

## Policy Statement on Site-Neutral Payments in Oncology

American Society of Clinical Oncology

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### INTRODUCTION

The phrase site neutrality is commonly used to describe efforts to reconcile payment differentials for the same or similar health care services provided in different settings of care. Under the fee-for-service Medicare program, the two dominant payment systems for oncology services—the Medicare physician fee schedule and the hospital outpatient prospective payment system—are based on different rate-setting methodologies. The differences in these rate-setting methodologies can result in different payment levels for similar or identical health care services.

In response to these differences in payment levels, some stakeholders and policymakers—including the Medicare Payment Advisory Commission (MedPAC), members of Congress, and the Centers for Medicare and Medicaid Services (CMS)—have proposed but not implemented various options for establishing site neutrality.<sup>1-3</sup> These site-neutrality proposals are focused on reducing Medicare payment levels in one setting of care without examining whether such modified payments would adequately meet the needs of Medicare beneficiaries with cancer in that setting. Furthermore, these site-neutrality proposals are based on the existing, outdated coding and reimbursement system, without accounting for the potential adverse impacts on the ongoing efforts to fundamentally reform the oncology delivery system or the overarching trend toward value-based payment models in all settings of care. Policymakers should focus comprehensively on how best to reform oncology policy to support the full scope of oncology services that patients with cancer require rather than jeopardizing patient outcomes by reducing the resources available for patient care on the basis of site neutrality or other narrow analyses.

This policy statement is divided into the following sections:

- Focus of site neutrality on flawed comparisons;
- Moving to a patient-centered approach for oncology coding and reimbursement;

- Transformative oncology models of care that support quality, value, and cost effectiveness;
- Addressing disparities in oncology care; and
- Recommendations.

### SITE NEUTRALITY FOCUSES ON FLAWED COMPARISONS

There is no logical basis for concluding that the reimbursement levels developed for oncology services under either of the two dominant Medicare reimbursement methodologies for outpatient oncology services should be substituted for reimbursement levels established under the other methodology. As a threshold issue, these two Medicare payment systems are based on different data sets for rate setting.

In the physician office setting, there is a complex process for establishing relative value units based on survey data and estimates of the amount of resources required to deliver each service based on the definition of the existing code. In contrast, in the hospital outpatient setting, CMS relies on charge data submitted to Medicare by hospitals. CMS uses an evolving series of assumptions and calculations developed over the years to estimate the amount to attribute to each service.

The differences between the two rate-setting methodologies are further exacerbated by additional factors. For example, the final Medicare payment levels established in both settings of care are influenced significantly by separate conversion factors established by CMS under rules that are unique to each setting of care. The conversion factors for the physician office and hospital outpatient settings are established in different ways that have little relationship to each other or to the actual cost of providing oncology care to Medicare beneficiaries. These conversion factors are based on the aggregate amount of Medicare funding allocated for each setting of care for a particular year.

Given these variables and challenges, there is no reasonable rationale for concluding that reductions are warranted in the payment levels for

either setting of care on the basis of payment levels established for the other setting.

### MOVING TO PATIENT-CENTERED APPROACH FOR ONCOLOGY CODING AND REIMBURSEMENT

The traditional codes used for outpatient oncology care are outdated, emphasizing face-to-face office visits with clinicians and the intravenous administration of anticancer drug regimens. Unfortunately, current Medicare codes and payment levels are inadequate to describe and support the complete scope of oncology services that are necessary to provide patients with cancer with the high-quality, high-value oncology care.

Although some ancillary services are separately recognized and paid in the existing coding systems (eg, some services provided by psychiatrists, physical therapists, and other health care professionals), the following list describes the services that are critically important to patients with cancer but are not adequately reflected under the existing codes and Medicare payment rates.

*Treatment planning, patient education, patient counseling, and coordination of care.* Oncologists and other oncology professionals spend extensive, uncompensated time developing treatment plans, performing patient education and counseling, and providing coordinated, patient-centered care.

*Social workers, psychologists, and other mental health workers.* A cancer diagnosis may prompt the need for mental health treatments, and mental health professionals on the oncology team provide patients with assistance in treatment planning and end-of-life decision making.

*Quality and value improvement and coordination.* An increasingly important aspect of modern oncology care requires labor-intensive activities that integrate and coordinate initiatives to promote high-quality, high-value care, including the use of continuous quality improvement tools and data, adherence to evidence-based pathways and guidelines, and participation in specialty-specific quality measurement activities.

*Patient navigators and triage nurses.* Patient navigators and triage nurses assist in care coordination, often working with multiple providers across diverse treatment settings. For example, these professionals can assess and manage patients with cancer receiving acute therapy and cancer-related issues at home, resulting in improved patient care and substantial cost savings by avoiding complications, emergency department visits, and unscheduled hospital admissions.

*Genetic counselors.* A genetic counselor provides patients with information about their cancer risk based on their genetic profile.

*Nutrition counselors and dietitians.* Patients need proper nutrition to achieve the best possible outcomes from their chemotherapy treatments, because poor nutrition can lead to increased mortality risk and poorer chemotherapy response.

*Financial counselors.* Individuals with cancer rely on professionals to help them understand and cope with the adverse financial impacts of their cancer treatment, sometimes referred to as the financial toxicity of cancer treatment.

*Community outreach.* In serving patients with cancer, meeting the needs of the local population requires ongoing needs assessments to identify and address barriers to oncology care, particularly in communities with significant socioeconomic challenges.

*Spiritual and emotional support for patients.* Spiritual and emotional support for patients with cancer as they progress through the treatment process is an essential and labor-intensive aspect of cancer care.

The lack of recognition of these essential services in the traditional coding and reimbursement systems used by Medicare and Medicaid in both the physician practice and hospital outpatient settings creates significant barriers to these important services for many individuals with cancer.<sup>4</sup>

### TRANSFORMATIVE ONCOLOGY MODELS OF CARE SUPPORTING QUALITY, VALUE, AND COST EFFECTIVENESS

Numerous stakeholders are collaborating on initiatives to improve care for patients with cancer and overall cost effectiveness by replacing the traditional coding and reimbursement policies for oncology. Initiatives developed by the American Society of Clinical Oncology (ASCO), the CMS Innovation Center, and other stakeholders are designed to transform the outdated coding and reimbursement system for oncology care by establishing bundled payments that include coverage and adequate reimbursement for the critical services that are unrecognized, uncompensated, or undercompensated under the traditional system.<sup>5,6</sup>

These transformative models rely on the delivery of an expanded set of professional services that promote efficiencies and reduce the odds of avoidable adverse outcomes, such as unplanned hospitalizations and unplanned emergency department visits. By providing adequate resources to oncology practices for the full scope of medically necessary services, these new models take a patient-centered approach to promoting value and improving patient outcomes in oncology care, with the promise of achieving lower aggregate expenditures under Medicare.

As a number of initiatives in the private sector have demonstrated, the financial savings that can be achieved by transforming the oncology delivery model are significant, perhaps dwarfing any savings derived from traditional site-neutrality initiatives.<sup>7,8</sup> In contrast, cutting existing reimbursement levels under site-neutrality rationales would exacerbate the underpayment by Medicare for the full scope of services that patients with cancer require, complicating ongoing efforts to transform the delivery of oncology care.

### ADDRESSING DISPARITIES IN ONCOLOGY CARE

The clinical and financial challenges faced by physician practices and hospitals treating individuals with cancer are exacerbated in low-income communities.<sup>9-11</sup> Reductions in reimbursement for providers serving low-income communities can present special challenges to the patients they serve. Commissioners of MedPAC recognized this concern in 2012, concluding that a MedPAC recommendation to reduce payment levels based on site neutrality might create barriers to health care services that did not previously exist for low-income patients.<sup>12</sup>

Serving low-income communities is more resource intensive because the primary needs of patients with cancer in these low-income communities are often extensive. Given the challenges

facing the professionals serving low-income individuals, it is imperative for Medicare and other insurers to provide adequate resources to cover the full scope of medical and ancillary services required to treat these individuals.

## RECOMMENDATIONS

The traditional approach to site neutrality under Medicare is flawed, reflecting a narrow and outdated view of the needs of individuals with cancer and the best options for delivering efficient, high-value care. Furthermore, it is not consistent with the broad movement in medicine toward value-based reimbursement for all care—regardless of setting. Instead of focusing on differences in payment levels under the existing codes and payment methodologies, policymakers and stakeholders should focus on a more nuanced approach that embraces modern views on delivering high-quality, high-value cancer care. To this end, ASCO recommends the following:

**Recommendation 1.** The existence of differences in reimbursement rates under the two dominant outpatient payment methodologies of Medicare does not provide a valid rationale for lowering payment levels in either setting of care. Reductions in payment levels for oncology care threaten to exacerbate the inadequacy of Medicare reimbursement policies to support the full scope of services that patients with cancer require. Policymakers should focus on creating

value-based incentives that raise quality and lower cost rather than arbitrarily cutting payment levels based on the site of care.

**Recommendation 2.** In many instances, the Medicare physician fee schedule results in lower payment levels for oncology services with similar code descriptions compared with the Medicare hospital outpatient prospective payment system. Physician practices provide essential access points to oncology care throughout the United States. Policymakers should ensure that payment levels for physician practices provide adequate support for the full scope of medical and ancillary services required to treat individuals with cancer.

**Recommendation 3.** Reductions in payment levels can be expected to exacerbate disparities in cancer care. Policymakers should engage in additional study of the full scope of services required by patients with cancer, including the specific needs of low-income individuals, before implementing any change in resources paid to oncology practices and hospitals.

**Recommendation 4.** Changes in reimbursement levels for oncology care should be based on a patient-centric approach that ensures adequate reimbursement—regardless of the setting of care—to support the full scope of medical and ancillary services required to provide Medicare beneficiaries with cancer with high-quality, high-value care. Policymakers should transform Medicare coding and payment for outpatient cancer care by implementing policies that are consistent with proposals such as the ASCO patient-centered oncology payment proposal and the CMS design for an oncology-focused model of care.

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