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The ideas and viewpoints expressed in this commentary are those of the author and do not necessarily represent any policy, position, or program of the NCCN.

PROMETHEUS Payment: Better Quality and a Better Business Case

Frustration with the quality of care provided by the American health care system has motivated a raft of new initiatives throughout the country. Medicare's "voluntary" hospital reporting program to which Congress attached financial penalties for noncooperation,¹ the purchasing principles of the Leapfrog Group,² and the 100,000 Lives Campaign³ are all manifestations of this dissatisfaction.

Although these efforts are all intended to improve care, they occur within the context of payment systems that have been decried, particularly by physicians, as unfair, administratively burdensome, and distracting from the ability to deliver optimal care. Pay for performance, which represents a positive change from the "one size fits all" quality approach of most health care payment systems, is at best transitional.⁴ Even the Institute of Medicine (IOM) has called for a new payment model as an essential feature of a better health care system for the 21st century.^{5,6}

The challenge would be to develop a model that would not only track explicitly to the values articulated by the IOM but also reduce administrative burden to providers and plans and improve quality of care—all in the context of a more transparent, patient-centric environment. Beginning in December 2004, a group of experts in quality, research, economics, healthcare financing, law, and medicine began to meet monthly to design PROMETHEUS Payment: Provider payment Reform for Outcomes, Margins, Evidence, Transparency, Hassle-reduction, Excellence Understandability and Sustainability.⁷ This commentary describes the salient features of the new model, its specific appeal to cancer care providers, and its potential benefits.

Fundamentals

The basic principle of PROMETHEUS Payment is to pay the right amount to the provider for the appropriate resources to be applied in accordance with the best science available to treat a specific condition, as expressed in a good clinical practice guideline (CPG). PROMETHEUS differs from all prior forms of payment because it takes as the starting point for the price an evidence-based case rate (ECR), which is modeled from the CPG and takes into account all of the providers who will interact with the patient in the delivery of CPG-based care, including physicians, hospitals, pharmacies, and imaging centers.

As patients develop complications and other comorbidities, the ECR payment amount is increased to account for the additional resources used. Eventually, however, a point comes when the ECR is broken; when the comorbidities rise to such a level that the basic condition that drives the ECR is no longer the primary reason for treatment. For example, treatment for a breast cancer patient who develops fevers, dehydration, and a wound infection after undergoing a lumpectomy with or without radiation is still paid for according to a risk-adjusted breast cancer ECR. If she has a heart attack, however, the ECR is broken.

As a voluntary system, PROMETHEUS allows providers to come forward and negotiate a price to deliver the part of the CPG that is within their expertise

PROMETHEUS Payment

and choice. They can configure themselves into any aggregations they choose. The model will work for solo practitioners, hematology–oncology groups, independent practice associations, stand-alone cancer centers, academic medical centers, hospitals bidding with physicians, and physicians bidding with rehabilitation providers or pharmacies, all the way to fully integrated delivery systems. No one holds the money of any other provider unless they choose to be paid that way. Providers who bid to treat patients in concert may still be paid separately.

The payment is triggered by the submission of a standard claim form, but that form is used only to track who has rendered which portion of the CPG. The bulk of the payment will be made prospectively; in essence, each provider receives a monthly portion of the bargained-for rate. (Physicians who are fearful of being paid prospectively can be paid fee-for-service under PROMETHEUS, with a reconciliation at the conclusion of treatment to the total amount that could be paid.) That portion would reflect 80% of the decided amount for acute conditions and 90% for chronic conditions. The 10% or 20% holdback creates a performance contingency fund that is paid based on measures that determine whether the provider delivered according to the bargain.

Whether the provider receives the full contracted amount depends on the results of a comprehensive scorecard that measures whether the salient elements of the CPG were delivered, the outcomes of care, and the patient's experience of care. Seventy percent of the score is determined by the provider's performance, but 30% of the score reflects the care provided by other providers treating the patient for that condition. This design is intended to motivate more clinical collaboration among otherwise independent providers, because each receives more financial benefits when they all perform well.

Half the monies are allocated based on quality results and the other half are allocated depending on efficiency (except in integrated delivery systems that take inherent risk for efficiency by bargaining to deliver all the care in the CPG). Because not all providers will score 100% on quality, the remainder of the quality funds are held in still another pool that is distributed to stellar performers as a bonus on top of the amount they bargained to be paid. Efficiency fund remainders are not paid out to providers because the plans incur expenses in paying beyond the bargained-

for amounts when providers are inefficient, particularly when those providers are not part of the PROMETHEUS Payment system.

Appeal to Cancer Care Providers

Many of the new quality initiatives of the past few years have been oriented primarily around chronic care, to which the American health care system has not devoted sufficient attention.⁸ The world of oncology may have felt excluded from much of this focus, although for patients diagnosed with cancer, their condition is in many ways chronic. Moreover, the rapid change in the business model for oncologists, who must now rely less on payment for chemotherapeutic agents, signals a propitious moment to consider a move toward this new model.

No evidence exists that cancer care is better than care for other conditions,⁹ and because of the aging population, the quality of that care will surely be the focus of more scrutiny. Because oncology has both a long tradition of standardization of care in clinical trials and well-established CPGs, including those of the National Comprehensive Cancer Network (NCCN), cancer care as a specialty offers an excellent opportunity for PROMETHEUS Payment implementation. Cancer, therefore, has been selected as one of the first conditions to be paid according to this model, with initial focus on lung cancer and colon cancer.

Today, there is interest among plans, employers, and providers in moving to something different, and PROMETHEUS offers a logical and easily understood approach. Although developing the infrastructure to make the program work involves significant complexities, that work has begun. PROMETHEUS is intended to be as “plug and play” as possible for health care plans so that their primary payment systems need not be disrupted or reordered. Moreover, the actual tracking of the payment is conducted by service bureaus that are independent of the plans, making payment potentially faster and the critical payment judgments credible and not subject to typical plan claims payment problems, including lost claims and questioned claims.

Other Benefits

Core values drive the PROMETHEUS Payment model. Transparency is a bedrock principle. All CPGs

Gosfield

on which payment is based, the ECR itself, prices, and reports about provider performance are all transparent; the model includes no black boxes.

The system is intended to be voluntary and predicated on the principle that providers negotiate their portion of the ECR directly with the plans rather than sign “take it or leave it” contracts or be forced to deal with profit-making intermediaries who skim monies from the real providers.¹⁰

A major expected benefit is administrative burden reduction. From the outset, the plan requires no prior authorizations, concurrent review, post-payment review, certificates of medical necessity, or other administrative features (including, potentially, drug formularies) that have characterized traditional payment models. All of their purposes are addressed in the agreed-on CPG that drives the payment. Physicians need not document evaluation and management code levels, because PROMETHEUS is indifferent to visit levels. Providers have considerable autonomy to determine how to provide care as long as the salient elements of the CPG are rendered.

PROMETHEUS also provides new ways for hospitals and physicians to help each other with their separate business cases for quality.¹¹ Hospitals cannot succeed in responding to the many new quality and efficiency mandates they confront without the passionate engagement of their key physicians.¹² PROMETHEUS provides a solid basis on which to begin this work and avoid the pitfalls of the physician-hospital organization debacles of the early 1990s.¹³

On The Horizon

The software “engine” that will enable PROMETHEUS Payment work is under construction. Pilot markets will begin to test implementation in early 2007, and much can be learned from pilots. So, why care now? The keys to the success of PROMETHEUS Payment are issues cancer care providers should confront no matter the

payment model. PROMETHEUS Payment provides a disciplined way to address those issues with one foot in the present and a clear eye to the very near future.

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