

An interview with Peter B. Bach, MD, MAPP

## Your open line to the CMS

By Lee S. Schwartzberg, MD, FACP

When Mark McClellan, MD, PhD, head of the Centers for Medicare & Medicaid Services (CMS), hired Peter Bach this past February to serve as a senior adviser on healthcare quality and cancer policy, community oncologists looked on approvingly. Dr. Bach came to CMS from the Memorial Sloan-Kettering Cancer Center in New York, where he is an associate attending physician. Although he is not an oncologist, Dr. Bach has a strong reputation for research on quality cancer care. A pulmonologist and intensivist by training, he has conducted epidemiological studies on racial disparities in the treatment and outcome of lung cancer patients, on the relationship between hospital volume and survival for lung cancer surgery, the risk factors for lung cancer, as well as the differences in primary care providers who treat patients of different races. He has also helped develop evidence-based treatment guidelines for lung cancer, chronic obstructive pulmonary disease, and end-of-life care for cancer patients.

*Community Oncology's* Editor-in-Chief, Lee Schwartzberg, MD, spoke with Dr. Bach recently about what lies ahead in the coming year for practice-based oncologists and their teams when it comes to the demonstration project to reimburse physicians for collecting data on treatment side effects, pay for performance, and quality care.

**Community Oncology: How has your previous experience prepared you for this latest**

### **task you've taken on?**

During my time both in fellowship training and as a faculty member at Sloan-Kettering, I conducted a number of studies examining Medicare patients, the quality of care they received, linking that care to their outcomes. And through those studies, I think I learned a lot about some of the barriers that patients and doctors face in providing high quality care and a lot about how to measure it.

**The demonstration project was the first real pay-for-performance CMS initiative for cancer care. It provided much needed "stop gap" funding as reimbursement ratcheted down in 2005. Will it be extended into 2006?**

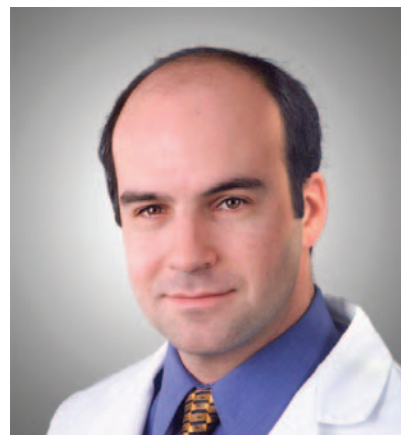
We're looking at options for next year. The demonstration project serves as a good jumping off point for our more general strategy in quality measurement and also in pay for performance. As you know, this year we asked oncologists giving chemotherapy in their offices to report back to us on cancer patient symptoms. The way those symptoms were reported was through the use of our billing system and special G-codes created specifically for this purpose. The fact that we have seen broad-based participation in the project convinces us that we can move forward in capturing measures that are important for quality of life in patients and also clinical practice measures.

The big question that a lot of us had was whether or not we could measure quality of care in physicians' offices. To measure quality of care in hospitals, we use hospital-based elec-

tronic transmission platforms, such as QNET. But collecting these data from practice-based physicians presented a challenge. By using our billing system, I think we have opened this up as much as we can.

### **So do you plan to continue using this method of capturing symptom information?**

No. I wouldn't say that specifically. We plan to continue working on ways of collecting data about quality from physicians in their offices. We haven't



**Dr. Peter B. Bach**

really decided whether or not that will be through a demonstration project next year in oncology. We are still seeking guidance from cancer experts such as yourself, in terms of what is a good way to move forward, what are the right things to be concerned about, what matters most to patients. Certainly, some of the feedback we have gotten about this year's project and how it might be improved is informing our thinking. Using the billing platform to collect data has been successful. It has been a pretty good

test and it has worked pretty well. We're encouraged that we can gather data without having to wait for the electronic health record revolution.

## **How are you going to use the data that you have?**

The plans for the data are really just in formation at this point. The year isn't over yet and as you know, there is a lag within the billing system so we are just getting preliminary data from the first quarter of this year.

**Some community oncologists have suggested that the demonstration project could be expanded so that additional symptoms such as anxiety and depression are addressed, for example. And others have questioned why symptom information was collected only on the day of chemotherapy.**

One of the hopes for the data is to try to understand the role that symptoms play in terms of other adverse events that occur with cancer patients, such as hospitalizations for pain control and things like that. This is a first step toward a larger approach to quality measurement and pay for performance.

## **But isn't the payment system somewhat fragmented now?**

Yes. We pay for care in a physician's office out of one payment system—Part B—and we pay for inpatient care out of a different system—Part A. We don't have a standardized mechanism that allows the benefits, and the funds that go with it, to follow the beneficiary. As a result, if a patient is helped to avoid hospitalization, for instance, oncologists can't accrue payment for the efforts they went to, revenues generated by that, and the cost to CMS for additional outpatient intervention. That's because right now, reimbursement for all of that goes into a different payment silo.

So if the doctor spends a little bit more money than we reimburse him

or her for, and the result avoids an inpatient stay that would have cost CMS thousands of dollars and would have been a great burden to the patient and his or her family, we don't have a system right now for linking those two things. We would like high quality outpatient care to be appropriately reimbursed and a system where payment for performance takes into account the impact of care on total spending and on patients.

**Based on symptoms, have you given any thought to expanding reimbursement into the less expensive per patient costs of additional outpatient treatment? Cumulatively, that could be huge considering the increasing use of reimbursable oral medication.**

Yes. That is one of the things that I am alluding to—the Part D benefit will modernize Medicare. Clearly, oral drugs are one of the mainstays of treatment, not only for cancer patients who are acutely ill, but also for patients who have diseases that are not symptomatic but are controlled through secondary prevention, which reduces the burden of illness. So, by modernizing Medicare and providing oral drugs for patients who sign up for the benefit, we hope to realize savings to the program, but most importantly, we hope to make major improvements in patients' quality of life.

We are giving a lot of thought to how we can encourage the appropriate use of oral drugs, be they for symptom control or active treatment; this is something that should be fomented not only through having a good benefit package but also through oncologists doing the best things for their patients and reaping benefits from the financial savings to the program. So, sure, we are happy to pay for a larger up-front cost if the net cost is neutral to us in terms of patients' improved quality of life. And if the net economic effect on us is positive and patients' lives are improved, all the better.

**Do you anticipate trying to correlate the incidence and intensity of symptoms with the way supportive care treatment is actually delivered, by reimbursable elements through Part B such as intravenous medications and so forth?**

That is a goal. Whether or not we can successfully draw all of those correlations in a convincing way this year based on these data is not really the litmus test that we are applying to this demonstration. It would be nice if we could illustrate those things. But measuring patient symptoms and getting doctors in the habit of submitting data that's important to patients and their families through our billing system or any other mechanism are key. Those two things alone make the program a success. Never mind the financial objective of the program, which, I think, has also been successful.

**We certainly agree. One last question on the demonstration project: Do you have a proposed timeline when the decision will be made for extension into 2006?**

No. We are working on it and will continue talking to the specialty groups such as the Community Oncology Alliance (COA). We are going to continue listening to some of the ideas coming from these groups on how we should move forward.

**We have talked about symptom control and that is a good first attempt to define quality care. But practically speaking, how can you more broadly define quality care and incorporate it into the Medicare payment system?**

I don't think CMS should be in the business of defining quality care, per se, but we should serve as a platform, if you will, as we have through the collection of symptom data this year. The measures and standards of quality are things that need to come from the provider community, the pa-

tient community, as well as our scientific colleagues at the National Cancer Institute or somewhere like that, because that is really where the expertise resides. Our expertise, if anything, is in figuring out how we can actually gather and disseminate the data.

We didn't sit in Washington and decide what made hospitals high quality; many other groups were working on that such as the National Quality Forum, the American Hospital Association, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). But once quality measures were established, we did create an opportunity for hospitals to submit measures of their performance. And we created an environment where those things could be viewed by the public and directly compared on the Internet. So I think it's in everyone's interest—both physicians and patients—to have quality observed and reported on. It remains a major focus for CMS.

One of the things we have seen is that through the process of quality measurement and reporting, we get net improvements in quality. A recent article in *The New England Journal of Medicine* looked at JCAHO hospital measures over 3 years. During that time period, there were very large increases in each hospital's performance. Presumably, some of it was due to the fact that hospitals were measuring their quality, reporting on it publicly, and dealing with it internally by asking questions like, Why is my performance on this metric lower than in the hospital across the street or the hospital in another town?

We actually saw something in that study that was really encouraging. If you look at some of the secondary prevention measures such as smoking cessation counseling for patients with smoking-related hospitalizations, the magnitude of the increase in performance was huge because of the process of reporting. Now, smoking-

cessation counseling isn't necessarily a routine part of clinical care and it is not necessarily something that acute care inpatient physicians have on their minds. But it is clearly something that is beneficial to patients. The research out there suggests that these hospitalizations are real teachable moments for patients, so increasing them through quality measurement and reporting seems like a really great idea.

I would argue that the same thing can and should be happening in oncology. It's particularly good if it is driven by physicians and patients. It certainly won't be good if it's driven by the government.

**I agree and I think that's the direction we would all like to go. The other side of the coin is looking at physician behavior—for example, using evidence-based practice guidelines in oncology, which most people think would be useful. How do you see CMS measuring and encouraging that?**

That's actually an idea that was proposed by people at COA and others. Quality measurement is a challenge, especially in subspecialties like cancer. One of the reasons is the variability we confront. Most quality measures have to focus on a highly defined subgroup of patients where they can have a denominator—the number of patients who, let's say, could get a treatment based on their clinical qualifications, their disease, its stage and cell type, and biomarkers or whatever, and a numerator—the number of people who actually got that treatment. It's very difficult in cancer to develop the number of measures that would be required to capture a meaningful fraction or even a representative fraction of all cancer care that is provided. It's also enormously burdensome for practicing oncologists or administrators to have to fumble with these measures while they are trying to do the difficult work of

providing patient care.

In cancer we are starting to focus on things like practice guidelines because, in a sense, all quality measures are elements abstracted from practice guidelines. What we have been thinking about is whether or not we could capture the adherence to guidelines. It would be useful to know how closely care follows these guidelines. But just knowing whether patients are on guidelines or not isn't really the full story. There are a lot of really good reasons in clinical practice why patients aren't on guidelines. And that is a version of quality monitoring that we would like to hear more about because it might be a really good way to proceed. Not being on guidelines might tell us a lot.

If we did a chart review and just looked at cancer patients across the country and asked whether or not their primary therapy adheres to practice guidelines, we would see broad variability. We would see variability by all sorts of things such as age, co-morbidity, and Karnofsky score. We would probably see even broader variability across cancer type. The evidence base and the different cancers vary.

Looking at whether or not patients are getting evidence-based treatment is actually kind of a good way of closing the loop. When we start to see a lot of patients with a particular cancer not getting evidence-based treatment, we are going to have to ask ourselves why. I think more often than not the answer will be because the evidence isn't that convincing; the practitioners who are treating these patients every day are aware of that, and they have made independent, innovative decisions about how to treat their patients. We should learn from that and disseminate the information. We have to sort that out.

**That is an incredibly valuable comment because I think closing**

**the loop is exactly what has never been done and it is very exciting to start thinking about how to develop an infrastructure to do that. Let's turn to another topic: One concern among community oncologists is that pay for performance is just a way of shifting reimbursement without creating a real incentive for quality. How does CMS address this?**

Actually, I'm not sure where that concern comes from. Everything that I have been talking about focuses on how we would like to improve quality of care. We think that one way to do this is to measure quality, to convey that patients' symptoms matter. But we want pay for performance to be a mechanism by which high quality care can be appropriately reimbursed. Sometimes high quality care takes more time and uses more office resources.

Right now, it's very difficult to devise mechanisms within the reimbursement system that support particular elements of care. What we would like is to create an environment where innovative practitioners with high quality practice setups, colleagues, and ancillary support can provide excellent care and receive the reimbursement needed to pay for those resources directed toward patients. We don't want to dictate from here how to do that; neither do we want to create an individual HCPC code for every valuable thing that could ever be done for a patient. That is not best for patients and it would be too prescriptive. We just want to create an environment where performance at the local level can be optimized.

Any successful pay-for-performance initiative will have to be appropriately adjusted—to the risks of comorbidities, to the healthcare setting where patients are being treated, to the patients' own barriers to payment, and other socioeconomic barriers. We don't want this to drive a

wedge in the healthcare system between well-financed practices that take care of patients with better reimbursement and practices that have fewer resources. We want to encourage innovation across the spectrum and pay appropriately for that. I think that leads to better care for patients. This isn't a way of shifting money around or playing favorites, this is a way to create flexibility.

**Along those lines, more than 80% of Americans with cancer are being treated in community cancer clinics. How can community cancer care and CMS work more closely together to find workable long-term solutions?**

First of all, I think community oncologists are doing a fabulous job of communicating with me and Dr. McClellan and getting their voices heard on the Hill and in other places. We really appreciate the input we are getting from the community. You should continue to alert us when you have concerns. Continue to encourage us when you feel we are going in the right direction. We need the clinical and scientific expertise that resides in the community and your feedback on how to move forward with quality measurement, how to modify the demonstration, where the glitches were in the demonstration this year. That is all very valuable to us. My line is open and there are a lot of other channels in CMS as well. We really want the community providers and patients to think about how we can move forward from a system that just pays for resource utilization to one that pays for quality.

**The just released proposed rule, the Medicare physician fee schedules, shows that community oncology reimbursement under Part B will be reduced by 5.6%, which, in our estimation, translates into more than \$400 million. If these cuts**

**continue, how can community oncology be expected to deliver the same quality of care and access in the face of rising delivery costs?**

That is a good question. In the proposed rule, we anticipate total Medicare increase in revenues for oncologists at 8%.

**Well, 8% based on historical drug acquisition and revenue. But that doesn't take into account changes in drug costs and average selling price + 6 and how that lags. Without looking at the projected drug increase, the payment cut is 5.6%. That is a hard cost which is already built into the proposed schedule. We could debate whether drug acquisition revenue is going to make up for that, but assuming that it doesn't—and we have grave concerns that it won't—how can quality care continue if payment cuts continue?**

In a sense that question has its own answer. This is a proposed rule and these are the impacts we projected, based on the demonstration project of this year being discontinued and no other project associated with payment going forward. It is also based on growth that stays as currently calculated and on small growth in volume of services provided by oncologists. I think it is very useful to look at that kind of number and say, OK, this is, in a sense, where we are if the shift continues in exactly the direction it is headed.

I don't think that anyone looks at payment cuts as a good thing. We want to foment high quality of care. If we are convinced we cannot do that in this kind of payment environment, we will have to address that, but I see these things as related. And clearly, last year's demonstration project, the launching of it, the way the payments were structured, echoed that sentiment: that it was important to marry the payment piece to the quality piece.

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