

Guest Editorial

A New Payment Model for Quality: Why Care Now?

Since the publication of *Crossing the Quality Chasm*,¹ the quest for significantly improved health care quality for all Americans has been joined by a wide variety of stakeholders. Beginning with the Institute of Medicine, virtually all recent commentators on quality acknowledge that for real change to occur, we need a different payment model.

Fee-for-service pay stimulates overuse—the more you do, the more you get paid. Capitation and diagnosis-related group payments reward underuse—the less you do, the more money you make. Pay-for-performance has emerged as an increasingly deployed technique to compel better quality results more quickly than the pace of historical evolution would produce, but it offers small amounts of money on top of fundamental systems that drive toward different results. How can these challenges be met in a new payment model? Some would prefer to focus on paying for outcomes alone. Not only is there considerable debate over whether there is any way to determine who is responsible for an outcome to which payment might be linked, but what would the price of an outcome be?

Beginning in December 2004, a multiple-stakeholder group of disparate experts in such areas as medicine, health care quality, finance, insurance, law, payment, and benefit design began to meet monthly to confront the toxicities in the current payment system by creating a new model that would be practical, realistic, and equitable for health plans, providers, and—most of all—the patients in whose service the health care system operates. The result

is the PROMETHEUS Payment model: **P**rovider payment **R**eform for **O**utcomes, **M**argins, **T**ransparency, **H**assle-reduction, **E**xcellence, **U**nderstandability, and **S**ustainability. The values driving the model are contained in its acronymic name. Using the Design for Six Sigma approach employed by General Electric, the design team defined the boundaries of the exercise: (1) the mechanism could not disrupt existing health plan processes; (2) it would have to explicitly lower administrative burden to providers; (3) transparency would be a bedrock of all processes; (4) it could not require legislation to implement; and (5) although parallel benefit design modes would strengthen the power of the model, our work would be oriented around how to pay providers fairly.

The fundamental mechanism of the PROMETHEUS Payment model is to take good clinical practice guidelines (CPGs) and analyze the cost of the resources necessary to deliver that continuum of care while taking into account all that science—and the patient—says the patient needs for his or her condition, and considering any comorbidities. From that calculation, an Evidence-informed Case Rate (ECR) is constructed encompassing all the care dispensed by all the providers involved in delivering the services in the CPG (eg, physicians, hospitals, laboratories, imaging centers, pharmacies, and rehabilitation providers). Because we know that there is not a true evidence base for all of the types of care a patient might require, the model will also draw on consensus judgments and empirically good processes, particularly in terms of quantifying the full range of resources necessary to deliver better care. In that way, we can take into account the time and effort providers should bring to bear to facilitate communication in care delivery, in addition to services and supplies.

PROMETHEUS Payment creates case rates that are grounded in the guidelines. That concept is simple, clinically relevant to the way physicians think and treat, and offers significantly better

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opportunities to address misuse, overuse, and underuse. It is important that the logic of the fundamental principle of the system seem ineluctably obvious and not fiendishly clever. Because physicians and their orders drive the vast proportion of what the rest of the health system delivers, it is particularly important that physicians find the concept compelling, different, and simple.

Science-based case rates alone, though, would not necessarily motivate providers to alter their current inefficient, nonoptimal care processes. What differentiates PROMETHEUS Payment from previous systems is the use of a withhold that is only paid based on a scorecard that measures whether the salient elements of the guideline were provided, the patient's experience of care, and the outcomes of care. Most significantly, a provider is scored 70% on what he does and 30% on what all of the other providers treating the patient do. This mechanism is intended to create a clear, inescapable incentive for otherwise independent providers (eg, physicians, hospitals, and rehabilitation agencies) to work together in clinical collaboration. Because of the impact of the care rendered by everyone treating the patient on the provider's financial success, providers have a real motivation to refer to higher quality and more efficient collaborators.

Rates are negotiated by any provider or combination of providers for those portions of the ECR budget they will provide. A portion of the negotiated rate (ie, 10% for chronic care and 20% for acute care) is withheld in a Performance Contingency Fund, and these monies are paid only when provider scores are adequate. First, the provider must meet a minimum quality threshold; then half of the contingency fund is applicable to quality results and half is applicable to efficiency. Providers are paid pro rata for their results after they meet the minimum quality threshold.

The concept of science-based case rates is not difficult. However, the infrastructure to make the model work—the “engine” to translate CPGs into ECRs, to track and allocate payment to the rendering provider, to gather data to populate the scorecard, and to give providers useful information during the delivery of care—is complex. These mechanisms will be in place, though, before the program is even tested in pilot markets. The key to initiating the pilot tests will be health plan enthusiasm.

The expected benefits are considerable. With its foundation of science-based care, an emphasis on transparency to all, and above all, its focus on clinical collaboration that does not require any change in

legal structures, the PROMETHEUS Payment model departs from previous payment models by focusing first on the patient's clinical needs. It keeps insurance risk at the plan and only assigns risk to providers for knowing what it costs them to treat a patient effectively and for managing care within their negotiated piece of the ECR budget. No provider holds the money of any other provider unless it chooses to be paid that way. PROMETHEUS Payment reduces administrative burden through the elimination of the plethora of administrative hoops of fire that most health plans impose (eg, prior authorizations, concurrent reviews, postpayment reviews, claims audits, certificates of medical necessity for ancillary and costly care, and drug formularies). All are replaced by the effect of the scorecard. This change alone would likely motivate physicians to participate, but it also helps health plans. For plans and providers, this payment model offers far greater certainty of cash flow and likely expenditures for a large proportion of the care that is paid for in this country. The design team estimates that the new model will be appropriate for about half of the care that Americans receive. It is far too complex for simple conditions like a urinary tract infection or chest cold, and it will never be able to accommodate the complexities of some patients' conditions, even with the built-in risk adjusters. Therefore, fee-for-service and capitation, and any other payment models that might emerge over time, will remain in place for the rest.

Still, the PROMETHEUS Payment program is unproven and, because it will be tested in 4 pilot markets, likely will not be in play for most sectors of the health care industry for a few years. Why should anyone care today? Because what the PROMETHEUS Payment model will reward is what providers should already be doing—and plans should be helping them.

Even today, providers who come together in clinically integrated relationships are protected under the antitrust rules in their fee negotiations, even though their primary functions are about improving quality. Hospitals are looking for ways to avoid the tensions of economic credentialing, conflict of interest policies, and financial disclosures that have characterized many current hospital-physician relationships and, instead, to engage with physicians to improve the hospital's quality of care. Clinical collaboration, which recognizes the physicians' business case for quality while helping them become more efficient and gain more time in their day, offers a significant opportunity for hospitals to work more effectively with physicians to achieve their common goal of providing

quality care to the patients the physicians bring to the hospital.

Physicians can improve their own circumstances by standardizing their care processes, becoming more resourceful in delivering care to improve financial margins, and by keeping these values in mind when making referrals to and from other providers.

Even without the PROMETHEUS Payment model, health plans could do much more to assist in these undertakings while enhancing a patient-centric view of quality. This is possible without unduly imposing on the providers who render the services on which health plans are measured and compared.

The challenges to improving health care quality and safety in the United States are considerable. Today, more than in the past 30 years, there is far more intense focus and substantial good work going on to address this critical issue. The best chance to maximize these efforts will require payment reform.

The PROMETHEUS Payment model offers a significant opportunity in that regard, even though it undoubtedly will need refinement and adjustment based on the pilot test results. Providers and health plans who step up to make PROMETHEUS real will be pioneers for the rest of the system. Pending widespread adoption, the concepts and values in PROMETHEUS Payment offer a disciplined way to approach the central quality mission of the American health care system.

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REFERENCE

1. Committee on Quality Health Care in America (Institute of Medicine). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.