

THE AMERICAN SOCIETY OF CLINICAL ONCOLOGY

CONSOLIDATED PAYMENTS FOR ONCOLOGY CARE

Payment Reform to Support
Patient-Centered Care for Cancer

May 2014



American Society of Clinical Oncology

ASCO MISSION

The American Society of Clinical Oncology (ASCO) is a professional oncology society committed to conquering cancer through research, education, prevention and delivery of high-quality patient care.

ASCO VISION

- All patients with cancer will have lifelong access to high-quality, effective, affordable and compassionate care.
- The most accurate cancer information will be available so that patients and physicians can make informed decisions about cancer prevention and treatment.
- Information we learn from every patient will be used to accelerate progress against cancer.
- Resources will exist to attract the best clinicians and investigators to provide optimal patient care and to conduct transformative research.
- ASCO will be recognized as the most trusted source of cancer information worldwide.

MEMBERSHIP

ASCO's diverse network of nearly 35,000 oncology professionals recognizes ASCO's dedication to provide the highest-quality resources in education, policy, the pioneering of clinical research and above all, advancing the care for patients with cancer. ASCO is unique in that we are the only organization that encompasses all oncology subspecialties, allowing our members to grow from the professional and personal expertise of their colleagues worldwide and across disciplines. International members make up approximately 30 percent of the Society's total membership and represent more than 120 countries. ASCO offers a variety of membership categories designed to fit different career stages and specific needs.

ACKNOWLEDGEMENTS

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Harold Miller, President and CEO of the Center for Healthcare Quality and Payment Reform, has provided extensive support and expertise in shaping this model. We recognize and greatly appreciate the help he has given to ASCO and the Payment Reform Workgroup.

CONSOLIDATED PAYMENTS FOR ONCOLOGY CARE: Payment Reform to Support Patient-Centered Care for Cancer

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EXECUTIVE SUMMARY

The American Society of Clinical Oncology has developed a new method of payment that would enable medical oncology practices to deliver high-quality, patient-centered care at a more affordable cost, reduce administrative costs for both practices and payers, and help make community oncology practices, particularly small and rural practices, financially sustainable so that patients can continue to obtain high-quality cancer care in their community. Consolidated Payments for Oncology Care (CPOC), developed by the ASCO Payment Reform Workgroup, features the following key elements:

Flexible payment better matched to the services oncology practices provide and oncology patients need. Today, oncology practices are paid only for face-to-face office visits with clinicians and for administration of parenteral medications; they receive no additional payment for providing other services that patients need and want, such as telephone calls and electronic mail with physicians; education and counseling services provided by nurses, social workers, and financial counselors; and help in managing oral medications. Under Consolidated Payments for Oncology Care, practices would receive five types of flexible, bundled payments designed to cover currently uncompensated time and costs as well as many of the services that are currently reimbursed:

- ***New Patient Payment.*** The oncology practice would receive this payment for each new patient. It would be much larger than what practices receive today for initial office visits, reflecting the extensive, uncompensated time oncologists and their staffs spend developing treatment plans and doing patient education and counseling.
- ***Treatment Month Payment.*** The oncology practice would receive this payment during each month the patient is being treated, regardless of whether the drugs used are oral or parenteral. A practice would receive one of four levels of payment each month, with higher payments to cover the higher costs of treating patients with multiple health problems and/or poor performance status and for patients receiving more toxic and complex drug regimens. This payment would replace all current payments for evaluation & management and infusion services, but reimbursement for drug costs would remain separate.
- ***Active Monitoring Month Payment.*** The oncology practice would receive this payment during months when the patient is not being actively treated with medications but is still receiving care and support from the practice, including testing and monitoring for recurrences or progression of cancer. Payments would be higher during the initial months after the end of treatment to reflect the additional help patients need during that transitional phase.
- ***Transition of Treatment Payment.*** The oncology practice would receive an additional payment during months when the patient's disease progressed or recurred or when significant treatment regimen changes were needed, reflecting the significant additional time needed for treatment planning and patient education.
- ***Clinical Trial Payment.*** The oncology practice would receive an additional monthly payment for each patient participating in a clinical trial. Today, lack of payment to cover the significant

time and costs associated with trials discourages many practices from participating in the research needed to develop and test new treatments.

- In addition to the five consolidated payments, the practice would continue to receive **separate payments for tests and major procedures** it performs and **reimbursement for the costs of purchasing and storing drugs** the practice administers in the office.

Simpler billing structure. Instead of billing 58 separate CPT codes for E&M and infusion services as is required today, with no additional payment for services such as phone calls or social services, under Consolidated Payments for Oncology Care the oncology practice would **only bill a total of 11 service codes** that better match the types and costs of services delivered and cover the full range of services provided—greatly reducing administrative costs for both oncology practices and payers and simplifying cost-sharing for patients.

More predictable revenues. Other than expenditures on drugs, most of the costs involved in running an oncology practice are fixed monthly expenses (e.g., staff salaries, rent). Consolidated Payments for Oncology Care would provide more predictable monthly revenues so that an oncology practice can sustain the services patients need. Moreover, an oncology practice's revenues would not be as dependent on using parenterally administered drugs as they are today, thereby reducing the financial penalties practices now face if patients are treated with oral anti-cancer agents.

Accountability for delivering high-quality, high-value evidence-based, patient-centered care. In order to assure patients and payers that the monthly payments under Consolidated Payments for Oncology Care would not cause patients to be under-treated, the amount of payment each oncology practice receives would be decreased by up to 10 percent if recommended care is not provided, if the quality of care is lower than what other oncology practices routinely deliver, or if patients experience many preventable complications. Practices that deliver higher quality care that meets national standards would be rewarded with up to 10 percent higher payments.

Support for coordinated, patient-centered care. Consolidated Payments for Oncology Care would complement other payment reforms that support primary care medical homes and accountable care organizations by giving medical oncologists the flexible resources they need to deliver the highest-quality oncology care to patients with cancer at an affordable cost.

Additional discussion and analyses are needed to refine the proposed definitions and measures in the Consolidated Payments for Oncology Care structure and to ensure that it would improve care for patients, deliver greater value to payers, and be feasible administratively and financially for oncology practices to implement. ASCO welcomes input and encourages the oncology community to review and engage in a national dialogue on this proposed new payment system.

PREFACE

In the spring of 2013, the American Society of Clinical Oncology convened an Oncology Payment Reform Workgroup to explore better ways to pay oncology practices. The members of the Workgroup included:

- Anupama Kurup Acheson, MD
- John Cox, DO
- Michael Diaz, MD
- Omar Eton, MD
- James Frame, MD
- Karen Hagerty, MD
- Denis Hammond, MD
- Dan Hayes, MD
- John Hennessy
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- Roscoe Morton, MD
- Ray Page, DO
- Kavita Patel, MD
- Charles Penley, MD
- Blase Polite, MD
- Christian Thomas, MD
- Jeffery Ward, MD
- Robin Zon, MD
- Dan Zuckerman, MD

The Workgroup was formed because of the widespread recognition of the need to control healthcare spending by Medicare, Medicaid, and commercial payers and the interest in new payment models to enable physicians in general and oncologists in particular to help control spending without harming patients or jeopardizing the viability of high-quality, independent oncology practices. Moreover, Medicare and commercial payers are not the only ones who bear the burden of the rising costs of healthcare; an increasing share of these costs is being passed on to patients. The cost of cancer diagnosis and treatment, even for patients with insurance, can lead to treatment delays, noncompliance, and exhaustion of savings. In fact, medical expenses are the leading cost of personal bankruptcy.

Congress and others have called on physicians to assume a leadership role in recommending new payment models that will promote quality and efficient resource utilization. Because of the high cost of cancer treatment and the concentration of cancer treatment in the Medicare population (more than 60% of diagnosed and treated malignancies occur in Medicare beneficiaries), oncology is a particular area of focus for efforts to control Medicare costs. In addition, policy-makers have been

re-examining Medicare's current method of paying for physician-administered drugs (i.e., paying average sales price plus 6%) because of concerns that it could incent overutilization of high-priced pharmaceuticals. Of the top ten Medicare physician-administered drug expenditures, for example, eight are for cancer treatment.

Federal interest in developing new payment models is increasing. The bipartisan legislation to repeal the flawed Sustainable Growth Rate formula that was approved in February 2014 by the House Energy and Commerce Committee, the House Ways and Means Committee, and the Senate Finance Committee would authorize and encourage the use of alternative payment models under Medicare Part B for all physicians, including oncologists. In 2013, the Centers for Medicare and Medicaid Services (CMS) highlighted an interest in oncology and high-cost drug therapies as part of the Innovation Center's Innovation Awards program, and the Innovation Center announced in 2014 that it is developing a demonstration program specifically focused on oncology. Private sector health insurance plans are also exploring and implementing new payment models for oncology.

ASCO's Payment Reform Workgroup met in person on June 17, 2013, September 17, 2013, and March 23, 2014 for day-long discussions to identify and evaluate options for payment reform and to develop recommendations for an improved payment system. The Workgroup also discussed options and refinements via telephone and email in between these meetings. Harold Miller, President and CEO of the Center for Healthcare Quality and Payment Reform, facilitated the discussions at the meetings and on the calls and prepared summaries of the group's recommendations.

This document summarizes the Workgroup's recommendations. The proposed system of Consolidated Payments for Oncology Care described in this document is intended to be a working draft for further discussion by the leadership and members of ASCO and other stakeholders, not an official position statement of ASCO. Additional discussion and analyses are needed to refine the definitions and measures that would be used in the payment system before it is implemented and to ensure that: (1) the new payment system will maximize quality of care while assuring value; (2) the benefits of changing to the new payment system justify the costs; (3) the new payment system can be designed and implemented in a way that will be beneficial to the wide range of cancer patients; and (4) the changes would be feasible for oncologists to implement in the diverse settings in which they practice.

I. PROBLEMS, OPPORTUNITIES, AND GOALS

A. Opportunities for Improving the Quality and Reducing the Costs of Oncology Care

There are many opportunities for improving the quality and reducing the costs of oncology care that oncologists want to pursue:

- Choosing appropriate anti-cancer treatment and supportive drug combinations to avoid preventable emergency room visits and hospital admissions, e.g., for intravascular volume depletion, dehydration, and electrolyte abnormalities due to inadequately controlled nausea and vomiting.
- Administering treatment in the lowest-cost settings.
- Reducing unnecessary testing and surveillance.
- Avoiding non-beneficial or futile treatment.
- Effectively utilizing supportive care and symptom control beginning at the time of diagnosis and continuing through treatment and during the post-treatment period.
- Better managing and controlling the total costs associated with treatment.

B. Problems with the Current System of Paying for Oncology Care

The current payment system for oncology practices creates significant barriers that make it difficult for oncologists to pursue these opportunities, to provide the most efficient, high-quality care for their patients, and to control total spending for payers:

- A significant proportion of practice revenue depends on the administration of drugs in the office.
- Practice revenues are lower when fewer drugs, less expensive drugs, and fewer parenterally administered drugs are prescribed for patients.
- There is no additional compensation for additional time spent with patients on the phone or through email.
- There is no additional compensation for additional time spent talking with family members of patients.
- There is no additional compensation for additional time spent coordinating care with other physicians/specialists.

- There is no explicit compensation for visits with or services provided by pharmacists, social workers, triage nurses, dieticians, exercise specialists, etc. who provide education and support to patients; payment is only made for visits with physicians, physician assistants, and nurse practitioners.
- Compensation is only for office visits with physicians, which can lead to unnecessary physician office visits that could be better handled by telephone or electronic communications and/or by a nurse or other non-physician member of the practice.
- Compensation relative to time spent during initial visits and consultations is low compared to compensation for follow-up visits, which can lead to overuse of visits for existing patients and make access for new patients more difficult.
- Inadequate/narrow payment for time spent with patients leads to over-reliance on revenues from ancillaries, drugs, etc.
- There is no difference in compensation regardless of the quality of care provided.
- Inadequate compensation for educating, enrolling, and coordinating care for patients in clinical trials discourages both physician and patient participation in trials.

C. Goals for Payment Reform

In order to most effectively overcome the problems with current payment systems and enable oncologists to pursue opportunities for improving quality and reducing costs, changes must be made to the way oncology practices are paid. Any new payment system should be designed to achieve seven goals:

1. Give oncology practices the flexibility to provide the most appropriate, patient-centered care;
2. Provide oncology practices with adequate resources to support high-quality care, serve as oncology medical homes for patients, and attract new physicians and staff to the practice of oncology;
3. Reduce the administrative burden on oncology practices;
4. Reward oncology practices for delivering high-quality care;
5. Enable oncology practices to help control total spending on oncology care without compromising patient safety;
6. Encourage collaboration among oncology practices in finding the best ways to deliver high-quality, affordable care; and
7. Facilitate collaboration between oncology practices, primary care practices, and other subspecialties to provide more coordinated, patient-centered care.

II. CONSOLIDATED PAYMENTS FOR ONCOLOGY CARE

A. Components of the Consolidated Payment System

Consolidated Payments for Oncology Care (CPOC) would have seven components designed to better achieve the goals defined in the previous section than the complex payment system currently used by Medicare and most commercial payers to pay oncology practices.

- 1. New Patient Payment.** When a new patient selects a medical oncology practice to diagnose and manage their oncology care, the practice would receive a single New Patient Payment to compensate the practice for all of the physician and staff time the practice devotes to initial patient evaluation, treatment planning, and patient education. This payment would replace current payments to the medical oncology practice for CPT-based evaluation and management (E&M) services (both for an initial patient visit and any follow-up visits before treatment begins). The costs of any diagnostic testing ordered by the practice would still be billed and paid separately. If a patient comes to an oncology practice for a consultation (e.g., a second opinion about appropriate treatment), but the patient does not intend to have the oncology practice manage their care on an ongoing basis, the oncology practice would be paid for any office visits needed for the consultation through traditional CPT E&M payments.
- 2. Treatment Month Payment.** Once a patient begins treatment with an oncology practice for diagnosed cancer, the practice would receive a single Treatment Month Payment during each month that the patient is receiving treatment (including curative or palliative anti-cancer treatment, hormonal treatment for diagnosed cancer, or treatment to prevent or mitigate symptoms of cancer or side effects of treatment) that is ordered by the practice. This payment would replace all current CPT-based payments for chemotherapy administration, therapeutic injections/infusions, hydration services, and established patient E&M visits. The payment would be made if the patients are using oral medications or infused/injected drugs. The payment would also be made if the patient is in hospice care if the oncologist is the hospice physician. The practice could receive both a Treatment Month Payment and a New Patient Payment in the same month if the patient began treatment within 30 days of their initial contact with the practice, otherwise the Treatment Month Payment would be paid in the month when treatment actually began.

There would be **four different levels of Treatment Month Payment** to reflect the differences in time and effort involved in treating different patients. The payment level for an individual patient would be higher (a) if the patient has more comorbidities, (b) if the patient has poorer performance status, (c) if the patient is receiving more toxic drugs, and (d) if the drugs are more complex or time-consuming to administer. (The payment level would not depend directly on the type or stage of cancer being treated.)

- 3. Active Monitoring Month Payment.** The oncology practice would receive an Active Monitoring Month payment in a month if the patient is still under the active care of the oncology practice but does not receive any treatment (oral or parenteral) for cancer during the month, either because of a temporary pause in treatment, because of the completion of

treatment, or because the patient decides not to receive anti-cancer treatment during that month. There would be **three levels of the Active Monitoring Month Payment**:

- **Level 3**, the highest amount, would be paid in three circumstances: (a) when no treatment is being given during the current month, but treatment resumes during the following month; (b) during each of the first three months immediately following the end of treatment, or (c) during all months following the end of treatment if the patient has metastatic disease (including patients who decided not to receive any anti-cancer treatment at all during their initial discussions with the oncology practice, but for whom the oncology practice is providing palliative care).
- **Level 2**, a lower amount, would be paid during the fourth, fifth, and sixth months following the end of treatment for patients with no evidence of disease, and for additional months if the patient has chronic problems resulting from the toxicity of treatment that require active support.
- **Level 1**, the lowest amount, would be paid each month that a patient with no evidence of disease remains under the active care of the practice from the seventh month after the end of treatment until up to 5 years after the end of treatment, unless guidelines suggest a longer or shorter surveillance period.

4. **Transition of Treatment Payment.** In certain circumstances, the practice would receive a Transition of Treatment Payment in a month in *addition* to either a Treatment Month Payment or Active Monitoring Month Payment in order to reflect the additional time involved in treatment planning and patient education when important changes occur in the patient's disease or treatment plan. There would be **two levels of the Transition of Treatment Payment**:

- **Level 2** would be paid in addition to an Active Monitoring Month Payment if the patient has a recurrence of cancer, a new primary tumor, or a delayed complication of treatment more than six months after treatment had ended with no evidence of disease.
- **Level 1**, a lower amount, would be paid in the following circumstances: (a) the patient's cancer has progressed to a more advanced stage of disease as documented by test results; (b) the patient changes to a different class of drugs because of high toxicity from a previous regimen; or (c) the patient has just completed treatment with no evidence of disease.

5. **Clinical Trial Payment.** In order to offset the additional time and costs associated with monitoring patients in clinical trials, an oncology practice would also receive a Clinical Trial Payment for each patient who is participating in a clinical trial during any month the practice is also receiving a Treatment Month or Active Monitoring Month Payment.

6. **Payment for Drugs Administered by the Practice.** If the oncology practice purchases and stores parenteral drugs for administration, the practice would receive a payment in addition to the Treatment Month Payment that would (a) reimburse the practice for the cost of purchasing

the drugs, and (b) provide adequate compensation for the practice's expenses and risk associated with purchasing and maintaining a comprehensive inventory of high-complexity, potentially dangerous, expensive drugs. Although the current method of paying oncology practices based on the Average Sales Price of drugs can achieve these goals, alternatives to this payment method should be developed that provide adequate compensation to the oncology practice for its costs of purchasing and managing drugs for patients without making the financial viability of the oncology practice dependent on the types of drugs it prescribes.

7. **Continued FFS Payment for Other CPT Codes.** An oncology practice would continue to be paid for any service other than evaluation & management, drug infusions/injections, and minor procedures that is eligible for payment under current CPT code-based payment schedules, such as laboratory tests, imaging, bone marrow aspirations, and use of portable pumps. In addition, the practice would be paid traditional CPT E&M fees for (a) patients who come for a consultation or second opinion, but who do not intend to have the practice manage their care, and (b) patients who visit the practice occasionally following the end of the period during which the Active Monitoring Month Payment is paid.

B. Annual Payment Adjustments to Reward Value and Ensure Adequacy

1. Value-Based Adjustment

The amount that an individual oncology practice receives for each of the payment components defined in the previous section would be increased if the practice is delivering higher-quality, lower-cost care, and the payment amounts would be decreased if the practice is delivering lower-quality, higher-cost care. Practices delivering care at levels of quality and cost comparable to their peers would receive standard payment levels.

Measures of Value

The Value-Based Adjustment would be determined annually based on an oncology practice's performance during the prior year on a combination of three measures of value:

- a) **Use of and Adherence to Care Pathways.** A practice would receive a higher score on this measure if it uses available care pathways to guide its care and if the practice's adherence to the pathway is at or above the average for the pathway. An eligible care pathway would provide evidence-based guidance to the oncology practice as to the most appropriate treatments, supportive care, testing, and other aspects of care to achieve better outcomes for patients. Higher scores would be given to practices that use and adhere to "value-based" pathways where they exist. (In cases where there are two alternative treatments with equivalent efficacy and toxicity, but there are significant differences in the costs of the alternative treatments, a value-based pathway would recommend the lower-cost treatment unless there are contraindications for the individual patient.)
- b) **Providing High Quality Care to Patients.** A practice would receive a higher score on this measure if it has better performance than peers on a composite of quality measures. These quality measures would be drawn from the measures included in the Quality Oncology Practice

Initiative (QOPI) that is developed and maintained by the American Society for Clinical Oncology. All payers would agree to use the same composite. The composite would include a combination of the Core QOPI measures that apply to all patients and a weighted average of the specific QOPI modules applicable to each relevant subset of the practice's patients. Measures designed to encourage appropriate care at end of life would be included. Additional measures would be developed and added to QOPI over time based on input from both oncology practices and payers.

- c) **Frequency of Emergency Room Visits for Patients.** A practice would receive a higher score on this measure if (i) its patients have a risk-adjusted rate of visits to emergency rooms for avoidable oncology-related reasons that is significantly lower than other oncology practices during the prior year, or (ii) there has been a significant reduction in the rate of such visits over the previous year. The practice would receive a lower score if the risk-adjusted rate of visits was significantly higher than other practices. The risk-adjustment would consider (i) differences in patient comorbidities, performance status, and drug toxicities as measured in the treatment month formula and (ii) the distance of the patient's home from the oncology practice.

Benchmarks and Rating of Performance

At the end of each year, the performance of oncology practices on each of the three value measures during that year would be tabulated, and the mean and standard deviation of those measures would be computed. That information would be made available to all practices at the beginning of the following year (the "performance year"). At the end of the performance year, each practice would be compared to the average performance of all practices during the prior year on each measure, and the practice would be rated "high" or "low" if its performance was more than one standard deviation higher or lower than average on that measure.

- For adherence to pathways, "high" performance would consist of adherence that is at or above average, since 100% adherence is not expected and is likely undesirable.
- For use of emergency rooms, since lower is better, the practice would be rated as "high" if the risk-adjusted rate of emergency room use by the practice's patients is one standard deviation or more below the mean for other practices in the prior year.

Each of the three measures would be weighted equally. The largest increase in payment would go to practices that are high on all three measures, and the largest reduction in payment would go to practices that are low on all three measures. Practices that are high or low on some measures and average on others would receive a smaller increase or decrease in payment. If a practice has acceptable adherence to pathways and quality of care and if its patients use emergency rooms at rates comparable to other oncology practices, it would receive the standard payment levels for all components.

Phase-in of Value-Based Adjustment

The Value-Based Adjustment would be phased in over a multi-year period. The phase-in would have the following elements:

- The size of the payment adjustments would be lower during the initial years of the new payment model, in order to allow oncology practices the time to implement the changes in care delivery needed to achieve high performance. These changes can only be made after the new, flexible payments are in place, so higher performance cannot be expected immediately.
- In order to allow time for the development of more comprehensive care pathways and value-based care pathways, and to allow time for oncology practices to integrate the use of pathways into their workflows, practices would initially be rewarded for participation in pathways, with no penalties for low levels of adherence.
- Because of the significant costs associated with collecting quality measures, oncology practices would initially be rewarded for reporting quality measures, with no penalties for low performance on the measures. The increased payments for reporting would help practices to offset the significant costs associated with data collection and reporting.

2. Optional Supplemental Payment for Enhanced Patient-Centered Care

In addition to the Value-Based Adjustments defined above, oncology practices receiving the payments defined in Section II-A should have the option to receive higher payments in order to provide expanded services to help patients avoid experiencing complications during treatment. Under this option, the oncology practice would receive a supplemental monthly payment during each Treatment Month in return for a commitment to provide additional support for patients in order to reduce the use of emergency rooms for oncology-related complications. The amount of the payment would be established by the practice and payer based on an estimate of the additional costs of providing additional services and support for patients experiencing nausea and other complications of their treatment or disease (e.g., more proactive outreach to at-risk patients, additional after-hours support, etc.). A target level for avoidable oncology-related emergency room (ER) visits would be jointly established by the practice and the payer by taking the rate of such visits during the year prior to the beginning of the new payment system and calculating the reduction in that rate needed to generate savings sufficient to offset the additional monthly payment. At the end of each calendar quarter, the actual risk-adjusted rate of avoidable oncology-related ER visits for the most recently available quarter would be compared to the target level. If the ER usage rate were higher than the target level, the supplemental monthly payment for subsequent months would be reduced in proportion to the difference between the actual rate and the target level. If the rate were lower than the target level, the supplemental payment in subsequent months would be increased in proportion to the difference between the actual rate and the target level. The target level would not be revised any more frequently than every three years.

3. Optional Shared Savings Payments

In addition to the Value-Based Adjustments and the optional Supplemental Payment for Enhanced Patient Care, oncology practices should also have the option to participate in a shared savings payment arrangement with the payer that is making the payments.

Under such an arrangement, the payer would estimate how much, in total, it would expect to spend on other oncology-related care for the practice's patients during the course of the year, including

laboratory testing, imaging, hospitalizations, oncolytic drugs, radiation oncology services, and supportive drugs. If the actual risk-adjusted spending for the practice's patients during the year was below that estimated level, then the difference (i.e., the "savings") would be calculated, and the payer would make a supplemental payment to the practice equal to a percentage of the calculated savings.

This optional shared savings payment would *supplement* the payments defined in Section II-A and the adjustments in Section II-B, it would not *replace* them. The serious problems with the current oncology payment system defined in Section I-B can only be solved by implementing a more flexible, patient-centered payment system such as the structured defined in Section II-A. Similarly, while the opportunities to reduce spending identified in Section I-A could help a practice generate savings that it could share under the optional shared savings arrangement, the only way to achieve these opportunities is with a payment system that corrects the problems defined in Section I-B.

The specific parameters of the shared savings arrangement would be established jointly by the practice and the payer. For example:

- **Range of Services Included.** The shared savings calculation could be based on a subset of services rather than all services if the oncology practice felt better able to control some services and costs. For example, the practice might want to exclude spending on oncolytic drugs because of the difficulty of predicting the development or cost of new drugs, but include other types of spending. If the practice is receiving the Supplemental Payment for Enhanced Patient Care, emergency room visits would be excluded from the shared savings calculation since the rate of such visits would be measured and rewarded as part of the Enhanced Patient Care Supplement.
- **Utilization vs. Spending.** Particularly for commercial payers, the practice might feel it is able to control *utilization* of some services, but not the actual *spending* on those services, since other providers, such as hospitals, might raise their prices if their utilization decreases. This could be addressed by basing the shared savings calculation on pre-defined standardized prices rather than actual payment amounts.
- **Risk Adjustment.** The determination as to whether and how much savings occurred should include appropriate adjustments for changes in patient comorbidities, patient performance status, drug toxicity, and other factors beyond the control of the oncology practice.

4. Adjustments for Inflation, Technology, Productivity, and Evidence

Each year, the payment amounts for each of the components would need to be updated to ensure they keep up with increases in costs resulting from general economic inflation and to ensure they reflect changes in best practices for oncology care.

5. Adjustments for Geographic Cost Differences

Because practice expenses are higher in some parts of the country than others, Medicare adjusts payment rates under the Physician Fee Schedule using Geographic Practice Cost Indexes (GPCIs). In order to maintain parity between the new payment model and current Medicare fees, the payment amounts defined in the Section II-A could also be adjusted for geographic cost differences. For commercial insurance, appropriate payment amounts would be negotiated by the oncology practice and the health insurance company or purchaser.

C. Magnitude of Payments and Adjustments

1. Amount of Payment for New Payment Components

The amounts that oncology practices would be paid for each the new payment components would be set at levels that would achieve three goals:

- **Match payments to relative time/costs of care.** The relative sizes of payment for each component should reflect the relative amount of time and cost typically incurred by oncology practices during the phase of patient care described by the payment system component.
- **Avoid losses of revenue to high-quality, efficient practices.** The aggregate amount of net revenue (i.e., total payments minus drug acquisition costs) that a typical oncology practice would receive under the new payment system from a participating payer should be no less than the aggregate amount of net revenue that the practice would have received from that payer under the current payment system.
- **Budget neutrality for payers.** The total spending by Medicare (or another payer) on oncology care for an oncology practice's patients, considering both what is paid to the oncology practice and what is paid for other costs of oncology care to the practice's patients (e.g., laboratory testing, imaging, emergency room visits, hospitalizations, parenteral drugs, oral drugs, etc.) should be no greater than it would otherwise be if the current payment system had continued.

It is important to recognize that the payments received under Consolidated Payments for Oncology Care (CPOC) would differ from payments under the current payment system in three important ways:

1. The total net revenue an *oncology practice* receives under CPOC could be *greater* than under the current system, at the same time that *total spending on oncology care* by Medicare and other payers is *lower* than under the current system. This is because the net revenue to the oncology practice represents only a small proportion of the total spending on oncology care for its patients, and so the savings from reductions in avoidable emergency room use and hospitalizations, reductions in unnecessary testing, etc. could more than offset higher payments to oncology practices.

2. The total payment that an oncology practice receives for any *individual patient* under CPOC would inherently differ from what it would have received under the current payment system, since CPOC is designed to better match payments to the real differences in time and costs for an oncology practice in caring for different patients. The payment levels would be set such that the total amount of the payments averaged across all of a practice’s patients would be similar to what they are today during the initial year of implementation. However, over time, oncology practices would likely redesign care in more patient-centered ways without the fear that revenues would decline under the less flexible payment system used today.

3. The amount of payment that an oncology practice receives in any particular month under CPOC would differ from what it receives under the current payment system. For example, the New Patient Payment is intended to be much larger than what a practice currently receives prior to the beginning of treatment, reflecting the large amount of time and services provided to new patients that is not reimbursable under the current payment system. During Treatment Months, the payment to the practice would vary based on the characteristics of the patient, the toxicity of the drugs, and the complexity of the treatment regimen, instead of just on whether the patient received infusions, how many infusions the patient received, and how often they had a face-to-face visit with the physician. During Active Monitoring Months, the payment to the practice would not depend on how many face-to-face visits the patient had with the physician, so the payment would differ from what the practice receives today depending on how often the physician currently sees the patient.

Of the five new payment components defined in Section II-A, the largest payment amount would be paid for the New Patient Payment. For most new patients, the oncologist and the staff of the oncology practice need to spend considerable time and effort to establish an accurate diagnosis; to educate the patient about their disease and the available treatment options; to develop a treatment plan based on the patient’s health conditions and preferences; to help the patient obtain financial and other forms of assistance they may need; and to provide a range of other services depending on the patient’s needs. In contrast, under the fee-for-service system, the time spent carrying out these important functions generally receives the least compensation.

The following table shows the approximate magnitude of the other payment components in comparison to the New Patient Payment:

Magnitude of Proposed Payment Components Relative to New Patient Payment		
New Patient Payment		100%
Treatment Month Payment	Level 1	25%
	Level 2	43%
	Level 3	61%
	Level 4	80%

Magnitude of Proposed Payment Components Relative to New Patient Payment		
Active Monitoring Month Payment	Level 1	2%
	Level 2	10%
	Level 3	25%
Transition of Treatment Payment (in addition to Treatment Month or Active Monitoring Month Payment)		
	Level 1	30%
	Level 2	50%
Clinical Trial Payment		
		5%

There would be no difference in the payment amount *for any individual component* of the payment model based on the type or stage of a patient’s cancer. However, the monthly payments and total payment to the oncology practice would likely differ for patients with different types and stages of cancer, since the type and schedule of treatments would differ and this would be reflected in the different levels and numbers of Treatment Month Payments, Active Monitoring Month Payments, and Transition of Treatment Payments for different patients.

2. Magnitude of Value-Based Adjustments

Under the Consolidated Payments for Oncology Care system, an oncology practice that is delivering quality care to patients that is consistent with available pathways and that controls avoidable emergency room visits similar to what is achieved by other practices would be paid adequately for that care and would be able to receive a predictable revenue stream without unexpected swings due to random statistical variation in performance measures or unrealistic standards of performance. The goal of the adjustments defined in Section II-B would be to (1) reward the subset of practices that develop new and better approaches to care that significantly improve quality and outcomes and (2) penalize the small number of practices that fall significantly short of providing the kind of high-quality, evidence-based care that most other practices deliver.

In any given year, most practices would receive the “standard” payment amount for each of the payment system components. As defined in Section II-B, only significant positive or negative deviations from the average level of performance that has already been achieved by other oncology practices would result in increases or decreases in payment. This would enable and encourage oncology practices to collaborate with each other to improve care, rather than forcing them to compete with each other to achieve small differences in performance that would generate small increases in payment.

The adjustments that are made would be large enough to discourage poor quality care and to reward innovation, but not so large that an oncology practice would be forced to focus more on the specific factors being measured than on delivering evidence-based care. As noted in Section II-B, the adjustments would be phased in over time in order to allow time for more and better value-based care pathways to be developed, for measures of quality and emergency room use to be developed

and refined, and for oncology practices to change the way they deliver care to further improve quality and reduce costs. Oncology practices need to have the more flexible, less treatment-dependent revenues provided by the new payment system before they can make the changes in care needed in order to achieve higher levels of performance on these measures.

The following table shows how the size of the Value-Based Adjustment could be phased in over a seven-year period.

Level of Performance on Value-Based Measures	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
High on Pathway Use + High on Quality + High on Avoiding ER Use	+1%	+2%	+3%	+4%	+6%	+8%	+10%
High on Two Measures + Low on One Measure	0.5%	+1%	+1.5%	+2%	+3%	+4%	+5%
High on One Measure + Low on Two Measures	0%	-0.5%	-1%	-2%	-3%	-4%	-5%
Low on Pathway Use + Low on Quality + Low on Avoiding ER Use	0%	-1%	-2%	-4%	-6%	-8%	-10%

D. How Proposed Payments Would Replace Current Payments

Consolidated Payments for Oncology Care would dramatically simplify billing and administrative costs for both oncology practices and payers. In place of the 58 different CPT codes currently used by oncology practices to bill for care (16 E&M codes and 42 different codes for injections and infusions), practices would bill a total of 11 new codes (1 New Patient Payment, 4 levels of Treatment Month Payment, 3 levels of Active Monitoring Month Payment, 2 levels of Transition of Treatment Payment, and 1 Clinical Trial Payment), as shown in the following table.

Phase of Patient Care	New CPT Service Billed by Oncology Practice	Existing CPT Codes No Longer Billed by Oncology Practice
New Patient	xx100 New Oncology Patient	99201 New Patient Office Visit – Level 1 99202 New Patient Office Visit – Level 2 99203 New Patient Office Visit – Level 3 99204 New Patient Office Visit – Level 4 99205 New Patient Office Visit – Level 5 99221 Initial Hospital Care – Level 1 99222 Initial Hospital Care – Level 2 99223 Initial Hospital Care – Level 3
Treatment	xx201 Treatment Month – Level 1 xx202 Treatment Month – Level 2 xx203 Treatment Month – Level 3 xx204 Treatment Month – Level 4	99211 Established Patient Office Visit – Level 1 99212 Established Patient Office Visit – Level 2 99213 Established Patient Office Visit – Level 3 99214 Established Patient Office Visit – Level 4 99215 Established Patient Office Visit – Level 5 99231 Subsequent Hospital Care – Level 1 99232 Subsequent Hospital Care – Level 2 99233 Subsequent Hospital Care – Level 3 96401 Subcutaneous chemotherapy administration 96402 Subcutaneous chemotherapy administration 96405 Intravesicular chemotherapy administration 96406 Intravesicular chemotherapy administration 96409 Push chemotherapy administration

Phase of Patient Care	New CPT Service Billed by Oncology Practice	Existing CPT Codes No Longer Billed by Oncology Practice
		96411 Push chemotherapy administration 96413 Infusion chemotherapy administration 96415 Infusion chemotherapy administration 96416 Infusion chemotherapy administration 96417 Infusion chemotherapy administration 96420 Intra-arterial push chemotherapy 96422 Intra-arterial infusion chemotherapy 96423 Intra-arterial infusion chemotherapy 96425 Intra-arterial infusion chemotherapy 96440 Pleural cavity chemotherapy 96446 Peritoneal cavity chemotherapy 96450 CNS chemotherapy 96521 Refilling and maintenance of portable pump 96522 Refilling and maintenance of implantable pump 96523 Irrigation of implanted venous access device 96542 Chemotherapy injection via subcutaneous reservoir 96549 Unlisted chemotherapy procedure 79005 Oral radiopharmaceutical therapy 79101 Radiopharmaceutical infusion 79200 Radiopharmaceutical intracavitary administration 79300 Radiopharmaceutical therapy 79403 Radiopharmaceutical therapy infusion 96365 Intravenous infusion, non-chemotherapy 96366 Intravenous infusion, non-chemotherapy 96367 Intravenous infusion, non-chemotherapy 96368 Intravenous infusion, non-chemotherapy 96369 Subcutaneous infusion, non-chemotherapy 96370 Subcutaneous infusion, non-chemotherapy 96371 Subcutaneous infusion, non-chemotherapy 96372 Injection, non-chemotherapy 96373 Intra-arterial injection, non-chemotherapy 96374 Intravenous push, non-chemotherapy 96375 Intravenous push, non-chemotherapy 96376 Intravenous push, non-chemotherapy 96379 Unlisted injection or infusion, non-chemotherapy 96360 Intravenous infusion, hydration 96361 Intravenous infusion, hydration 36415 Collection of venous blood
Post-Treatment	xx301 Active Monitoring Month – Level 1 xx302 Active Monitoring Month – Level 2 xx303 Active Monitoring Month – Level 3	99211 Established Patient Office Visit – Level 1 99212 Established Patient Office Visit – Level 2 99213 Established Patient Office Visit – Level 3 99214 Established Patient Office Visit – Level 4 99215 Established Patient Office Visit – Level 5 99231 Subsequent Hospital Care – Level 1 99232 Subsequent Hospital Care – Level 2 99233 Subsequent Hospital Care – Level 3 36415 Collection of venous blood
Transition of Disease or Treatment	xx401 Transition of Treatment – Level 1 xx402 Transition of Treatment – Level 2	
Participation in Clinical Trial	xx500 Participation in Clinical Trial	

The following CPT and HCPCS-based payments would still be billed to Medicare and other payers by an oncology practice in addition to the New Patient Payment, Treatment Month Payment, and Active Monitoring Month Payment when the relevant services were provided:

- Major office procedures (e.g., bone marrow aspirations)
- Portable pumps and other DME
- Laboratory tests
- Imaging
- ASP-based payments for infused and injected drugs

The oncology practice would also bill for consultations (CPT 99241-99245, 99251-99255) rather than a New Patient Payment if a patient did not begin treatment with the practice or otherwise enter ongoing care with the practice.

If the oncology practice is part of a multi-specialty group, the other specialists in the group would still bill for E&M and procedural services as they do today. Consolidated Payments for Oncology Care are only intended to replace current payments made to medical oncologists, not to change or replace payments made to physicians or other providers in other specialties.

E. How Payment Would Differ from Today in Specific Situations

TYPE OF SERVICE PATIENT RECEIVES FROM THE PRACTICE	PAYMENT UNDER THE CURRENT MEDICARE PAYMENT SYSTEM	PAYMENT UNDER CONSOLIDATED PAYMENTS FOR ONCOLOGY CARE
A patient sees a physician in the office or hospital	The practice bills an E&M CPT code for each visit	The practice receives a monthly payment regardless of how many office visits the patient makes
A patient speaks to a physician on the telephone or communicates with the physician by email	The practice receives no payment for non-visit based contacts	The practice receives a monthly payment regardless of the type of communication between the practice and the patient
A patient speaks to or sees a pharmacist, nurse, social worker, etc. at the practice	The practice receives no payment for contacts other than with physicians, nurse practitioners or physician assistants	The practice receives a monthly payment regardless of which members of the practice staff assist the patient
A patient needs no contact with the oncology practice during a month	The practice receives no payment	The practice receives a monthly payment if the patient is under the care of the practice regardless of whether a visit is needed
A patient receives a drug treatment in the office	The practice bills a CPT code for administration of chemotherapy or supportive drugs If the practice purchases the drugs, it is paid 6% above the average sales price determined by Medicare	The practice receives a monthly payment for treatment of the patient If the practice purchases the drugs, it is paid an amount sufficient to cover the costs of acquiring and maintaining an inventory of those drugs
A patient receives a lower cost drug from the practice	If the practice purchases the drug, its revenue is lower	The change in the practice’s net revenue will depend on the method used to pay for the drugs The practice may receive a higher monthly payment if the lower-cost drug is on the pathway used by the practice

TYPE OF SERVICE PATIENT RECEIVES FROM THE PRACTICE	PAYMENT UNDER THE CURRENT MEDICARE PAYMENT SYSTEM	PAYMENT UNDER CONSOLIDATED PAYMENTS FOR ONCOLOGY CARE
A patient is prescribed oral anti-cancer treatment	There is no payment to the practice if the patient does not visit the office	The practice would be paid during the months the patient is receiving anti-cancer treatment to help ensure appropriate adherence and avoid side effects
A patient’s care is effectively managed by the practice and the patient does not need to go to the ER or hospital for treatment-related complications	There is no change in payment to the practice	The practice receives higher payments if it delivers high-quality care and has low rates of avoidable ER use

F. How the Proposed Payment System Compares to Other Payment Systems

Although Consolidated Payments for Oncology Care (CPOC) may seem radically different from the current method of paying oncology practices, similar types of payment approaches have been used by Medicare and other payers for many years in other specialties, and many payers are now moving toward using similar types of approaches in other areas of healthcare.

Monthly Payments to Physician Practices

Under Consolidated Payments for Oncology Care, an oncology practice would receive a monthly payment for all of the services it delivers to the patient during a month.

Medicare has used a similar system for many years to pay nephrologists for dialysis care of patients with End Stage Renal Disease (ESRD). Sixteen different monthly codes are used, depending on the patient’s age, where the treatment is given, and how often the physician sees the patient.

Monthly Payments Not Tied to Physician Office Visits or Specific Services

Under Consolidated Payments for Oncology Care, Treatment Month Payments would be paid monthly regardless of whether the patient sees a physician in the office. Active Monitoring Month Payments would be paid monthly even if no specific procedures are performed.

Medicare and many commercial payers are now paying monthly, per-patient payments to primary care practices in order to support the practices’ ability to implement patient-centered medical home principles. The payments are explicitly “non-visit based,” i.e., they are paid regardless of whether the patient sees a physician in the office during a month that the payment is made or whether any specific services are delivered. These payments provide not only more predictable revenues to primary care practices, but they provide the flexibility to use telephone calls, e-mail, nurses, and other staff to provide the support that patients need.

Payments Based on Patient Characteristics As Well As Types of Services

Under Consolidated Payments for Oncology Care, the size of Treatment Month Payments would be based on characteristics of the patients (comorbidities and performance status) as well as the nature of the treatments.

Medicare's payments to dialysis centers for patients with ESRD are based on age, body mass index, body surface area, and the presence of six comorbidities.

In Medicare's Comprehensive Primary Care Initiative, primary care practices receive a monthly non-visit based payment that ranges between \$8 and \$40 based on the number and severity of health problems that the practice's patients have.

Under Medicare's Inpatient Prospective Payment System, hospitals are paid higher amounts under many DRGs for patients with relevant comorbidities.

Combining Multiple Services into a Single Payment

Under Consolidated Payments for Oncology Care, Treatment Month payments would cover the costs of both evaluation and management services and the delivery of treatment-related procedures by the oncology practice.

Similarly, "global fees" are currently paid to surgeons and obstetricians by Medicare and most commercial payers; these payments cover both the procedure performed and relevant office and hospital visits during the global period before and after the procedure.

Adjustments to Payments Based on Differences in Quality and Value

Under Consolidated Payments for Oncology Care, an oncology practice's payment would be increased or decreased based on its performance on a composite of measures of quality and utilization specific to the type of care that practice delivers. These adjustments would be phased in over time.

Medicare has made quality-based adjustments to payments to outpatient dialysis facilities under the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) since 2012. The facility is scored based on performance on clinical measures and on reporting on safety and patient experience. For clinical measures, the facility is compared to its own baseline performance (the "improvement score") as well as to the national performance rate (the "achievement score"), and the facility is evaluated on whichever measure is more favorable. If a facility does not meet the minimum Total Performance Score, its payment is reduced by a percentage based on the score.

Medicare is now phasing in adjustments to all physician practices' payments through its Value Based Payment Modifier. The measures used are specific to the type of patients the physician practice cares for, and include measures of both quality and utilization/cost.

G. How the Proposed Payment System Would Complement Other Payment Reforms

Primary Care Patient-Centered Medical Homes

Consolidated Payments for Oncology Care would give oncology practices the same kinds of payment flexibility and accountability that are being given to primary care practices in many patient-centered medical home (PCMH) programs. The proposed oncology payment system would complement a primary care medical home payment program by giving both the primary care provider (PCP) and the oncology practice financial support to allow telephone and electronic consultations and coordination between the PCP and oncology practice without requiring patient visits to either, and by defining which quality and utilization metrics should be monitored and managed by the primary care practice and which should be monitored and managed by the oncology practice.

Episode Payments

Consolidated Payments for Oncology Care could be used in conjunction with "Episode Payments" for certain types of cancer or certain aspects of treatment if a practice and payer wished to do so. Different types of Episode Payments can be defined, but the general concept would be to bundle together multiple months of care and/or services beyond those included in the proposed oncology payment system (e.g., including in a single payment the cost of drugs or testing or emergency room visits in addition to the costs of services from physicians and other staff in the oncology practice). This complementarity could work as follows:

- Consolidated Payments for Oncology Care could be used for any types of cancer or groups of patients that were not included in the Episode Payments. For example, if an Episode Payment were intended only to cover adjuvant therapy, the proposed payment system could be used for metastatic therapy.
- If an Episode Payment is only intended to cover a portion of the patient's care, Consolidated Payments for Oncology Care could be used for the remaining portions of care. For example, if an Episode Payment is intended to cover just the treatment phase of care, the practice could continue to receive the New Patient Payment and the Active Monitoring Month Payments, but the Treatment Month Payments and potentially the Transition-of-Treatment Payments could be replaced by the new Episode Payment.
- Consolidated Payments for Oncology Care could also help to define the appropriate size of an Episode Payment. Consolidated Payments for Oncology Care defines an appropriate amount of

payment needed in each month for the time and costs that an oncology practice incurs to deliver high-quality patient care (including services that are not currently reimbursed under fee-for-service). An appropriate episode or condition-based payment could be constructed by combining these monthly amounts over the time period that is to be covered by the episode payment along with any other costs that are to be included in the Episode Payment. The differences in the number of months of payments and the levels of payments that are made for patients with different types and stages of cancer under the proposed oncology payment model could be used to determine how to adjust the Episode Payment amounts by type and stage of cancer.

Accountable Care Organizations

Consolidated Payments for Oncology Care could be used inside an overall global payment or shared savings payment for an Accountable Care Organization (ACO), and indeed, it would help an ACO be more successful by clearly defining what financial support the oncologists need in terms of payment change to enable them to help achieve better outcomes at lower costs.

If the oncology practice has opted to participate in the Optional Shared Savings program defined in Section II-B, the oncology-related shared savings calculation could be used to determine what portion of an overall shared savings payment to the ACO should be allocated to the oncology practice to reflect the oncology-related savings it was able to achieve for the ACO-attributed patients that the oncology practice cared for.

H. Expected Benefits of the Proposed Payment System

Consolidated Payments for Oncology Care represents a significant change from the current method by which oncology practices are paid for medical oncology, and it improves on the current payment system in many ways that will help achieve the goals defined in Section I-C:

- It ***provides oncology practices more flexibility*** to deliver quality, patient-centered care than under the current physician fee schedule. Payments are not determined by whether or how often a patient is seen face-to-face or by which member of the oncology practice staff assists the patient, so practices would be better able to support team-based care, provide patient and family education, use shared decision-making, provide telephone and email support, etc. and to focus office visits on those patients who need to be seen in the office and to spend adequate time with them.
- It ***better matches payments to the time and costs of high quality care*** by an oncology practice during each phase of the treatment process. In particular, it should improve access to oncology care for new cancer patients by compensating oncology practices more appropriately for the time involved in diagnosis and treatment planning for new patients.
- It ***reduces or eliminates the current financial penalty practices face if they prescribe oral medications*** for patients instead of parenteral drugs, since payments during treatment months would be based on the patient receiving treatment rather than on whether the patient received infusions or injections of drugs.
- It ***reduces administrative time and costs*** for both oncology practices and payers by replacing 58 CPT codes (16 E&M codes and 42 different codes for injections and infusions) with a total of 11 new codes (1 New Patient Payment, 4 levels of Treatment Month Payment, 3 levels of Active Monitoring Month Payment, 2 levels of Transition of Treatment Payment, and 1 Clinical Trial Payment).
- It ***rewards oncology practices that deliver high-quality care***. Oncology practices that deliver high-quality care would be paid more than those that deliver low-quality care, and practices that find ways to significantly improve quality would be paid even more.
- It ***encourages collaboration among oncology practices to improve quality and reduce costs***. Payments to oncology practices would be based on their performance relative to standards defined in advance, not based on whether they do slightly better than other practices during the current year.
- It ***encourages participation in clinical trials*** by providing higher payments to cover the higher costs of data collection and surveillance.

- It would *reduce (or slow the growth of) total spending on oncology care, while improving the quality of care for patients and maintaining or increasing operating margins for oncology practices*. Oncology practices would have the flexibility, tools, and incentives to:
 - Reduce use of treatments that have little or no benefit for patients;
 - Reduce overuse of lab tests and imaging;
 - Reduce avoidable emergency room visits by patients; and
 - Reduce the variability in care and the use of non-evidence-based care.

III. DETAILS OF PAYMENT COMPONENTS

A. New Patient Payment

A single New Patient Payment would be paid for any new patient until treatment begins, even if multiple office visits occurred before treatment began. A New Patient Payment would also be paid for a new patient who decides, after discussion with the oncologist and oncology practice staff, not to receive any anti-cancer treatment for their disease. A New Patient Payment would not be paid for a patient who sees an oncologist for a consultation or second opinion but obtains treatment from a different oncology practice. One face-to-face visit with a medical oncologist who is part of the oncology practice would be required to receive the New Patient Payment, similar to an E&M code for a new patient, but the payment would not vary based on the number of contacts with a physician prior to the beginning of treatment.

No E&M codes for new patient office visits, new patient hospital visits, or established patient visits could be billed by medical oncologists or physician extenders supervised by medical oncologists in the practice if the practice bills for a New Patient Payment. From that point forward, the practice would only be able to bill for Treatment Month Payments or Active Monitoring Month Payments until such time that the patient was no longer under the care of the practice or until the maximum number of Active Monitoring Month Payments had been billed following the end of treatment.

B. Treatment Month Payment

A single Treatment Month Payment would be paid to the oncology practice that is managing the patient's care in each month in which a patient with diagnosed cancer received a treatment ordered by the practice, regardless of whether the treatment was infused, injected, or oral. Face-to-face contact with a physician would not be required for a Treatment Month Payment. Treatment would include:

- Anti-cancer treatment with curative or palliative intent
- Hormonal treatment for diagnosed cancer
- Medications to prevent or mitigate serious symptoms of cancer and/or side effects of treatment (including delayed side effects)

Each month would start on the same day of the month as the date that the first treatment was given (in the case of infusions) or ordered (in the case of oral drugs). If treatment was started on the 28th or 29th of February or on the 31st of another month, the next treatment month would begin on the last day of each subsequent month.

A Treatment Month Payment would also be made to the practice if the patient is in hospice care and an oncologist in the practice is the patient's hospice physician.

The medical oncologists in the practice could not bill E&M codes for office or hospital visits, codes for the administration of drugs, or codes for minor procedures if the practice is billing for a Treatment Month Payment or if it has previously billed for a New Patient Payment. A practice could not bill for a Treatment Month Payment if another medical oncology practice bills for a New Patient Payment during that month.

If the oncology practice receiving the payment does not provide infusions or injections of drugs itself, but uses a hospital infusion center or other provider to do so, the oncology practice would need to work out an arrangement to compensate that infusion center for its services from the oncology practice's Treatment Month Payment.

There would be four different levels of Treatment Month Payments. The appropriate level would be determined based on four characteristics of the patient and the treatment that is prescribed:

1. The patient's comorbidities, measured using the Charlson Comorbidity Scale but with no points assigned to cancer diagnoses (see Table 1)
2. The patient's performance status, measured using the ECOG scale (see Table 2)
3. The toxicity of the patient's drug regime (see Table 3)
4. The complexity of the drug regimen for both the practice and patient (see Table 4)

The scores for each factor would be added to calculate a total score, and that total score would be used to determine the level of Treatment Month Payment as follows:

- Level 1: Total score of 0-2
- Level 2: Total score of 3-5
- Level 3: Total score of 6-8
- Level 4: Total score of 9-16

A Treatment Month Payment would be paid in a month even if a New Patient Payment or a Transition-of-Treatment Payment is also paid in that same month.

Services provided to the patient by other physicians or providers who are not part of the oncology practice, such as diagnostic testing, and services or procedures delivered by the oncology practice that would be billable using CPT codes other than E&M codes or chemotherapy administration codes would be paid in addition to the Treatment Month Payment.

Table 1 Comorbidity Factor	
Points	Total Charlson Comorbidity Index, Excluding Points for Cancer Diagnoses
0	0-3
1	4-7
2	8+

Table 2 Performance Status Factor		
Points	ECOG Score	ECOG Criteria
0	0-1	Able to work
1	2	Capable of self-care but unable to work

2	3+	Requires assistance with self-care	
Table 3 Toxicity of Drugs Factor			
Points	Hospitalization Risk (% risk grade III/IV toxicity)	Impact on QOL and ADLs (% risk grade I/II toxicity)	Risk of Toxic Death (% risk)
0	<20%	<50%	<1%
2	20% - 35%	50%-74%	1%-9%
4	>35%	>75%	<10%

Table 4 Drug Administration Factor			
Points	Infusions/Injections (Including combo infusion/oral)	Multiple Infusions/Mo nth	Oral Drugs Only
0	Any injection (subcutaneous or IM), Port flush, D/C 5FU pump, Central line maintenance		Single Drug (2 nd and subsequent months)
1	Less than one hour of nursing care, Monoclonal therapy with low incidence of adverse event, Chemo infused in less than 15 minutes or IVP, Uncomplicated hydration, Bisphosphonate therapy, Iron replacement therapy	2+ treatments per month at level 0	Single Drug (Initial month) or Single Drug with on-off pattern (2 nd and subsequent mos)
2	2-3 hours of nursing care, Single agent chemotherapy, Single agent chemo + bisphosphonate, Single agent chemo + monoclonal (other than Rituxan), Side effect management requiring supportive drugs, Subsequent day chemotherapy less than 3 hours, Single agent Rituxan, Weekly combo therapy 2-3 hours	2+ treatments per month at level 1	Multiple Drugs every day or Single Drug with on-off pattern (initial month)
3	4-5 hours of nursing care, Combination therapy, Any level 3 regimen on a research protocol that requires VS monitoring, Weekly combination regimens with a monoclonal		Multiple Drugs w/ on-off pattern (2 nd and subsequent months)
4	6-8 hours of nursing care, Combination therapy lasting more than 6 hours, Chemo regimens requiring an advanced procedure, Patient at lower acuity but requires full care	2+ treatments per month at level 2	Multiple Drugs w/ on-off pattern (initial month)
6	Stem cell transplant	2+ treatments per month at level 3	
8		2+ treatments per month at level 4	

C. Active Monitoring Month Payment

Active Monitoring Month Payments would be paid during months in which the patient's oncology care is being managed by the oncology practice, but the patient is not receiving anti-cancer treatment or supportive drugs.

No E&M codes or codes for minor procedures could be billed by the practice if it is billing for an Active Monitoring Month Payment.

There would be three different categories of Active Monitoring Month Payment:

- Level 3, the highest amount, would be paid in any of three circumstances:
 - (a) when no treatment is being given during the current month, but treatment resumes during the following month;
 - (b) during each of the first three months immediately following the end of treatment for patients with no evidence of disease, and
 - (c) during all months following the end of treatment if the patient has metastatic disease (including patients who originally decided not to receive any anti-cancer treatment) until the patient dies, unless the patient resumes treatment, transitions to hospice, or moves to care by another physician practice (oncology or PCP)
- Level 2, a lower amount, would be paid in the following circumstances:
 - (a) during the fourth, fifth, and sixth months following the end of treatment for patients with no evidence of disease; and
 - (b) during subsequent months if the patient has chronic problems resulting from the toxicity of treatment that require active support.
- Level 1, the lowest amount, would be paid each month from the seventh month after the end of treatment until 5 years after the end of treatment, unless a treatment pathway, a clinical trial, or other guidelines suggest a longer or shorter surveillance period.

The patient would be required to have seen a physician, nurse practitioner, or physician assistant at least once during the 6 months following the end of treatment in order to receive the Level 2 and/or Level 3 payments. The patient would be required to see a physician, nurse practitioner, or physician assistant at least once each year in order to continue receiving the Level 1 payment.

D. Transition-of-Treatment Payment

A Transition-of-Treatment Payment would be paid during a month in addition to either a Treatment Month Payment or an Active Monitoring Month Payment if a significant change in the patient's diagnosis or treatment occurred during the month. There would be two different categories of Transition-of-Treatment Payment:

- Level 2, the higher amount, would be paid if the patient has a recurrence of cancer, a new primary tumor, or a significant delayed complication of treatment more than six months after the patient's treatment had ended with no evidence of disease.
- Level 1, the lower amount, would be paid in three circumstances:
 - (a) the patient has progressed to a more advanced stage of disease as documented by test results;
 - (b) the patient changes to a different class of drugs because of progression of disease or high toxicity from a previous drug regimen, or
 - (c) the patient completes treatment with no evidence of disease.

Only one Transition-of-Treatment Payment would be paid in a month regardless of how many office visits occurred or if treatment changed multiple times.

A face-to-face visit with the physician would be required to receive the Transition-of-Treatment Payment, similar to current E&M visit payments.

E. Clinical Trial Payment

If a patient enrolls in a clinical trial, a Clinical Trial Payment would be paid to the practice during each month that the practice is receiving a Treatment Month Payment or Active Monitoring Month payment for that patient. The Clinical Trial Payment would be in addition to the Treatment Month and Active Monitoring Month Payments and would continue as long as the patient remained in the clinical trial. The amount of the payment would be designed to offset the additional time and costs that the practice incurs to record additional data regarding the treatment and the patient's response, to prepare reports to the trial research staff, to store the trial drugs, etc.

F. Payment for Drugs Administered by the Practice

If the oncology practice purchases and stores parenteral drugs for administration to patients, it would continue to be paid for those drugs under the current method based on Average Sales Price. Alternative payment methodologies should be explored that would:

- Reimburse the practice for the cost of the drugs it acquired;

- Provide adequate compensation for the practice's expense and risk associated with purchasing and maintaining a comprehensive inventory of high-complexity, potentially dangerous, expensive drugs; and
- Not make the financial viability of the practice dependent on the types of drugs it purchases.

IV. DETAILS ON VALUE-BASED PAYMENT ADJUSTMENTS

A. Encouraging the Use of Care Pathways

“Care Pathways” are evidence-based guidelines describing the types of cancer therapy, supportive care, testing, surveillance, and patient assistance that are most appropriate for patients with particular characteristics. Experience to date has shown that the use of such pathways can benefit both patients and payers by reducing inappropriate variation in care that can lead to both under-treatment and overuse. Consequently, it would be desirable for the value-based adjustment in the payment system to encourage oncology practices to support the development and use of appropriately designed Care Pathways.

However, most current pathways focus primarily on which drug regimens have the best combination of efficacy and toxicity, and they often fall short of defining the full range of services and support that oncology practices need to provide to patients in conjunction with those treatments in order to ensure the best results for patients and minimize complications and defining the appropriate types of testing and surveillance that should be used. This overly narrow focus could potentially cause problems for both patients and oncology practices, and could potentially result in increases in overall spending on oncology care. Consequently, value-based payment adjustments for use of pathways will need to be phased in over time in order to allow improvements to be made to the pathways as well as to allow oncology practices time to utilize pathways most effectively.

1. Guiding Principles for the Development and Use of Oncology Care Pathways

The following principles should guide the development and use of Care Pathways and the ways that the Value-Based Adjustment should support that:

- **Pathways Should Be Developed With the Input of Oncologists.** Care Pathways must be applicable to the kinds of patients that oncologists see and must recommend utilization of the kinds of care resources likely to be available to community oncologists and their patients.
- **Pathways Should Describe All Aspects of Cancer Care, Not Just Anti-Cancer Treatment.** To the maximum extent possible and supported by evidence, Care Pathways should define aspects of oncology *care* beyond just the treatment of the patient’s cancer, e.g., the types of supportive care, palliative care, lab tests, imaging, and other services the patient should receive.
- **Pathways Should Give Appropriate Consideration to Costs of Alternative Approaches to Care.** Where possible and appropriate, Care Pathways should be “value-based,” i.e., when there are two alternative approaches to treatment or supportive care available that are appropriate for the patient and have equivalent efficacy and toxicity, the Care Pathway should recommend the lower cost approach.
- **Oncology Practices Should Be Able to Use the Same Pathways With All Payers.** Oncology practices should not be expected to use different pathways for similar patients simply because the patients have

different types of health insurance. Payers should work together to support the development of pathways that all payers can use.

- **Efficient Methods of Using Pathways and of Documenting and Auditing Adherence to Pathways Should be Developed.** For example, pathways that can be integrated into electronic health records (“e-Pathways”) will be easier to use, document use of, and audit use of than those requiring paper documentation.
- **100% Adherence to Pathways is Likely Impossible and Undesirable; Deviations Should Be Used to Advance Knowledge about Appropriate Care.** Pathways should be used to reduce *inappropriate* variation but not to prevent *appropriate* variation or to discourage testing of improved approaches. Particularly in the early stages of pathway development, pathways will not be able to define appropriate care for all patients. Because of this, oncology practices should neither be financially penalized for less than 100% adherence, nor financially rewarded for higher than expected adherence. If a patient has characteristics that are not covered by the Pathway that the practice is using, or if there are other reasons that the oncologist believes that adherence to the Pathway would be inappropriate (e.g., the patient has just moved and needs to continue on a regimen started by a different practice, even though it is different from what the Pathway recommends), the oncology practice should have the ability to deviate from what the Pathway recommends. Practices should submit information about deviations from Pathways to the developers of the Pathways to help expand and improve future versions of the Pathways.
- **Standards for Adherence to Pathways Should Be Established in Advance Based on Evidence and Experience.** If payments to an oncology practice are to be adjusted based on the rate at which the practice adheres to pathways, the practice’s adherence rate should be compared to an expected minimum adherence level that is defined in advance for the pathway based on the experience of other practices that have used the pathway. An oncology practice should know at the beginning of a measurement period what adherence rate is expected; the standard should not be established after the fact. If adherence rates increase nationally due to improvements in the pathways and/or improvements in the ability of practices to adhere, then the minimum expected adherence rates can be increased for future years.
- **Initially, Payments Should Be Increased for Practices Using Pathways; Increases Should Be Large Enough to Cover the Cost and Time of Acquiring and Implementing Pathways.** Oncology practices will incur significant costs in purchasing access to pathways (if they are commercially developed), in implementing them in their practices, and in documenting adherence. Particularly in the initial years of pathway development and use, higher payments should be made to oncology practices that use and adhere to pathways, and the payments should be at least large enough to cover these costs. Since studies have indicated that use of Pathways reduces unwarranted variation in care and spending, the higher payments to practices for implementation of Pathways should be more than offset by savings on other types of services delivered outside of the oncology practice.
- **CMS Should Develop a Certification Process for Care Pathways.** CMS should work with the oncology community to develop criteria for evaluating Care Pathways and certifying that they are appropriate for Medicare and other payers to support. If multiple Medicare Certified Pathways are available for a particular type of cancer, an oncology practice should have the flexibility to choose which Pathway it will use, as long as the practice will be evaluated against that Pathway for all patients with that type of cancer. Criteria for certifying pathways could include:
 - The quality of the evidence used in developing the pathway, and the process for continuously updating and enhancing the recommendations in the pathway;

- The proportion of patients the pathway is intended to cover (within the type of cancer on which the pathway focuses);
 - The expected adherence rate, and the actual adherence rate with the most recent version of the pathway;
 - The measured outcomes associated with adherence to the pathway (in absolute terms and/or relative to other pathways);
 - The costs of care associated with adherence to the pathway (in absolute terms and/or relative to other pathways); and
 - The ease of use of the pathway for patient care, documentation, and billing.
- **After Certified Pathways Have Been Developed, Practices Should be Expected to Use and Adhere to Them, and Payments Should Be Reduced If Pathways Are Not Used.**
 - **Payers and Providers Should Collaborate to Evaluate the Effectiveness of Pathways in Improving Patient Outcomes and Controlling Costs.** Encouraging and rewarding development of pathways and adherence to pathways is only desirable if the pathways actually improve the quality of care for patients and/or reduce the cost of care without harming quality.

2. How Payment Should Support the Implementation and Use of Care Pathways

For the purposes of the Value-Based Adjustment described in Section II-B, an oncology practice would be rated as “high,” “low,” or “appropriate” based on its use of pathways. The rating would depend on whether a Care Pathway exists, whether the practice uses the pathway, and the level of adherence to the pathway. There would be at least two phases of implementation; during the first phase, practices would be rated based on whether they use pathways, but not the level at which they adhere to them; in the second phase, ratings would be based on adherence.

Availability of Care Pathway(s)	How an Oncology Practice Uses Pathways	Rating of Oncology Practice in PHASE 1	Rating of Oncology Practice in PHASE 2
No Pathway exists for a particular type of cancer		“Appropriate”	“Appropriate”
One or more Care Pathways exist for a particular type of cancer	The practice <i>does not use</i> any available pathway	“Low”	“Low”
	The practice <i>uses a pathway</i> and reports on its adherence and reasons for deviation.	“Appropriate”	N/A
	The practice uses a pathway and its <i>adherence rate is</i>	“Appropriate”	“Low”

Availability of Care Pathway(s)	How an Oncology Practice Uses Pathways	Rating of Oncology Practice in PHASE 1	Rating of Oncology Practice in PHASE 2
	<i>more than one standard deviation below average</i>		
	The practice uses a pathway and its <i>adherence rate is less than one standard deviation below average</i>	“Appropriate”	“Appropriate”
	The practice uses a pathway and its <i>adherence rate is at or above the minimum expected level</i>	“Appropriate”	“High”

B. Encouraging High Quality of Care

Oncology practices should be encouraged to measure and continuously improve on the quality of the care they deliver. Higher payments should be made to oncology practices with higher quality care, as long as “quality” is measured appropriately. However, since quality measures for oncology are still evolving, adjustments to payments will need to evolve with the development of more and better quality measures. The Quality Oncology Practice Initiative (QOPI[®]) developed by the American Society of Clinical Oncology should be the foundation for Value-Based Adjustments to payments for oncology practices; many QOPI measures are already endorsed by the National Quality Forum and are being used by Medicare and commercial payers to reward oncology practices for quality measurement and/or performance.

1. Guiding Principles for the Use of Quality Measures in Oncology Payment

The following principles should guide the development and use of quality measures in conjunction with healthcare payment systems:

- **Quality Measures Should Be Developed With the Input of Oncologists.** Quality measures must be applicable to the kinds of patients that community oncologists see and must utilize data that can be affordably collected by community oncologists.
- **Quality Measures Should Capture All Aspects of Cancer Care, Not Just Anti-Cancer Treatment.** To the maximum extent possible and supported by evidence, quality measures should capture aspects of oncology *care* beyond just the treatment of the patient’s cancer, e.g., the types of supportive care, palliative care, and other services the patient should receive.
- **Quality Measures Should Encourage Appropriate Care for Patients as They Approach the End of Life.**
- **Oncology Practices Should Be Able to Use the Same Quality Measures With All Payers.** Oncology practices should not be expected to use different quality measures for similar patients simply because the

patients have different types of health insurance. Payers should work together to support the development of quality measures that all payers can use.

- **Efficient Methods of Collecting and Reporting Quality Measures Should Be Developed.** For example, quality measures that can be extracted directly from electronic health records (“e-measures”) will be easier to document and report than those requiring paper documentation or special calculations from EHRs.
- **Standards of Performance on Quality Measures Should Be Established in Advance Based on Evidence and Experience.** If payments to an oncology practice are to be adjusted based on the practice’s performance on quality measures, a target performance level should be defined in advance based on the actual performance of practices on the quality measure in the most recent year(s) available. An oncology practice should know at the beginning of a measurement period what level of performance is expected; the standard should not be established after the performance period ends. The performance standards can be increased in future years as overall performance improves.
- **Initially, Modifications to Payments Should Be Based on Quality Reporting, Rather than Performance; Payment Differentials Should Be Large Enough to Cover Practices’ Cost and Time of Collecting and Compiling Measures.** Oncology practices will incur significant costs in collecting data and calculating quality measures. Particularly in the initial years of quality measurement, higher payments should be made to oncology practices that collect and report quality measures, and the payments should be at least large enough to cover these costs.
- **After Performance Benchmarks Have Been Established, Payments Should Be Modified Based on Performance on Quality Measures.** Initially, only positive adjustments (i.e., increases) to payments should be made in order to give oncology practices sufficient time to obtain feedback and improve performance. Reductions in payments for poor performance should only be introduced when there is greater comfort with the reliability of the measures and the benchmarks being used.
- **Payers and Oncology Practices Should Collaboratively Establish Performance Standards on Quality Measures.** When quality benchmarks and performance standards are established, it is difficult to anticipate all potential problems or unintended consequences. Medicare and commercial payers should work collaboratively with oncologists to assess whether changes are needed in the quality measures that are used, the benchmarks that are established for performance, and the way practices are rated on their performance.

2. How Payment Should Support Quality Measurement and Improvement

For the purposes of the Value-Based Adjustment described in Section II-B, an oncology practice would be rated as “high quality,” “low quality,” or “appropriate quality” based on reporting and performance on quality measures. Value-based adjustments to payment based on quality measures should be phased in, so that oncology practices have the ability to set up systems for collecting, reporting, and improving performance on measures, and so that benchmarks based on actual performance can be established.

Measurement and Performance on Quality by Oncology Practice	Rating of Oncology Practice in PHASE 1	Rating of Oncology Practice in PHASE 2	Rating of Oncology Practice in PHASE 3
Oncology practice <i>does not collect and submit quality measures</i> applicable to all patients to a national registry for medical oncology (e.g., QOPI*)	“Appropriate”	“Low”	“Low”
Oncology practice collects and submits measures, and <i>quality measures are more than one standard deviation below average for comparable patients</i>	“High” (No penalty in Phase 1 for poor performance on quality measures)	“Appropriate”	“Low”
Oncology practice <i>quality measures are within one standard deviation above or below average levels</i>	“High”	“Appropriate”	“Appropriate”
Oncology practice <i>quality measures are more than one standard deviation above average levels</i>	“High”	“High”	“High”

*Alternative registries, certifications, and quality measures other than QOPI could be used if available.

C. Encouraging Lower Utilization of Emergency Rooms

Oncology practices should be encouraged to (1) plan and modify treatment and supportive care for patients in ways that minimize side effects and complications for patients and (2) create systems for responding quickly to patient problems in ways that avoid the need for patients to seek care in an emergency room for cancer treatment-related side effects and complications. Consolidated Payments for Oncology Care would support the ability of oncology practices to implement tools and techniques to support more patient-centered care, and the Value-Based Adjustment should reward practices that achieve low rates of emergency room visits for its patients.

1. Guiding Principles for Reducing Avoidable Use of Emergency Rooms

The following principles should guide the development and use of payment adjustments designed to support efforts to reduce avoidable emergency room visits:

- Oncology Practices Will Need Time and Resources to Implement Patient-Centered Care Processes.** Oncology practices that want to redesign their care systems using tools and techniques that have succeeded in helping other practices deliver more patient-centered care will need to receive flexible payments that support those improvements in care.

- **Payment for Oncology Practices Should Not Require the Use of Non-Evidence Based Structures or Processes.** Oncology practices should have the flexibility to innovate in care delivery processes and to adapt care delivery structures to the unique needs of their patients and community, as long as they can successfully control avoidable use of emergency room visits and hospitalizations.
- **Payment Adjustments Should Be Based on *Avoidable, Oncology-Related Utilization of Emergency Rooms Measured Using Definitions Developed With Input from Oncologists.*** Oncology practices should not be held accountable for emergency room visits or hospitalizations that are due to patient conditions that an oncology practice cannot reasonably expect to influence. Because of the difficulty of accurately determining the causes of emergency room visits from claims data, it may be desirable to create a composite measure of emergency room use that gives higher weight to emergency room visits that are highly likely to be related to a patient’s oncology treatment, and lower weight to emergency room visits where the relationship to oncology care is less certain.
- **Performance Benchmarks Should Be Risk/Acuity-Adjusted to Reflect Differences in the Toxicity of Different Treatment Regimens.** The comorbidity, performance status, and toxicity measures used to determine the appropriate level of the Treatment Month Payment could be used as the foundation for the risk/acuity-adjustment.
- **Performance Benchmarks Should Be Geographically Adjusted to Reflect Differences in Access to Care.** In a rural or inner-city area where patients have greater difficulty accessing alternative care resources, or in a community where a hospital is promoting the use of emergency rooms, or in a state where regulations limit the ability to offer access to non-physician care, an oncology practice should not be expected to achieve the same results as other oncology practices.
- **Payers and Oncology Practices Should Collaboratively Establish Performance Standards for Use of Emergency Rooms.** When quality benchmarks and performance standards are established, it is difficult to anticipate all potential problems and unintended consequences. Medicare and commercial payers should work collaboratively with oncologists to assess whether changes are needed in the quality measures that are used, the benchmarks that are established for performance, and the way practices are rated on their performance.

2. How Payment Should Support the Development of Oncology Medical Homes and Minimize the Use of Emergency Rooms

For the purposes of the Value-Based Adjustment described in Section II-B, an oncology practice would be rated as “high,” “low,” or “average” based on its patients’ utilization of emergency rooms for problems related to their cancer or their treatment for cancer.

Value-based adjustments to payment based on emergency room use should be phased in, so that oncology practices have the time to create better systems for preventing patient problems and responding quickly when they do occur. During the first phase of implementation, an oncology practice would be rewarded either for achieving low rates of emergency room use or for achieving certification as an “oncology medical home.” In the second phase of implementation, all practices would be evaluated on the actual outcomes they achieve.

Oncology Practice Performance in Avoiding ER Visits	Rating of Oncology Practice in PHASE 1	Rating of Oncology Practice in PHASE 2
The practice meets accreditation standards for oncology medical home	“High”	No impact on payment (Payment levels determined by rate of emergency room and hospital use)
The practice’s patients have risk-adjusted rates of emergency room visits for oncology-related conditions that are more than one standard deviation above average	“Typical” (unless the oncology practice meets the standards for oncology medical homes)	“Low” (unless the practice has reduced the risk-adjusted rate of ER visits)
The practice’s patients have risk-adjusted rates of emergency room visits for oncology-related conditions that are more than one standard deviation above average, but the risk-adjusted rate has decreased by at least one-half of the difference between the prior year’s rate and the average	“High”	“Typical”
The practice’s patients have risk-adjusted rates of oncology-related ER visits that are within one standard deviation above or below average	“Typical”	“Typical”
The practice’s patients have risk-adjusted rates of oncology-related ER visits more than one standard deviation below average	“High” (regardless of whether practice meets standards for oncology medical homes)	“High”

V. TRANSITIONING TO CONSOLIDATED PAYMENTS FOR ONCOLOGY CARE

A. Setting the Payment Levels

Because the components of Consolidated Payments for Oncology Care do not have a one-to-one relationship with codes in the current payment system and because they are intended to cover some services that are not compensated at all today, a process is needed to ensure that the standard payment amounts for each component from a participating payer (Medicare or commercial) are set such that:

- The relative sizes of payment for each component reflect the relative amount of time and cost typically incurred by oncology practices during the phase of patient care described by the payment system component. (This does not mean that the practice should be required to document that it spends this amount of time in order to receive the payment, however.)
- The aggregate amount of net revenue (i.e., total payments minus drug acquisition costs) that a typical oncology practice would receive under the new payment system from a participating payer would be no less than the aggregate amount of net revenue that the practice would have received from that payer under the current payment system.
- The total spending by Medicare (or other payer) on oncology care for an oncology practice's patients, considering both what is paid to the oncology practice and what is paid for other costs of oncology care to the practice's patients (e.g., laboratory testing, imaging, emergency room visits, hospitalizations, parenteral drugs, oral drugs, etc.), is no greater than it would otherwise be if the current payment system had continued.

As noted in Section II, it is important to recognize that the total net revenue an *oncology practice* receives under Consolidated Payments for Oncology Care could be *greater* than under the current system, at the same time that *total spending on oncology care* by Medicare and other payers is *lower* than under the current system. This is because the net revenue to the oncology practice represents only a small proportion of the total spending on oncology care for its patients. For example, analyses of Medicare spending on oncology patients indicate that the payments to an oncology practice for E&M visits and chemotherapy administration represent less than 10% of total spending on the patients; most of the spending goes to pay for the costs of drugs, imaging, and hospitalizations. If use of pathways and better symptom management could reduce the remaining spending by 3%, one could increase the net revenues to the oncology practice by 10% and still reduce total spending by 2%.

As was also noted in Section II, it is important to recognize that the total payment that an oncology practice receives for any *individual patient* under Consolidated Payments for Oncology Care would inherently differ from what it would have received under the current payment system, since the new payment system is designed to better match payments to the real differences in time and costs for an oncology practice in caring for different patients. The payment levels would be set such that the

total amount of the payments averaged across all of a practice's patients would be similar to what they are today during the initial year of implementation. However, over time, oncology practices would be expected to redesign care in the most patient-centered way without the fear that revenues would decline under the less flexible payment system used today.

A 4-step process should be used to set initial payment levels that achieve these goals:

- 1. Use Oncologists' Experience/Expertise to Develop Initial Estimates for Payment Levels.** Since the new payment categories are intended to support services that are currently not paid for and therefore are either not being delivered or are being delivered but not measured, the appropriate magnitude of the payment categories cannot be determined by looking at current payments. Oncology practices need to determine how much time and cost they are spending today in each of the phases of care covered by the payment categories and how much they would spend under Consolidated Payments for Oncology Care to determine the appropriate magnitudes for each of these categories. A "starting hypothesis" for the relative magnitudes of the payments is included in Section II-C; this was developed using input from oncologists about the relative amounts of time and effort they currently provide during the four stages of patient care envisioned in the payment model (i.e., new patients, treatment months, active monitoring months, and transitions of treatment). These relative values need to be converted into dollar values of payment using a "conversion factor" for each payer that would result in revenues to a typical practice that would be at least as large as the practice receives today.
- 2. Refine the Estimates Through Modeling on Oncology Practice Data.** A diverse group of oncology practices should be asked to use their patient data to calculate their payments under Consolidated Payments for Oncology Care (CPOC) using the "starting hypothesis" payment levels. Those practices with access to claims data for other services, such as lab tests, imaging, ER visits, etc. could help with the aspects of CPOC dependent on those costs, and those practices that are currently collecting and reporting oncology quality measures could help with those aspects of the model. The practices participating in this analysis would calculate the difference between the current practice net revenues and the revenues under CPOC, and would also determine the sources of the variance (i.e., which patients and which aspects of care represent the major sources of the variance.) Based on these analyses, revisions would be made to the payment levels to reduce the variance between current revenues and the revenues that would be generated under CPOC and to reduce any disparities in total payments for particular types of patients that would not be compatible with better care (e.g., situations when the new payment amount would be lower than the current payment amount for a patient who would be felt to need significantly more time or services than what is currently being paid for). To the extent that a practice believes that some of its costs could be reduced for types of patients where variances exist if CPOC were in place, then those variances could be ignored or given lower weight than variances in areas where costs would be expected to increase.
- 3. Model the Impacts of Draft Payment Levels on Medicare Spending.** The revised payment levels and category definitions would then be applied to a sample of Medicare claims to

estimate the costs or savings for Medicare associated with implementation of Consolidated Payments for Oncology Care and to determine the sources of the variance.

4. **Model the Impacts of Draft Payment Levels on Commercial Spending.** Similar analyses should be done using commercial claims data to estimate the impact on commercial insurers. Since most oncology practices receive payments from multiple commercial health plans, each of which pays using different amounts and even different rules, these analyses need to be performed using multi-payer data. A growing number of communities across the country have multi-payer commercial databases that could be used for this purpose, and many have been designated as “Qualified Entities” and are now receiving Medicare claims data that would enable truly all-payer analyses to be conducted.
5. **Revise the Payment Levels (and the Payment Category Definitions if Necessary).** Based on the analyses in steps 2-4, the payment levels and potentially the category definitions would be revised and the analyses should be redone until it is felt that the best possible progress in achieving the three goals described at the beginning of this section has been achieved with the information that can reasonably be assembled.

Once the initial payment levels are established, they will need to be updated regularly, both to ensure they keep up with increases in costs resulting from general economic inflation and to ensure they reflect changes in best practices for oncology care. At a minimum, Medicare payment amounts should be adjusted annually based on the Medicare Economic Index.

B. Principles and Options for Implementation of CPOC

Although there are significant advantages to Consolidated Payments for Oncology Care for oncology practices, for patients, and for payers, a considerable amount of time and effort will be needed for both oncology practices and payers to make the transition from the current fee-for-service structure to the new payment system. Oncology practices will want to significantly redesign the way they deliver care in response to the new flexibility and accountability they will have under CPOC; they will also need to redesign their billing and documentation systems to support the new payment system. Moreover, as defined in previous sections, each of the accountability elements of the payment model will need to be phased in as the measures and pathways that support those elements are developed and refined. Smaller oncology practices will likely need more time and support than large practices. Adaptations to the unique characteristics of local healthcare markets will also likely be needed; for example, oncology practices in regions where the majority of payers are willing to implement CPOC will likely be able to transition more quickly than practices where only one payer is willing to do so.

For all of these reasons, a multi-year transition process will be needed.

1. Guiding Principles for the Transition Process

The following principles should guide the transition process:

- The transition process should be designed to encourage as many oncology practices as possible to begin using CPOC for at least a subset of their patients.
- The transition process should give oncology practices the flexibility to implement CPOC only for specific types of cancer if they wish, or to implement CPOC across all or most of their patients if they choose to do so.
- Oncology practices that make the commitment to implement CPOC should have the ability to continue in CPOC indefinitely or until such time that there is clear evidence that it needs to be terminated or fundamentally changed in some way. CPOC should not be implemented on a “demonstration” basis with an arbitrary ending date because of the uncertainty and potential loss of investment this would cause for physicians and the disruption this could cause for patients.
- The timing of the phases for implementation of the accountability elements of CPOC should be adjusted based on the speed at which value-based pathways and reliable measures of quality and avoidable utilization are developed.
- Adjustments to timetables and the details of CPOC should be made through a collaborative effort of oncology practices and payers.

2. Options for Oncology Practices to Help Them Transition

Oncology practices should have at least two different options for how they could transition from the current fee-for-service system to Consolidated Payments for Oncology Care.

Option 1: Phase in Consolidated Payments for Oncology Care by Type of Cancer

Oncology practices that wish to begin implementing CPOC for specific types of cancer should have the ability to do so. For example, a practice might choose to use CPOC for patients receiving adjuvant therapy first, while continuing to receive payment for other kinds of patients using the current system of E&M codes, drug administration codes, and payment for drugs.

This cancer-by-cancer approach would be consistent with the reality that there are differences in the availability of pathways and quality measures for different types of cancer, and also that the patient mix or resources available to a particular practice may be more conducive to focusing on one or a few types of cancer initially before attempting to implement care changes and payment changes across a broader range of patients.

The disadvantage of implementing CPOC only for a subset of cancers is that many practices may feel that it is very difficult to fundamentally change the way they deliver care if they are only being paid under the new payment model for a subset of patients. For example, if a practice is paid for office visits with physicians for some patients, but on a more flexible basis for other patients, it will be difficult for it to justify investing in better phone systems, hiring non-physician patient education

and support staff, etc. since only a small proportion of its revenues would have the necessary flexibility.

Option 2: Implement CPOC for All Patients, But with Risk Corridors

Oncology practices that wish to implement CPOC for all patients should also have the ability to do so. However, because using CPOC for all patients would represent a significant change for a practice and also significant uncertainty during the initial years when data are limited and the accountability components of CPOC are still evolving, oncology practices that want to implement CPOC for all patients should have the ability to be protected against large swings in revenue for practices during the initial implementation years. Similarly, payers may be concerned about whether their spending would increase under CPOC and would want to limit any unexpectedly large increases in payment. Both the practice and the payer could be protected as follows:

- If the practice and payer calculate or estimate that, under the previous payment system, the practice would have received total payments in a calendar quarter that would have been a certain percentage (say, 3%) more than it receives under CPOC, it would then receive a supplemental payment from the payer equal to the amount of the difference above that predefined percentage (i.e., its loss relative to the previous payment system would be capped at the predefined percentage, e.g., 3%). If it is estimated that the practice would have received total payments under the previous system that would have been lower by at least the predefined percentage, then its payments under CPOC would be reduced to limit the practice's total increase in revenue due to the new payment system to the fixed percentage (e.g., 3%). These symmetrical adjustments would help maintain budget neutrality for the payer.
- In subsequent years, the percentage limits on how much revenue could differ for practices participating in CPOC would be increased, until a point when all practices would operate under Consolidated Payments for Oncology Care with no adjustments based on the previous system.

The calculations as to what would a practice would have received under the previous system could be carried out in one of two ways:

- One way would be for the practice to continue recording CPT codes for patients as it would have under the previous system, in addition to billing new monthly codes under CPOC. The practice may, as a practical matter, be doing that anyway for other patients if it is still receiving payment from some payers under the traditional payment system
- A second way would be for the payer and practice to estimate how much would likely have been paid for similar patients under the previous system. This method is less precise, but it would not require the practice to maintain the equivalent of parallel billing systems for patients.

C. Helping Oncology Practices Implement CPOC

Participation by Medicare will be critical to success in implementing CPOC. However, because it will be difficult for oncology practices to restructure their operations for one payer, even a payer as large as Medicare, commercial payers should also be encouraged to participate, particularly large national payers.

An assessment should be made of the types of HIT tools that will be needed to support successful implementation of CPOC. Many of the tools will be similar to those being pursued by primary care medical homes and accountable care organizations, but it will be important to ensure the specific needs of oncology practices are addressed because of the unique issues of coding, pathway compliance, and quality reporting they will face.

Assistance should be available to oncology practices in accurately coding under CPOC and ensuring that Medicare and other payers implement CPOC appropriately, particularly in terms of adjudicating compliance with pathways.

D. Transitioning to Episode-Based Payment Models

Although Consolidated Payments for Oncology Care would provide significantly greater flexibility for oncology practices and significantly more accountability for quality and cost than exist under the current fee-for-service system, some payers and oncology practices are going further, by developing and using “case rates,” “episode payment models” or “condition-based payment models” that provide even more flexibility and accountability for the physician practice than CPOC, as well as greater opportunity for physicians to share in savings from significantly redesigning and improving treatment.

There are many variations in how a case rate, episode payment, or condition-based payment model can be defined, but the basic concept would be to have a single payment for a patient for a fixed period of time (longer than the single month defined in CPOC), a single payment for a full line of therapy, or even a single payment for all treatment of a patient’s condition. Since the time and costs involved in a patient’s care will legitimately vary based on the type of cancer the patient has, the patient’s comorbidities, etc. the size of an episode payment or condition-based payment would need to be risk-adjusted or severity-adjusted in some fashion based on these factors.

Consolidated Payments for Oncology Care could serve as a helpful transitional step toward these episode or condition-based payment models for payers and practices that wish to use them. The monthly payments in CPOC would define the appropriate amount of payment needed in each month for the time and costs that an oncology practice incurs to deliver high-quality patient care (including services that are not currently reimbursed under fee-for-service). An episode or condition-based payment could then be constructed by combining these monthly amounts over the time period that is to be covered by the episode payment. The differences in the number of months of payments and the levels of payments that are made for patients with different types and stages of cancer could be used to determine how to adjust the episode payment amounts by type and stage of cancer.

In addition, if an episode payment is only intended to cover a portion of the patient’s care, CPOC could be used for the remaining portions of care. For example, if an episode payment is intended to cover just the treatment phase of care, the practice could continue to receive the New Patient

Payment and the Active Monitoring Month Payments, but the Treatment Month Payments and potentially the Transition-of-Treatment Payments could be replaced by the new Episode Payment.

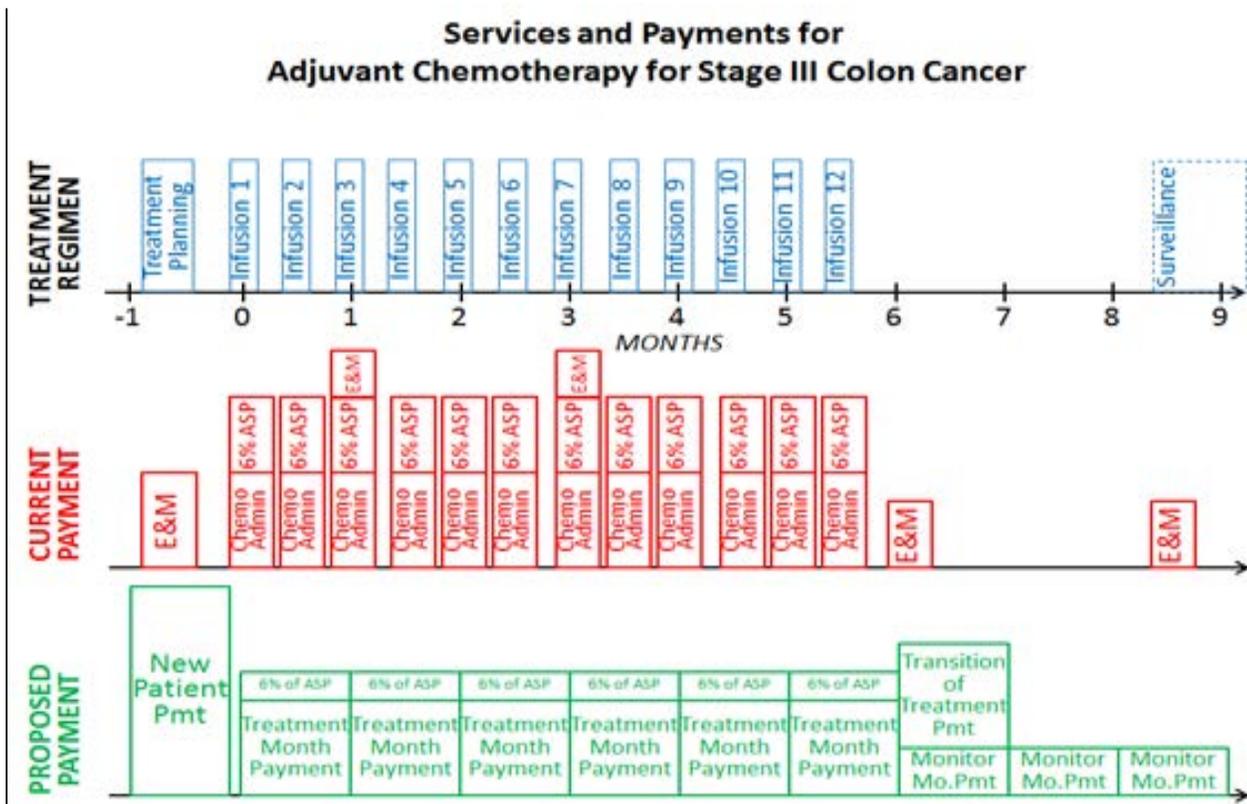
The adjustments for quality, use of pathways, etc. that are defined for CPOC could be applied to the Episode Payment, although it would be necessary to separate out any costs that would be directly included in the episode payment. For example, if drug costs or emergency room visits were bundled into the episode payment, then there would be no need for separate adjustments for those factors, but the adjustments for quality and other costs could still be made.

APPENDIX: HOW PAYMENT WOULD WORK IN SPECIFIC CASES

This Appendix contains detailed illustrations of how Consolidated Payments for Oncology Care would compare to the current payment system for particular types of patients.

A. Adjuvant Chemotherapy for Stage III Colon Cancer (FOLFOX VI)

- (Up to) 12 cycles of treatment, each cycle consisting of 2 days of:
 - Leucovorin IV
 - Oxaliplatin IV
 - 5FU IV Push
 - 5 FU IV Pump
 - Antiemetics (Oral or IV)
- Surveillance following completion of treatment



Month	Day	Services to Patient	Current Payments	Proposed Payments
*	*	Initial Patient Visit with Physician	<ul style="list-style-type: none"> New Patient E&M 	<ul style="list-style-type: none"> New Patient Payment
*	*	Follow-up Patient Visit with Physician	<ul style="list-style-type: none"> Established Patient E&M 	
*	*	Patient Calls and Education with Practice Staff	<i>No Payment</i>	
1	1	Cycle 1/Day 1: Leucovorin IV Oxaliplatin IV 5FU IV Push 5 FU IV Pump Antiemetics (Oral or IV)	<ul style="list-style-type: none"> Chemotherapy Administration Therapeutic Injections & Infusions Hydration Services ASP +6% for Infused Drugs Established Patient E&M (if greater than Level 1) 	<ul style="list-style-type: none"> Treatment Month 1 Payment (Level 1-4 TBD) Payment for drugs purchased and infused in the office
1	2	Cycle 1/Day 2: Antiemetics Leucovorin IV Oxaliplatin IV 5FU IV Push 5 FU IV Pump Antiemetics (Oral or IV)	<ul style="list-style-type: none"> Chemotherapy Administration Therapeutic Injections & Infusions Hydration Services ASP +6% for Infused Drugs Established Patient E&M (if greater than Level 1) 	
1	3	Cycle 1/Day 3 Disconnect Pump	<ul style="list-style-type: none"> Established Patient E&M 	
1	**	Phone Contacts with Patient or Visits with Nurses or Other Staff	<i>No Payment</i>	
1	**	Physician Visit if Necessary	<ul style="list-style-type: none"> Established Patient E&M 	

Month	Day	Services to Patient	Current Payments	Proposed Payments
1	15	Cycle 2/Day 1: Leucovorin IV Oxaliplatin IV 5FU IV Push 5 FU IV Pump Antiemetics (Oral or IV)	<ul style="list-style-type: none"> • Chemotherapy Administration • Therapeutic Injections & Infusions • Hydration Services • ASP +6% for Infused Drugs • Established Patient E&M (if greater than Level 1) 	
1	16	Cycle 2/Day 2: Leucovorin IV Oxaliplatin IV 5FU IV Push 5 FU IV Pump Antiemetics (Oral or IV)	<ul style="list-style-type: none"> • Chemotherapy Administration • Therapeutic Injections & Infusions • Hydration Services • ASP +6% for Infused Drugs • Established Patient E&M (if greater than Level 1) 	
1	17	Cycle 2/Day 3 Disconnect Pump	<ul style="list-style-type: none"> • Established Patient E&M 	
1	**	Phone Contacts with Patient or Visits with Nurses or Other Staff	<i>No Payment</i>	
1	**	Physician Visit if Necessary	<ul style="list-style-type: none"> • Established Patient E&M 	
2	1-3	Cycle 3/Days 1-3	Same as Other Cycles	<ul style="list-style-type: none"> • Treatment Month 2 Payment • Payment for drugs purchased and infused in the office
2	15-17	Cycle 4/Days 1-3	Same as Other Cycles	
2	**	Phone Contacts with Patient or Visits with Nurses or Other Staff	<i>No Payment</i>	
2	**	Physician Visit if Necessary	<ul style="list-style-type: none"> • Established Patient E&M 	

Month	Day	Services to Patient	Current Payments	Proposed Payments
3	1-3	Cycle 5/Days 1-3	Same as Other Cycles	<ul style="list-style-type: none"> • Treatment Month 3 Payment • Payment for drugs purchased and infused in the office
3	15-17	Cycle 6/Days 1-3	Same as Other Cycles	
3	**	Phone Contacts with Patient or Visits with Nurses or Other Staff	<i>No Payment</i>	
3	**	Physician Visit if Necessary	<ul style="list-style-type: none"> • Established Patient E&M 	
4	1-3	Cycle 7/Days 1-3	Same as Other Cycles	<ul style="list-style-type: none"> • Treatment Month 4 Payment • Payment for drugs purchased and infused in the office
4	15-17	Cycle 8/Days 1-3	Same as Other Cycles	
4	**	Phone Contacts with Patient or Visits with Nurses or Other Staff	<i>No Payment</i>	
4	**	Physician Visit if Necessary	<ul style="list-style-type: none"> • Established Patient E&M 	
5	1-3	Cycle 9/Days 1-3	Same as Other Cycles	<ul style="list-style-type: none"> • Treatment Month 5 Payment • Payment for drugs purchased and infused in the office
5	15-17	Cycle 10/Days 1-3	Same as Other Cycles	
5	**	Phone Contacts with Patient or Visits with Nurses or Other Staff	<i>No Payment</i>	
5	**	Physician Visit if Necessary	<ul style="list-style-type: none"> • Established Patient E&M 	
6	1-3	Cycle 11/Days 1-3	Same as Other Cycles	<ul style="list-style-type: none"> • Treatment Month 6 Payment • Payment for drugs
6	15-	Cycle 12/Days 1-3	Same as Other Cycles	

Month	Day	Services to Patient	Current Payments	Proposed Payments
	17			purchased and infused in the office
6	**	Phone Contacts with Patient or Visits with Nurses or Other Staff	<i>No Payment</i>	
6	**	Physician Visit if Necessary	<ul style="list-style-type: none"> Established Patient E&M 	
7	**	Physician Visit to Discuss Results of Treatment and Ongoing Surveillance	<ul style="list-style-type: none"> Established Patient E&M 	<ul style="list-style-type: none"> Transition-of-Treatment Payment
7	**	Phone Contacts with Patient	<i>No Payment</i>	
8	**	Phone Contacts with Patient or Visits with Nurses or Other Staff	<i>No Payment</i>	<ul style="list-style-type: none"> Active Monitoring Month Payment
8	**	Physician Visit if Necessary	<ul style="list-style-type: none"> Established Patient E&M 	
9	**	Physician Visit and Review of CEA	<ul style="list-style-type: none"> Established Patient E&M 	<ul style="list-style-type: none"> Active Monitoring Month Payment
10	**	Phone Contacts with Patient or Visits with Nurses or Other Staff	<i>No Payment</i>	<ul style="list-style-type: none"> Active Monitoring Month Payment
10	**	Physician Visit if Necessary	<ul style="list-style-type: none"> Established Patient E&M 	
11	**	Phone Contacts with Patient or Visits with Nurses or Other Staff	<i>No Payment</i>	<ul style="list-style-type: none"> Active Monitoring Month Payment
11	**	Physician Visit if Necessary	<ul style="list-style-type: none"> Established Patient E&M 	

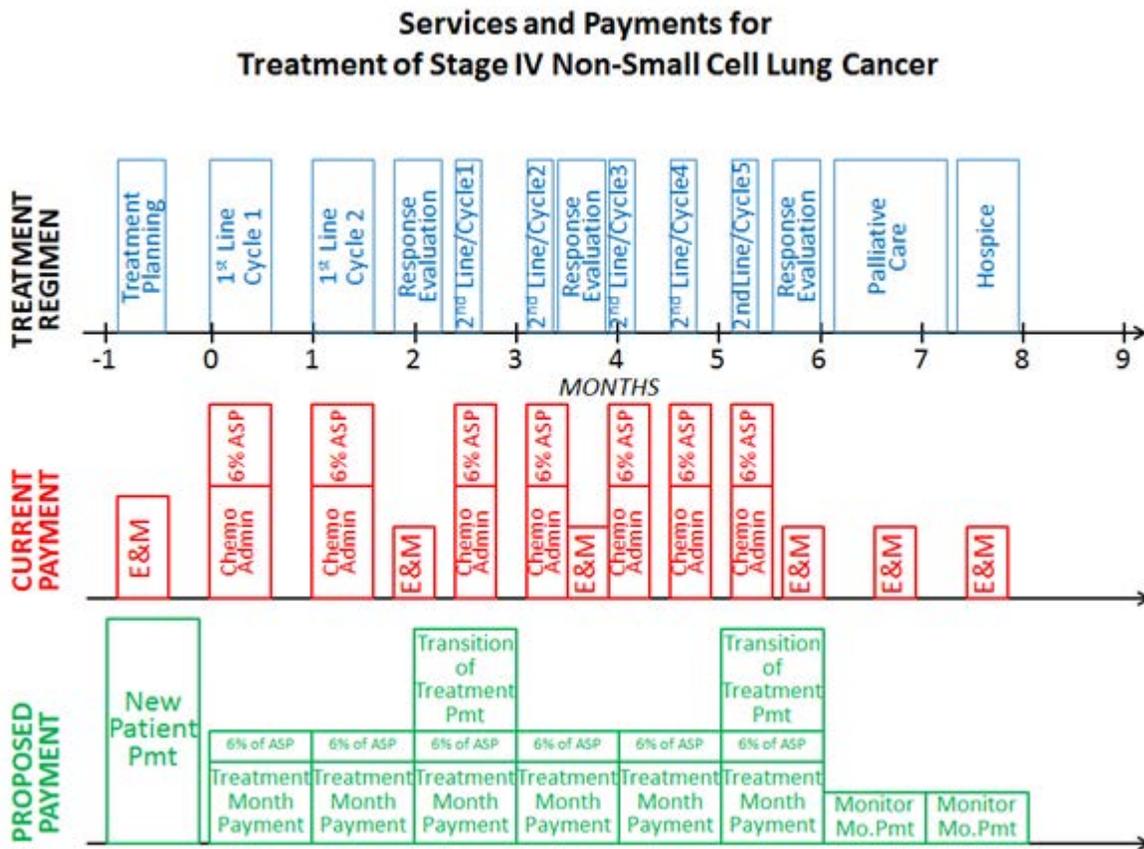
Month	Day	Services to Patient	Current Payments	Proposed Payments
12	**	Physician Visit and Review of CEA	<ul style="list-style-type: none"> • Established Patient E&M 	<ul style="list-style-type: none"> • Active Monitoring Month Payment

* Initial patient visits and contacts may occur an undefined number of months or days prior to the initiation of treatment

** Phone contacts, office visits with nurses, and office visits with physicians may occur unpredictably during the course of the month depending on patient questions, side effects, etc.

B. Treatment for Stage IV (Metastatic) Non-Small Cell Lung Cancer

- First Line Therapy, Two 28-Day Cycles, No Tumor Response
 - Cisplatin IV (1 day)
 - Gemcitabine IV (3 days)
 - Antiemetics (Oral or IV)
- Second Line Therapy, Five 21-Day Cycles Before Tumor Progression
 - Docetaxel IV (1 day)
- Transition to Palliative Care and Hospice



Month	Day	Services to Patient	Current Payments	Proposed Payments
*	*	Initial Patient Visit with Physician	<ul style="list-style-type: none"> New Patient E&M 	<ul style="list-style-type: none"> New Patient Payment
*	*	Follow-up Patient Visit with Physician	<ul style="list-style-type: none"> Established Patient E&M 	
*	*	Patient Calls and Education with Practice Staff	<i>No Payment</i>	
1	1	1 st Line/Cycle 1/Day 1: Cisplatin IV Gemcitabine IV Antiemetics (Oral or IV)	<ul style="list-style-type: none"> Chemotherapy Administration Therapeutic Injections & Infusions Hydration Services ASP +6% for Infused Drugs Established Patient E&M (if greater than Level 1) 	<ul style="list-style-type: none"> Treatment Month 1 Payment (Level TBD) Payment for drugs purchased and infused in the office
1	8	1 st Line/Cycle 1/Day 8: Gemcitabine IV	<ul style="list-style-type: none"> Chemotherapy Administration Therapeutic Injections & Infusions Hydration Services ASP +6% for Infused Drugs Established Patient E&M (if greater than Level 1) 	
1	15	1 st Line/Cycle 1/Day 15: Gemcitabine IV	<ul style="list-style-type: none"> Chemotherapy Administration Therapeutic Injections & Infusions Hydration Services ASP +6% for Infused Drugs Established Patient E&M (if greater than Level 1) 	

Month	Day	Services to Patient	Current Payments	Proposed Payments
1	**	Phone Contacts with Patient or Visits with Nurses or Other Staff	<i>No Payment</i>	
1	**	Physician Visit if Necessary	<ul style="list-style-type: none"> Established Patient E&M 	
2	1	1 st Line/Cycle 2/Day 1: Cisplatin IV Gemcitabine IV Antiemetics (Oral or IV)	<ul style="list-style-type: none"> Same as Previous Cycle 	<ul style="list-style-type: none"> Treatment Month 2 Payment (Level TBD) Payment for drugs purchased and infused in the office
2	8	1 st Line/Cycle 2/Day 8: Gemcitabine IV	<ul style="list-style-type: none"> Same as Previous Cycle 	
2	15	1 st Line/Cycle 2/Day 15: Gemcitabine IV	<ul style="list-style-type: none"> Same as Previous Cycle 	
2	**	Phone Contacts with Patient or Visits with Nurses or Other Staff	<i>No Payment</i>	
2	**	Physician Visit if Necessary	<ul style="list-style-type: none"> Established Patient E&M 	
3	6	Scan for Tumor Response	<ul style="list-style-type: none"> Imaging Payment 	<ul style="list-style-type: none"> Imaging Payment
3	8	Physician Visit to Discuss Lack of Tumor Response and Decision Whether to Begin Second Line Therapy	<ul style="list-style-type: none"> Established Patient E&M 	<ul style="list-style-type: none"> Transition-of-Treatment Payment
3	8	2 nd Line/Cycle 1 Docetaxel IV	<ul style="list-style-type: none"> Chemotherapy Administration Therapeutic Injections & Infusions Hydration Services ASP +6% for Infused Drugs Established Patient E&M (if greater 	<ul style="list-style-type: none"> Treatment Month 3 Payment Payment for drugs purchased and infused in the office

Month	Day	Services to Patient	Current Payments	Proposed Payments
			than Level 1)	
4	1	2 nd Line/Cycle 2 Docetaxel IV	<ul style="list-style-type: none"> • Same as Previous Cycle 	<ul style="list-style-type: none"> • Treatment Month 4 Payment • Payment for drugs purchased and infused in the office • Imaging Fees
4	19	Scan	<ul style="list-style-type: none"> • Imaging Fees 	
4	21	2 nd Line/Cycle 3 Docetaxel IV	<ul style="list-style-type: none"> • Same as Previous Cycle 	
5	14	2 nd Line/Cycle 4 Docetaxel IV	<ul style="list-style-type: none"> • Same as Previous Cycle 	<ul style="list-style-type: none"> • Treatment Month 5 Payment • Payment for drugs purchased and infused in the office
6	8	2 nd Line/Cycle 5 Docetaxel IV	<ul style="list-style-type: none"> • Same as Previous Cycle 	<ul style="list-style-type: none"> • Treatment Month 6 Payment • Payment for drugs purchased and infused in the office
6	19	Scan	<ul style="list-style-type: none"> • Imaging Fees 	<ul style="list-style-type: none"> • Imaging Fees
6	21	Physician Visit to Discuss Lack of Tumor Response and Decision to Begin Palliative Care	<ul style="list-style-type: none"> • Established Patient E&M 	<ul style="list-style-type: none"> • Transition-of-Treatment Payment
7	**	Phone Contacts with Patient or Visits with Nurses or Other Staff	<i>No Payment</i>	<ul style="list-style-type: none"> • Active Monitoring Month Payment
7	**	Physician Visit if Necessary	<ul style="list-style-type: none"> • Established Patient E&M 	

Month	Day	Services to Patient	Current Payments	Proposed Payments
8	**	Phone Contacts with Patient or Visits with Nurses or Other Staff	•	• Active Monitoring Month Payment
8	**	Physician Visit if Necessary	• Established Patient E&M	
8		Patient Dies		

* Initial patient visits and contacts may occur an undefined number of days or months prior to the initiation of treatment

** Phone contacts, office visits with nurses, and office visits with physicians may occur unpredictably during the course of the month depending on patient questions, side effects, etc.