2014 Medicare (and Private Insurance) Payment Reform for Oncology

Ensuring the Delivery of Quality & Value-Based Cancer Care

**PHASE 1**
- Drugs at ASP + 6% E&M
- Onc/Hem Services
- Quality & Value Reporting

**Implement within 1 year**
- Current fee-for-service (FFS) payment structure for drugs and services (E&M and Oncology/Hematology [Onc/Hem] specific codes).
- Compliance with Measures reporting & Oncology Patient Satisfaction (OPS) reporting — 0% to 2% Quality/Value Adjustment (QVA) based on formula.
- *Measures are Stage I (see following pages) and full OPS reporting.

**PHASE 2**
- Drugs at ASP + 6% E&M
- Onc/Hem Services
- Quality & Value Performance

**Implement within 2 years**
- Current FFS payment structure for drugs and services (E&M and Onc/Hem specific codes).
- Additional payment or decrease tied to relative Measures performance & OPS performance — -2% to 5% QVA based on a specific formula. Any increases from Phase 1 built into formula such that Phases 1 & 2 are revenue neutral.
- Compliance with Measures/OPS* reporting qualifies practice to receive MEI increase.
- *Measures are Stage I & II and full OPS reporting.

**PHASE 3**
- Drugs at ASP + 6% E&M
- Onc/Hem Services
- Shared Savings

**Implement within 3 years**
- Current FFS payment structure for drugs and services (E&M and Onc/Hem specific codes).
- Additional 50/50 shared savings benchmarked against regional or national comparison group. Savings quantified on ER utilization and hospitalizations, and drug/infusion costs (if available by diagnosis). Imaging and radiation costs also included if provided by provider. Practices must hit established quality Measures/OPS* targets to qualify for any savings.
- Compliance with Measures/OPS* reporting qualifies practice to receive MEI increase.
- *Measures are Stage I & II and full OPS reporting.

**PHASE 4**
- Episode of Care (Drugs & Services)
- Shared Savings

**Implement within 5 years**
- Practice is paid based on a predetermined episode of care (by cancer type; adjuvant and metastatic) that combines services and drugs. A demonstration project will be fielded by CMS at least 3 years prior to national implementation in order to develop/refine episode payments.
- Shared savings benchmarked against comparison group as in PHASE 3 but increases to 60/40 (practice/Medicare) for greater risk assumption by providers.
- MEI increase applied to episode of care payments.
- Measures are Stage I, II & III (III if feasible), to-be-developed outcomes measures, and full OPS reporting.

**NOTES**
- Assumes suspension of the SGR for oncology/hematology.
- “Onc/Hem Services” includes infusion, imaging, radiation, and others provided.
This is the expanded list of quality and value measures that have been approved by the Oncology Medical Home (OMH) Steering Committee. This list is the direct result of reviews by the OMH Payer Sub-Committee, the Ad-hoc Measures Sub-Committee, and the complete OMH Steering Committee. This list is the endorsement of measures in an on-going process to recognize and reward quality, value, and positive outcomes in cancer care. Note that these are simple one-line descriptions of the measures but are supported by extensive documentation on the composition and calculation of each measure.

<table>
<thead>
<tr>
<th>Patient Care Measures</th>
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<tbody>
<tr>
<td>% of cancer patients that received a treatment plan prior to the administration of chemotherapy.</td>
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<tr>
<td>% of cancer patients with documented clinical or pathologic staging prior to initiation of first course of treatment.</td>
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<tr>
<td>% of chemotherapy treatments that have adhered to NCCN guidelines or pathways.</td>
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<tr>
<td>Antiemetic drugs given appropriately with highly emetogenic chemotherapy treatments.</td>
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<tr>
<td>% of cancer patients undergoing treatment with a chemotherapy regimen with a 20% or more risk of developing neutropenia and also received GCSF/white cell growth factor.</td>
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<tr>
<td>Appropriate use of advanced imaging for early stage breast cancer patients.</td>
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<tr>
<td>Appropriate use of advanced imaging for early stage prostate cancer patients.</td>
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<tr>
<th>Resource Utilization</th>
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<tr>
<td># of emergency room visits per chemotherapy patient per year.</td>
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<tr>
<td># of hospital admissions per chemotherapy patient per year.</td>
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<tr>
<td><strong>Survivorship</strong></td>
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<td>------------------</td>
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<tr>
<td>% of cancer patients that received a survivorship plan within X days after the completion of chemotherapy.</td>
</tr>
<tr>
<td>% of chemotherapy patients that received psycho/social screening and received measurable interventions as a result of the psycho/social screening.</td>
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<tr>
<td>Survival rates of stage I through IV breast cancer patients.</td>
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<tr>
<td>Survival rates of stage I through IV colorectal cancer patients.</td>
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<tr>
<td>Survival rates of stage I through IV NSC lung cancer patients.</td>
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<th><strong>End of Life</strong></th>
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<tr>
<td>% of patients that have Stage IV disease that have end-of-life care discussions documented.</td>
</tr>
<tr>
<td>Average # of days under hospice care (home or inpatient) at time of death.</td>
</tr>
<tr>
<td>% of patient deaths where the patient died in an acute care setting.</td>
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<tr>
<td>A measurement of chemotherapy given near end of life.</td>
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**Stage I Measures**

**Stage II Measures**

**Stage III Measures**
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Model Description

Practicing community oncologists and oncology practice administrators have been working for over 2 years on payment reform for Medicare and private insurance specific to oncology. This effort relates to COA’s major initiative on the Oncology Medical Home, and the specific development of practical measures of quality and value relating to cancer care delivery. The model described below is a four-part initiative intended to transform the current Medicare reimbursement system (and that of private insurance) and to tie payment to the documented delivery of quality, value-based cancer care. Unlike unproven, conceptual approaches, the model has elements that are being tested today in actual practice and pilots being conducted with private insurers.

PHASE 1
Implemented within 1 year

Medicare Part B reimbursement for drugs is retained at the current rate of average sales price (ASP) plus 6%. All services — including evaluation and management (E&M), infusions, etc. — are paid at rates established by the annual Medicare Physician Fee Schedule. These payments relate to oncology and hematology services.

An overall additional payment modifier for services can be earned by participating oncology/hematology providers. In order to be eligible, providers must report certain quality measures endorsed by the Oncology Medical Home Steering Committee. Reporting of these codes can be implemented through the Medicare Part B reimbursement coding system. Additionally, providers must be reporting participation in Oncology Patient Satisfaction (OPS) data collection. Participation in both Measures and OPS reporting will allow providers to receive up to a 2% increase in services payments.

This model — Phases 1 through 4 — in general assumes that the sustainable growth rate (SGR) formula will be eliminated. Providers participating in Measures/OPS reporting will receive an annual adjustment in services payments based on the Medicare Economic Index (MEI).

PHASE 2
Implemented within 2 years

Medicare Part B reimbursement for drugs is retained at the current rate of average sales price (ASP) plus 6%. All services — E&M, infusions, etc. — are paid at rates established by the annual Medicare Physician Fee Schedule. These payments relate to oncology and hematology services.

An overall additional payment modifier for services can be earned by participating oncology/hematology providers; however, providers can also experience a negative modifier based on non-participation or low performance results. In this phase, reporting on Measures and OPS moves to a performance score based on an established formula. Based on participation level and performance, providers will receive from a 5% increase to a 2% decrease in services payments. The formula will be based on established levels of participation and performance that weight Measures and OPS performance. Performance scores are established relative to other providers. The formula will incorporate the overall increase provided in Phase 1, such that Phases 1 and 2 will be revenue neutral from the standpoint of legislative budget scoring.

Providers participating in Measures/OPS reporting will receive an annual adjustment in services payments based on the Medicare Economic Index (MEI).
**PHASE 3**  
Implemented within 3 years

Medicare Part B reimbursement for drugs is retained at the current rate of average sales price (ASP) plus 6%. All services — E&M, infusions, etc. — are paid at rates established by the annual Medicare Physician Fee Schedule. These payments relate to oncology and hematology services.

Phase 3 moves to performance based on both quality and value outcomes. First, providers must continue to report and be gauged on performance relating to Measures and OPS. In order to participate in any shared savings, established thresholds of value must be hit. Second, providers will be eligible to receive additional payment based on savings realized relating to lower hospitalizations and emergency room (ER) utilization, and treatment costs they can impact (if available by diagnosis). The shared savings formula will also include diagnostic imaging and radiation therapy services, if provided by the practice internally. Providers will be compared with an established regional or national comparison group to determine any treatment savings. Providers meeting quality (Measures and OPS) thresholds will be eligible to receive 50% of the determined savings, with the other 50% retained by Medicare.

Providers participating in Measures/OPS reporting will receive an annual adjustment in services payments based on the Medicare Economic Index (MEI).

**PHASE 4**  
Implemented within 5 years

CMS and private payers will work with the oncology community to establish Episode of Care Payment Modules (ECPM). These ECPMs will combine total drug costs (both acquisition and facilities costs) and patient management costs (including the providers hospital costs) by cancer type, adjuvant and metastatic. The ECPMs will cover a designated episode of treatment, such as a cycle of chemotherapy.

Similar to Phase 3, an additional payment will be available under a shared savings program, which will also necessitate providers reporting and meeting a threshold level of quality via Measures and OPS scoring. Providers will be eligible to receive 60% of the determined savings, with the other 40% retained by Medicare. This higher shared savings going to providers is balanced by the higher risk that providers are assuming in an episode of care payment system.

Because a great deal of work has to go into the development of the ECPMs, this will require implementation of a pilot demonstration project at least 3 years prior to national rollout of this Phase 4. The demonstration pilot can be funded by the Centers for Medicare and Medicaid Innovation (CMMI) and would involve 5-6 oncology practices actually testing the ECPM model in a risk-neutral pilot design. Oncologists and practice administrators would work closely with CMS in developing and implementing this pilot.

The specific feasibility of this ECPM phase is documented by the oncology providers currently participating in the UnitedHealthcare Episode of Care Oncology Pilot Program. However, due to the different types of cancer, and severity/stage of the disease, developing and implementing ECPMs is a difficult task. This is why this phase needs to be piloted.

Providers participating in Measures/OPS reporting will receive an annual adjustment in services payments based on the Medicare Economic Index (MEI).