Oncology Payment Reform Legislation
Released by Representatives Cathy McMorris Rodgers (R-WA) and Steve Israel (D-NY)

Cancer Care Payment Reform Act (H.R. 1934)

According to the National Institutes of Health (NIH), by 2020 medical expenditures on cancer care are projected to reach $158 billion. However, researchers at the National Cancer Institute say that spending on cancer in 2020 could be as high as $207 billion, depending on the cost of new therapies and procedures for diagnosing, treating, and monitoring cancer.

During the past several years, community oncologists have developed the oncology medical home (OMH) and have partnered with insurers to pilot novel payment reform systems tied to the OMH concept. The results have been nothing short of remarkable — better patient outcomes and substantial cost savings to insurers and cancer patients. H.R. 1934 builds off of the OMH model, those private insurer payment reform pilots, and the alternative payment model framework in bipartisan Medicare reform. The aim of H.R. 1934 is to modernize the way cancer clinics are reimbursed in order to develop better treatment outcomes and cost efficiency that will benefit both cancer patients and taxpayers.

H.R. 1934 was developed based on input from oncologists and practice administrators actually involved in implementing oncology payment reform, as well as stakeholders representing patients, payers, pharmaceutical and biotechnology companies, and drug distributors. It is intended to provide a framework for enhancing the quality of cancer care based on important identified elements of quality cancer care and also for improving cost efficiencies, without being overly prescriptive to oncology professionals.

Key Components of the Legislation

H.R. 1934 amends title XVIII of the Social Security Act to establish a national OMH demonstration project under the Medicare program to reform the payment system for cancer care in order to enhance the quality of care and to improve cost efficiency.

The 5-year nationwide demonstration project is open to oncology practices billing under Medicare Part B, including both independent and hospital-affiliated community cancer clinics, and is comprised of three phases, as summarized below.

The Government Accountability Office (GAO) will produce a report no later than January 1, 2019. The objective of the GAO report will be to assess the success of the program in enhancing the quality of cancer care and the cost efficiency of care delivered, and to make recommendations on transforming all of Medicare reimbursement for cancer care.

Phase I

- An oncology practice comprised of one or more oncologists billing under Medicare Part B will participate by attesting that the practice will become accredited as an OMH.

- Accreditation will be through an entity that has accreditation specific to oncology including the Commission on Cancer, National Committee for Quality Assurance, or any other entity certified by the Secretary of Health and Human Services (Secretary).

- Participating oncology practices will receive a per-month “care coordination management fee” for each Medicare beneficiary being treated for cancer by the practice. The fee will

be paid during the first year in two increments: at the end of the first six months and at the end of the second six months of Phase I.

- If the practice fails to gain at least contingency OMH accreditation before the end of Phase I, the second six-month fee will not be paid. The fee will be jointly determined by the Secretary and oncologists billing under Medicare Part B.

Phase II

- The practice will continue to receive the same "care coordination management fee" as in Phase 1 but contingent on the practice reporting on at least 10 quality measures, including reporting on patient satisfaction using a survey based on the Consumer Assessment of Healthcare Providers and Systems produced by the Agency for Healthcare Research and Quality, or similar oncology-specific survey recognized by the Secretary.

- The fee will be paid in two six-month installments, as in Phase I; however, failure to report on the required quality measures and patient satisfaction will invalidate the practice from receiving the fee.

- The measures are summarized in the bill; however, the Secretary in conjunction with oncologists billing under Medicare Part B, patient groups, allied health professionals, private health issuers, and pharmaceutical/biotechnology companies that have implemented alternative oncology payment models (collectively "Oncology Experts") can modify or add to the measures.

Phase III

- The demonstration project will move to a shared savings phase whereby oncology practices will share in savings provided that certain threshold measures of quality and patient satisfaction are met.

- The Secretary, in conjunction with Oncology Experts, will determine both the formula for shared savings, which will be based on regional/national benchmarks with all other providers of oncology services (participating in the demonstration project and not; including Medicare Part B providers and others), and minimum threshold levels of quality and patient satisfaction.