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HEALTHCARE
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PAYMENT REFORM

EXECUTIVE SUMMARY

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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First Edition
December 2019

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 pay-

ing 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



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