



Office of External Affairs

FACT SHEET

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DEMONSTRATION OF IMPROVED QUALITY OF CARE FOR CANCER PATIENTS UNDERGOING CHEMOTHERAPY

Overview: Quality cancer treatment includes many components beyond providing chemotherapy drugs: determining patient status and preferences; identifying and planning for appropriate chemotherapy regimens; assessing patient symptoms, complaints, and quality of life; and supporting and educating caregivers. In addition to reducing cancer burden or providing cures, effective cancer care also involves managing pain, minimizing nausea and vomiting, and limiting fatigue. These steps may also help reduce the overall costs of cancer care, by avoiding hospitalizations with complications and services that are ineffective or that have side effects that outweigh the expected benefits. In particular, clinicians armed with appropriate assessments and the best evidence-based practice guidelines can reduce some of the unpleasant and frequent side-effects that often accompany cancer and chemotherapy treatment, obtain the best possible clinical outcomes, and avoid unnecessary costs.

Background: CMS seeks to encourage quality care in all facets of cancer treatment. During CY 2005 CMS initiated a one-year demonstration project to focus on measuring patient outcomes in three areas of concern often cited by patients undergoing chemotherapy: controlling pain, minimizing nausea and vomiting, and reducing fatigue. Standardized assessment scales are being used to measure the symptoms of patients receiving chemotherapy, and CMS is collecting data based on these assessments and on subsequent treatments to trace changes in outcomes.

To facilitate the collection of information, CMS established new billing codes to be reported by practitioners in the demonstration. The codes correspond to four patient assessment levels for each of the three patient symptom areas: nausea and/or vomiting; pain; and fatigue. These levels, based on the Rotterdam scale, have already proven effective in cancer care, are easily understood by patients, and have been in widespread use. Practices reporting data on all three factors to Medicare qualify for an additional payment of \$130 per encounter. By billing the designated codes, the practitioner self-enrolls in the project.

Results of Demonstration: CMS has begun to receive preliminary data from this demonstration. At this point, only a minority of patients appear to suffer significant symptoms: 2 percent with substantial (i.e. "quite a bit" or "very much") nausea/vomiting; 8 percent with a similar degree of pain; and 26

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percent with a similar degree of fatigue. As the data become more complete, CMS plans to analyze the relationships between the reported symptoms and hospitalizations and emergency department visits for related conditions (such as intractable pain, dehydration, etc.). These analyses will inform us in any future efforts CMS undertakes to obtain patient reported data, as well as provide more insights about the use of G-codes for data collection. With regard to participation in the program, it appears (based again on preliminary data) that the volume of claims submitted is meeting our expected participation.

Access to Care: CMS is also actively monitoring chemotherapy claims data on an ongoing basis to ascertain whether beneficiaries' access to chemotherapy in physicians' offices has been impacted by the changes implemented during 2005. At this time, CMS does not have evidence to suggest that access problems have occurred as a result of the payment policy changes enacted by the Medicare Modernization Act of 2003 (MMA). Office-based chemotherapy care appears to be continuing at historical levels.

Physician Fee Schedule Proposed Rule: In the proposed rule for the physician fee schedule, our impacts reflect, for 2005 to 2006, an anticipated total Medicare increase in revenues for oncologists of 8.1 percent. This increase reflects an expected increase in the volume of drugs paralleling historical trends, payment rates for drugs – the single largest Medicare revenue source for oncologists – staying stable during 2006 after significant decreases in 2005, and the physician fee schedule following the current projections.

The agency intends to continue to actively pursue discussions with oncology providers and organizations that represent cancer patients to obtain a better understanding of their experience under this demonstration program. Further, the agency intends to engage all stakeholders on the merits of the program and the opportunities to better capture data on the clinical care of patients with cancer, and improve the provision of that care. Some of the issues under consideration include:

- Are there more effective time frames for inquiring about patient quality of life and symptoms. For example, whether the patient had significant symptoms during the month prior to treatment?
- Are there more effective alternatives to collecting data on quality of life than focusing exclusively on cancer patients receiving intravenous chemotherapy treatment in physicians' offices? For example: cancer patients receiving chemotherapy in other settings, who may be more severely ill, or who are receiving other types of cancer treatments; or, cancer patients who stop or delay chemotherapy, potentially because of problems with nausea and vomiting or fatigue, or because the patient has elected a course of treatment focused on palliation that does not include chemotherapy?
- Are there more effective measures related to quality of care, for example, measures related to the use of evidence-based practice guidelines?
- How should the experience of the oncology demonstration program be considered in the context of physician payments?

Such an open process should aid the agency in ensuring appropriate oncology payments, and in supporting a mindset in the cancer care community that is focused on Medicare promoting the delivery of high quality, patient centered cancer care, rather than simply paying more for additional chemotherapy services. These priorities are critical parts of efforts by CMS and the Congress to improve quality and patient outcomes, and avoid unnecessary costs through the Medicare physician payment system.

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