The primary distinction between the PROMETHEUS Payment® model and other episode-based payments is that under PROMETHEUS Payment®, the dollar amounts available to pay providers start with clinical practice guidelines and expert opinion as to what resources should be brought to bear to treat specific clinical conditions. But the scoring system has been designed not to require physicians to rigidly adhere to a prescribed list of services which provide the basis for the rate calculations; rather physicians need flexibility in treating patients, particularly chronic patients. Many of these patients have related co-morbidities. Studies have shown that to require delivery of all the services set forth in multiple guidelines—like those for COPD and asthma, and hypertension—on a simple cumulative basis could harm patients, while needlessly increasing costs.¹⁷ So, this physician may have not provided some of the services contemplated by one ECR because they conflicted clinically with another. And, as a result, not all the monies allocated in the typical ECRs were utilized. This is clinically appropriate. As a result, if a physician leaves money on the table for his typical ECRs, he may have appropriately deviated from the guidelines but the quality score safeguards against his skimping on care. As to his performance on the other chronic conditions, he came in about as expected on asthma and was a little over budget on COPD and CHF. Together, his management style on typical ECRs generated an additional \$155,066, just on the typical patients without complications.

Now we look at the “Total Budget for PAC” which reflects the 50% of the prior year's expenditures on potentially avoidable complications.¹⁸ The design expects that complications will occur. In fact, the design provides an allocation for them. However, to the extent physicians can avoid complications, the more money they will make. This physician did extremely well in avoiding complications for asthma, did very well on avoiding complications of diabetes, did somewhat better than expected on CAD and

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¹⁷ Boyd, Darer, et al, “Clinical Practice Guidelines and Quality of Care for Older Patients With Multiple Comorbid Diseases”, JAMA, Vol 294, No.6, (Aug 10, 2005), pp. 716-724

hypertension, but really missed the mark on COPD. His treatment of CHF had slightly lower expenses of complications than budgeted. These complications might represent hospitalizations for exacerbations, steeply increased drug expenses, patient compliance failures or simply patients at risk with poor family histories. We do not know from the data alone, but this type of information gives the physician a very clear direction on which to focus his attention in figuring out how to do better going forward.

Subtracting the total dollars actually spent on complications, from the total dollars budgeted for complications, even with the variances among the conditions, this physician generated another \$49,209 in savings over what was budgeted in the ECR. This figure, combined with the savings on the typical cases provides a total pool of savings of \$204,275 (\$155,066 + \$49,209). But this program is not about simple savings. If it were, there would be an incentive not to deliver to patients what they need. The design is not intended to be a pure gainsharing model. The application of the quality scores against the pool of savings is what distinguishes this model from other programs which are driven solely by cost savings. The quality scores are an essential component of the program and, given the quality scores this physician achieved with his hospital partner, the physician would be paid an additional \$94,681 ($\$204,275 * 46.35\%$).

It is also important to note that if his hospital had performed better and scored better, he would have been paid more. If he had managed his patients with COPD as well as he is managing his asthmatics and hypertensives, he would have made more money. These figures give him actionable directions to improve care both on efficiency and quality. In addition, since most physicians (and hospitals) will not score in the 90s, there will be monies left in the PAC Pools. The balance of those incentive funds will be distributed to the top 25% of quality performers. Together, there are multiple bases on which providers can find common ground to improve care and do better financially. And those who do the best on quality, by comparison with others, stand to make even more money. This further incentivizes providers to do better with each additional patient as well as in comparison to their peers.

¹⁸ Again, the principles for these calculations are set forth in "Making PROMETHEUS Payment® Rates Real: Ya' Gotta' Start Somewhere."

Effects

This earliest version of the scoring methodology is intended to lower administrative burden to all and capture salient data on quality that will be meaningful to patients, employers, and health plans, and useful to providers. We have taken what is available today, and adapted it to the philosophy and purposes of the PROMETHEUS Payment[®] design as distinct from any other current payment programs. While the model shares the measures of some of the best pay for performance programs, because the ECRs are constructed so differently from existing payment models, the significance of those measures is changed. The scoring supports financial incentives for appropriate compensation for the “quantum” of quality produced, better reimbursement for clinical collaboration which yields better scores, and flexibility in the techniques of care delivery. “Continuous scoring” rewards good care with each additional well-treated patient, and yields better results for providers who do better overall.

As the model is tested in pilot sites, like much in the PROMETHEUS Payment[®] model, we also will continuously refine our approach. As better condition-specific metrics become available, they will be parsimoniously added to the mix, substituting for today’s metrics which may not be ideal. We have much to learn from the application of the methodology, but, like the ECRs, we have to start somewhere to change healthcare with a better payment model. The PROMETHEUS Payment[®] model is a dynamic work in progress, and like the healthcare it is designed to improve, expects changes over time as well.

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PROMETHEUS Payment[®], Inc. is a not for profit corporation which has been created to steward the further development and implementation of the PROMETHEUS Payment model.

PROMETHEUS Payment is specifically designed to: (1) improve quality (2) lower administrative burden (3) enhance transparency and (4) support a patient-centric and consumer driven environment, all while facilitating better clinical coordination throughout health care.

By creating common clinical incentives for all parties, the likelihood of significant system reform is enhanced even though in the fullness of time PROMETHEUS Payment will not substitute for all fee for service and capitation. In the last analysis, PROMETHEUS Payment is intended to create a payment environment where doing the right things for the patient helps providers and insurers do well for themselves.

For more information on the PROMETHEUS Payment system, visit www.prometheuspayers.org.