



CENTER FOR
HEALTHCARE
QUALITY &
PAYMENT REFORM

A Better Way to Pay for Cancer Care

*The Problems with CMS Oncology Payment Models and
How to Create Patient-Centered Cancer Care Payment*

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EXECUTIVE SUMMARY

The Challenge of Payment Reform for Cancer Care

A “high-value” cancer care system should ensure that cancer patients have the ability to obtain both the treatment that offers the best opportunity for a cure and other services that minimize their suffering before, during, and after treatment, all at the most affordable cost possible. Unfortunately, for many patients, our current healthcare system fails to achieve these goals. A primary reason is that the fee-for-service payment system currently used by Medicare and other payers underpays or doesn’t pay at all for many of the services that cancer patients need, and it does not assure that patients will receive high-quality, evidence-based treatment.

Congress has encouraged the creation and implementation of “Alternative Payment Models” (APMs) in an effort to address the problems with fee-for-service payment. Unfortunately, the APMs for oncology that have been developed by the Center for Medicare and Medicaid Innovation (CMMI) not only fail to solve most of the problems with the fee-for-service payment system, they create new problems with the potential to harm patients and force oncology practices out of business.

Fortunately, there is a better way to design an APM for oncology. Patient-Centered Cancer Care Payment can fix the problems with current payment systems without harming patients, and thereby support the delivery of higher-quality, more affordable care for cancer.

The Strengths and Weaknesses of Fee-For-Service Payment

There are many problems with the fee-for-service payment system used by Medicare and most other payers to support cancer care. The most serious problems fall into four major categories:

- 1. No Payment or Inadequate Payment for High-Value Services.** Although oncology practices can be paid for hundreds of specific services, ranging from drawing blood for a lab test to infusing chemotherapy or delivering radiation, there are no fees at all for high-value services such as care management and palliative care, and fees are inadequate to support the time needed for critical services such as diagnosis and treatment planning. Because of these gaps in payment, patients will receive unnecessarily expensive services or experience problems that result in costly hospitalizations.
- 2. A Problematic Method of Paying for Cancer Drugs.** There are serious problems with the “ASP+x%” methodology that Medicare and most commercial payers use to pay an oncology practice for the chemotherapy

drugs it uses to treat patients. In some cases, oncology practices are paid far less than what it costs them to acquire a drug, and in other cases, they make significant profits that they use to subsidize the losses on other drugs and services. As a result, the drug that achieves the best outcome for the patient may not produce the best financial result for the oncology practice.

- 3. A Problematic Method of Paying for Radiation Therapy.** Fee-for-service payment is poorly suited for radiation therapy because the radiation oncology practice can only cover the high costs of expensive radiation therapy equipment if the practice delivers enough doses of radiation to enough patients. If evidence-based care guidelines indicate that patients don’t need that many treatments, the practice will lose money.
- 4. No Assurance of High-Quality Care at the Most Affordable Cost.** Fees are paid based solely on whether a service was delivered, regardless of whether the service was appropriate or necessary, whether it achieved the desired outcome, and whether it caused any harm to the patient. “Pay for performance” (P4P) programs, such as the Merit-Based Incentive Payment System (MIPS) in Medicare, do little or nothing to correct these problems because there are no measures of whether evidence-based treatment is being used for most types of cancer, and the measures that are used do not assure that each individual patient receives appropriate high-quality care for their individual needs.

Despite these problems, the fee-for-service payment system also has four important *strengths* that benefit patients:

- 1. A physician has no financial incentive to delay or withhold needed treatment.**
- 2. Payments are higher for patients who need more services.**
- 3. Physician practices and hospitals know how much they will be paid for the services they deliver.**
- 4. Providers are not rewarded or penalized for things they cannot control.**

Most of the alternative payment models in Medicare not only fail to adequately address the problems with the fee-for-service payment system, they also fail to preserve its strengths.

The Strengths and Weaknesses of the CMS Oncology Care Model

In 2015, the Center for Medicare and Medicaid Innovation (CMMI) created an APM for cancer care called the Oncology Care Model (OCM). Under OCM, a participating oncology practice:

- continues to be paid all current fee-for-service payments.
- receives “Monthly Enhanced Oncology Services” (MEOS) payments for patients receiving chemotherapy and is required to deliver “enhanced” services to the patients.
- is eligible to receive a “Performance-Based Payment” if total spending on patients during chemotherapy is below CMS-determined “Target Prices;” the Performance-Based Payment is reduced if the practice has low performance on quality measures

In addition, if the oncology practice is participating in one of the “downside risk” tracks of OCM, it has to pay a penalty to CMS if spending on its patients exceeds Target Prices.

OCM directly addresses three of the problems with the fee-for-service payment system: it provides a new payment that can support care management services for a patient receiving chemotherapy, it creates a financial penalty if an oncology practice’s patients have a high rate of avoidable complications, and it reduces the loss of revenues for a practice when it avoids delivering unnecessary services.

However, most of the other problems with the current payment system are not addressed by OCM:

- **OCM provides no additional resources for diagnosis and treatment planning.**
- **OCM provides no payment for palliative care services.**
- **OCM makes no improvements in the method of payment for cancer drugs.**
- **OCM makes no improvements in the method of payment for radiation therapy.**

In addition, the payment methodology used in the Oncology Care Model creates serious problems for patients and oncology practices:

- **OCM Creates a Financial Incentive to Withhold Needed Treatment.** An oncology practice can receive a bonus through the Performance-Based Payment (PBP) for withholding the delivery of an expensive treatment that a patient needs. The quality component of OCM does nothing to prevent an oncology practice from stinting on care.
- **OCM Penalizes Practices for Using Evidence-Based Care and Encourages Practices to Avoid Patients Who Need More Expensive Treatments.** The methodology CMS uses to set Target Prices fails to adjust for important clinical differences between patients, changes in evidence about effective treatments, and large increases in the prices of drugs, and CMS reduces all Target Prices by an arbitrary “discount.” This means that if a practice treats patients based on the most current evidence, spending will likely exceed the Target

Prices and subject the oncology practice to financial penalties.

- **OCM Rewards Practices for Delays in Completing Treatments.** In OCM, CMS pays for services in six-month “episodes,” which means oncology practices will receive significantly higher payments if they stretch out patient treatments to last longer than six months.
- **OCM Encourages Oncology Practices to Avoid Patients Who Have Health Problems Unrelated to Cancer Treatment.** The Performance-Based Payment in OCM is determined based on *total* spending on *all* services that an oncology practice’s patients receive for all of their health issues, not just services related to their cancer. An oncology practice will be less likely to receive a Performance-Based Payment, and more likely to have to pay a penalty, if it has a higher-than-average number of patients with health problems other than cancer.

Many oncology practices are now facing the prospect of either (a) joining one of the downside risk tracks and paying penalties to CMS based on this flawed methodology, or (b) exiting the OCM program altogether and losing the additional payments it provides. Either way, the loss of revenues will likely result in reduced services and poorer outcomes for patients.

The Problems with “Oncology Care First”

On November 1, 2019, CMS released a draft version of a new payment model called “Oncology Care First” that is designed to replace the Oncology Care Model (OCM). Unfortunately, Oncology Care First (OCF) fails to correct most of the serious problems with OCM and makes some of the problems worse.

In Oncology Care First (OCF), all participating oncology practices would be subject to penalties based on the problematic Performance-Based Payment methodology used in the Oncology Care Model. As a result, just like the Oncology Care Model:

- **OCF would reward oncology practices for withholding needed treatments.**
- **OCF would reward oncology practices for delays in completing treatments.**
- **OCF would penalize oncology practices for using evidence-based care.**
- **OCF would encourage oncology practices to avoid treating patients who need more expensive treatments and who have health problems unrelated to cancer treatment.**

OCF would replace the Monthly Enhanced Oncology Services (MEOS) payment with a new monthly “Enhanced Services Payment” for all of the patients receiving services from the oncology practice, with higher payment amounts for patients receiving chemotherapy and lower amounts for other patients. However, it is not clear whether the amounts of the Enhanced Services Payments will be the same as the OCM MEOS payments for patients receiving chemotherapy, and the amounts may not be adequate to support the costs of enhanced services for patients who are not receiving chemotherapy. OCF would also replace the fees an oncology practice

currently receives for Evaluation & Management (E/M) Services and for administration of chemotherapy with a “Monthly Population Payment” (MPP). Although the MPP would give oncology practices greater flexibility regarding the services they deliver and more predictable cash flow, the payments may not be adequate to support the costs of delivering the services that patients need, because the amount of the MPP would not be adjusted for important differences in patient needs. Compared to current payments, oncology practices could be underpaid for new patients, patients who need longer or more frequent infusions, patients who are receiving the most toxic chemotherapy regimens, patients with more complex needs, and patients with more advanced cancer.

Oncology Care First would also still fail to address many of the other serious problems in the fee-for-service system:

- OCF does not provide the additional resources needed for diagnosis and treatment planning.
- OCF provides no payment for palliative care services.
- OCF makes no improvements in the method of payment for cancer drugs.
- OCF makes no improvements in the method of payment for radiation therapy.

The Problems with the CMS Radiation Oncology Model

In July 2019, CMS proposed to create a “Radiation Oncology (RO) Model” specifically focused on payments for radiation oncology services. Under the RO Model, a radiation oncology practice would receive a single payment for all of the radiation therapy services a patient receives during a 90-day period following the first treatment, instead of the more than 100 separate fees that are currently paid for individual services and treatments.

This type of bundled payment for a full set of radiation treatments delivered to a patient would reduce the mismatch between revenues and costs caused by current dose-based fees, and better enable a radiation oncologist to select the number of doses that are best for the patient without concern about the financial implications for the practice. However, in order to make payments on a per-patient basis rather than a per-dose basis, the amount of payment has to be based on the types of treatments that a particular type of patient is likely to need using current evidence about effective treatment.

Unfortunately, the methodology for setting the bundled payment amounts in the CMS Radiation Oncology Model fails to properly adjust for the differences in costs of radiation treatment modalities or for the differences in the types and amounts of treatments individual patients will need. Payment amounts in the CMS RO Model would not be based on the actual cost of delivering services, and the payment amounts would not be based on the most current evidence about appropriate treatment and advances in technology. As a result:

- The RO Model would discourage radiation oncology practices from treating patients who require more extensive or expensive treatments.

- The RO Model could force small radiation oncology practices out of business, reducing patient access to treatment.

The Radiation Oncology Model focuses solely on changing the amount of payment for radiation treatment. It does even less to address the other problems in the fee-for-service system than the Oncology Care Model:

- The RO Model provides no additional payments to support diagnosis and treatment planning.
- The RO Model provides no additional payments to support care management services during treatment.
- The RO Model provides no payment for palliative care services.
- The RO Model provides no additional payment for survivorship support.
- The RO Model creates no penalties for failure to follow evidence-based guidelines for treatment.

A Better Way: Patient-Centered Payment for Cancer Care

The problems with the current and proposed CMS payment models for oncology cannot be solved by incremental modifications. What is needed is a fundamentally different approach – a *patient-centered* approach to oncology payment.

The goal of an Alternative Payment Model for cancer care should not just be to reduce spending, but to reduce spending *while maintaining or improving quality*. The best way to ensure this happens is to focus on reducing *avoidable* spending, i.e., specific services that are unnecessary, unnecessarily expensive, or harmful to patients. There are two principal areas where there is significant avoidable spending in the care of cancer patients:

- Use of treatments and other services that are not consistent with evidence-based guidelines.
- Emergency department visits and hospital admissions for complications of cancer treatment.

The amount of potential savings in these two areas is so large that it could easily exceed the arbitrary “discount” amounts that CMS has been requiring in its APMs.

These opportunities to reduce spending and improve the quality of cancer care exist because the fee-for-service payment system does not support the changes in services needed to address them. In particular, oncology practices need the ability to:

- spend adequate time to accurately diagnose the patient and choose evidence-based treatment;
- receive adequate payment to cover the cost of delivering evidence-based treatments to patients;
- rapidly identify and address complications of treatment when they arise; and
- provide palliative care for patients with advanced cancer.

If oncology practices receive adequate payments to support delivery of these services, then it is both feasible and

appropriate for them to take accountability for achieving reductions in avoidable services.

In an APM designed this way, there is no risk of under-treating patients, because the focus is only on actions that will reduce spending without harming patients. Moreover, by reducing services that can be harmful and/or substituting services that provide better outcomes at lower cost, patients can actually be better off both physically and financially through the APM.

Patient-Centered Cancer Care Payment should have the following components:

- 1. A payment to support adequate time for diagnosis and treatment planning.**
- 2. Payments for care management while patients are undergoing treatment and for a period of time after treatment ends for cancer survivors.**
- 3. Fees or bundled monthly payments for office visits.**
- 4. Payments for palliative care services for patients with advanced cancer.**
- 5. Fees or bundled monthly payments for the administration of chemotherapy.**
- 6. Cost-based payments for chemotherapy drugs.**
- 7. Condition-based payments for radiation therapy.**
- 8. Penalties for failure to follow evidence-based guidelines.**
- 9. Penalties for high rates of ED visits and hospital admissions for complications of treatment.**
- 10. Penalties for failure to deliver high-quality services to patients.**
- 11. Payments to support development of evidence and maintenance of guidelines.**

If all of these components are included with adequate payment amounts, all of the problems with the current fee-for-service system can be addressed while also avoiding the problems created by CMS oncology APMs.

Under Patient-Centered Cancer Care Payment, the oncology practice would continue to bill for and receive separate “fees” for the care that cancer patients receive, but these fees are very different from the current fee-for-service payment system. The payments would be based on the patient’s specific needs during each month of care, not based on the number or types of services the patient receives. This ensures that a patient with greater needs can receive additional services to address those needs, but it avoids creating an incentive to deliver more services simply to generate more revenues the way the current fee schedule does.

Because it is structured in this way, Patient-Centered Cancer Care Payment can be easily implemented by Medicare and other payers using their existing claims payment systems, and it can also easily be implemented by oncology practices using their existing billing systems. All that is needed is to create new CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) codes and modifiers for each of the payments.

Development and Testing of Episode Payments

Although creating a single payment for a full episode of cancer care would increase the predictability and comparability of payments for patients and payer and it would increase the flexibility of payments for oncology practices, defining episode payments for cancer is far more challenging than for other health conditions because of the many different subtypes of cancer, the very different costs of treatment for different types of cancer, and the diversity of needs among cancer patients. A very sophisticated and precise method of risk adjustment will be needed in order to even consider use of an episode payment model for cancer care. This will take time to develop, and it will need to be carefully tested and evaluated before it could be implemented broadly.

Efforts to try and develop workable episode payment models for cancer care should be done *in parallel* with implementation of Patient-Centered Cancer Care Payment, not instead of it. It would be inappropriate to delay implementing Patient-Centered Cancer Care Payment to help patients who currently have cancer while waiting to see if an even better approach can be developed.

Accelerating Value-Based Payment for Cancer Care

Cancer patients and oncology practices should not be forced to choose between the flawed fee-for-service system and an even more flawed alternative payment model. It is neither necessary nor appropriate to force oncology practices to take large amounts of downside risk or to hold them accountable for how health problems other than cancer are being treated. Patient-Centered Cancer Care Payment corrects the problems with current fee-for-service payments without creating new problems that could cause serious harm to both patients and oncology practices.

COMPARISON OF ALTERNATIVE PAYMENT MODELS TO FEE-FOR-SERVICE PAYMENT

STANDARD FEE-FOR-SERVICE PAYMENT	ONCOLOGY CARE MODEL	ONCOLOGY CARE FIRST	RADIATION ONCOLOGY MODEL	PATIENT-CENTERED CANCER CARE PAYMENT
PROBLEMS WITH FEE-FOR-SERVICE PAYMENT				
No payment or underpayment for high-value-services				
Underpayment for diagnosis and treatment planning	No change	Reduced pmt	No change	New payment
No payment for care management during treatment	New payment	New payment	No change	New payment
No payment for palliative care services	No change	No change	No change	New payment
Underpayment for survivorship care	No change	Higher payment	No change	New payment
Problematic method of payment for infused/injected drugs				
ASP+x% does not match the acquisition cost of drugs	No change	No change	No change	Payment based on acquisition cost
No payment for pharmacy operation costs	No change	No change	No change	New payment
Loss of revenue due to patient bad debt	No change	No change	No change	Adjusted for in drug payment
Problematic method of payment for radiation therapy				
Dose-based payments encourage unnecessary treatment	No change	No change	Episode payments instead of dose-based fees	Episode payments instead of dose-based fees
Dose-based payments do not match cost of treatment	No change	No change	Payments not based on cost of evidence-based care	Payments based on cost of evidence-based care
No assurance of high-quality care at most affordable cost				
No penalty for failure to follow evidence-based guidelines	No change	No change	No change	Penalty for failure to follow guidelines
No penalty for high rates of treatment complications	Penalty for high ED/hospital spending	Penalty for high ED/hospital spending	No change	Penalty for high rates of treatment-related ED visits & admits
Financial penalty for reducing avoidable services	Reduced penalty	Reduced penalty	Reduced penalty	No penalty
STRENGTHS OF FEE-FOR-SERVICE PAYMENT				
No incentive to delay or deny treatments patients need	Reward for stinting on care	Reward for stinting on care	Reward for stinting on care	Penalty for failure to deliver needed treatment
Higher payments for patients who need additional services	Inadequate adjustment for patient needs	Inadequate adjustment for patient needs	Inadequate adjustment for patient needs	Payments adjusted based on patient needs
Providers know in advance how much they will be paid	Amount of payment not known before services are delivered	Amount of payment not known before services are delivered	Payment amounts are known in advance	Payment amounts are known in advance
No penalties or rewards for things providers can't control	Penalties for changes in spending oncologists cannot control	Penalties for changes in spending oncologists cannot control	Performance standards based primarily on oncology services	Performance standards and penalties based on cancer-related services

I. THE CHALLENGE OF PAYMENT REFORM IN ONCOLOGY

Cancer is a fearsome disease because of the high probability of getting cancer in one's lifetime, the lack of a guaranteed cure, the suffering caused by both the disease and its treatment, and the high cost of treatment. Although significant advances have been made in preventing cancer, more than one million Americans are diagnosed with cancer each year and face the challenges associated with the disease and its treatment.

A "high-value" cancer care system would ensure that cancer patients have the ability to obtain both the treatment that offers the best opportunity for a cure and other services that minimize their suffering before, during, and after treatment, all at the most affordable cost possible. Unfortunately, for many patients, our current healthcare system fails to achieve these goals.

Fee-for-Service Payments Don't Support High-Value Cancer Care

A primary reason many patients don't receive truly high-value cancer care is that Medicare, Medicaid, and most commercial insurance plans don't pay for it. Section II explains why the fee-for-service payment system underpays or doesn't pay at all for many services that cancer patients need, and why it does not assure that patients will receive high-quality, evidence-based treatment.

These problems have not only affected the quality of care individual patients receive, they have also caused oncology practices to close or be acquired by large health systems.¹ These closures and acquisitions make it more difficult for patients to access cancer care² and increase the prices paid for services.³ In an effort to control rising costs, many employers and commercial insurance plans have required the use of prior authorization programs, narrow networks, and high deductibles, but these approaches have created additional barriers to the delivery of timely, high-quality cancer care while failing to significantly affect the cost of care.

Medicare Alternative Payment Models Don't Support High-Value Cancer Care

In the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress encouraged the creation of "Alternative Payment Models" (APMs) in an effort to address the problems with fee-for-service payment.⁴ The primary vehicle for creating APMs in the Medicare program has been the Center for Medicare and Medicaid Innovation (CMMI). The statute creating CMMI authorizes it to "test innovative payment and delivery models to reduce...[Medicare or Medicaid]...expenditures...while preserving or enhancing the quality of care."⁵

In 2015, CMMI created an Alternative Payment Model called the Oncology Care Model to "provide Medicare beneficiaries struggling with cancer with high-quality

care around the clock and to reward doctors for the value, not volume, of care they provide."⁶ The Oncology Care Model (OCM) provides new monthly payments to medical oncology practices in addition to traditional fee-for-service payments. Oncology practices participating in OCM report that these payments have enabled them to deliver care management services for cancer patients that they could not otherwise afford to provide. However, OCM also has a "performance-based payment" component that can inappropriately penalize oncology practices for delivering the care that patients need and reward practices for withholding needed care. Section III describes the strengths and weaknesses of OCM, showing how it not only fails to address many of the key problems in standard fee-for-service payments, but how it also creates new problems for patients and physicians that do not exist in the current payment system.

In November, 2019, CMMI announced plans to replace the Oncology Care Model with a new Alternative Payment Model called "Oncology Care First."⁷ Unfortunately, as explained in Section IV, Oncology Care First (OCF) fails to correct the serious problems with the Oncology Care Model, and the changes it does make in the Oncology Care Model have the potential to create additional problems for patients and oncology practices.

The Oncology Care Model is focused on patients whose cancer is being treated with chemotherapy, not on patients treated with radiation therapy. In July, 2019, CMS proposed an APM called the Radiation Oncology (RO) Model to "improve the quality of care for cancer patients receiving radiotherapy treatment, and reduce provider burden by moving toward a simplified and predictable payment system."⁸ Unfortunately, rather than enabling improvements in care, implementation of the RO Model would be likely to harm patients and reduce access to high-quality care. Section V describes the specific aspects of the RO Model that create these problems.

Patient-Centered Cancer Care Payment

Fortunately, there is a much better way to design alternative payment models for cancer care than the flawed approach that CMS has used in its oncology APMs. There are many opportunities to significantly reduce spending in cancer care without harming patients, and these should be the focus of an APM for cancer care. To be successful in achieving these savings, however, the APM needs to fix the problems in the current fee-for-service system.

Section VI describes the opportunities for reducing avoidable spending in cancer care and the changes in services needed to achieve these opportunities. It explains how to create Patient-Centered Cancer Care Payment that will support these changes in order to achieve better care for patients at a more affordable cost.

II. THE STRENGTHS AND WEAKNESSES OF FEE-FOR-SERVICE PAYMENT

A. The Problems with Fee-For-Service Payment for Cancer Care

There are many problems with the fee-for-service payment system used by Medicare and most other payers to support cancer care. The most serious problems fall into four major categories:

1. No payment or inadequate payment for high-value services;
2. A problematic method of paying for cancer drugs;
3. A problematic method of paying for radiation therapy; and
4. No assurance of high-quality care at the most affordable cost.

1. No Payment or Inadequate Payment for High-Value Services

Under the fee-for-service payment system, oncology practices can be paid for hundreds of specific services, ranging from drawing blood for a lab test to infusing chemotherapy or delivering radiation. However, there are no fees at all for a number of services that could improve patient outcomes and save money. In other cases, the fees paid by Medicare, Medicaid, or other payers may not be enough to cover the cost of delivering a service, particularly in a small practice. Because of these gaps in payment:

- Patients cannot receive many desirable services because oncology practices cannot afford to deliver them;
- Patients who don't receive these desirable services may receive more expensive services instead, or they may experience problems that result in costly hospitalizations; and
- Oncology practices that deliver services without payment have to charge more for the services that they can be paid for, which increases costs for the patients and payers receiving those services.

These problems occur in every phase of a patient's care for cancer:

- Current payments are inadequate to support accurate diagnosis and selection of appropriate treatments;
- Current payments fail to support care management services during treatment;
- Current payments fail to support palliative care for patients with advanced cancer or severe complications; and
- Current payments are inadequate to support good follow-up care for cancer survivors.

a. Inadequate Payments for Diagnosis and Treatment Planning

High-quality cancer care starts with accurately diagnosing the patient's disease, identifying the treatment options based on the most current research, and engaging in a shared decision-making process with the patient to determine which treatment option, if any, will be pursued.

Diagnosis and treatment planning for cancer becomes more complicated every year with the advent of new diagnostic tests, new drugs and other types of treatment, and new evidence about the effectiveness of different treatments. If there are different options for treatment with significant tradeoffs between efficacy in prolonging life and negative impacts on the patient's quality of life, patients need adequate time and information to make the choice that is right for them. Moreover, once a diagnosis is determined and treatment is chosen, most patients and their families will need extensive education and assistance in dealing with the physical, psychological, and financial challenges of managing both their disease and the chosen treatment.

This process is repeated, potentially multiple times, for patients whose cancer progresses. The choices about what treatment to use when the initial treatment(s) have failed, and whether to continue treatment at all, are difficult for both the oncologist and the patient and require considerable time and compassion.

Medicare and most health insurance plans pay for only a small part of this time and assistance. Fees are only paid for short face-to-face office visits between a patient and a physician (or other clinician), not for the additional time the physician spends outside of the patient visit and not for education or assistance provided to the patient and family by other staff at the oncology practice, such as nurses, financial counselors, social workers, etc.

Failure to pay adequately for diagnosis and treatment planning, both initially and when cancer progresses, can result in inaccurate diagnoses, use of less effective or unnecessarily expensive treatments, and failure to discontinue toxic treatments that are unlikely to prolong life. Studies of the causes of incorrect diagnoses find that in many cases, the physician or other clinician who made the diagnosis needed to spend more time on the patient's case and/or needed better decision support tools.⁹

b. No Payments for Care Management During Treatment

There are many serious side effects of treatment for cancer, such as pain, nausea, vomiting, diarrhea, and reduced immunity to other diseases. These side effects are not only unpleasant, they can lead to serious complications, such as dehydration, malnutrition, and infection,

that require emergency care or hospitalization and potentially result in death.¹⁰

In some cases, oncology practices can prevent or mitigate these side effects; in other cases, when side effects do occur, rapid intervention by the oncology practice can often prevent them from turning into more serious complications. However, success in both prevention and rapid intervention requires that (1) patients have an adequate understanding of preventive approaches, have the ability to implement them, and understand the importance of contacting the oncology practice quickly when symptoms first develop, and (2) the oncology practice has the ability to respond quickly and appropriately when patients do have problems.

Patient education, rapid evaluation of potential signs of complications, and rapid response to serious complications requires that an oncology practice have adequate nursing and support staff to spend time providing education to patients, to proactively call patients to ensure they are not having problems with their treatment, and to quickly evaluate and treat problems before they become more serious. However, Medicare and most health insurance plans do not pay for these services. Payments are only made for administering chemotherapy or radiation therapy treatments to the patient and for brief face-to-face visits with the oncologist, nurse practitioner, or physician assistant.

There is an even bigger gap in payment for the growing number of cancer patients who are receiving oral chemotherapy drugs. Since these patients don't need to come to the oncology practice to receive their medications the way that patients receiving infused or injected chemotherapy do, the oncology practice has fewer opportunities to verify that the patient is receiving the right doses of drugs at the right times, and practice staff will not see the patient in person as frequently to identify and intervene early when there are problems. Patients on oral anti-cancer therapy both underuse and overuse medications, particularly with regimens that have complex schedules, and this can result in worse outcomes and higher costs. Appropriate care for these patients requires that nurses or other practice staff proactively contact the patients to ensure they are taking their medications appropriately and advise them on how to deal with missed dosages, side effects, potential drug interactions, etc. However, there is currently no payment for these services from Medicare or most health plans.

c. No Payment for Palliative Care During Treatment

Many cancer patients experience severe pain both during and after treatment, and treating this pain effectively has become increasingly challenging because of concerns about overuse of opioids. In addition to pain and complications such as nausea and infections that were discussed earlier, many patients also experience fatigue, depression, and other physical and emotional problems, as well as financial problems due to the cost of treatment and inability to work. Family members and friends who help cancer patients can also experience injuries, stress, and financial challenges that can harm their health.

Services to address these problems, rather than to treat the cancer itself, are called "palliative care"¹¹ Ideally, palliative care should be provided by an interdisciplinary team that includes physicians who specialize in palliative care, nurses, dietitians, pharmacists, chaplains, psychologists, and social workers. An interdisciplinary team enables the cancer patient and their family or caregiver to receive holistic care that addresses the full range of physical, emotional, social, and spiritual issues they face in a coordinated way.

Although high-quality palliative care is expensive, multiple studies have found that palliative care saves more than it costs because patients receiving palliative care are less likely to be hospitalized and to receive unnecessary or avoidable services. American Society of Clinical Oncology guidelines recommend providing palliative care along with treatment¹² and National Comprehensive Cancer Network guidelines recommend that palliative care be provided to patients beginning when they are first diagnosed with cancer.¹³

A growing number of commercial insurance plans pay for palliative care services, but Medicare only pays for palliative care as part of hospice services, which means it is only available to cancer patients on Medicare if they decide to stop receiving treatment and if their physician certifies they are not expected to live more than six months.

d. Inadequate Payment for Survivorship Support After Treatment

Even if cancer treatment successfully eliminates the disease, patients may continue to experience many side effects after treatment ends, ranging from continued pain or functional limitations to other serious health problems such as heart disease, bone fractures, and hearing loss. In addition, patients want and need to be monitored carefully for recurrence of their cancer.

This means that patients will continue to need both care management and palliative care services after cancer treatment ends. Oncology practices will face the same payment barriers if they try to deliver these services after treatment ends that they faced in delivering them during treatment. However, the gaps between payment and cost may be even greater because the more time that practice staff spend helping these patients, the less time they will have for the patients who are receiving treatment.

e. A Large Gap Between Payments and the Cost of Cancer Care Services

The cumulative effect of the gaps in payment is significant. Most oncology practices deliver at least some of the services described above despite the fact that they lose money by doing so. Data from the National Practice Benchmark for Oncology indicate that fee-for-service payments only cover 2/3 of the costs of the services that oncology practices provide.¹⁴

In most cases, the only way that oncology practices can afford to deliver these services is if they can generate profits on the chemotherapy and radiation therapy treatments they administer to patients. The fact that they can

SERVICES ONCOLOGY PRACTICES NEED TO DELIVER TO PATIENTS	SERVICES ONCOLOGY PRACTICES RECEIVE PAYMENT FOR UNDER FEE-FOR-SERVICE
<ul style="list-style-type: none"> • Review tests & pathology reports • Determine type and stage of cancer • Identify and evaluate treatment options • Identify clinical trial options • Discuss treatment options with patient and family • Develop plan of care • Coordinate care with other physicians & providers • Educate patient about treatment • Provide education to family • Provide genetic counseling • Provide psychological counseling • Provide nutrition counseling • Provide financial counseling • Determine insurance coverage • Obtain pre-authorization approvals • Document information in health records • Prescribe oral drugs • Administer IV therapy • Plan radiation treatment • Administer radiation therapy • Purchase and maintain inventory of drugs • Order tests • Review test results • Evaluate patient progress • Meet with patient to discuss progress • Answer calls from patients • Call patients at home to assess medication adherence and identify problems • Respond when patients experience complications • Manage patients' pain • Keep detailed records for clinical trials • Discuss end-of-life planning with patient • Develop a survivorship or end-of-life plan • Respond to post-treatment complications • Supervise hospice care • Bill insurance companies • Collect required cost-sharing from patients 	<ul style="list-style-type: none"> • Payments for short face-to-face visits with physicians <i>(No payments are made for services delivered by nurses, social workers, financial counselors, etc., and no payments are made for time spent by physicians on phone calls with patients and other physicians, or the time spent researching current evidence to identify the best treatment for a patient.)</i> • Payments to administer infusions and injections of chemotherapy and other drugs • Payments to plan and deliver radiation therapy • Payments for the cost of drugs purchased and administered by the oncology practice

do so is because of problems with the way payments are made for chemotherapy and radiation therapy, which are discussed in more detail below. Moreover, because the revenues that practices do receive are primarily derived from delivery of infused chemotherapy and radiation therapy, the gaps between payments and costs are larger for oncology practices that have patients with types of cancer most appropriately treated with oral chemotherapy regimens or treatments with high potential for serious side effects. The gaps are also larger for practices that are successful in treating cancer and have many patients requiring survivorship care after treatment ends.

2. A Problematic Method of Paying for Cancer Drugs

For treatments involving chemotherapy administered through an intravenous infusion or injection, the oncology practice acquires an inventory of the drugs it expects to be using, and then the practice is paid for the drugs after they are administered to individual patients. This process is commonly referred to as “buy and bill.” This process benefits patients, because it means the oncology practice can immediately administer needed drugs without waiting for the drugs to be shipped to the patient or the practice from an outside pharmacy.

The problem with the buy and bill system is the “ASP+x%” methodology that Medicare and most commercial payers use to pay the oncology practice for the drugs it has purchased. The total amount of payment the oncology practice receives for a drug is equal to (1) the most recent national figure for the “Average Sales Price” (ASP) of the drug, plus (2) an additional percentage of the ASP amount.

In Medicare, the total payment is supposed to be ASP+6%, but under the 2% sequestration rule that is currently in effect, the actual amount is ASP+4.3%. Many commercial payers pay much higher markups, e.g., ASP+10% or ASP+25%.

The oncology practice is usually required to collect a portion of the ASP+x% amount from the patient who is receiving the drug. In Medicare, the practice is required to collect 20% of this amount from the patient, and 80% is paid by Medicare. A patient with a high deductible health insurance plan could be required to pay the full cost of the treatment until the deductible is reached.

There are several serious problems with the ASP+x% methodology used in the buy and bill system:

- **ASP+x% Does Not Equal Acquisition Cost.** The actual amount an oncology practice pays for a drug may have little relationship to the ASP amount, for several reasons:
 - ◆ **Delay in Calculating ASP.** The ASP amount is calculated based on prices from a time period two calendar quarters earlier, and the amount an oncology practice pays for a drug today may be significantly different than the prices six months earlier. Since the prices of most drugs have been increasing, not decreasing, the price paid by the oncology practice will often be higher than the ASP amount.
 - ◆ **Wholesale Markups Are Not Included.** ASP is based on the average amount manufacturers receive from direct buyers, but oncology practices are rarely the direct buyers. Practices that purchase drugs

through a wholesaler may pay a markup to the wholesaler in addition to what the wholesaler pays for the drug, but the markups will not be reflected in the ASP calculations.

- ◆ **Differential Rebates and Discounts for Different Practices.** Many manufacturers provide large rebates or discounts to encourage the use of their drugs. These rebates/discounts may go to either the practice, the wholesaler, or both. Although these rebates and discounts are supposed to be factored into the ASP calculation, if small practices receive smaller rebates and discounts than larger practices, then the small practice is more likely than a large practice to pay more than the ASP amount.
- ◆ **340B Discounts Are Not Included.** Hospitals that participate in the 340B discount program are able to purchase chemotherapy and other drugs at substantial discounts from standard prices.¹⁶ The hospitals participating in the 340B program receive the same ASP+x% payment as non-340B hospitals and community oncology practices, which means that 340B hospitals are likely to make profits even on drugs where the ASP amount is below acquisition costs for community oncology practices.

The x% markup will not make up for the shortfall between the ASP amount and the actual acquisition cost if the price of the drug has increased over the past six months by more than the markup percentage, so the oncology practice would still lose money on the drug. For example, in Medicare, if the price of the drug has increased by more than 4.3% during the past six months, the average cost to acquire the drug today will be more than ASP+4.3%. Conversely, if the price of the drug has decreased (e.g., because of introduction of a generic competitor), the acquisition cost may be significantly lower than the ASP amount, and the additional payment from the +x% markup will increase the practice’s profit from using the drug.

- **No Payment for Costs of Operating the Practice Pharmacy.** In addition to paying to acquire the drugs, the oncology practice will need to equip and staff a pharmacy that maintains an inventory of drugs and ensures that the proper drugs and dosages are used for treatment of individual patients. The only revenue to cover this cost is the percentage markup on the drugs. A portion of the pharmacy’s costs are related to the price of the drugs – if a vial of a drug cannot be fully used (e.g., because the patient does not need the full amount, because the vial is contaminated or accidentally broken, etc.), then the practice cannot be reimbursed for the unused drug even though it incurred the cost of purchasing it. Aside from this, the cost of operating the pharmacy involves staff salaries, equipment costs, etc. that do not vary based on the price of the drugs used. Consequently, even if the ASP+x% payments to the practice are greater than the actual acquisition cost for the drugs, the net margin may not be enough to cover the costs of operating the pharmacy, particularly if the patients being treated by the practice at the moment only require drugs with lower prices.
- **Losses on Patient Cost-Sharing.** If a patient is unable to pay the cost-sharing amount for the drug, then the actual amount the practice receives is lower than ASP+x%. The higher the cost of the drug, the more likely it is that the patient will be unable to pay the full cost-sharing amount, and the higher the dollar loss for

the practice. In traditional Medicare, there is no maximum limit on a beneficiary's out-of-pocket spending, either per-treatment or over the course of a year. This means the longer the patient receives treatment, the more likely it is that they will be unable to pay the full amount of their cost-sharing obligation, unless they have supplemental insurance. Delays in payment also increase the practice's costs because of the loss of interest on bank balances or the need to borrow money to cover cash flow needs.

ASP+x% Can Penalize an Oncology Practice for Using the Most Appropriate Drugs

Because of all of the above factors, an oncology practice will make a profit from the ASP+x% payment on some drugs, and for others, the payment will cause the practice to lose money. For patients where there is a choice of two or more drugs to use for treatment, the practice will be financially penalized if it uses a drug that would cause it to incur a loss, and it would have a financial disincentive to use a drug that generates a smaller profit margin, since it would have less revenue to offset the losses on other, unprofitable drugs or the losses on other services the practice delivers to patients that are not adequately supported by fees. The drug that the practice can afford to use may not be the drug that achieves the best outcome for the patient.

Although the ASP+x% payment methodology has been criticized for encouraging the use of expensive drugs, it is not necessarily the case that the incentive favors the use of expensive drugs, at least in community oncology practices. While it is true that the x% markup generates a higher dollar amount for a more expensive drug, this represents the *gross* amount of payment, not the *net profit* to the practice. The shortfall between the ASP amount and acquisition cost may also be larger in dollar terms for a more expensive drug, and this may more than offset the higher dollar amount provided by the x% markup.

For example, if the average sales price of Drug A at the beginning of the year is \$10,000 and the average sales price of Drug B is \$20,000, then in the second half of the year, the oncology practice would receive \$10,430 for Drug A from Medicare (ASP + 4.3%) and \$20,860 for Drug B. But if the price of both drugs increased by 10% during that six-month period, the acquisition cost for Drug A would be \$11,000 and the acquisition cost for Drug B would be \$22,000. As a result, the ASP+4.3% payment would cause the oncology practice to lose \$570 on Drug A and \$1,140 on Drug B.

No one knows how much profit or loss oncology practices make on drugs because there is no requirement for reporting the actual acquisition costs or the impact of the various rebates and discounts that flow through the complex process of drug purchasing.

However, since a 340B hospital is able to acquire the drugs at as much as a 50% discount, its profit will generally be higher when it uses a more expensive drug.¹⁷ This means that the 340B hospital does have a financial incentive to use the more expensive drug, because the dollar amount of the margin on the drug will almost always be higher if it uses a more expensive drug. In the example, if the hospital can acquire Drug A for \$5,500

and Drug B for \$11,000, then using Drug A to treat a Medicare beneficiary would generate a profit of \$4,930 for the hospital, whereas using Drug B would generate a \$9,860 profit.

3. A Problematic Method of Paying for Radiation Therapy

For a patient receiving chemotherapy, each additional dose of a drug that is administered represents an additional out-of-pocket cost to the oncology practice. Because of the high cost of many chemotherapy drugs, the majority of the cost associated with administering treatment comes from the drug itself, rather than the cost of the staff who administer the drug. In economic terms, most of the cost of chemotherapy is a "variable" cost, i.e., the cost varies directly with the number of treatments given. It makes sense to pay fees for this kind of service, because when an additional drug is administered, an additional cost is incurred and an additional payment is needed. The problem with payments for chemotherapy drugs is not the use of fees, but calculating fees the wrong way. If the ASP+x% payment amount was replaced with a payment that matched the actual cost of the drug, then there would be relatively little financial incentive or disincentive associated with administering more or fewer drugs.

In contrast, for a patient receiving radiation therapy, an oncology practice incurs relatively little additional out-of-pocket cost for each dose (fraction) of radiation it delivers to patients. The equipment used to administer the radiation is very expensive and the practice has to spend money to maintain the equipment and hire the staff to operate it, but the total cost to the practice associated with the equipment does not vary significantly based on how many treatments are given. This means that most of the cost of radiation therapy is a fixed cost to the practice.

No matter how the fees are set, fee-for-service payment will be poorly suited for services with high fixed costs. The payment for each treatment has to be large enough that, in aggregate, the payments received during the course of a month or year cover all of the fixed costs. This requires making an assumption about how many treatments will be delivered in order to set the fee for treatment at or above the average cost per treatment. However, once the fee is set, if more treatments are delivered than what was assumed, the additional payments will represent pure profit to the radiation oncology practice (because all of the fixed costs would be covered by the number of treatments assumed in calculating the fee), and if fewer treatments are delivered than the assumed volume, the radiation oncology practice would receive less revenue than needed to pay for its fixed costs, causing a loss.¹⁸

Despite this, the standard way of paying for radiation oncology treatments is to pay a fee for each treatment that is administered. Since the types of equipment used for some types of radiation treatments are much more expensive than others, the fee-for-service payments are higher in order to cover the higher average cost per treatment, but this also means that the profit from delivering one more service using expensive equipment will be big-

ger than the profit from delivering one more inexpensive service.

4. No Assurance of High-Quality Care at the Most Affordable Cost

A general problem with the fee-for-service payment system is that there is no direct accountability for the quality of care. A fee is paid based solely on whether a service was delivered, regardless of whether the service was appropriate or necessary, whether it achieved the desired outcome, and whether it caused any harm to the patient. In terms of cancer care, three of the most serious problems are:

- **No Penalty for Failure to Follow Evidence-Based Guidelines for Treatment and Other Services.** An oncology practice can be paid for administering chemotherapy or radiation even if evidence indicates that a different drug, type of radiation, or dosage would be more effective. The practice will also be paid for delivering or ordering laboratory tests, imaging studies, and other types of medications even if there is no evidence that the patient will benefit from them.
- **No Penalty for Failure to Avoid Side Effects and Complications and to Treat Them Promptly.** An oncology practice receives the same payment for treating a patient regardless of whether the patient experiences preventable side effects and complications or how quickly and effectively the practice addresses those issues.
- **Financial Penalty for Avoiding Complications and Unnecessary Services.** Under the fee-for-service system, an oncology practice can actually be penalized financially if it takes actions to avoid side effects and complications, both because there may be no payment for the services needed to prevent complications and also because the practice is paid for treating complications, so it would lose revenue if there aren't as many complications to treat.

Both cancer and the complications from cancer treatment can be deadly, so failure to use the most effective treatments and methods of avoiding and treating complications can also be deadly. In addition, because the treatments for cancer and its complications are expensive, delivering the wrong treatment, failing to avoid complications, and failing to treat complications promptly can also increase the cost of cancer care significantly.

Pay for Performance Programs Do Not Ensure Patients Receive High Quality Care

Most payers have created “pay for performance” (P4P) programs in an effort to create a linkage between fee-for-service payments and the quality of the care that patients receive. In Medicare, the Merit-Based Incentive Payment System (MIPS) increases or decreases the fee-for-service payments that physician practices receive based on measures of quality and spending.

However, MIPS and most P4P programs do little or nothing to correct the problems described above for patients with cancer:

- **No measures of whether evidence-based treatment is being used for most types of cancer.** Despite the fact that there are evidence-based guidelines for all types of cancer, the MIPS program only has measures to assess whether evidence-based treatments are being delivered for three specific types of cancer (multiple myeloma, HER2+ breast cancer, and metastatic colorectal cancer with specific gene mutations).
- **No measures of the rate of avoidable complications or effectiveness in treating complications.** There are measures of whether pain intensity has been quantified and whether there is a plan for addressing moderate to severe pain, but there is no measure of how often pain occurs and whether it is being treated effectively. There are no measures of other important symptoms and complications, such as how often patients experience dehydration or infections severe enough to require hospital admission.
- **Use of measures that have little to do with the most important aspects of quality cancer care.** In the MIPS program, an oncology practice can be rewarded or penalized almost exclusively based on whether it screened its patients for tobacco use, alcohol use, and high blood pressure, and whether it ensured they received flu and pneumonia vaccines.
- **No assurance that the services an individual patient receives are appropriate, high-quality, and achieve the desired results for that patient.** Even where there are quality measures of things that are important in cancer care, the quality measures are typically defined in terms of the percentage of times that a pre-defined standard of quality was met or an outcome was achieved for a *group* of patients, not for each *individual* patient. Moreover, the measures are defined in terms of the results that the provider achieved for patients in the *past* (i.e., the patients who were treated during whatever past performance period is used for measurement). In many cases, the measures reflect the provider's performance two years or more in the past, which may bear little relationship to how the provider is currently performing, much less how it will perform in the future.¹⁹ The provider is still paid when a service is delivered to an individual patient even if that service failed to meet the standard of quality underlying the performance measures for that patient.
- **Penalties for addressing the unique needs and preferences of individual patients.** For most measures, there is no method by which physicians can exclude patients from the measure if the patient has specific characteristics or preferences that make the standard approach to treatment inappropriate. One physician's score could be worse than another physician's score simply because the first physician has more patients who aren't appropriate for use of the standard approach that the measure is based on.

B. The Strengths of Fee-for-Service

Although there are clearly a number of serious problems with the fee-for-service payment system, it would not have persisted for so long without any redeeming features. Patients with cancer, as well as patients with other health problems, benefit from several important strengths of the fee-for-service payment system:²⁰

- **A physician has no financial incentive to delay or withhold needed treatment.** Although the fee-for-service payment system does not do enough to ensure that patients will receive appropriate, high-quality care, there is no financial incentive to *withhold* treatments that patients *need*. In fee-for-service, physicians and other providers are only paid when they deliver services to patients.
- **Payments are higher for patients who need more services.** Although fee-for-service payment is criticized for rewarding “volume over value,” any payment system that doesn’t adequately support a higher volume of services *when more services are needed* can result in worse outcomes for patients and higher long-run costs. Under the fee-for-service system, if a patient needs additional treatments, they can receive them. Moreover, fee-for-service payment amounts are generally higher for services that cost more to deliver, so there is no financial penalty for delivering those services when a patient needs them.

- **Physician practices and hospitals know how much they will be paid for the services they deliver.** Under fee-for-service payment, a cancer care provider knows exactly what they will be paid for delivering a service before they deliver that service. Without that certainty, oncology practices would be less willing to deliver expensive services to their patients, or to deliver additional services for which there is no payment.
- **Providers are not rewarded or penalized for things they cannot control.** Under fee-for-service payment, a physician is paid for delivering a specifically-defined service. The payment is contingent on the physician performing the tasks associated with that service, but the payment does not depend on whether other providers or the patient did something undesirable or failed to do something they should have.

Most of the alternative payment models in Medicare not only fail to adequately address the problems with the fee-for-service payment system, they also fail to preserve its strengths, which can make things worse for patients, not better.²¹ As will be discussed below, this is particularly true in oncology.

PROBLEMS WITH FEE-FOR-SERVICE PAYMENT FOR CANCER CARE

- **No payment or underpayment for high value services**
 - ◆ Underpayment for diagnosis and treatment planning
 - ◆ No payment for care management during treatment
 - ◆ No payment for palliative care services
 - ◆ Underpayment for survivorship care
- **Problematic method of payment for infused/injected drugs**
 - ◆ ASP+x% does not match the acquisition cost of drugs
 - ◆ No payment for pharmacy operation costs
 - ◆ Loss of revenue due to patient bad debt
- **Problematic method of payment for radiation therapy**
 - ◆ Dose-based payments encourage unnecessary treatment
 - ◆ Dose-based payments do not match cost of treatment
- **No assurance of high-quality care at most affordable cost**
 - ◆ No penalty for failure to follow evidence-based guidelines
 - ◆ No penalty for high rates of treatment complications
 - ◆ Financial penalty for reducing avoidable services

STRENGTHS OF FEE-FOR-SERVICE PAYMENT FOR CANCER CARE

- **No incentive to delay or deny treatments patients need**
- **Higher payments for patients who need additional services**
- **Providers know in advance how much they will be paid**
- **No penalties or rewards for things providers can’t control**

III. THE STRENGTHS AND WEAKNESSES OF THE CMS ONCOLOGY CARE MODEL

A. The Structure of the Oncology Care Model (OCM)

The Center for Medicare and Medicaid Innovation announced the “Oncology Care Model” (OCM) in 2015 as a five-year demonstration to change the way medical oncology practices are paid when using chemotherapy to treat Medicare beneficiaries with cancer.²² CMS selected 190 oncology practices across the country to participate in OCM beginning in 2016.

OCM has the following components:²³

- **Continuation of All Fee-for-Service Payments.** Participating oncology practices continue to be paid for all services that are eligible for Medicare fee-for-service payments at the same payment levels as practices not participating in OCM.
- **Additional Monthly Payments for Patients Receiving Chemotherapy.** For each patient who receives chemotherapy, a practice participating in OCM can receive an additional “Monthly Enhanced Oncology Services” (MEOS) payment. The monthly payment continues for six months even if the patient does not receive treatment each month, unless the patient transfers to hospice or dies. If the patient continues to receive chemotherapy 6 months after the initial month of treatment, the practice can receive MEOS payments for an additional 6 months. MEOS payments for a patient can continue indefinitely, in six-month episodes, as long as the patient is receiving chemotherapy.
- **Performance-Based Payments Based on Spending Relative to CMS “Target Prices.”** During each six-month period in which the practice is receiving the MEOS payment, CMS tabulates the total Medicare spending on all services the patient receives, regardless of whether the services are related to their cancer. CMS calculates a “Target Price” for each patient and subtracts the total actual Medicare spending. These differences are then summed over all of the practice’s patients. If the sum is positive (i.e., the total Medicare spending for all patients treated by the practice was lower than the total of all of the Target Prices), the practice is eligible to receive a Performance-Based Payment.
- **Reduction in Performance-Based Payments Based on Quality Measures.** Each practice is assigned an “Aggregate Quality Score” (AQS) based on its performance on six measures of quality and patient experience. The score for each measure is based on the practice’s performance on that measure compared to other oncology practices across the country. If the sum of all six scores for a practice (i.e., its AQS) is less than 75% of the maximum score the practice could have received, the practice’s Performance-Based Pay-

ment is reduced by up to 100% below the amount that it would otherwise have been able to receive based on the calculation of savings.

- **Penalties if Spending Exceeds Target Prices.** If the oncology practice is in one of the “two-sided risk” tracks, and if the total actual spending for all of the practice’s patients is higher than the total of the Target Prices, the oncology practice must pay a penalty to CMS (referred to as a “recoupment”), regardless of its quality scores. If the practice is in the “upside-only” track, the practice does not have to make a payment to CMS if spending exceeds the Target Prices, but if it has not reduced spending below the Target Prices by 2019, it will be forced to either accept two-sided risk or leave the program altogether.
- **Requirements for Delivery of Specific Services.** In order to participate in OCM, an oncology practice is required to provide four “enhanced services” to patients: (1) “the core functions of patient navigation,” (2) a care plan that contains the 13 components recommended by the Institute of Medicine, (3) 24/7 access to an appropriate clinician with real-time access to medical records, and (4) treatment with therapies consistent with national guidelines. The practice is also required to use certified electronic health record technology and to “use data to drive continuous quality improvement.”

B. Overview of OCM’s Strengths and Weaknesses

1. The Fee-for-Service Problems Addressed by OCM

As shown in Table 1, OCM directly addresses three of the problems with the fee-for-service payment system: it provides a new payment that can support care management services for a patient receiving chemotherapy, it creates a financial penalty if an oncology practice’s patients have a high rate of avoidable complications, and it reduces the loss of revenues for a practice when it avoids delivering unnecessary services. Specifically:

- **OCM Provides Significant Additional Resources for Care Management Services During Treatment.** The Monthly Enhanced Oncology Services (MEOS) payment provides significant additional financial resources to an oncology practice while a patient is receiving chemotherapy. The practice receives a payment of \$160 per month for six months if the patient receives chemotherapy for at least one month, and it can receive the same MEOS payments for additional six-month episodes if chemotherapy treatment continues for longer than six months.

**TABLE 1
COMPARISON OF ONCOLOGY CARE MODEL TO FEE-FOR-SERVICE PAYMENT**

STANDARD FEE-FOR-SERVICE PAYMENT	CMS ONCOLOGY CARE MODEL
PROBLEMS WITH FEE-FOR-SERVICE PAYMENT	
No payment or underpayment for high-value-services	
Underpayment for diagnosis and treatment planning	No additional payment unless patient receives chemotherapy
No payment for care management during treatment	Significant additional resources through MEOS payments
No payment for palliative care services	No payment for palliative care services
Underpayment for survivorship care	MEOS payments do not continue after treatment ends
Problematic method of payment for infused/injected drugs	
ASP+x% does not match the acquisition cost of drugs	No change
No payment for pharmacy operation costs	No change
Loss of revenue due to patient bad debt	No change
Problematic method of payment for radiation therapy	
Dose-based payments encourage unnecessary treatment	No change
Dose-based payments do not match cost of treatment	No change
No assurance of high-quality care at most affordable cost	
No penalty for failure to follow evidence-based guidelines	No change
No penalty for high rates of treatment complications	Penalty for failure to avoid ED visits and hospital admissions
Financial penalty for reducing avoidable services	Potential bonus payment for reducing avoidable services
STRENGTHS OF FEE-FOR-SERVICE PAYMENT	
No incentive to delay or deny treatments patients need	Bonus payment if spending is reduced, including when needed services are withheld. Oncology practices are paid more if treatment is delayed beyond 6 months.
Higher payments for patients who need additional services	Poor risk adjustment system can penalize oncology practices that treat patients who have higher needs
Providers know in advance how much they will be paid	Oncology practices cannot predict how much they will receive prior to delivering services
No penalties or rewards for things providers can't control	Oncology practices are penalized for increases in drug prices and for services delivered by other physicians and hospitals to treat health problems unrelated to cancer

- **OCM Creates Financial Penalties for High Rates of Complications Requiring Hospital Treatment.** OCM has two separate mechanisms for penalizing practices for high rates of complications:

- ◆ First, if a practice's patients experience a high rate of complications that require treatment in an Emergency Department or admission to a hospital, Medicare spending on the practice's patients will be higher, and that will reduce the likelihood that the practice will receive a Performance-Based Payment.
- ◆ Second, one of the quality measures is the rate of ED visits for patients receiving chemotherapy, so a practice could see its Performance-Based Payment reduced even further if its patients had high rates of ED visits.

If a practice were in one of the two-sided risk tracks, the practice could potentially have to pay a penalty if it had a high rate of complications requiring expensive treatment.

- **OCM Can Partially Reduce Revenue Losses from Reducing Avoidable Services.** Under OCM, if an oncology practice delivers fewer billable services, it will reduce its own revenue, but it will also reduce Medicare spending for its patients. If the total spending falls below the OCM Target Prices, the practice will receive a Performance-Based Payment, and that will offset a portion of the revenue it lost from delivering fewer services.

2. The Problems Not Addressed by OCM

However, most of the other problems with the current payment system that were described in Section II are not addressed by OCM:

- **OCM Provides No Additional Resources for Diagnosis and Treatment Planning.** Although oncology practices are required to prepare a care plan in order to participate in OCM, OCM does not provide any payment specifically for this work. The MEOS payments are only paid if the patient receives chemotherapy, so there is no additional compensation for the time involved in a decision not to pursue treatment at all or to receive treatment other than chemotherapy. No distinction is made between a patient continuing on the same chemotherapy regimen for an extended period of a time and a patient whose treatment needs to change because their disease continues to progress, even though the latter requires that the practice spend significantly more time determining the new treatment options and engaging the patient in deciding what to do. There are also no resources specifically focused on ensuring accuracy of diagnosis; indeed, if a detailed review of tests results in a determination that the patient does not have cancer, there is no additional payment at all, even though there would be significant savings to Medicare and many benefits to the patient from avoiding unnecessary cancer treatments.
- **OCM Provides No Payment for Palliative Care Services.** The MEOS payments are not large enough to support the delivery of palliative care services in addition to care management services, and there is no payment at all if the patient does not receive chemotherapy or after chemotherapy ends.

- **OCM Provides Very Limited Additional Resources for Survivorship Support.** The oncology practice can only receive MEOS payments while the patient is receiving chemotherapy. The payments can continue for at most a few months after chemotherapy ends and they may not continue at all (depending on when during a six-month episode the treatment ends), so there is little or no additional payment to help patients who experience complications after successfully completing treatment.
- **OCM Makes No Improvements in the Method of Payment for Cancer Drugs.** Physician practices and hospitals that are participating in OCM continue to be paid for infused or injected chemotherapy using the same ASP+x% formula as other oncology care providers. Although the Performance-Based Payment component of OCM discourages the use of more expensive drugs, it does so without regard to whether the ASP+x% payment is higher or lower than the cost of the drug and regardless of whether the drug is appropriate for the patient. This is discussed in more detail below.
- **OCM Makes No Improvements in the Method of Payment for Radiation Therapy.** OCM makes no changes in the way payments are made for radiation oncology services. The Performance-Based Payment component encourages the use of fewer radiation treatments, but it makes no distinction between whether reducing the number of treatments will help or harm the patient or whether the reduced revenues from fewer treatments will be sufficient to cover the costs of the radiation equipment.
- **OCM Creates No Penalties for Failure to Follow Evidence-Based Guidelines for Treatment and Other Services.** Although an oncology practice participating in OCM is expected to follow evidence-based treatment guidelines, the practice is paid for a patient's treatment and other services even if they are not consistent with evidence-based guidelines. No distinction is made between practices based on the rate at which they follow evidence-based guidelines.
- **OCM Has Only Limited Penalties for Failure to Avoid or Address Side Effects That Do Not Result in ED Visits or Hospitalization.** As discussed earlier, the Performance-Based Payment in OCM creates a financial penalty for a practice when a patient has to visit an Emergency Department or be admitted to the hospital for a side effect or complication of treatment that could have been avoided or treated at a lower cost. However, the penalty is based on the rate of ED visits or the cost of the services needed to treat the problem, so there is little or no penalty if a patient experiences pain or other side effects that do not involve ED visits or expensive treatment. Although there are quality measures in OCM related to pain, they measure whether the intensity of the pain has been *quantified* and if there is a *plan* for addressing the pain, not whether the pain has actually been *treated* or *resolved*. In theory, if patients' symptoms are not being addressed adequately, the practice would receive a low rating on the patient experience measure, but since this is only one of six quality measures being used in OCM, a practice could

do poorly on this measure and still receive the full Performance-Based Payment.

3. Problems Created by OCM That Do Not Exist in Fee-for-Service Payment

Although the additional payments for care management and the penalties for complications would represent an improvement over fee-for-service even if the other issues were not addressed, the payment methodology used in the Oncology Care Model creates serious problems because it fails to preserve the strengths in the fee-for-service system that were described in Section II-B:

- **OCM Creates a Financial Incentive to Withhold and Delay Needed Treatment.** In OCM, an oncology practice can receive a financial bonus if it uses lower-priced treatments or orders fewer services for patients, even if the treatments and services were essential to properly diagnose and treat the patients. In addition, there are financial incentives in OCM to delay treatment for patients, even if that could result in worse outcomes for the patients.
- **OCM Creates Penalties for Treating High-Need Patients.** In OCM, an oncology practice can be penalized (either by losing MEOS payments, losing the opportunity for a Performance-Based Payment bonus, or having to pay a penalty to CMS) if it accepts patients who will need care from multiple oncology practices, who will require large numbers of treatments and other services, who need very expensive cancer treatments, or who have non-cancer-related health problems that require treatment at the same time as their cancer treatment.
- **Oncology Practices Cannot Predict How Much They Will Be Paid for Their Services Under OCM.** An oncology practice will not know how much revenue it will receive in either MEOS payments or Performance-Based Payments, or whether it will need to pay a penalty to CMS, until many months after services have been delivered. It is less likely that a practice will incur significant costs in delivering new services or redesigning existing services if it cannot predict whether its revenues will be sufficient to cover those additional costs.
- **OCM Penalizes Oncology Practices for Things Outside of Their Control.** In OCM, an oncology practice can be financially penalized if physicians who don't belong to the oncology practice, hospitals, or other service providers deliver unnecessary or unusually expensive treatments to the oncology practice's patients, including treatments and services that have nothing to do with the patient's cancer.

The specific problems with the OCM payment methodology that cause these problems are described in more detail in sections C and D.

C. The Strengths and Weaknesses of the OCM MEOS Payment

1. Significant Additional Resources for Patient Care Management

The Monthly Enhanced Oncology Services (MEOS) payments under OCM represent a significant increase in the resources available to the participating oncology practices. The practice receives the \$160 MEOS payment monthly for at least six months for each patient who receives chemotherapy, and many patients receive treatment for more than six months, so this represents more than \$1,000 in additional revenues for each patient. CMS data indicate that, on average, the additional revenues oncology practices have received from the MEOS payments are roughly equivalent to what the practice would receive if its Evaluation and Management (E/M) payments for office visits were doubled in size, but the MEOS payments give the practice greater flexibility than it would receive from an increase in E/M payments, since the MEOS payments do not depend on how many face-to-face visits the patient has with a physician.

Participating oncology practices have stated that this significant increase in revenue has enabled them to make significant improvements to care management services. This is not surprising since most oncology practices have wanted to make these improvements but could not do so because current fee-for-service payments do not pay directly for the services, as discussed in Section II. Although CMS requires a practice to deliver several types of services in order to participate in OCM, the evaluation of the first year of the program indicated that practices had also instituted extended office hours, same-day appointments, and other changes that were not required by OCM.²⁴

2. Problems with the MEOS Payment Methodology

Beneath the surface, however, there are several serious problems with the methodology used to make the MEOS payments that have the potential to financially penalize small practices, discourage practices from serving more complex patients, and encourage changes in treatment that could harm patients.

- **OCM MEOS Payments May Not Be Adequate to Support Required Service Enhancements.** Under OCM, a practice is required to implement a series of service enhancements; the only direct compensation for these service enhancements is the MEOS payment. Although the MEOS payments are significant, there is no assurance that the revenue from the payments will be adequate to cover the additional staffing and other costs required to deliver the enhanced services, particularly for small practices. For example, in order for an oncology practice to hire a nurse to provide the patient navigation services required under OCM, it would need to receive the MEOS payments for enough patients to cover the nurse's salary and benefits as well as other expenses associated with navigation. A small practice with a small number of Medicare patients might not receive sufficient revenues from the MEOS payments

to do so.

Moreover, patients who are receiving complex or toxic treatment regimens or who have multiple comorbidities will generally require more intensive care management services, but under OCM, an oncology practice receives the same \$160 per month MEOS payment for every patient, regardless of their characteristics. An article about the program written by CMS officials stated that the payment “was calculated based on the estimated staffing required to provide the enhanced services,” but they did not describe what level of staffing they had estimated was needed or what mix of patients they assumed for their calculations.²⁵

- **OCM MEOS Payments Encourage Oncology Practices to Delay Completion of Treatment.** Under OCM, CMS pays a participating practice six monthly MEOS payments following the first dose of chemotherapy, and if a patient’s chemotherapy treatments extend beyond six months, CMS gives the practice another six full months of MEOS payments. This means that if the patient’s course of chemotherapy takes 7 months instead of 6 months, the practice will receive nearly \$1,000 more in MEOS payments. This creates a perverse incentive for an oncology practice to choose a treatment regimen that lasts more than six months or to delay the final treatment for a patient who could otherwise finish treatment in six months.
- **OCM Can Penalize Practices for Treating Cancer Patients Who Require Multiple Types of Treatments.** CMS created a new billing code (G9678) for OCM so that oncology practices are able to bill for and receive MEOS payments beginning in the first month that a new patient receives chemotherapy. However, CMS requires the practice to return the MEOS payments for a patient if CMS determines that the patient made more office visits during the six-month episode to a different oncology practice for cancer-related reasons. This means that if (1) a patient is receiving chemotherapy from both a medical oncology practice and a separate radiation oncology practice, or if the patient is receiving chemotherapy from a medical oncologist after receiving surgery from a surgical oncologist, and (2) if the patient happens to have one more office visit with the radiation oncologist or surgical oncologist than with the medical oncologist during the six-month episode, CMS will not “attribute” the episode to the medical oncologist, and the medical oncology practice will have to return the MEOS payments it has received for that patient, even though the practice was providing care management services to that patient. This is likely to happen for many cancer patients; a study of Medicare beneficiaries diagnosed with breast, colorectal, or lung cancer found that as many as 20% received more than one type of treatment (chemotherapy, radiation therapy, and/or surgery) and of these, 85-95% received care from different oncology practices.²⁶
- **MEOS Payments May Not Increase Revenues for Oncology Practices.** The Performance-Based Payment methodology includes the MEOS payments in the calculation of average spending for the oncology practice, but they are not included in the Target Price. This means the practice will only receive a Performance-Based Payment if it can reduce other spending by

more than the amount it receives in MEOS payments. Under the downside risk tracks, the oncology practice would actually have to pay the MEOS payments back to CMS if it does not reduce other spending by more than the revenue it received from MEOS payments. Although some of the services oncology practices have been able to deliver using the MEOS payments are likely to reduce other types of spending, there is no assurance that the savings will offset the payments, since neither the payment amounts nor the services that CMS requires practices to deliver were specifically designed to achieve equivalent amounts of savings. Since the MEOS payments are used to cover the costs of new services the practice is delivering, the practice will lose money if it has to return all or part of those payments to CMS through Performance-Based Payment penalties.

D. The Problems with the OCM Performance-Based Payment

In addition to the problems with the MEOS payment methodology described above, the methodology CMS uses to calculate Performance-Based Payments (PBP) creates even more serious problems:

1. **OCM Rewards Oncology Practices for Withholding Needed Treatments.** In OCM, an oncology practice receives a Performance-Based Payment (PBP) if the amount Medicare spends on healthcare services for the patient during the six-month chemotherapy episode is below the “Target Price” established by CMS. If the practice withholds a treatment that a patient needs, or uses a less effective treatment that is less expensive, Medicare will spend less on the patient, and if the savings are large enough, the practice will qualify for a Performance-Based Payment. The quality component of OCM does nothing to prevent an oncology practice from being rewarded in this way. The practice’s Aggregate Quality Score is not affected if the practice fails to use evidence-based treatments for a patient’s cancer or even if the patient dies due to use of inappropriate treatment.
2. **OCM Penalizes Practices for Using Evidence-Based Care and Encourages Practices to Avoid Patients Who Need More Expensive Treatments.** In OCM, CMS sets the Target Price for a cancer patient by using a statistical formula to “predict” the spending. There are several fundamental problems with the CMS formula:
 - ◆ **Failure to Adjust for Important Clinical Differences Between Patients.** The formula uses information about the patient contained in claims data, not the more detailed clinical information about the patient that the oncologist uses to determine the most appropriate treatment, such as the molecular subtype of the cancer, the stage of cancer, the kinds of treatment the patient received previously, the patient’s ability to tolerate more toxic treatments, etc. As a result, the formula will set the same Target Price for two patients who need different treatments, even if the treatments differ significantly in cost.
 - ◆ **Failure to Adjust for Changes in Evidence About Effective Treatments.** The formula is based on the costs of the types of treatments used in the past for

a particular type of cancer, not the treatments recommended by the most current evidence. No change is made in the Target Price even if new evidence shows that changes should be made in the treatments used in the past for similar patients in order to achieve a reduction in mortality or improved quality of life. As a result, for many patients, the Target Price could be very different from the cost of the most effective treatment regimen.

- ◆ **Failure to Adequately Adjust for Introduction of New Treatments.** New cancer-fighting drugs are being introduced constantly, and the prices of innovative new drugs are typically much higher than older drugs. The CMS formula includes a “Novel Therapy Adjustment” which is supposed to account for this. However, the adjustment is only made if the oncology practice is using the new drug for a higher proportion of its patients than non-OCM oncology practices, and even then, the adjustment only reflects 80% of the difference. As a result, the formula will still penalize any practice that uses an expensive new drug to treat a patient regardless of how much benefit the patient receives.
- ◆ **Failure to Adequately Adjust for Large Increases in the Prices of Drugs.** Even if evidence indicates that the same chemotherapy drugs used in the past continue to be the most effective in treating patients with a particular type of cancer, the prices of those drugs are likely to have increased significantly from previous years. The CMS formula for calculating the Target Price does not adjust for the actual changes in the prices of the drugs used by the practice for the types of patients it is treating; instead, CMS uses the amount spent on treatment in previous years and “trends” that amount forward using the *average* increase in spending at non-OCM practices for *all* cancer patients with *all* types of cancer. As a result, the Target Price will be lower than the actual cost of treating a patient if the price of the drug that patient needs has increased by a higher-than-average amount.
- ◆ **Failure to Include the Full Cost of Part D Medications in the Measure of Spending.** The actual measure of “total spending” used in calculating the Performance-Based Payment only includes a portion of the cost of an oral chemotherapy drug paid for under Medicare Part D, whereas it includes the full cost of a chemotherapy drug that is infused or injected by a nurse at the oncology practice and is paid for under Medicare Part B.²⁷ This means that if an oncology practice uses a Part B drug instead of a Part D drug to treat a patient, the practice’s spending will be more likely to exceed the Target Price for the patient and subject the practice to a penalty, even if the cost of the Part B drug is actually lower or if the drug is more effective in treating the patient’s cancer.
- ◆ **Target Prices Are Reduced by an Arbitrary “Discount.”** For practices participating in the “upside-only risk” track, the OCM methodology reduces the Target Price for each patient by 4% below the average amount that CMS predicts would be spent on that patient. This “OCM Discount” implicitly assumes that at least 4% of spending on the patients at every practice is unnecessary or unnecessarily expensive and can be reduced without harming the patients. A smaller discount (2.5% or 2.75%) is applied in the “two-sided risk” tracks, but the practice also faces a penalty for exceeding that amount. CMS has not provided any rationale for how any of these numbers were chosen, other than to say that the smaller discount in the two-sided risk tracks “may provide an incentive to opt for” one of those tracks.²⁸

The combined result of all of these problems is that the CMS Target Price will likely be very different from the cost of evidence-based treatment for many patients. It isn’t clear exactly how many patients this affects or how large the errors are, because CMS has never released any information describing the predictive accuracy of its formula, even though this information would have been automatically produced by the statistical software it used to develop the formula. This kind of information about model fit is routinely provided regarding the risk adjustment formulas used in other payment systems and quality measures, so there is no reason it should not be provided for a payment system like OCM that could have significant impacts on cancer patients and oncology practices. However, even without this statistical information, the fact that so many new drugs are being released each year and the price increases for many drugs are so high strongly suggests that the Target Prices set using the CMS formula will be lower than the actual cost of evidence-based care for a high percentage of patients. This will have a negative impact on the practice regardless of which risk track it is in. If the oncology practice is in the two-sided risk track, the practice will have to pay a penalty to CMS. If the practice is in the upside-only risk track, it could be forced to leave the OCM program.

These financial penalties create perverse incentives for practices to avoid treating patients who require expensive treatments and to use lower-cost treatments that are less effective.

3. **OCM Rewards Practices for Delays in Completing Treatments.** The CMS Target Price formula does not attempt to predict the cost of the full course of cancer treatment for a patient. Instead, it is supposed to predict spending during a six-month “episode”. A Performance-Based Payment is awarded to a practice if actual spending during the six months following the beginning of chemotherapy is less than the Target Price CMS establishes for that six-month period. The definition of an episode in OCM is very different from the definitions of episodes used in other payment models. For example, in the CMS Bundled Payments for Care Improvement program, an episode includes the full course of treatment for the condition (e.g., a hospital stay for a surgical procedure) plus a specific window of time (90 days) following completion of treatment when typical follow-up care is provided and when any complications are likely to occur. These episodes do not have a fixed total length of time; the episode for a patient will be longer if their hospital treatment takes longer. In contrast, in OCM, an episode is defined as a fixed six-month period of time following the initiation of chemotherapy, regardless of whether the cancer patient’s treatment takes more or less time than that. CMS staff have said that the 6-month episode length was chosen because an analysis of claims data showed that expenditures “stabilized after 4 to 6 months” which “suggested that 6-month episodes were most likely to capture discrete treatment courses across a range of cancer types.”²⁹ However, that analysis actually showed a continuous distribution of

treatment lengths and spending, so the six month time period was a completely arbitrary choice.³⁰ Not only do different treatment regimens last for different lengths of time, the same treatment regimen could last for more or less than six months for different patients; for example, patients who experience side effects or other problems will often require temporary delays in chemotherapy.³¹

Under the OCM Performance-Based Payment methodology, if one or more of a patient's chemotherapy treatments are delayed more than 6 months after the initial treatment, two things happen:

- ◆ the delayed treatments will not be counted toward the spending in the initial episode. This reduces spending during the 6-month period compared to what it would have been if all of the treatments had been completed on time, and therefore it is more likely that the spending will be lower than the Target Price for that episode.
- ◆ the delayed treatments will trigger a new 6-month episode, which will have the same Target Price as the first episode, since the variables used to predict the Target Price are the same. However, since only a fraction of the total treatments will be delivered during the second episode, it is likely that spending during that episode will also be lower than the Target Price.

This not only rewards the oncology practice if a patient has a complication that causes a delay in completing treatment, it creates a perverse financial incentive for the practice to spread out treatments over more than 6 months even if they could all be safely and appropriately delivered within 6 months, particularly in cases where the CMS Target Price is underpredicting the true cost of treatment.

For example, suppose that a patient is receiving a chemotherapy regimen that takes 6 months to administer and that Medicare pays \$18,000 for the complete set of treatments, but the CMS Target Price for the 6-month episode is \$17,000.

- ◆ If the treatment is completed within 6 months, the oncology practice would either have to pay CMS \$1,000 (the difference between the cost and the Target Price), or receive \$1,000 less in Performance-Based Payments than it would otherwise receive.
- ◆ If the oncology practice delays the last monthly treatment until the 7th month following the initiation of chemotherapy, the spending during the first six months would be \$15,000 and the spending during the second 6 months would be \$3,000. The practice would then be eligible for a \$2,000 Performance-Based Payment for the first episode (because the \$15,000 in spending would be \$2,000 less than the \$17,000 Target Price) and the practice would be eligible for a \$14,000 Performance-Based Payment for the second episode (because the Target Price for the second episode would also be \$17,000, but there would only be \$3,000 in spending), for a total Performance-Based Payment of \$16,000.

Rather than reducing Medicare spending on the episode, the Performance-Based Payment methodology would almost double it, since Medicare would be paying \$18,000 for the treatment and it would have to also pay the practice \$16,000 for the Performance-Based Payment, for a total of \$34,000.

In addition, as noted in the discussion of the MEOS payment, if treatment extends for more than six months, the practice will also receive twice as much in MEOS payments (an additional \$960), so in combination, there is a significant financial reward associated with a delay in treatment. The quality measures in OCM would do nothing to avoid this, nor would there be any easy way for CMS to determine whether a treatment delay is due to problems the patient is experiencing or an intentional delay in treatment.

4. OCM Encourages Oncology Practices to Avoid Patients Who Have Health Problems Unrelated to Cancer Treatment.

The Performance-Based Payment in OCM is determined based on *total* spending on *all* services that an oncology practice's patient receives for all of their health issues, not just services related to their cancer. For example, if a patient suffers injuries in a car accident after beginning chemotherapy, the cost of treating those injuries is counted as part of the spending during the chemotherapy episode. If the patient has elective hip replacement surgery after beginning cancer treatment, the cost of the surgery is counted even though it is unrelated to either the patient's cancer or the treatment for that cancer. If the patient has COPD, a heart condition, or another chronic disease, and the cost of treatment for that health problem has increased (either because the disease has progressed or the medications used to treat the disease have increased in cost), the increased cost is counted toward total spending during the six months of the episode. As much as 40% of the spending in OCM episodes is for services unrelated to cancer.³²

The formula for calculating the OCM Target Price adjusts only for the *number of chronic* conditions a patient had in the calendar year *prior* to beginning chemotherapy. It does not adjust for the types of chronic conditions, the severity of the conditions, changes in the severity of the conditions, or changes in the cost of treating the conditions, and it does not adjust for any new acute or chronic conditions occurring during the year in which the patient begins cancer treatment.

The lack of adjustment for non-cancer-related spending in the Target Price formula means that an oncology practice will be less likely to receive a Performance-Based Payment, and more likely to have to pay a penalty (if it is in the two-sided risk track), if it has a higher-than-average number of patients with other chronic health problems or if its patients are unlucky enough to have serious accidents after beginning cancer treatment, even though the oncology practice has no ability to control or change these non-oncology-related costs.

E. Risks of Reduced-Quality Care for Cancer Patients and Loss of Oncology Practices

All of the practices that agreed to participate in the Oncology Care Model selected the “upside-only” risk track. This meant that during the initial years of the demonstration, the practices would receive a significant increase in revenues from the MEOS payments and have the potential to earn Performance-Based Payments, with no potential of having to pay a penalty to CMS if total spending on the practice’s patients exceeded the problematic OCM Target Prices.

However, the OCM participation agreement specified that if an oncology practice did not receive a Performance-Based Payment by 2019, the practice would either have to accept downside risk (i.e., to pay penalties to CMS if spending exceeded Target Prices) or to exit the OCM program altogether. Both of these choices are very problematic for both the oncology practices and their patients with cancer:

- **Service Reductions Likely Needed at Practices Exiting OCM.** OCM has generally been viewed as a success in its initial years because oncology practices have been able to significantly expand their services to patients using the large MEOS payments they have received. If a practice is forced to exit the program, it will no longer receive the MEOS payments, which makes it unlikely that it could continue to deliver the expanded services. As discussed in Section II, the fee-for-service system does not support the kinds of services that many oncology practices are able to deliver with the MEOS payments.
- **Service Reductions Likely Needed at Practices Remaining in OCM.** Several of the problems with the OCM methodology make it extremely difficult for a participating oncology practice to receive a Performance-Based Payment and highly likely that a practice would have to pay a penalty to CMS, even if the practice does not order or deliver any unnecessary or unnecessarily expensive services. The penalties would have to be paid by the practice from the revenues it generates from its billable services, so practices would have less money to spend on the many types of services they provide to patients for which there are no direct fees. Moreover, practices would not know whether they would have to pay a penalty until long after services are delivered, so they would need to reduce their costs significantly in order to create a sufficient reserve of funds to pay the penalties. If a patient’s oncologist is facing the need to pay large penalties to CMS, the patient should be particularly concerned about the perverse incentives in the OCM methodology to withhold needed services, use lower-cost services that result in worse outcomes, and delay completion of treatment.

CMS has not publicly released any information about spending or payments in OCM. However, an analysis by the Avalere consulting firm estimated that only one-fourth of OCM practices received Performance-Based Payments during the initial years of OCM, which means that the majority of practices could be faced with the

choice of exiting or taking on downside risk during the final year of the program. The analysis also estimated that one-half or more of OCM practices would have to pay penalties under the two-sided risk tracks, so if a practice does remain in OCM, it would have to find ways to reduce its costs sufficiently to enable payment of these penalties.³³

The potential penalties under the downside-risk tracks in OCM are so large that they could easily bankrupt an oncology practice. Medicare data show that approximately twenty times as much is spent on drugs, tests, hospitalizations and other services to cancer patients during treatment as the patient’s oncology practice receives in fee-for-service payments for the services it delivers.³⁴ This means that even if the *total* spending per patient is only 1% higher than the Target Prices set by CMS, the practice would have to repay this 1% amount to CMS. That penalty would have to come from the small amount of Medicare revenue the practice receives for the services it delivers. Paying a penalty for a 1% difference in total spending would require 20% of the practice’s Medicare revenue. Although OCM limits the maximum amount that a practice would have to pay in penalties to 20% of total episode spending, 20% of total episode spending is equivalent to four times as much as the total revenue the practice receives from Medicare, so even a penalty lower than the maximum would be large enough to send a practice into bankruptcy.

The likelihood of a large penalty is particularly high for small oncology practices. Random variations in patient needs and the costs of services could cause a practice to be penalized or rewarded for reasons unrelated to the practice’s efforts to deliver good care and control spending. These random variations would be larger for small practices that have fewer patients, since even a single high-cost patient could cause the average spending for a small practice to increase dramatically. A study conducted by the RAND Corporation for CMMI estimated that spending would decline by more than the 4% target in one out of every nine oncology practices due solely to random variation. This also implies that an equivalent proportion of practices that actually reduced spending by more than 4% would not get credit for doing so and could be terminated from the program through no fault of their own.³⁵

IV.

THE PROBLEMS WITH “ONCOLOGY CARE FIRST”

On November 1, 2019, CMS released a draft version of a new payment model called “Oncology Care First” that is designed to replace the Oncology Care Model (OCM).³⁶ (OCM was designed as a five-year demonstration that is scheduled to end in June 2021.)

Unfortunately, Oncology Care First (OCF) fails to correct most of the serious problems with OCM described in the previous section. It includes several new features, some aspects of which are positive but others have the potential to create additional problems beyond those that exist under OCM.

A. The Same Problematic Performance-Based Payment as OCM

Oncology Care First (OCF) includes a Performance-Based Payment component which would calculate bonuses and penalties using a methodology almost identical to the problematic approach used in the Oncology Care Model. As a result, just like the Oncology Care Model:

- OCF would reward oncology practices for withholding needed treatments;
- OCF would reward oncology practices for delays in completing treatments;
- OCF would penalize oncology practices for using evidence-based care; and
- OCF would encourage oncology practices to avoid treating patients who need more expensive treatments and who have health problems unrelated to cancer treatment.

CMS indicates that it is considering calculating trend factors and the “novel therapy adjustment” separately for each cancer type in Oncology Care First rather than the practice level calculations performed in the Oncology Care Model, and using a slightly different attribution methodology in OCF than in OCM, but neither of these changes would solve the fundamental problems with the methodology that are described in Section III.

The perverse incentives under the Performance-Based Payment methodology are most problematic if the oncology practice is required to pay penalties to CMS when spending exceeds Target Prices. As explained in Section II-E, even when spending exceeds Target Prices by only 1%, an oncology practice could lose approximately 20% of its revenue, and the maximum penalties would be multiple times the total Medicare revenue a practice receives.

In Oncology Care First, CMS plans to subject every participating practice to these large penalties. Oncology practices that participated in the Oncology Care Model would

be subject to the penalties immediately, whereas new participants would be exempt from the penalties for only one year. As explained in Section III-E, this has the potential to bankrupt oncology practices, particularly small practices, and it would likely force participating practices to reduce services to patients in order to create reserve funds large enough to pay the penalties.

B. An “Enhanced Services Payment” Instead of the OCM MEOS Payment

OCF would replace the Monthly Enhanced Oncology Services (MEOS) payment with a new monthly “Enhanced Services Payment.” The stated purpose of the Enhanced Services Payment is to support five “enhanced services” that an oncology practice would be required to deliver in order to participate in OCF. Four of these five services are the same as those required under the current Oncology Care Model: (1) “the core functions of patient navigation,” (2) a care plan that contains the 13 components recommended by the Institute of Medicine, (3) 24/7 access to an appropriate clinician with real-time access to medical records, and (4) treatment with therapies consistent with national guidelines. The new, fifth requirement is not really a service *per se*; the practice would be required to begin implementing electronic patient-reported outcomes (ePROs).

1. Differences Between the Enhanced Services Payment and MEOS

The Enhanced Services Payment would differ from the OCM MEOS payment in three important ways:

- **Difference #1: Payments Would Be Made Regardless of Whether Patients Are Receiving Chemotherapy.**
 - ◆ In OCM, oncology practices only receive MEOS payments for patients who have begun receiving chemotherapy, and the practice only receives MEOS payments for more than six months for the same patient if the patient continues receiving chemotherapy more than six months after the initial dose of chemotherapy.
 - ◆ In OCF, an oncology practice would receive an Enhanced Services Payment for any patient who makes a cancer-related visit to the practice or receives another type of billable Evaluation & Management (E/M) service, regardless of whether the patient receives chemotherapy. The practice could receive an additional Enhanced Service Payment if the patient receives at least one cancer-related E/M Service from the practice during the second half of the calendar year (if the previous visit or service was in the first half of the year) or in the next calendar year.

- **Difference #2: The Payment Amounts Would Be Stratified Into Three Levels.**
 - ◆ In OCM, oncology practices receive the same MEOS payment for each patient.
 - ◆ In OCF, there would be three different levels of the Enhanced Services Payment. The highest amount would be paid for patients who are receiving chemotherapy, a lower amount would be paid for patients who are being treated with hormonal therapy and not chemotherapy, and the lowest amount would be paid for patients who are not receiving either chemotherapy or hormonal therapy.
- **Difference #3: Practices Would No Longer Bill for the Payments.**
 - ◆ In OCM, when a patient begins receiving chemotherapy, the oncology practice submits a claim for the first monthly MEOS payment for that patient on the claim form it submits for the other services delivered to the patient, and it receives the MEOS payment along with the payments for the other services. CMS created a new billing code (G9678) so that practices could submit these claims. The practice can continue to submit claims for MEOS payments each month that the patient continues to be eligible. However, CMS can later require the practice to return the MEOS payments if CMS “attributes” the patient to a different oncology practice because the patient made more visits to the other practice in the six months after the MEOS payment began.
 - ◆ In OCF, the practice would not bill for the Enhanced Services Payment. Every six months, the practice would receive a “prospective” payment based on the number and types of patients CMS predicts the practice will see during the six-month period. Then, at some point after the end of the six-month period, CMS would determine the number of patients who actually received a cancer-related E/M service from the practice and whether they received chemotherapy or hormonal therapy based on claims forms submitted by the practice. If CMS determines that the practice was eligible for a higher total Enhanced Services Payment than the prospective amount that it received, CMS would make a supplemental payment, and if CMS determined the practice had received a higher Enhanced Services Payment than it deserved, the practice would have to repay the difference.

2. Problems with the Enhanced Services Payment

As discussed in Section II, patients with cancer need significant education, assistance, and support from an oncology practice before treatment begins, during treatment, and after treatment ends, regardless of whether they decide to receive radiation therapy or chemotherapy, and they need assistance even if they decide not to pursue treatment at all. Unlike the MEOS payment in OCM, the Enhanced Services Payment would not be limited to patients who are receiving chemotherapy, so it could potentially enable delivery of care management services to more cancer patients than has been possible under OCM.

However, there are several problems with the proposed structure of the payment that could limit any beneficial impacts and limit the ability to continue delivering the services that have been supported by MEOS payments:

- **Enhanced Services Payment Amounts May Be Lower Than MEOS Payments for Patients Receiving Chemotherapy.** CMS has not defined how much the Enhanced Services Payments would be. Since the payments would be made for more types of patients than the MEOS payments, CMS would either have to (1) spend more in total on the Enhanced Services Payments than it spends on the MEOS payments, or (2) reduce the Enhanced Services payments below the MEOS payment amounts for patients receiving chemotherapy. Moreover, since the Enhanced Services Payments would be included in the spending measure used in calculating the Performance-Based Payment, the oncology practice would have to repay any increase in payments to CMS if the practice cannot reduce other spending by an equivalent amount. As a result, oncology practices may not be able to sustain all of the services they have delivered using the MEOS payments.
- **Enhanced Services Payment Amounts May Not Be Adequate to Support the Costs of Enhanced Services for Patients Not Receiving Chemotherapy.** A service can only be delivered to a patient if the payment for that service is adequate to support the cost of the service, so the mere fact that CMS will pay Enhanced Services Payments for patients who are not receiving chemotherapy does not mean that the oncology practice will receive enough money to deliver meaningful services to those patients. It seems likely that the Enhanced Services Payments for patients who are not receiving chemotherapy will be very small, since they are not specifically targeted to the subset of patients who need intensive care management services. In fact, CMS plans to make an Enhanced Services Payment for a patient if the patient made a single visit to the practice, even if the patient received no other services from the practice, and even if a different practice is also receiving the Enhanced Services Payment for the same patient. For example, if a patient was already receiving treatment from one oncology practice and made a single visit to a different oncology practice solely for a second opinion, CMS apparently plans to pay the second practice an Enhanced Services Payment even though that practice would not be providing any of the enhanced services to that particular patient. The Enhanced Services Payments for all of these patients would also be included in the spending measure for the Performance-Based Payment, so practices could be forced to pay back the payments to CMS if they do not find ways to reduce other billable services.
- **Enhanced Services Payments Are Not Stratified Based on Differences in Patient Needs.** As noted in Section III, some cancer patients need far more time and assistance than others, and it would be preferable to stratify the amounts of an Enhanced Services Payment so they would better match the differences in costs across practices than the single MEOS payment. However, the differences in patient needs are affected by many more factors than whether they are receiving chemotherapy or not. For example, a patient who is receiving a low-toxicity chemotherapy regimen may need far less assistance than a patient who is no longer receiving chemotherapy but experiencing persistent side effects from the treatment. The proposed method

of stratifying the Enhanced Services Payments fails to properly target higher payments to the patients who actually need more services.

- **Elimination of MEOS Billing Codes Removes the Ability to Target Enhanced Services Payments Based on Patient Needs.** The current MEOS billing code provides a way for an oncology practice to affirm that it is providing enhanced services to the patient for whom it will be receiving the MEOS payment. By eliminating the MEOS billing code and basing the Enhanced Services Payments solely on whether a patient received a single E/M service from an oncology practice, CMS will have no way to determine whether the practice is providing ongoing care to a patient or merely providing a second opinion or some other one-time service. Moreover, all of the information that CMS has about cancer patients comes from the claims data submitted by oncology practices. CMS cannot stratify the Enhanced Services Payments in a more sophisticated way unless it has a way to know which patients have greater needs, and that information is not currently collected through claims. The most efficient and effective way to stratify patients would be to define a separate billing code for each category of patients, so that the oncology practice can indicate which category is applicable to a particular patient by submitting the appropriate billing code.

C. A “Monthly Population Payment” Instead of Fees for Office Visits and Chemotherapy Administration

The one completely new element of Oncology Care First is that a participating oncology practice would receive a “Monthly Population Payment” (MPP) instead of the fees it currently receives for Evaluation & Management (E/M) Services and for administration of chemotherapy.

1. How the Monthly Population Payment Would Work

A very complex mechanism would be used for making the Monthly Population Payments (MPP):

- Although the MPP payment uses the word “Monthly” in the name, the oncology practice would only receive two MPP payments each year, one for services delivered in the first six months of the calendar year, and one for services delivered in the second six months.
 - An oncology practice would receive two MPP payments for a patient during the year if the patient made at least one cancer-related office visit to the practice or received another type of cancer-related Evaluation & Management (E/M) Service from the practice between January and June and at least one visit or E/M service during the second half of the year. If the patient only received E/M services during the first or second half of the year, the oncology practice would only receive one MPP for that patient during the year.
 - If a patient received an E/M service at two different oncology practices during the same six-month period, both practices would receive the MPP payment for that patient.
- If the practice receives an MPP payment for a patient, it would not receive standard Physician Fee Schedule (PFS) payments for E/M services delivered to that patient nor would it receive any fees for drug administration services.³⁷ CMS says that it is also considering including “additional services...such as imaging or lab services” in the MPP.
 - If a patient is receiving chemotherapy in a hospital outpatient department rather than at the oncology practice’s own offices, the MPP would be split into two pieces, a “Management Component” that would be paid to the oncology practice and an “Administration Component” that would be paid to the hospital.
 - The amount of the MPP payment for an individual patient would differ based on only two factors: (1) the general type of cancer the patient has (i.e., breast, lung, colon, etc.) and (2) whether the patient is receiving (a) chemotherapy, (b) hormonal therapy only (for breast, bladder, or prostate cancer), or (c) neither chemotherapy or hormonal therapy. The MPP amount for two patients who were receiving chemotherapy for the same type of cancer would be the same regardless of how many treatments the patient received, how many office visits the patient made, etc.
 - Cancer patients would not pay cost-sharing on the MPP payment. Patients would instead continue to pay standard cost-sharing amounts based on the specific types of office visits and drug administration services they received from the practice, even though the practice would not be receiving payments from Medicare based on the number or types of services delivered.
 - The oncology practice would not submit a bill for the MPP payment. Instead CMS would calculate an initial MPP amount based on the number and types of patients that CMS estimates the practice will be providing services to during the coming six months, and CMS will send that payment to the practice automatically. At some point after the end of each six-month period, CMS would determine the number of patients who actually received a cancer-related E/M service from the practice and whether they received chemotherapy or hormonal therapy based on claims forms submitted by the practice. If CMS determines that the practice was eligible for a higher total MPP amount than the prospective amount that it received, CMS would make a supplemental payment, and if CMS determined the practice had received a higher MPP amount than it deserved, the practice would have to repay the difference.
 - The actual amount of the MPP payment that an oncology practice would receive would be calculated in several steps:
 - ◆ CMS would calculate the median amount spent nationally on E/M and drug administration services for cancer patients during a historical baseline period, with the median calculated separately for each of the different categories of patients (i.e., there would be a separate category for each type of cancer, and that would further be divided into a category for the subset of patients receiving chemotherapy, the patients not receiving chemotherapy, and the patients receiving hormonal therapy but not chemotherapy for breast, bladder or prostate cancer).

- ◆ CMS would adjust these amounts based on the change in spending on those services in each category for non-OCF practices between the baseline period and the current payment period.
- ◆ CMS would then make a “participant-specific adjustment” to those trended amounts specific to each oncology practice. CMS has not specified how these adjustments would be calculated, but in other CMS models, the adjustment is based on a fraction of the ratio between the individual practice’s actual spending and the national median spending during the baseline period. This means that practices that historically billed for more than the median amount of services would receive somewhat higher MPP payments and practices that billed for less than the median amount in the past would receive a somewhat lower amount.
- ◆ The amounts for each payment category would then be multiplied by the actual number of patients in that category who were receiving services at the practice during the six-month period to determine the amount the practice would receive in that category.
- ◆ CMS has not specified how it would calculate the separate amounts for the Management Component and Administration Component of the MPP. The Administration Component would apparently be intended to reflect some of the fees currently paid for Evaluation & Management Services as well as the fees paid for drug administration services.

2. Advantages of the Monthly Population Payment

As indicated above, the Monthly Population Payment would replace two types of current fee-for-service payments: (1) the fees that the oncology practice currently receives for Evaluation & Management (E/M) services, and (2) the fees the practice (or a hospital outpatient department) receives for administering drugs to patients through infusions and injections. There are two primary reasons why it could be beneficial for an oncology practice to receive a monthly payment instead of these fees:

- **The MPP Would Allow Greater Flexibility in Service Delivery.** Most current E/M fees require a face-to-face visit with a physician, nurse practitioner, or physician assistant. This means the practice loses money if it can address a patient’s need over the telephone or via email, or if a nurse can adequately address the patient’s needs during an office visit without the patient having to see a physician or other clinician. A monthly payment that is not tied to specific kinds of visits would provide greater flexibility to meet patient’s needs.
Current drug administration fees are paid to cover the cost of skilled nurses and other practice staff who ensure patients receive infused and injected medications accurately and safely. However, skilled nurses are also needed to ensure that patients taking oral chemotherapy drugs are doing so correctly and safely. Oncology practices are currently penalized financially when they prescribe an oral drug instead of an infused drug because there are no fees for the time their nurses spend educating and monitoring the patients who are receiving oral drugs. A monthly payment that is not tied specifically to infused/injected medications would more equitably support use of both oral and infused/injected medications.

- **The MPP Would Provide More Predictable Cash Flow for Oncology Practices.** Most of the basic costs of any physician practice are for personnel, rent, and equipment leases, all of which are largely constant from month to month. A monthly payment can provide stable and predictable revenue to pay for these costs, whereas FFS revenues are dependent on how many office visits patients happen to make during the month.

If the oncology practice administers chemotherapy to patients, it needs to have a specialized staff of nurses and pharmacists and specialized equipment in order to perform infusions. The costs of these staff and equipment are also largely constant from month to month, and a monthly payment would provide more stable and predictable revenue to support these costs than fees dependent on how many patients happen to need infusions during the month.

3. Problems with the Monthly Population Payment

Greater flexibility and predictability are only beneficial if the monthly payments are adequate to support the costs of delivering the services that patients need. The proposed Monthly Population Payment fails to do this, for two reasons:

- **The MPP Fails to Address Current Shortfalls in FFS Payments.** As discussed in detail in Section II, the fees that oncology practices currently receive from E/M and drug administration services fall far short of the amounts needed to support the full range of services that patients need. The MPP is intended to simply replace the revenue generated by these fees, not to provide more revenue to cover the currently unfunded and underfunded costs. The greater flexibility to deliver additional types of services under the MPP is of no value if the MPP is not large enough to enable the practice to deliver any additional services.
- **The MPP Fails to Adjust the Amount of Payment for Important Differences in Patient Needs.** If an oncology practice has a high proportion of patients who need more assistance, the practice will need more staff with adequate time to provide the patients with the help they need, and that will require higher revenues. Under the fee-for-service system, the practice would be able to receive higher revenues automatically for delivering more of the services that are supported by fees. In contrast, under the MPP, the practice would receive the same amount of revenue regardless of whether its patients needed more services. CMS plans to stratify the MPP using only two factors – the type of cancer the patient has and whether the patient is receiving chemotherapy or not – and ignore other factors that can have a much bigger impact on the time and services a patient needs. This means the MPP would underpay practices for treating many categories of patients:
 - ◆ **Underpayment for new patients.** The Medicare Physician Fee Schedule pays higher E/M fees for office visits with new patients than with established patients because of a longstanding recognition that new patients will require more time. In contrast, under OCF, an oncology practice would receive the

same MPP amount for a new patient as it would for a patient who has been under the practice's care for months or years.

- ◆ **Underpayment for patients who need longer or more frequent infusions.** Patients whose chemotherapy requires more frequent infusions or longer infusions will require more staff time and equipment. The fee-for-service system pays more for these patients, but the MPP amount would be the same.
- ◆ **Underpayment for patients receiving the most toxic chemotherapy regimens.** Patients who are receiving more toxic chemotherapy regimens that require careful monitoring and rapid intervention will need to be seen by the oncology practice staff more frequently and quickly. The fee-for-service system pays more for patients who require more visits, but the MPP would not.
- ◆ **Underpayment for patients with more complex needs.** Patients with other health problems in addition to cancer, patients who live alone, patients who have functional limitations, patients experiencing side effects from treatment, etc. will need more time and assistance from the oncology practice, but the practice would receive the same MPP regardless of whether a patient had any of these characteristics. In fact, under OCF, a practice would receive the same MPP amount for a patient who made one visit to a practice for a second opinion as it would for a patient who was visiting the practice frequently for complications and side effects.
- ◆ **Underpayment for patients with more advanced cancer.** The oncologist and other practice staff will need to spend more time with patients who have more advanced cancer, but the MPP would pay the same amount for these patients as for patients with early stage cancers that are responding well to treatment.
- **The MPP Could Make It More Difficult for High-Need Patients to Receive Good Cancer Care.** If Oncology Care First pays an oncology practice the same amount for a high-need patient as a low-need patient, one of two things will happen. If the practice accepts high-need patients for care, it will not be able to take care of as many other patients, its MPP revenues (which are based on how many patients the practice cares for) will decrease, and the practice may be forced out of business. Alternatively, the practice may be forced to refuse to accept as many high-need patients in order to maintain a high enough patient caseload to cover its costs. Either way, high-need patients could lose access to care.
- **The MPP Would Reduce Cash Flow for Expanding Practices.** Under OCF, an oncology practice would not bill for the MPP; CMS would make an initial payment based on the volume of patients that CMS *assumes* the oncology practice will be caring for during the next six months, and then, at an unspecified point after that six month period ends, CMS will make an additional payment to the practice if a higher-than-expected number of patients received services. In contrast, under the fee-for-service system, a practice with an increasing number of patients would be able to immediately bill and be paid more to support expanded services.
- **The MPP Would Not Reduce the Administrative Burdens of Fee-for-Service Coding and Billing.** Although the MPP would replace all of the E/M and drug

administration fees to the oncology practice, this does not mean that the practice would no longer have to code or bill for these services; the MPP would only represent the Medicare share of the amount that practices would have received for these services; the practice would still have to bill patients for each service in order to receive the 20% patient co-insurance amount.

D. No Improvements in Other Problematic Aspects of Fee-for-Service Payment

The relatively limited differences between Oncology Care First and the Oncology Care Model mean that Oncology Care First fails to address many of the serious problems in the fee-for-service system for the same reasons described in Section III.

- **OCF Does Not Provide Significant Additional Resources for Diagnosis and Treatment Planning.** Although oncology practices would receive an Enhanced Services Payment based on their first visit to the practice, the payment amount would likely be very small for a patient who does not receive chemotherapy. There would also be no difference in any of the payments for a new patient or a patient who is transitioning to a new type of treatment than for patients who have been receiving the same treatments for an extended period of time.
- **OCF Provides No Payment for Palliative Care Services.** The Enhanced Services payments would not be large enough to support the delivery of palliative care services in addition to care management services, particularly for patients who are not receiving chemotherapy.
- **OCF Provides Limited Additional Resources for Survivorship Support.** Although OCF would provide Enhanced Services Payments for patients after they complete chemotherapy, it is not clear how large the payment amounts would be, and as noted earlier, it seems unlikely that they would be large enough to support much in the way of new services.
- **OCF Makes No Improvements in the Method of Payment for Cancer Drugs.** Physician practices and hospitals that are participating in OCF would continue to be paid for infused or injected chemotherapy using the same ASP+x% formula as other oncology care providers. As discussed in Section III with respect to OCM, although the Performance-Based Payment component of OCF would discourage the use of more expensive drugs, it would do so without regard to whether the ASP+x% payment is higher or lower than the cost of the drug and regardless of whether the drug is appropriate for the patient.
- **OCF Makes No Improvements in the Method of Payment for Radiation Therapy.** OCF makes no changes in the way payments are made for radiation oncology services. The Performance-Based Payment component would encourage the use of fewer and less-expensive radiation treatments, but it makes no distinction between whether reducing the number or cost of treatments will help or harm the patient or whether the reduced revenues from fewer treatments will be

sufficient to cover the costs of the practice's radiation equipment.

- **OCF Creates No Penalties for Failure to Follow Evidence-Based Guidelines for Treatment and Other Services.** Although an oncology practice participating in OCM is expected to follow evidence-based treatment guidelines, the practice is paid for a patient's treatment and other services even if they are not consistent with evidence-based guidelines. No distinction is made between practices based on the rate at which they follow evidence-based guidelines.
- **OCF Has Only Limited Penalties for Failure to Avoid or Address Other Types of Side Effects.** As discussed in Section III with respect to OCM, the Performance-Based Payment in OCF would not reward or penalize practices based on whether patients experience pain or other side effects that do not involve ED visits or expensive treatment. Although OCF plans to require that oncology practices collect information on patient-reported outcomes, there is no indication as to whether or how these would be used to modify payments.

E. Failure to Incorporate the Recommendations of Practicing Oncologists

It is surprising and disappointing that Oncology Care First fails to correct most of the serious problems with the Oncology Care Model. The problems with the Oncology Care Model have been known since the time the OCM design was first announced,^{38, 39} and practicing oncologists have regularly provided CMS with both examples of the specific problems OCM has caused for practices and patients and specific recommendations on how to fix the problems.⁴⁰ In the materials describing Oncology Care First, however, there is no indication that CMS has even tried to solve the problems or is interested in making the changes needed to do so.

It is particularly disappointing that Oncology Care First continues to use simplistic methods of stratifying payment amounts and risk-adjusting Target Prices even though better approaches are available. There is universal recognition that most effective treatments for cancer have to be very precisely chosen based on the molecular subtype of cancer, the stage of cancer, and other characteristics of the patient, and that the support services patients need before, during, and after treatment are affected as much or more by the specific characteristics of the patient and the specific treatment they are receiving than the type of cancer they have. Yet as described earlier, the Monthly Population Payments and the Enhanced Services Payments in OCF would only be stratified by the general type of cancer and whether a patient is receiving chemotherapy or not, and the Performance-Based Payments would continue to be based on a crude statistical formula that does not even attempt to make adjustments for changes in evidence about the effectiveness of treatment or the actual cost of the most effective treatment.

As part of the Medicare Access and CHIP Reauthorization Act (MACRA) passed in 2015, Congress established a formal process to allow physicians to propose how alter-

native payment models should be designed in order to reduce Medicare spending without harming patients. Physicians can submit a detailed proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC), and PTAC reviews the proposal using ten criteria that are established in regulations by the Secretary of Health and Human Services. If PTAC determines that a proposed payment model meets the criteria, it can recommend to the Secretary of HHS that the model be implemented or tested.⁴¹

In 2016 and 2017, two highly-regarded oncology practices developed and submitted proposals to PTAC for innovative ways of paying for oncology services:

- Hackensack Meridian Health (HMH) and Cota, Inc. submitted a proposal in March 2017 to create an *Oncology Bundled Payment Program Using CNA-Guided Care*. Under this proposed payment model, an oncology practice would receive a bundled payment for care of patients with newly diagnosed breast, colon, rectal, and lung cancer, and the oncology practice would be responsible for paying for all of the appropriate treatments and services to the patient over the next 12 months using this bundled payment.⁴²
- Innovative Oncology Business Solutions and the National Cancer Care Alliance submitted a proposal in February 2018 for a payment model called "MASON" (*Making Accountable Sustainable Oncology Networks*). Under this proposed payment model, an oncology practice would be responsible for delivering most oncology-related services to cancer patients within a specific "target price" amount.⁴³

Both of these proposals are similar to the Oncology Care Model and Oncology Care First in defining a specific budget or "target price" for the care of a patient with cancer. However, they do so in ways that (1) avoid the most serious problems with OCM and OCF, and (2) solve more of the problems with the fee-for-service payment system than either OCM or OCF. For example:

- In both the HMH and MASON payment models, the bundled payment amount or target price would be determined based on multiple clinical characteristics of the individual patient and based on the type of treatment that was recommended by current evidence and guidelines, rather than differentiating only on the type of cancer the patient had and other information available in claims data as OCM and OCF do.
- In both proposals, patients would be classified into one of a number of different clinical categories, and a target price would be assigned to each category based on the expected cost of care for the patients in that category. In contrast, OCM and OCF use linear regression models that assume every factor has only an additive effect on costs.
- In the HMH model, the payment amount would be designed to cover a 12-month period of time, which significantly reduces any incentive to extend treatment in order to increase payments compared to the 6-month time period used in OCM and Oncology Care First. In the MASON model, the target price is intended to cover a full episode of treatment rather than a specific time period; a new episode is initiated only when the disease or the treatment changes.

- In the MASON model, a practice would receive a new \$750 payment for new patients in order to support accurate diagnosis and treatment planning.
- In the MASON model, payments for drugs would not be included in the target prices so that oncologists are not rewarded for withholding expensive drugs or penalized when drug prices increase. MASON would also eliminate the current ASP+x% payment for drugs and replace it with a payment based on the practice's acquisition cost plus a fee to cover pharmacy operation costs.
- In both models, the oncology practice would have its payments reduced if it failed to follow evidence-based treatment guidelines without justification.

PTAC recommended that the Secretary of Health and Human Services implement demonstration programs to test both of these proposals.^{44, 45} As required by law, the Secretary responded publicly to both recommendations:

- In the response to PTAC's recommendations on the model proposed by Hackensack Meridian Health (HMH) and Cota, Inc., the Secretary said that HHS was "very interested in collaborating with HMH, Cota Inc., and other individuals and stakeholder entities in further exploration of how this proposal model or its components could potentially be incorporated into future payment models."
- In the response to PTAC's recommendations on the MASON model, the Secretary stated that he recognized the differences in MASON from OCM were things that "OCM participants would appreciate," and said he would ask the CMS Innovation Center to "engage further with the submitter and other stakeholders to discuss enhancements to that existing [OCM] model and other potential models intended to improve care."

None of the elements of either of the proposals recommended by PTAC were incorporated into the Oncology Care First model. In its Request for Information, CMS stated that it "greatly appreciate[s] the oncology-related proposals submitted" to PTAC and that it is "continuing to think of ways to incorporate elements of these proposals submitted to PTAC as well as PTAC's recommendations and comments."⁴⁶ At a November 4, 2019 meeting, CMS representatives stated publicly that CMS was unlikely to implement any payment models for medical oncology other than Oncology Care First.

**TABLE 2
COMPARISON OF “ONCOLOGY CARE FIRST” TO FEE-FOR-SERVICE PAYMENT**

STANDARD FEE-FOR-SERVICE PAYMENT	CMS ONCOLOGY CARE FIRST
PROBLEMS WITH FEE-FOR-SERVICE PAYMENT	
No payment or underpayment for high-value-services	
Underpayment for diagnosis and treatment planning	Payments for new patients may be lower
No payment for care management during treatment	Additional resources through Enhanced Services Payments
No payment for palliative care services	No payment for palliative care services
Underpayment for survivorship care	Additional resources through Enhanced Services Payments
Problematic method of payment for infused/injected drugs	
ASP+x% does not match the acquisition cost of drugs	No change
No payment for pharmacy operation costs	No change
Loss of revenue due to patient bad debt	No change
Problematic method of payment for radiation therapy	
Dose-based payments encourage unnecessary treatment	No change
Dose-based payments do not match cost of treatment	No change
No assurance of high-quality care at most affordable cost	
No penalty for failure to follow evidence-based guidelines	No change
No penalty for high rates of treatment complications	Penalty for failure to avoid ED visits and hospital admissions
Financial penalty for reducing avoidable services	Potential bonus payment for reducing avoidable services
STRENGTHS OF FEE-FOR-SERVICE PAYMENT	
No incentive to delay or deny treatments patients need	Bonus payment if spending is reduced, including when needed services are withheld. Oncology practices are paid more if treatment is delayed beyond 6 months.
Higher payments for patients who need additional services	Poor risk adjustment system can penalize oncology practices that treat patients who have higher needs
Providers know in advance how much they will be paid	Oncology practices cannot predict how much they will receive prior to delivering services
No penalties or rewards for things providers can't control	Oncology practices are penalized for increases in drug prices and for services delivered by other physicians and hospitals to treat health problems unrelated to cancer

V. THE PROBLEMS WITH THE CMS RADIATION ONCOLOGY MODEL

Chemotherapy is not the only approach to treating cancer. Many patients are treated primarily with radiation therapy, and others receive a combination of chemotherapy and radiation therapy either sequentially or simultaneously. However, the CMS Oncology Care Model is exclusively focused on patients who are receiving chemotherapy; an oncology practice can only receive MEOS payments for patients who are receiving chemotherapy, and the performance-based payments are tied to six-month episodes that are triggered by chemotherapy. Although Oncology Care First would include patients receiving services from any kind of oncology practice – medical oncology, radiation oncology, or surgical oncology – the largest Enhanced Services Payments would be associated with patients receiving chemotherapy, and the Performance-Based Payments would still be based solely on spending for patients receiving chemotherapy.

In July 2019, CMS proposed to create a “Radiation Oncology (RO) Model” specifically focused on payments for radiation oncology services.⁴⁷ Unfortunately, rather than solving the problems with current payments for radiation oncology, the proposed structure of this model has the potential to harm both patients and radiation oncology practices.

A. The Structure of the Radiation Oncology (RO) Model

Under the Radiation Oncology (RO) Model, a radiation oncology practice would receive a single payment for all of the radiation therapy services a patient receives during a 90-day period following the first treatment, instead of the more than 100 separate fees that are currently paid for individual services and treatments.⁴⁸

The RO Model would pay a different amount for each of 17 different kinds of cancer. The payment amount for each type of cancer would be determined in several steps:

- First, CMS would calculate the average amount per patient that it has paid each radiation oncology practice in previous years for all current radiation oncology fees during the 90 days following initiation of radiation treatment.
- If the average per-patient amount for a radiation oncology practice was higher than the national average payment, the payment amount for that practice would be increased by a fraction of the difference, and if the average for a practice was lower than the national average, the payment amount for that practice would be reduced by a fraction of the difference. This “efficiency factor” is intended to adjust for unmeas-

ured differences in patient characteristics as well as differences in practice treatment patterns.

- Those practice-specific amounts would then be reduced by a 4-5% “discount” to produce savings for Medicare.
- The payment would be further reduced by a 2% “quality withhold.” A portion of this withhold amount could be paid to the practice in the future based on its performance on quality measures.
- Finally, the payment would be reduced by an additional 2%. The practice would be eligible to receive this “incorrect payment withhold” after CMS determines that the practice had not received payments for ineligible patients, but this could take as long as 21 months from the time a patient was treated.

Unlike other CMS APMs, CMS has proposed to make participation in the RO Model mandatory for radiation oncology practices in approximately 40% of the country, and prohibit practices in the rest of the country from participating.

B. Strengths and Weaknesses of the Radiation Oncology Model

As discussed in Section II, the current fee-for-service system is problematic for radiation oncology services. The revenue for a radiation oncology practice is directly related to the number of doses (fractions) of radiation that it delivers to patients. However, most of the costs of radiation therapy are fixed costs that do not vary much based on the number of doses delivered. As a result, a radiation oncology practice can lose significant amounts of money when it delivers fewer doses of radiation and it can make large profits when it delivers extra doses, particularly if the treatments use the more expensive equipment that have higher fees.

A bundled payment for a full course of radiation delivered to a patient would significantly reduce this mismatch between revenues and costs. The revenue to the radiation oncology practice would no longer change based on whether a patient received one more or one fewer dose of radiation. This would allow the radiation oncologist to select the number of doses that are best for the patient, without concern about the financial implications for the practice.

Although the high fixed cost of each type of equipment means that the practice’s costs will not change significantly based on the exact number of doses that are given to an individual patient, the costs *will* differ depending on which specific types of radiation treatments the practice uses, because the costs of the different equipment differ significantly. As a result, if the payments are going to be

made on a per-patient basis rather than a per-dose basis, the payments would have to be based on the types of treatments that a particular type of patient is likely to need based on current evidence about effective treatment.⁴⁹ Unfortunately, the methodology for setting the bundled payment amounts in the CMS Radiation Oncology Model fails to properly adjust for the differences in costs of radiation treatment modalities or for the differences in the types and amounts of treatments individual patients will need:

- **Payment amounts in the CMS RO Model would not be based on the actual cost of delivering services.** The CMS RO Model does not even attempt to determine what it does cost or should cost to treat patients with a particular type of cancer and other characteristics. CMS has proposed to simply take the average amount that Medicare has spent in the past and reduce it by an arbitrary discount.
- **Payment amounts would not be based on the most current evidence about appropriate treatment and advances in technology.** New treatments for cancer are being developed constantly, and new evidence about treatment effectiveness is being published constantly. However, the CMS RO APM methodology would calculate payment amounts based on treatments that were used in the past, regardless of whether the appropriate treatments were being used then, and with no adjustment for changes in technology or evidence that have occurred in subsequent years. The regulation proposes to “trend” the historical payment amounts based on changes in Medicare fees and changes in utilization by providers who are not participating in the RO Model, rather than on changes in the costs of the technologies used for treatment and changes in the mix of treatments that evidence indicates are appropriate.

If payments do not match the cost of delivering evidence-based care, patients could easily be harmed:

- **The RO Model would discourage radiation oncology practices from treating patients who require more extensive or expensive treatments.** There are significant differences in the appropriate radiation treatments that are most appropriate for different cancer patients. In the CMS RO Model, as in the CMS Oncology Care Model, payments would only differ based on the type of cancer and on other information that is recorded in claims data. However, the most appropriate treatment for a patient will depend on a variety of clinical factors, such as the stage of cancer, and on characteristics of the patients other than their disease. This information is only available in the patient’s clinical records. As a result, practices would be underpaid for patients who need more extensive and expensive treatments.
- **The RO Model could force small radiation oncology practices out of business, reducing patient access to treatment.** In combination, the discounts and quality/patient experience adjustments could result in at least a 4-5% cut in payments and as much as a 6% cut for both radiation oncology practices and treatment facilities. The “efficiency adjustment” could result in an additional cut of several percentage points for practices whose patients need more-expensive-than-average

treatments. The “incorrect payment withholds” will delay an additional 2% of payments by as much as 21 months. This means that radiation oncology practices could initially experience revenue reductions of 8% or more under the proposed model. This could force some practices to close, particularly in rural areas, and independent practices could be forced to merge with hospitals and health systems in order to cover their costs.

The Radiation Oncology Model focuses solely on changing the amount of payment for radiation treatment. It does even less to address the other problems in the fee-for-service system than the Oncology Care Model:

- **The RO Model provides no additional payments to support diagnosis and treatment planning.**
- **The RO Model provides no additional payments to support care management services during treatment.**
- **The RO Model provides no payment for palliative care services.**
- **The RO Model provides no additional payment for survivorship support.**
- **The RO Model creates no penalties for failure to follow evidence-based guidelines for treatment.**
- **The RO Model has no penalties for high rates of treatment-related ED visits and hospitalizations.**

C. Failure to Incorporate the Recommendations of Practicing Oncologists

It is surprising and disappointing that the CMS Radiation Oncology Model has these problems, since radiation oncologists proposed a better design two years earlier. The American Society of Radiation Oncology (ASTRO) prepared and submitted a detailed concept paper for a Radiation Oncology Alternative Payment Model (RO-APM) to CMS in April, 2017.⁵⁰ The RO-APM model was designed to improve patient care quality and outcomes, not just to reduce Medicare spending on radiation treatments.

The RO-APM was designed to focus on five primary disease sites (breast, lung, prostate, colorectal, and head and neck) and two secondary disease sites (bone metastases and brain metastases). Current fees for individual treatments would be replaced by a prospective payment covering a full episode of care for the patient. Under the RO-APM, the radiation oncologist would take accountability not only for radiation treatments but also for other services during the episode such as ED visits that could result from complications of treatment. Rather than the arbitrary 90-day period used in the CMS model, the RO-APM episode would begin at the point of clinical treatment planning, extend through the end of treatment (however long that took) and then extend an additional 90 days after the last radiation therapy treatment to ensure that the radiation oncology practice was accountable for complications that occurred after the end of treatment.

In order to enable the radiation oncology practice to provide care management services to the patient during

treatment, the practice would receive a monthly Patient Engagement and Care Coordination (PECC) fee similar in amount to the MEOS payment in the Oncology Care Model.

Throughout the episode, the radiation oncology practice would be accountable for delivering high-quality care. This would begin with a requirement for shared decision making about treatment, care management, and survivorship planning. The radiation oncology practice would

be required to follow standards of performance and clinical guidelines for selection and administration of radiation treatments, and the practice would be accountable for quality using a set of radiation oncology-specific measures.

When CMS released the Radiation Oncology Model, it gave no reasons why it ignored the recommendations that had been made by radiation oncologists and why it proposed a clearly inferior and problematic approach.

**TABLE 3
COMPARISON OF CMS RADIATION ONCOLOGY MODEL TO FFS PAYMENT**

STANDARD FEE-FOR-SERVICE PAYMENT	CMS RADIATION ONCOLOGY MODEL
PROBLEMS WITH FEE-FOR-SERVICE PAYMENT	
No payment or underpayment for high-value-services	
Underpayment for diagnosis and treatment planning	No additional payment
No payment for care management during treatment	No payment for care management services
No payment for palliative care services	No payment for palliative care services
Underpayment for survivorship care	No additional payment
Problematic method of payment for infused/injected drugs	
ASP+x% does not match the acquisition cost of drugs	No change
No payment for pharmacy operation costs	No change
Loss of revenue due to patient bad debt	No change
Problematic method of payment for radiation therapy	
Dose-based payments encourage unnecessary treatment	Episode payments would not depend on number of doses
Dose-based payments do not match cost of treatment	Episode payments would not be based on cost of treatment
No assurance of high-quality care at most affordable cost	
No penalty for failure to follow evidence-based guidelines	No change
No penalty for high rates of treatment complications	No change
Financial penalty for reducing avoidable services	Higher profits from reducing unnecessary treatments
STRENGTHS OF FEE-FOR-SERVICE PAYMENT	
No incentive to delay or deny treatments patients need	Payment cuts and inadequate adjustment of payments for differences in patient needs would discourage use of higher-cost treatments for patients who need them
Higher payments for patients who need additional services	Payment cuts and inadequate adjustment of payments for differences in patient needs would discourage use of higher-cost treatments for patients who need them
Providers know in advance how much they will be paid	Payment amounts would be defined before care is delivered
No penalties or rewards for things providers can't control	Payments are based only on radiation oncology services

VI. PATIENT-CENTERED PAYMENT FOR CANCER CARE

As shown in the previous sections, both the current and proposed CMS payment models for oncology fail to correct most of the problems with the current fee-for-service system that prevent cancer patients from receiving the highest-quality care at the most affordable cost. Even worse, these APMs could harm cancer patients by creating problematic incentives to stint on needed care and avoid patients with more complex needs.

The problems with these payment models cannot be solved by incremental modifications. What is needed is a fundamentally different approach – a *patient-centered* approach to oncology payment, instead of a *payer-centered* or *provider-centered* approach.

A. How to Create a Patient-Centered Alternative Payment Model

There are four basic steps to creating a patient-centered Alternative Payment Model (APM) for any kind of patient care, including cancer care:⁵¹

Step 1: Identify specific opportunities to reduce avoidable spending. The goal of an Alternative Payment Model is not just to reduce spending, but to reduce spending *while maintaining or improving quality*. The best way to ensure this happens is to start by identifying *avoidable* spending, i.e., specific services that are unnecessary, unnecessarily expensive, or harmful to patients. An APM that enables and encourages oncology practices to reduce or eliminate these services would reduce spending without harming patients.

Step 2: Design changes in services that will reduce the avoidable spending. In most cases, reducing avoidable spending requires delivery of new or different services that achieve similar or better outcomes for patients at a lower cost. The specific changes in services that are needed must be identified in advance in order to determine what the services will cost and to ensure there is adequate evidence that the services will reduce avoidable spending by more than it costs to deliver them.

Step 3: Identify the barriers in the current payment system to implementing the changes in services. It will be impossible for physicians, hospitals, and other providers to deliver new or different services if they will lose money by doing so. As discussed in Section II, the current fee-for-service system creates barriers to delivering many high-value services, either because there is no payment at all for the service, the payment is less than the cost of delivering the service, or the provider will experience losses by reducing the use of the avoidable services. Most current APMs fail to remove these barriers.

Step 4: Pay adequately to support high-value services and hold providers accountable for reducing avoidable spending. Alternative Payment Models should be specifi-

cally designed to overcome the barriers in current payment systems so that avoidable spending is reduced. There are two key components to a successful APM:

- **Adequate payment for high-value services.** The APM needs to pay adequately for the services needed to reduce avoidable spending so that physicians, hospitals, and other providers can deliver them.
- **Accountability for reducing avoidable spending.** In return for receiving the payments, the providers must take accountability for achieving the reductions in avoidable services, and the APM needs to enforce that accountability.

In an APM designed through this process, there is no risk of undertreating patients, because the focus is only on actions that will reduce spending without harming patients. Moreover, by reducing services that can be harmful and/or substituting services that provide better outcomes at lower cost, patients can actually be better off both physically and financially through the APM.

This approach to APM design is more consistent with what Congress intended than most of the APMs that have been implemented by CMS to date. Section 1115A of the Social Security Act only permits the Center for Medicare and Medicaid Innovation to test payment models where “there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.”⁵²

The sections below describe how to use this process to design a patient-centered payment model for cancer care.

B. Opportunities to Reduce Avoidable Spending in Cancer Care

There are two principal areas where there is significant avoidable spending in the care of cancer patients:

- Use of treatments and other services that are not consistent with evidence-based guidelines.
- Emergency department visits and hospital admissions for complications of cancer treatment.

The amount of potential savings in these two areas is so large that it could easily exceed the arbitrary “discount” amounts that CMS has been requiring in its APMs.

1. Services That Aren’t Consistent With Evidence-Based Treatment Guidelines and Pathways

Oncologists have been in the forefront of medical specialties in developing detailed, evidence-based guidelines for

treating their patients. The National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines define which treatments should be used and which treatments should not be used for specific patients.⁵³ In addition, oncologists have also been active contributors to the “Choosing Wisely” program. The American Society of Clinical Oncology, the American Society for Radiation Oncology, the Commission on Cancer, the Society of Surgical Oncology, the Society of Gynecologic Oncology, and others have developed lists of treatments and services that should be avoided in the diagnosis, treatment, and monitoring of cancer patients because they are of “low value,” i.e., they either provide little benefit or the potential harms outweigh the benefits.⁵⁴ There are also many efforts to create “clinical pathways” that provide more specific guidance about which treatments and services to use when there are significant tradeoffs between efficacy, toxicity, and or cost.⁵⁵

A number of studies have shown that evidence-based treatment guidelines are not being followed in a high percentage of cases. For example, two studies of the treatment of women with metastatic breast cancer found that 18-19% received treatment that was inconsistent with NCCN Guidelines.^{56, 57} Two studies of adherence to the American Society of Clinical Oncology (ASCO) Choosing Wisely guidelines were not being followed in as many as 50-60% of the cases where the guidelines were applicable.^{58, 59}

Because of the high cost of cancer treatments and services, unnecessary use of a treatment or service can substantially increase spending as well as potentially harm the patient. One of the studies of non-adherence to Choosing Wisely guidelines found that Medicare spending was higher for patients whose care did not match the guidelines, and that costs were tens of millions of dollars higher as result of the non-adherence across all of the guidelines examined.⁶⁰ Several studies have found that use of evidence-based pathways can achieve significant savings.⁶¹ As the example in the sidebar illustrates, increasing adherence to even a single guideline has the potential to generate significant savings and generate better outcomes for patients.

Care that fails to follow evidence-based guidelines not only increases spending for health insurance plans, but it also increases the financial burden on patients. A study of Medicare beneficiaries with metastatic breast cancer found that the cost-sharing responsibility for patients whose care did not follow NCCN guidelines was almost \$2,000 higher.⁶²

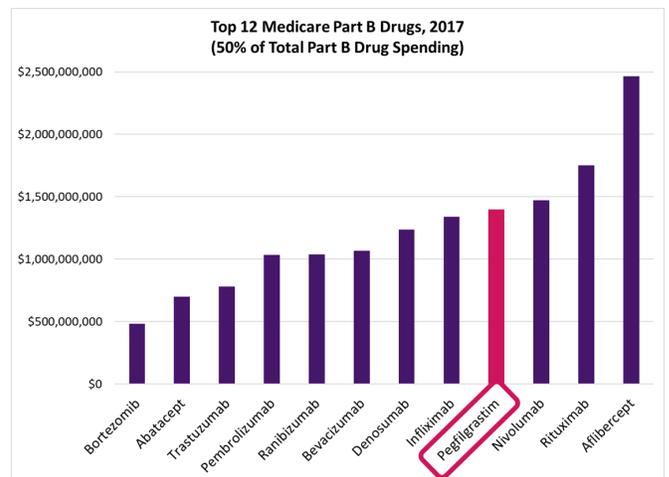
Example of the Potential for Savings From Following Evidence-Based Guidelines: Use of White-Cell Stimulating Factors in Cancer Treatment

One of the biggest sources of Medicare drug spending in cancer care isn't a chemotherapy drug; it is pegfilgrastim, a drug that is used to stimulate production of white blood cells to reduce the chance of infection resulting from chemotherapy.⁶³ Medicare spent more than \$1.4 billion on pegfilgrastim injections in 2017, the fourth-highest amount of spending on any Part B medication. The drug is very expensive, averaging more than \$15,000 per patient in 2017.⁶⁴ In 2017, Medicare paid community oncology practices more for use of pegfilgrastim than for any chemotherapy drug.

Although white-cell stimulating factors (CSFs) such as pegfilgrastim can help prevent serious infections when patients receive highly toxic chemotherapy, they are of limited benefit when patients are receiving lower-toxicity chemotherapy, and the drugs can also cause patients to have bone pain and other side effects. The American Society of Clinical Oncology's *Choosing Wisely* guideline recommends use of CSFs for primary prevention of febrile neutropenia only for chemotherapy regimens with a 20% or higher risk of the complication.

Several studies, in different parts of the country and for both Medicare and commercially insured patients, have found only 70% adherence to the *Choosing Wisely* guideline^{65, 66, 67} Other studies have found even lower rates of adherence.^{68,69} If 30% of the patients getting the drug don't really need it, that could represent more than \$400 million in savings for the Medicare program – which is equivalent to the savings that would be generated if the price of every Part B drug was reduced by 1.4%.

Non-compliance cuts both ways. There is also evidence that some patients who *should* get pegfilgrastim *don't* get it, and this could potentially result in unnecessary ED visits and hospital admissions.⁷⁰ The proportion of patients receiving the drug who shouldn't exceeds the proportion who don't get it but should, so more appropriate use could not only reduce spending on drugs but also reduce spending on ED visits and hospital admissions. One study found a significant decrease in spending on ED visits and hospital admissions from more appropriate use of white-cell stimulating factors and other medications.⁷¹



2. ED Visits and Hospital Admissions for Complications of Cancer Treatment

Chemotherapy and radiation treatments that are effective in attacking cancer also have the potential to create side effects such as nausea, diarrhea, and neutropenia. If actions are not taken to prevent these side effects or to treat them promptly when they do occur, they can lead to serious complications such as dehydration and infection. Many patients go to emergency departments (EDs) for treatment of these complications, and they may be admitted to the hospital if the complications are severe.

Studies have shown that chemotherapy-related ED visits and hospitalizations occur frequently and represent a significant portion of overall spending on cancer care. One study of commercially-insured cancer patients receiving chemotherapy found there were approximately two ED visits per patient per year, half of which were chemotherapy-related, and there was an average of one inpatient admission per patient per year, approximately 40% of which were chemotherapy-related. Total spending on chemotherapy-related ED visits and hospital admissions averaged more than \$9,000 per patient.⁷² A 2017 study of Medicare beneficiaries receiving chemotherapy found average spending of nearly \$5,000 per patient on inpatient care.⁷³ A 2018 study of commercially-insured patients receiving either chemotherapy or radiation found that more than one-fourth of patients had at least one ED visit and that half of the ED visits were made for potentially-preventable reasons related to cancer.⁷⁴

Consequently, preventing treatment-related complications and intervening more quickly when they do occur could significantly reduce the amounts that Medicare and other payers spend on care of cancer patients as well as improve the patients' quality of life.

C. Changes in Services Needed to Reduce Avoidable Spending and Barriers to Implementation

These opportunities to reduce spending and improve the quality of cancer care exist because the fee-for-service payment system does not support the changes in services needed to address them.

1. Adequate Time for Accurate Diagnosis and Treatment Planning

Evidence-based guidelines and pathways for cancer treatment are extremely complex. The appropriate treatment for an individual patient depends not just on the general type of cancer (e.g., breast cancer vs. lung cancer) but on the specific molecular subtype of cancer, the stage of cancer, any previous treatments the patient has received, and other characteristics of the patient. The process is even more complex because new cancer treatments are being introduced constantly, the evidence about effectiveness is being updated regularly, and there is not clear evidence about what is best for every specific combination of disease and patient characteristics.

Moreover, there may be two or more options for treatment that involve significant tradeoffs between efficacy and toxicity, i.e., the treatment with a higher probability of slowing or reversing the progression of the cancer may also have more serious side effects on the patient. Cancer patients can die from their treatment as well their cancer, so decisions about which treatment to use and whether to pursue any treatment at all are literally life and death in nature. Not only do the best treatment options need to be identified by the patient's oncologist, the patient needs to play an active role in making the decision about treatment and they need to understand the choices well enough to make an informed decision.

Consequently, "following evidence-based guidelines" is a very time-consuming process, which begins with accurately determining the precise diagnosis and continues through a compassionate process of shared-decision making with the patient. The process is repeated each time a patient's cancer progresses.

Barriers in the Current Payment System

As previously discussed in Section II-A, the fee-for-service payments from Medicare and most health insurance plans do not pay adequately to support this process. Fees are only paid for short face-to-face visits between the patient and the oncologist. There is no fee paid for the considerable amount of time the oncologist must spend outside of the patient visit to determine the correct diagnosis and to determine the current best treatment or treatment options for the patient, or for the additional time the physician needs to spend in order to explain and discuss the choices with the patient as part of a shared decision-making process. There are no fees paid for the education and other support services provided to the patient and members of their family by other members of the practice staff during the diagnosis and treatment planning process. Increasing the rate of adherence to guidelines will require oncology practices to spend more time on these tasks, and that can only be done if changes are made in payments in order to support the higher amount of time.

As discussed earlier, the current CMS oncology APMs do nothing to change payments during this critical step in the process.

2. Adequate Payment for Appropriate Treatments

In addition to having adequate time to identify the right treatment for a patient based on the most current evidence and to help the patient make a choice when options are available, the oncology practice needs the ability to actually deliver the chosen treatment to the patient. An oncologist should never have to choose an inferior treatment because the practice cannot afford to deliver the right treatment, and a cancer patient should never have to worry that the oncologist is choosing a treatment, not because it is best for the patient, but because it is more profitable for the practice.

Barriers in the Current Payment System

As explained in Section II, the payments made by Medicare and most health insurance plans for both chemo-

therapy and radiation therapy do not align with the costs of delivering those treatments. As a result, an oncology practice can be financially penalized for treating patients appropriately and financially rewarded for using unnecessary or inappropriate treatments.

As discussed in Sections III and IV, the Oncology Care Model and Oncology Care First do nothing to change the structure of payments for chemotherapy, and the performance-based payment components of OCM and OCF could create additional problematic incentives for oncologists. The proposed CMS APM for radiation oncology would not adequately address the problems with current payments for radiation therapy and could create problematic new financial incentives.

3. Rapid Identification and Response to Complications of Treatment

Several projects have shown that significant reductions in ED visits and admissions can be achieved by redesigning the way care is delivered to patients receiving chemotherapy:

- The Patient Care Connect Program at the University of Alabama at Birmingham Health System Cancer Community Network (UAB) employed nonclinical patient navigators to screen for distress and to encourage patients to seek early help from the oncology practice, rather than to delay care or to use the ED for non-life-threatening conditions.⁷⁵ The project significantly reduced ED visits and hospitalizations and achieved savings 10 times as great as the cost of the navigators.⁷⁶
- In the Community Oncology Medical Home (COME HOME) project, an improved triage system and enhanced access to outpatient treatment enabled early, rapid, low-cost interventions such as intravenous hydration when patients experienced chemotherapy-related complications. An independent evaluation showed significant reductions in ED visits, hospitalizations, and total cost of care for the patients.⁷⁷

Barriers in the Current Payment System

Most oncology practices can't implement these successful approaches for a simple reason: they can't afford to. The oncology practices described above were only able to carry out these interventions because they received special federal grant funding to do so.

There are two problems with the fee-for-service payments from Medicare and most health insurance plans that create barriers to reducing complication-related ED visits and hospitalizations:

- **No fees for care management services.** As discussed in Section II-A, the current fee-for-service system does not include payments for time spent educating patients about how to prevent complications and about the importance of contacting the oncology practice as soon as symptoms occur, and there is no payment for telephone triage services that enable an oncology practice to respond quickly when patients do call to report symptoms.
- **Loss of revenue for treating symptoms rather than treating cancer.** For many patients, prompt admin-

istration of intravenous (IV) hydration or antibiotics at a medical oncology practice office can avoid the need for an ED visit or hospital admission. However, this would require that the practice reserve staff time and equipment so it could provide IV therapy as soon as a patient needed it, and that could reduce the number of chemotherapy treatments the practice would be able to deliver. Since fee-for-service payments for chemotherapy are much higher than payments for IV hydration, this would cause the oncology practice to lose money.

A good Alternative Payment Model will need to remove these barriers in order to enable savings from reductions in ED visits and hospital admissions to be achieved. The Oncology Care Model and Oncology Care First both provide additional resources that would help address these gaps, but there is no mechanism for ensuring that the payment amounts are adequate to cover the costs of the services.

4. Palliative Care for Patients with Advanced Cancer

Some patients will require more intensive services to prevent ED visits and hospital admissions than the education, triage, and IV therapy services described above. Patients with more advanced forms of cancer, patients who have been receiving treatment for a long period of time, and patients with other health problems will be much more likely to experience severe symptoms and complications, and patients with functional limitations or limited caregiver support may have a harder time avoiding complications from symptoms.

These patients need palliative care services from an interdisciplinary team that can provide the specific kinds of support needed to address the patients' pain, lack of appetite, depression, and other problems. Studies have shown that palliative care services can successfully reduce the rate of both ED visits and hospital admissions for these kinds of patients.⁷⁸

Barriers in the Current Payment System

Although a number of commercial insurance plans and Medicare Advantage plans pay for these kinds of palliative care services while a patient is receiving treatment for cancer and other serious illnesses, the traditional Medicare program only pays for palliative care as part of hospice services, not while a patient is still undergoing treatment. None of the current or proposed CMS oncology payment models include support for palliative care services for cancer patients.

D. How to Create Patient-Centered Cancer Care Payment

Payments that support patient-centered cancer care will need to (a) remove the barriers in the current payment system that prevent oncology practices from delivering the high-value services described in the previous section, and (b) hold oncology practices accountable for achieving the reductions in avoidable services. Because there are multiple opportunities for savings and multiple barriers in current payment systems, there need to be eleven different components of Patient-Centered Cancer Care Payment (PCCCP):

1. A payment to support adequate time for diagnosis and treatment planning;
2. Payments for care management while patients are undergoing treatment and for a period of time after treatment ends for cancer survivors;
3. Fees or bundled monthly payments for office visits;
4. Payments for palliative care services for patients with advanced cancer;

5. Fees or bundled monthly payments for administration of chemotherapy;
6. Cost-based payments for chemotherapy drugs;
7. Condition-based payments for radiation therapy;
8. Penalties for failure to follow evidence-based guidelines;
9. Penalties for high rates of ED visits and hospital admissions for complications of treatment;
10. Penalties for failure to deliver high-quality services to patients; and
11. Payments to support development of evidence and maintenance of guidelines.

If all of these components are included and defined properly, all of the problems with the current fee-for-service system described in Section II can be addressed while also avoiding the problems created by the CMS oncology APMs.

**TABLE 4
FOCUS AND COMPONENTS OF A SUCCESSFUL ONCOLOGY APM**

TYPES OF SPENDING THAT CAN BE REDUCED WITHOUT HARMING PATIENTS	CHANGE IN CARE DELIVERY NEEDED TO ACHIEVE SAVINGS	BARRIERS CREATED BY CURRENT PAYMENT SYSTEM TO CHANGING CARE DELIVERY	PAYMENT MODEL COMPONENTS NEEDED TO SUPPORT HIGHER-VALUE CARE
Use of expensive treatments and services that evidence shows have little or no benefit	Accurate and precise diagnosis, and determination of which treatments and services are consistent with current evidence-based guidelines	No payment for time spent outside of office visits to determine accurate diagnosis and to identify treatment options based on most current evidence	Payment to support diagnosis and treatment planning
	Avoid use of non-evidence-based treatments and services	Loss of revenues if fewer or lower-cost treatments and services are delivered	Adequate payments for evidence-based services that eliminate need for subsidies from drug margins Payment for treatments based on costs so treatment choices do not affect profits
Emergency Department visits and hospital admissions due to complications from cancer treatment	Patient education and proactive monitoring of patient symptoms	No payment for patient education and telephone contacts with patients to monitor symptoms	Payment for care management services
	24/7 triage and prompt office-based treatment of patients when symptoms and complications occur	No payment for phone response and triage Low payment for treatment of symptoms	
	Home support and symptom management for patients with severe symptoms and/or functional limitations	No payment for palliative care services	Payment for palliative care services

1. Payment for Diagnosis and Treatment Planning

High-quality cancer care starts with an accurate, precise diagnosis and an evidence-based plan of treatment selected through a shared decision-making process. The first component of Patient-Centered Cancer Care Payment should be a **Diagnosis and Treatment Planning (DTP) Payment** specifically designed to support the significant time and costs associated with accurate diagnosis and treatment planning.

The simplest and most effective way to implement this is to create a new billing code that oncology practices can submit to Medicare and other payers in order to receive the DTP Payment for a new patient. The oncology practice should only receive the DTP Payment if it is accepting responsibility for providing ongoing care to the patient, rather than providing a second opinion about diagnosis or treatment, and submission of the DTP Payment billing code enables the practice to attest that the practice and the patient will have this relationship.

A second DTP Payment billing code should be created to support the time involved in accurate staging and making new choices about treatment when a patient's cancer has progressed.

The dollar amount of the DTP Payments should be based on the cost of delivering high-quality diagnosis and treatment planning services. As discussed in subsection VI-F below, the initial payment amounts will need to be based on estimated costs and then refined based on the experience of the participating oncology practices.

2. Payment for Care Management During and Following Treatment

The second component of Patient-Centered Cancer Care Payment should be **Care Management (CM) Payments** designed to support care management services for each patient. CM Payments should be paid monthly for each patient who is receiving treatment from the practice. The amount of the CM Payment should be higher for patients who are receiving more toxic or complex treatments and for patients who have other characteristics that make them more susceptible to complications of treatment. In addition, oncology practices should receive smaller CM Payments on a monthly basis for patients who have completed treatment in order to help them manage the long-term side effects of treatment.

Here again, the simplest and most effective way to implement this is to create a series of new billing codes that oncology practices can submit to Medicare and other payers in order to receive the CM Payment for a specific patient. The oncologist would determine whether a patient met the criteria for a higher payment amount, and if so, the practice would submit the appropriate billing code for that patient.

Although this is analogous to the monthly MEOS billing code created for the Oncology Care Model, the CM Payment billing code would differ in several key ways:

- The CM Payment would not be tied to arbitrarily-defined time periods, but would be paid for each

month while a patient is undergoing treatment and after treatment ends;

- The CM Payment would be stratified so that higher payments are made for patients who will need more intensive services;
- The CM Payment should be based on the costs of delivering high-quality care management services; and
- The CM Payment should be paid for each patient whom the oncology practice indicates that it providing care for, not based on a statistical attribution methodology using claims data.

3. Payments for Office Visits and Other Oncology Practice Services

Patient-Centered Cancer Care Payment also needs to pay for the costs associated with patient office visits and other routine services (e.g., blood testing) that are currently supported using fee-for-service payments. Practices would need to continue delivering these services in addition to the care management services described above in order to properly monitor and evaluate the health of patients, both while they are undergoing treatment and after treatment ends. There are two different ways this could be done:

- **Continued use of current FFS billing codes.** Patient-Centered Cancer Care Payment could continue to pay for the costs of office visits and other routine services using the same fee-for-service billing codes currently used by Medicare and other payers. These payments would be in addition to the DTP and CM payments the practice would receive for a patient.
- **Creation of new monthly Monitoring & Evaluation Services (MES) Payments.** Alternatively, the current fee-for-service codes for office visits and other routine services could be replaced by a family of new, monthly **Monitoring & Evaluation Services (MES) Payments**. As discussed in Section IV with respect to the OCF MPP payments, monthly payments would better match the general staffing and overhead costs of a physician practice, but they have to be stratified in a way that ensures the practice has enough resources to support more frequent office visits and other services for patients who need them. Higher MES Payment amounts would need to be paid for patients who have health conditions other than cancer that require closer monitoring, and lower amounts would be paid after treatment ends when less intensive monitoring is needed.

Regardless of which approach to payment is used, the amounts of payment would need to be sufficient to cover the costs of delivering the services.

4. Payments for Palliative Care Services

Patient-Centered Cancer Care Payment should also make monthly **Palliative Care Services (PCS) Payments** for the subset of cancer patients whose cancer has advanced to a more serious stage or who have experienced serious side effects or complications. The PCS Payments could either be made directly to a palliative care team for eligible patients, or the payments could be made to the on-

cology practice and it could then contract with a palliative care team to deliver the services.

The specifics of the PCS Payments can be based on the Patient and Caregiver Support for Serious Illness (PACSSI) payment model that was developed by the American Academy of Hospice and Palliative Medicine⁷⁹ and recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in May, 2018.⁸⁰ Under PACSSI, monthly payments would be made for patients with cancer who have functional limitations and have had recent ED visits or hospital admissions, and a higher monthly amount would be paid for patients with more severe problems.

If the patient is continuing to receive cancer treatment from the oncology practice, the practice should continue to receive Care Management Payments for that patient in addition to the Palliative Care Services Payments. However, if the patient is no longer receiving treatment, then the PCS Payments would be paid but the CM Payments would be discontinued.

As with the other payment components, the PCS Payment amounts would need to be sufficient to cover the costs of delivering high-quality palliative care services.

5. Cost-Based Payments for Chemotherapy Drugs

For patients receiving chemotherapy to treat their cancer, Patient-Centered Cancer Care Payment should eliminate the potential for an oncology practice to lose money when it uses the most appropriate drugs to treat its patients. In addition, the other payments an oncology practice receives through Patient-Centered Cancer Care Payment should be adequate to support the costs of the services oncology practices deliver so that there is no need to subsidize those services using the profit margins on drugs.

The potential for large losses and profits on chemotherapy drugs can be eliminated by replacing the current ASP+x% payment for drugs with a new **Practice-Administered Drug Cost (PADC) Payment** with three components:

- **Reimbursement for Drug Acquisition Cost:** The practice should be reimbursed for its actual costs for acquiring the drugs it administers to patients. The practice could be paid initially based on ASP, as it currently is, but then the practice's payments would be periodically reconciled (e.g., quarterly or annually) against the actual acquisition costs the practice incurred during that period.
- **Adjustment for Drug Wastage/Breakage and Bad Debt:** The practice would receive an additional amount equal to a small percentage of the acquisition cost (e.g., 1-2%) to cover the costs of drug wastage and breakage and the bad debt for the co-insurance patients owe on the drugs.
- **Pharmacy Operations Cost Payment:** The practice would receive a small monthly Pharmacy Operations Cost (POC) Payment for each patient to cover the fixed costs of the specialized staff and expensive equipment for the internal pharmacy in the practice that stores and dispenses the drugs.

It is important to emphasize that using PADC Payment in place of ASP+x% is only feasible if the other payments in Patient-Centered Cancer Care Payment are adequate to support the costs of the time and services oncology practices are currently subsidizing using the profit margins on drugs in addition to the costs of new and expanded services that patients need.

6. Monthly Payments for Chemotherapy Administration Services

In addition to paying for the cost of acquiring the drugs and operating the internal practice pharmacy that stores and dispenses the drugs, Patient-Centered Cancer Care Payment needs to pay for the costs associated with administration of chemotherapy to individual patients. Similar to the MES Payments, there are two different ways this could be done:

- **Continued use of current FFS billing codes.** Patient-Centered Cancer Care Payment could continue to pay for the costs of chemotherapy administration using the same fee-for-service billing codes currently used by Medicare and other payers.
- **Creation of new monthly Chemotherapy Administration Services (CAS) Payments.** Alternatively, the current fee-for-service codes could be replaced by a family of new, monthly **Chemotherapy Administration Services (CAS) Payments.** As discussed in Section IV with respect to the OCF MPP payments, monthly payments would better match the way costs are delivered, but they have to be stratified in a way that does not penalize practices for treating patients who need more services from the practice. Higher payments would need to be made for patients who are receiving more complex or toxic treatments or who have other health conditions that require closer monitoring. The Chemotherapy Administration Services Payments need to be paid separately from the Monitoring & Evaluation Services Payments because some patients receive their chemotherapy in a separate hospital outpatient department, not at the oncology practice that is managing their care.

Regardless of which approach to payment is used, the amounts of payment would need to be sufficient to cover the costs of delivering high-quality treatment services.

7. Episode Payments for Radiation Therapy

For patients who need radiation therapy to treat their cancer, Patient-Centered Cancer Care Payment should pay for these services using bundled **Radiation Therapy Episode (RTE) Payments.** As discussed in Section V, this is the approach that has been recommended by radiation oncologists as a better way to support the high fixed costs of radiation therapy equipment than current fee-for-service payments. Rather than paying a separate fee for each individual dose of radiation, the radiation oncology practice would receive a single bundled payment for the entire course of radiation treatment. However, unlike the CMS Radiation Oncology Model, the amount of the payment would be based on differences in the length and type of treatment that evidence-based guidelines indi-

cate is appropriate for the specific type, size, and location of the patient's cancer.

The RTE Payment amounts would need to be updated annually so that payments would be based on the latest evidence about what types and amounts of treatment are most effective for different kinds of patients and also based on the most current technologies and the costs of using them. This would avoid the problems with the CMS Radiation Oncology Model discussed in Section V.

8. Penalty for Failure to Follow Evidence-Based Guidelines

One of the two primary mechanisms for achieving savings will be reducing or eliminating the use of treatments and other services that evidence-based guidelines recommend against. Consequently, Patient-Centered Cancer Care Payment needs to have a mechanism for ensuring that the oncology practice is following current evidence-based guidelines except where there is a legitimate reason for deviation. Since delivering or ordering a treatment or service that is inconsistent with evidence-based guidelines could cause an increase in spending on treatments or other services, an appropriate penalty is to reduce the payments the practice is receiving for its own services, since this would partially or fully offset the spending that should have been avoided.

There are two different ways a penalty can be operationalized:

- **Penalties Based on Aggregate Adherence Rates.** Under this approach, the oncology practice would document whether the treatments or services that it delivered or ordered for each patient during a particular period of time (the “performance period”) are either consistent with applicable evidence-based guidelines or there is a legitimate reason for deviation. The percentage of patients for whom there are not documented reasons for deviation would be calculated, and the practice would be required to pay a penalty that is proportional to that percentage multiplied by the total payments the practice received during the performance period.
- **Payments for Services Contingent on Adherence with Guidelines.** The oncology practice would only bill the payer for a particular service if the practice documented that the service was consistent with guidelines or that there was a legitimate reason for a deviation.

The first approach is similar to the pay-for-performance (P4P) mechanisms commonly used in many payment systems today. It allows the amount of the penalty to be scaled up or down to any desired level. However, it also means that the individual patient and their health insurance plan (Medicare, Medicaid, or a commercial plan) would have to pay for a service even though it was inconsistent with evidence, and there would only be a penalty if the rate of non-adherence to guidelines was high enough.

The second approach would ensure that a patient and their payer would only pay for a service if it was consistent with evidence-based guidelines. However, this could represent a very large penalty, particularly for a small practice, if a practice erroneously ordered an un-

necessary service. An intermediate approach would be to tie the penalty only to the Diagnosis and Treatment Planning Payment, i.e., the oncology practice could only receive the DTP payment if it documented that the treatment plan was consistent with evidence-based guidelines or there was a legitimate reason for deviation.

Under either approach, the penalties should be focused on the use of treatments and services that strong evidence explicitly *recommends against*, not on services for which there are no guidelines or where the guidelines are based on weak evidence. Randomized Control Trials (RCTs) are difficult and expensive to conduct, and there are no RCTs that are applicable to many specific patient situations, such as a patient with multiple or unusual comorbidities and patients with metastatic cancer who have already been treated with preferred chemotherapy drugs. The APM should avoid penalizing physicians for using their best judgment in these situations or for accommodating patient preferences. As discussed earlier, there are many opportunities to achieve savings by reducing the use of services where there are clear guidelines.

9. Penalty for High Rates of ED Visits and Hospital Admissions for Complications of Treatment

The other primary mechanism for achieving savings will be reducing ED visits and hospital admissions due to complications of chemotherapy. Assuming that the oncology practice receives adequate payments for care management services, it should be able to help many of its patients avoid treatment complications and avoid the need to go to an emergency department for treatment of the complications. However, it will likely be impossible for any practice to completely avoid having any of its patients make such ED visits, partly because success depends on the willingness and ability of patients to do what is needed to prevent complications and seek prompt assistance from the practice when complications occur, and partly because different patients respond differently to treatments, so there will inherently be random variation in the rates of complications occurring in different groups of patients.

In order to encourage oncology practices to reduce ED visits and hospital admissions as much as possible without penalizing them inappropriately for things they cannot control, Patient-Centered Cancer Payment should include a penalty for oncology practices that have unusually high rates of complication-related ED visits and hospital admissions.

To implement this, the treatment complication-related ED and hospital admission rates for each practice should be calculated and risk-adjusted based on factors that affect the rate and severity of complications, such as the toxicity of the treatments and the health status of the patient. It will not be clear how low these rates can be until the other changes in payment are made and improved services can be delivered. In order to create a reasonable performance benchmark, the risk-adjusted rates for each practice can be compared to the average rates for all oncology practices during the previous year. The Monitoring & Evaluation Payments and the Care Management

Payments to an oncology practice should be reduced by a pre-determined percentage if the risk adjusted rates of visits and admissions for the practice's patients are higher than the average for other practices by a statistically significant amount.

10. Penalty for Failure to Deliver High-Quality Care

Two of the most important aspects of quality cancer care are ensuring that the patient is receiving the right treatment based on the most current evidence, and minimizing the kinds of serious side effects and complications that require admission to the hospital. The two previous accountability components would do that, so they automatically create accountability for quality as well as accountability for reducing avoidable spending.

As discussed in Section II, quality cancer care also means helping patients minimize the pain and discomfort that accompany cancer treatment. Consequently, Patient-Centered Cancer Care Payment should have an accountability component that is focused on the patient's quality of life. This can be done using two complementary mechanisms:

- **Accountability for Delivery of Evidence-Based Services.** Guidelines should be developed based on evidence as to the types of services that an oncology practice can deliver to its patients in order to improve their quality of life. Unless the patient refused the services, success or failure in delivering the services would be under the control of the oncology practice, and so one of the two mechanisms for penalties that were described above for evidence-based treatment accountability could also be used for these guidelines.
- **Accountability for Outcomes.** Obviously, what really matters for patients is the actual outcomes they experience in terms of pain and other quality of life issues, not just whether they are receiving services that are supposed to address those issues, even if there is evidence indicating that the services improve outcomes for most patients. However, there is currently no agreement on what outcomes can and should be measured,⁸¹ so additional work will be needed before it would be appropriate to add accountability for outcomes in Patient-Centered Cancer Care Payment. Even if there is agreement about what to measure, it will not be clear exactly what level of performance should be deemed as "good" until after the services needed to achieve good performance are being paid for and delivered. Consequently, an outcome accountability mechanism should be similar to what is described above with respect to avoidable ED visits and hospital admissions, i.e., one or more risk-adjusted outcome measures would be calculated for the patients in each oncology practice, and those measures would be compared to the averages for other oncology practices. If a practice has a level of performance that is below average by a statistically significant amount, the payments to the practice would be reduced.

11. Development of Evidence and Maintenance of Guidelines

Finally, since success of Patient-Centered Cancer Care Payment will depend on adherence to evidence-based guidelines for both treatment and supportive services, it will be necessary to both continue generating new evidence and update the guidelines as evidence about new treatments and services is developed. This work should be led by oncologists, since it is important that guidelines be driven by what is best for patients, not what saves money. The American Society of Clinical Oncology has established Criteria for High-Quality Clinical Pathways⁸² and has begun reviewing payer-developed pathways to ensure they are firmly grounded in evidence.⁸³

Real-world evidence about the effectiveness of new and different approaches to treatment and care cannot be generated without data from oncology practices. Registries of data are a key mechanism for assembling and analyzing such data, but the process of collecting and submitting data to a registry, maintaining the registry, and analyzing the data is expensive. Consequently, an oncology practice participating in Patient-Centered Cancer Care Payment should receive a monthly **Clinical Registry Submission (CRS) Payment** for each patient if the oncology practice submits data on the patient to one or more registries that are used for generating new evidence about cancer services.

COMPONENTS OF PATIENT-CENTERED CANCER CARE PAYMENT (PCCCS)

Payments to Support High-Quality Care

- Diagnosis and Treatment Planning (DTP) Payment
- Care Management (CM) Payments
- Monitoring & Evaluation Services (MES) Payments
- Palliative Care Services (PCS) Payments
- Practice-Administered Drug Cost (PADC) Payment
 - ◆ Reimbursement for Drug Acquisition Cost + Adjustment for Wastage/Breakage/Bad Debt
 - ◆ Pharmacy Operations Cost (POC) Payment
- Chemotherapy Administration Services (CAS) Pmt
- Radiation Therapy Episode (RTE) Payments
- Clinical Registry Submission (CRS) Payment

Accountability for Quality and Spending

- Penalty for failure to follow evidence-based guidelines on treatment
- Penalty for high rates of ED visits and hospital admissions for complications of treatment
- Penalty for failure to deliver high-quality care

**TABLE 5
COMPARISON OF PATIENT-CENTERED CANCER CARE PAYMENT
TO FEE-FOR-SERVICE PAYMENT**

STANDARD FEE-FOR-SERVICE PAYMENT	PATIENT-CENTERED CANCER CARE PAYMENT
PROBLEMS WITH FEE-FOR-SERVICE PAYMENT	
No payment or underpayment for high-value-services	
Underpayment for diagnosis and treatment planning	New payment for diagnosis and treatment planning
No payment for care management during treatment	New payments for care management during treatment
No payment for palliative care services	New payments for palliative care services
Underpayment for survivorship care	New payments for care management after treatment ends
Problematic method of payment for infused/injected drugs	
ASP+x% does not match the acquisition cost of drugs	Payment for drugs based on acquisition cost, not ASP
No payment for pharmacy operation costs	New monthly payment for pharmacy operation costs
Loss of revenue due to patient bad debt	Payments for drugs are adjusted for patient bad debt
Problematic method of payment for radiation therapy	
Dose-based payments encourage unnecessary treatment	Payments for full course of treatment, not dose-based fees
Dose-based payments do not match cost of treatment	Payments based on cost of evidence-based treatment
No assurance of high-quality care at most affordable cost	
No penalty for failure to follow evidence-based guidelines	Explicit penalty for failure to follow evidence-based guidelines
No penalty for high rates of treatment complications	Explicit penalty for high rates of ED visits and hospital admissions due to complications of treatment
Financial penalty for reducing avoidable services	Payments no longer based on number of services delivered
STRENGTHS OF FEE-FOR-SERVICE PAYMENT	
No incentive to delay or deny treatments patients need	Oncology practices would not receive bonuses based on whether spending was reduced or the amount of savings
Higher payments for patients who need additional services	All payments would be stratified to provide higher amounts for patients with higher needs
Providers know in advance how much they will be paid	All payment amounts and performance targets are defined in advance
No penalties or rewards for things providers can't control	Performance targets and penalties are based solely on appropriate use of cancer-related services

E. Comparison to Fee-for-Service Payment and CMS Oncology APMs

As shown in Table 5, the Patient-Centered Cancer Care Payment structure described above would address each of the problems with current fee-for-service payment systems that were described in Section II. As shown in Figure 1, the payments would be customized to patient needs in each phase of care, with far more support for the critical diagnosis and treatment planning phase and the post-treatment phases of care than the payments in the Oncology Care Model or Oncology Care First provide.

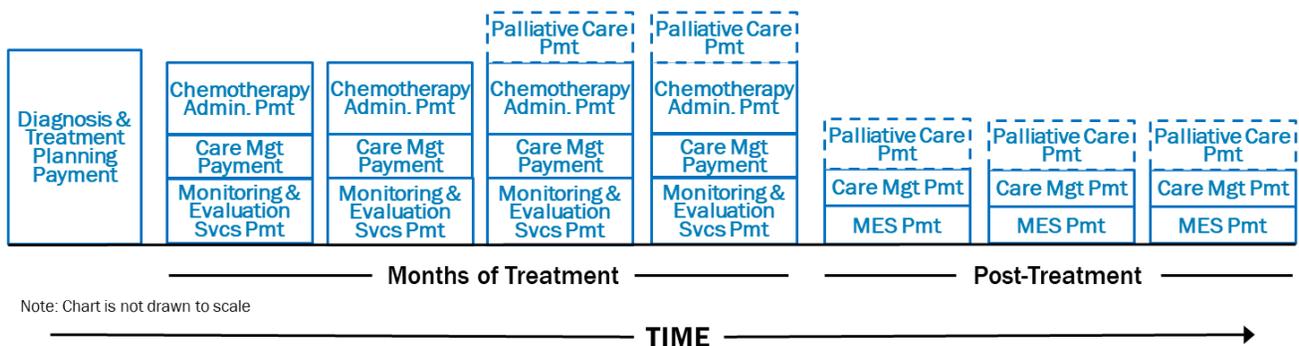
As illustrated in Figure 2, the payment amounts in Patient-Centered Cancer Care Payment would be stratified based on the specific characteristics of patients and their treatment that affect the costs of services. Using multiple categories of payments with stratification structures customized to each category ensures that oncology practices receive adequate payment both to administer more complex treatments and to provide appropriate support for higher-need patients.

As shown in Figure 3, the higher spending associated with the new payments for diagnosis and treatment planning, care management services, and palliative care services would be offset by the savings generated by avoiding the use of non-evidence-based services, reducing ED visits and hospital admissions for complications of treatment, and paying for chemotherapy drugs based on their actual cost to the practice. The penalties in Patient-Centered Cancer Care Payment would ensure that savings are generated by each oncology practice if the opportunities exist for its patients, without requiring each individual practice to save a specific amount of money as the CMS oncology APMs do.

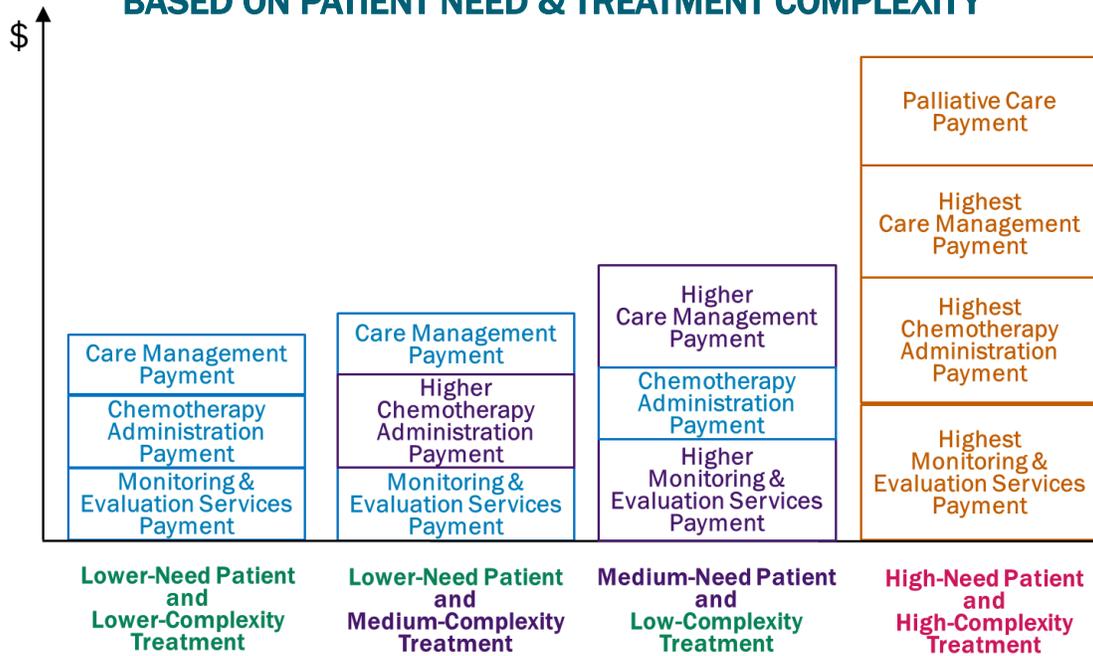
As a result, unlike the CMS oncology payment models, the stratified monthly payments and the accountability components of Patient-Centered Cancer Care Payment would not undermine the aspects of the fee-for-service system that benefit patients, payers, and oncology practices. Under Patient-Centered Cancer Care Payment, there would be:

- **No financial incentive to withhold treatment or other services.** The oncology practice would not profit by withholding services that a patient needed. In fact, the oncology practice would be penalized for failing to deliver evidence-based services to a patient without a clear clinical reason for doing so. The practice would also not make profits or incur losses for using an expensive drug as part of a patient's treatment because the practice would be paid for the drug based on the cost of acquiring it.
- **No financial incentive to delay treatment.** Payments to the practice would not increase or decrease simply because a patient's treatment lasted longer than an arbitrary "episode" length.
- **No financial incentive to avoid treating higher-need patients.** If a patient needs more services, the oncology practice would receive a higher payment for that patient. However, the practice would not be paid more simply for delivering more services, and the practice would be penalized if it delivered services that evidence-based guidelines recommended against.
- **No financial incentive to avoid treating patients with multiple health problems.** The oncology practice would only be accountable for cancer-related services, not for treatments and services the patient received from other providers for unrelated health conditions.

**FIGURE 1
DIFFERENT PAYMENTS FOR DIFFERENT PHASES OF CARE
IN PATIENT-CENTERED CANCER CARE PAYMENT**

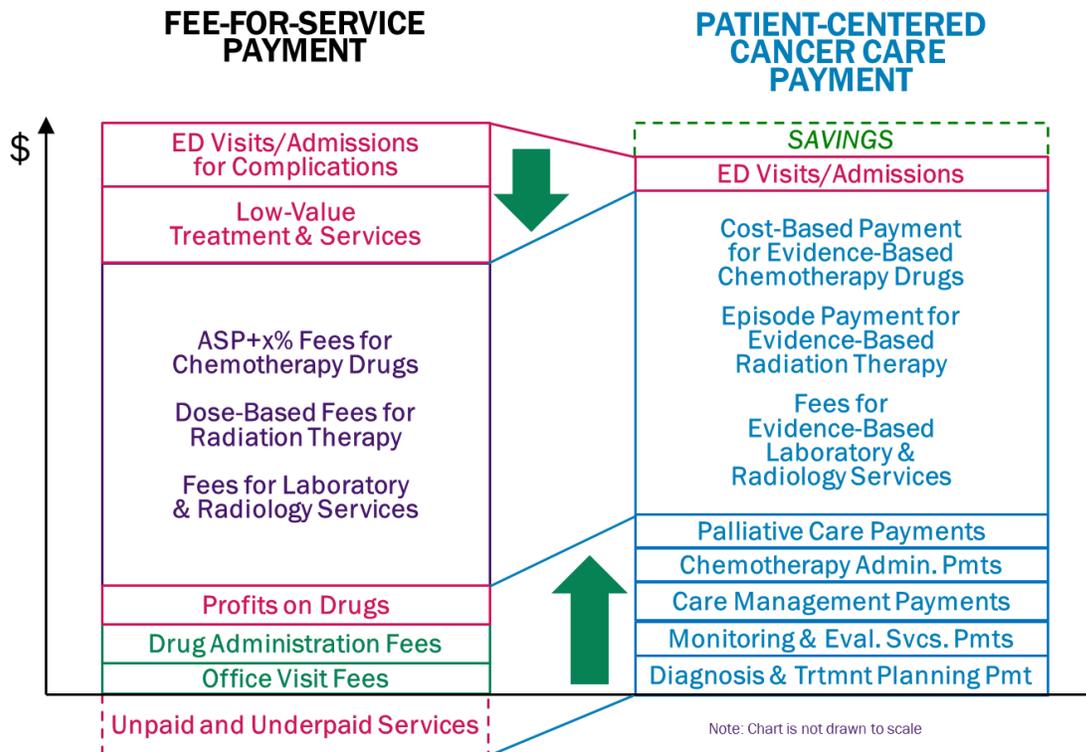


**FIGURE 2
STRATIFICATION OF
PATIENT-CENTERED CANCER CARE PAYMENTS
BASED ON PATIENT NEED & TREATMENT COMPLEXITY**



Note: Chart is not drawn to scale

**FIGURE 3
HOW PATIENT-CENTERED CANCER CARE PAYMENT
IMPROVES PAYMENT AND GENERATES SAVINGS**



Note: Chart is not drawn to scale

F. Implementing Patient-Centered Cancer Care Payment

1. Implementation Through the Medicare Physician Fee Schedule

Under Patient-Centered Cancer Care Payment, the oncology practice would continue to bill for and receive separate “fees” for the care that cancer patients receive, but these fees are very different from the current fee-for-service payment system. The payments to the oncology practice would be based on the patient’s specific needs during each month of care, not based on the number or types of services the patient receives. This ensures that a patient with greater needs can receive additional services to address those needs, but it avoids creating an incentive to deliver more services simply to generate more revenues the way the current fee schedule does.

Because it is structured in this way, Patient-Centered Cancer Care Payment can be easily implemented by Medicare and other payers using their existing claims payment systems, and it can also easily be implemented by oncology practices using their existing billing systems. All that is needed is to create new CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) codes and modifiers:

- **DTP Codes:** Two CPT/HCPCS codes will be needed to implement the Diagnosis and Treatment Planning (DTP) Payments, one to pay for the initial diagnosis and treatment planning process, and one to pay for restaging and revisions to treatment processes.
- **CM Codes:** A family of CPT/HCPCS codes will be needed to implement the Care Management (CM) Payments. One group of codes would define different categories of patients based on the intensity of care management they require during treatment, and a second group of codes would be defined for patients who are not receiving active treatment. The oncology practice would determine which category matched the patient’s characteristics and bill for the appropriate code each month.
- **MES Codes:** Two or more CPT/HCPCS codes will be needed to implement monthly Monitoring & Evaluation Services (MES) Payments. Multiple codes are needed so that higher payments can be made for patients with characteristics that warrant more office visits and proactive monitoring. The oncology practice would determine which category matched the patient’s characteristics and bill for the appropriate code each month.
- **PCS Codes:** Two or more CPT/HCPCS codes will be needed to implement Palliative Care Services (PCS) Payments. At least two codes are needed so that higher payments can be made for patients with characteristics that require more intensive palliative care services. The oncology practice or palliative care provider would determine which category matched the patient’s characteristics and bill for the appropriate code each month.
- **CAS Codes:** Two or more CPT/HCPCS codes will be needed to implement Chemotherapy Administration Services (CAS) Payments. Several codes are needed so that higher payments can be made for patients who

need more complex chemotherapy regimens. The oncology practice would determine which category matched the patient’s current treatment regimen and bill for the appropriate code for that month.

- **POC Codes:** A CPT/HCPCS code will be needed to implement the Pharmacy Operations Cost (POC) Payments. The oncology practice would bill for this code each month for each patient who is receiving chemotherapy treatments.
- **RTE Codes:** A family of CPT/HCPCS codes will be needed to implement the Radiation Therapy Episode (RTE) Payments. Multiple codes are needed to reflect the different types and amounts of radiation therapy that evidence recommends for different types of cancer and patients with different characteristics. The radiation oncology practice would determine which category matched the patient’s characteristics and bill for the appropriate code.
- **CRS Codes:** Finally, a CPT/HCPCS code will be needed to implement the Clinical Registry Submission (CRS) Payments. If the oncology practice submitted data on a patient to an approved clinical registry during the month, it would submit the billing code and be paid.

The 20-30 new billing codes described above would be used by oncology practices *instead of* more than 100 narrowly defined billing codes in the current Medicare Physician Fee Schedule, so the administrative burdens of coding and billing would be reduced.

It is quite feasible for CMS to create and implement these types of new codes to support better oncology care. For example, CMS created a HCPCS Code (G9678) so that oncology practices could bill for the MEOS payments in OCM. In the 2006 Medicare Oncology Demonstration, CMS created over 80 new billing codes specifically for oncology.⁸⁴ CMS also has created billing codes in other areas that are paid on a monthly basis based on patient needs or characteristics rather than based on the specific service delivered.⁸⁵

CMS should work with oncology practices to define each of these codes so that they can be incorporated into the fee schedules for Medicare and other payers. There are already formal processes for creating CPT codes through the American Medical Association’s CPT Editorial Panel⁸⁶ and for creating HCPCS Level II codes through the CMS HCPCS Workgroup.⁸⁷

The penalty components of Patient-Centered Cancer Care Payment can also be implemented through the Medicare Physician Fee Schedule using the mechanisms that have already been created for current fees. Under the Merit-Based Incentive Payment System (MIPS), CMS currently adjusts payment rates for the services delivered by individual practices based on their performance on quality and cost measures, and a similar approach can be used to make any reductions in Patient-Centered Cancer Care Payment Amounts needed if an oncology practice fails to follow evidence-based guidelines or to maintain low rates of ED visits and hospital admissions for treatment-related complications. If any payments for an individual patient are contingent on use of evidence-based guidelines for that patient (i.e., the second option described for imposing penalties), the oncology practice would simply have to

document adherence to the guidelines before submitting a billing code for that patient.⁸⁸

The revised payment amounts for chemotherapy drugs can be implemented through a cost-based reconciliation process, similar to what CMS currently uses to pay for services delivered by Critical Access Hospitals and Rural Health Clinics. The practice would bill for infused and injected drugs using the standard HCPCS J-Codes for those drugs, and it would receive an initial payment based on the current ASP+x% methodology. The practice would then periodically submit a cost reconciliation report to CMS that (a) documents the actual costs it incurred to acquire the drugs it had billed for and (b) calculates the difference between the costs and the initial payments received. If the costs exceed the payments, the oncology practice would receive an additional payment from CMS, and if the initial payments had exceeded the costs, the practice would return the difference. Participation in Patient-Centered Cancer Care Payment (PCCCP) can and should be voluntary. Oncology practices that wish to participate would use the new PCCCP billing codes, and those that do not wish to participate would continue to use the standard billing codes.

2. Ensuring Adequate Payment Amounts

As discussed in Section II, payments for cancer services have to be adequate to cover the costs of delivering high-quality services. Consequently, in addition to creating billing codes for the various components of Patient-Centered Cancer Care Payment, appropriate payment amounts need to be defined and they need to be regularly updated to match changes in the cost of care.

It will be difficult to specify the “right” payment amounts for each of the billing codes in Patient-Centered Cancer Care Payment before it is actually implemented. It is impossible to know what the costs of new services will be since providers cannot deliver the services until the PCCCP payments are in place. For example, careful diagnosis and treatment planning requires more time than the current payment system supports, but the exact amount of time needed from various types of practice staff for different types of patients will only be known after oncology practices have a Diagnosis and Treatment Planning payment that supports their ability to deliver the services. Moreover, it is likely that the costs will decrease over time as oncology practices use the greater flexibility under Patient-Centered Cancer Care Payment to redesign the way they deliver care.

This “chicken and egg” problem can best be solved through a mutual commitment by both CMS and oncology practices to collect data on the costs of delivering services and to update payment amounts appropriately and frequently:

- the initial payment amounts can be based on information from the Oncology Care Model and other demonstration projects described earlier, but in some cases, educated guesses may be needed until initial data on actual costs are available.
- a subset of oncology practices should be asked to collect data on costs and patient characteristics that can be analyzed to refine the payment amounts. Because these data are needed to improve the design of

the APM, not to improve care for the practice’s current patients, the oncology practices should receive additional payments to cover the costs they incur in collecting and submitting the data.

- based on the data collected, the payment amounts for each of the PCCCP billing codes should be revised to better match the actual costs of delivering high-quality care. This should be done at least annually in order to minimize any unintended consequences of inappropriately low or high payments.

3. Development and Testing of Episode Payments for Future Use

In contrast to the “episode” payment models being used for some types of procedures and conditions, Patient-Centered Cancer Care Payment does not pay a single pre-defined amount for all of the services a patient needs during any specific pre-defined period of time. Because it continues to use multiple billing codes for separate subgroups of services, PCCCP would continue to have two weaknesses of the fee-for-service system:

- it would be impossible for a patient or payer to know in advance how much they are likely to have to pay for care of their cancer, or to compare the cost of treatment between different practices.
- although the oncology practice would have more flexibility to customize care to individual patients’ needs than under the current fee-for-service system, services would still have to “fit” into specific payment categories.

Although creating a single payment for a full episode of cancer care could address these weaknesses, defining episode payments for cancer is far more challenging than for other health conditions because of the many different subtypes of cancer, the very different costs of treatment for different types of cancer, and the diversity of needs among cancer patients. There will be serious problems for both patients and oncology practices if the episodes are not defined in a way that supports delivering the right care for individual patients, similar to the problems described in Section III that are caused by the simplistic “Target Prices” defined in the Oncology Care Model.

A very sophisticated and precise method of risk adjustment will be needed in order to even consider use of an episode payment model for cancer care. This will take time to develop, and it will need to be carefully tested and evaluated before it could be implemented broadly. Because of the diversity of cancer types and patients, it may only be feasible to create accurate episode prices for the most common types of cancer, and it may only be feasible for large oncology practices to implement such an approach because of the inherent random variations in services and costs that will exist across different patients.

As discussed in Section III, two leading groups of oncologists (Hackensack Meridian Health, in partnership with Cota, Inc., and Innovative Oncology Business Solutions, in partnership with the National Cancer Care Alliance) proposed plans for developing risk-adjusted episode payment structures for oncology care, and the Physician-Focused Payment Model Technical Advisory Committee

recommended that CMS support further development and testing of both of their approaches. This development and testing process can and should be done through the Center for Medicare and Medicaid Innovation.

However, efforts to try and develop workable episode payment models for cancer care should be done *in parallel* with implementation of Patient-Centered Cancer Care Payment, not instead of it. Every patient with cancer needs to receive the highest quality care at the most affordable cost. Patient-Centered Cancer Care Payment can be used for all types of cancer patients and it can be implemented quickly. It would be inappropriate to delay implementing Patient-Centered Cancer Care Payment while waiting to see if an even better approach can be developed.

VII. ACCELERATING VALUE-BASED PAYMENT FOR CANCER CARE

Cancer patients and oncology practices should not be forced to choose between the flawed fee-for-service system and an even more flawed alternative payment model. Patient-Centered Cancer Care Payment can correct the problems with current fee-for-service payments without creating new problems that could cause serious harm to both patients and oncology practices. Moreover, it can be implemented immediately, across the entire country, without waiting for many years to complete the evaluation of yet another problematic APM. Patients who have cancer today need better care *now*.

Many people have been led to believe that a payment system can only be successful if it forces participating physicians to accept large amounts of downside risk. There is no evidence to support this, and as discussed in this report, creating downside risk for oncology practices has the potential to harm patients by encouraging or forcing physicians to withhold needed care and potentially forcing oncology practices out of business entirely.

Patient-Centered Cancer Care Payment would require oncology practices to take on meaningful “downside risk” through the penalties built into the payments. But unlike OCM and other CMS APMs, the risk in Patient-Centered Cancer Care Payment would be directly tied to whether the practice followed evidence-based guidelines and delivered the services necessary to avoid ED visits and hospital admissions from treatment-related complications. This approach to risk appropriately encourages the delivery of high-quality, affordable care without creating perverse incentives to stint on care or the potential to bankrupt a physician practice when it treats complex patients.

Moreover, Patient-Centered Cancer Care Payment does not hold oncology practices accountable for the total cost of all services their patients receive because the oncologists do not deliver or order all of those services, they cannot control those services, and they should not be expected to interfere with the services that other physicians are delivering to patients for health issues unrelated to cancer. They should certainly coordinate care with other physicians, and Patient-Centered Cancer Care Payment would support the time and staffing needed to do that. The accountability components of Patient-Centered Cancer Care Payment would focus on the aspects of cancer spending where oncologists have the ability to achieve savings, increasing the likelihood of making significant reductions in spending as well as improving outcomes for patients.

There is an urgent need to improve the quality and affordability of healthcare in America. Although changes are clearly needed in the current fee-for-service payment system to achieve that, the cure shouldn't be worse than the disease. The current focus on forcing physicians to take risk for the total cost of care has failed to move the country forward toward true value-based care, and increasing the level of risk in problematic payment models will make things worse, not better. It is time to embrace a new approach to value-based payment – a patient-centered approach. Cancer care is an ideal place to start.

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