A POSSIBLE OPTION MENU

• QUALITY
  ➢ Add palliative care performance measures for public reporting and/or to determine whether a provider qualifies for shared savings or bonus payments
  ➢ Add palliative care performance measures to the Medicare Hospital Value-Based Purchasing Program, the value-based payment modifier under the Medicare physician fee schedule, or other pay-for-performance-type payment programs
• CODING
  ➢ Create one or more new CPT codes describing palliative care services (perhaps service bundles) for payment under Medicare and other payer physician fee schedules
  ➢ Secure separate Medicare payment for the advance care planning codes (CPT 99497-99498)
• AGENCY OUTREACH
  
  ➢ Work with Innovation Center as it implements its Oncology Care Model (Cf bundled payment system and medical home options from the January option menu)
  
  ➢ Continue conversation with CMS about opportunities for integration of palliative care into the ACO delivery model (Cf “Grant waivers to ACOs under the Medicare Shared Savings Program to provide broader coverage of palliative care services (e.g., to ACOs under two-sided shared savings/shared risk models)” from the January options menu)
  
  ➢ Other ideas?
• Potential Areas for Exploration Regarding Education and Training
  ➢ Pay palliative care specialists to coach/assist other physicians in providing basic or primary palliative care services
  ➢ Enhance support for palliative care professional education and training programs
CHARTING A COURSE: KEY QUESTIONS FOR DISCUSSION

• What are the specific services and settings for which better coverage and payment is most needed?

• Who should be paid for those services (e.g., a hospital, physician group practice, home health agency, hospice, and/or some other entity)?

• In the Medicare context, can the services fit under an existing benefit category (e.g., physicians’ services) or must a new or modified benefit category be Congressionally approved?

• Is there enough evidence/rationale to support new “national” or payer-wide policy or would a demonstration project be more defensible (but still an acceptable outcome)?
A POSSIBLE OPTION MENU
(IN NO PARTICULAR ORDER)

• Create one or more new CPT codes describing palliative care services (perhaps service bundles) for payment under Medicare and other payer physician fee schedules

• Develop a new bundled payment system for selected conditions that incorporates palliative care services (Cf. Consolidated Payments for Oncology Care payment system developed by the ASCO Payment Reform Work Group)

• Consider a Palliative Care Medical Home concept, under which physicians would receive a monthly payment for certain patients and perhaps qualify for shared savings or bonus payments

• Grant waivers to ACOs under the Medicare Shared Savings Program to provide broader coverage of palliative care services (e.g., to ACOs under two-sided shared savings/shared risk models)
• Add palliative care performance measures to the Medicare Hospital Value-Based Purchasing Program, the value-based payment modifier under the Medicare physician fee schedule, or other pay-for-performance-type payment programs

• Add a palliative care benefit category to Medicare or modify an existing benefit category (many variations possible)

• Pay palliative care specialists to coach/assist other physicians in providing basic or primary palliative care services

• Secure separate Medicare payment for the advance care planning codes (CPT 99497-99498)
MORE MENU ITEMS

• Add palliative care performance measures for public reporting and/or to determine whether a provider qualifies for shared savings or bonus payments

• Add requirements to the hospital, nursing home, home health, and other provider conditions of participation

• Enhance support for palliative care professional education and training programs

• Other?
RECENT DEVELOPMENT:
THE ONCOLOGY CARE MODEL

- On February 12, 2015, CMS posted a request for applications for a new Oncology Care Model.
- Goal is to recruit at least 100 physician practices and to begin the 5-year initiative by spring 2016.
- Intended to be a multi-payer initiative though non-Medicare payers are not bound by the CMS payment methodology.
- Model involves 6-month episodes triggered by administration of chemotherapy.
- Eligible physician practice would receive a per beneficiary per month (PBPM) payment of $160 during the episode.
  - Eligible beneficiaries who receive chemotherapy from a participating practice would be automatically enrolled.
- Normal fee-for-service rules would apply.
- An episode-based target payment would be calculated based on historic data for all Part A/B services and some Part D costs (for beneficiaries with Part D coverage), producing a risk-adjusted benchmark, and then adjusted to give Medicare an up-front “discount.”
  - Would be compared to actual spending, including PBPM payments.
ONCOLOGY CARE MODEL, CON’T

• Semi-annual, lump-sum performance-based payments would apply; would be calculated retrospectively.
  ➢ The difference between the target price and the performance year actual expenditures would represent the maximum performance-based payments that the practice could receive.
  ➢ The amount of performance-based payments may be adjusted by a performance multiplier, depending on practice performance on various measures (a practice would need to exceed a minimum quality threshold to receive a performance-based payment).
  ➢ Practices that do not qualify for a performance-based payment by the end of the third performance year would be removed from the model.
  ➢ A maximum expenditure reduction of 20% of the benchmark (before taking the CMS discount) would apply (and a maximum loss percentage of 20% would also apply under the two-sided risk model); would cap performance-based payments and losses.

• One-sided risk can apply for the entire 5 years, but practices will be offered the option to switch to two-sided risk on a semi-annual basis beginning in the third model year.
  ➢ Discounts would be applied in calculating the target price, 4% under one-sided risk and 2.75% under two-sided risk.
OCM: PRACTICE REQUIREMENTS

• Provide and attest to 24 hours a day, 7 days a week patient access to an appropriate clinician who has real-time access to practice’s medical records.
• Attestation and use of ONC-certified EHRs.
• Utilize data for continuous quality improvement (must collect and report data on several metrics).
• Provide core functions of patient navigation.
• Document a care plan that contains the 13 components in the Institute of Medicine (IOM) Care Management Plan.
• Treat patients with therapies consistent with nationally recognized clinical guidelines.
EXCERPTS FROM THE PRELIMINARY LIST OF OCM QUALITY AND PERFORMANCE MEASURES

• Percentage of all Medicare FFS beneficiaries managed by a practice who are admitted to hospice for less than 3 days in the last 30 days of life.

• Percentage of OCM-FFS beneficiary face-to-face visits in which the patient is assessed by an approved patient-reported outcomes tool. This would include a minimum of the PROMIS tool short forms for anxiety, depression, fatigue, pain interference, and physical function.

• Percentage of OCM-FFS beneficiaries with at least one palliative care consultation per OCM-FFS episode.
EXCERPTS FROM THE COMPONENTS OF THE IOM CARE MANAGEMENT PLAN

• Treatment goals (curative, life-prolonging, symptom control, palliative care)
• Advance care plans, including advanced directives and other legal documents
• A plan for addressing a patient’s psychosocial health needs, including psychological health needs, including psychological, vocational, disability, legal, or financial concerns and their management
MORE ON THE ONCOLOGY CARE MODEL

• The Oncology Care Model is the most recent expression of CMS views regarding alternative payment models for specialty care.
• However, many details about the model are not yet specified and others are labeled preliminary or subject to change.
• Also, the reaction of oncology stakeholders is not yet fully known.
• Some elements of the model are likely to be considered attractive while others are likely to be viewed as problematic by various stakeholders.