

111TH CONGRESS
1ST SESSION

H. R. 2872

To improve the quality and cost effectiveness of cancer care to Medicare beneficiaries by establishing a national demonstration project.

IN THE HOUSE OF REPRESENTATIVES

JUNE 15, 2009

Mr. DAVIS of Alabama (for himself, Ms. KILROY, and Mr. ISRAEL) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To improve the quality and cost effectiveness of cancer care to Medicare beneficiaries by establishing a national demonstration project.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Medicare Quality Can-
5 cer Care Demonstration Project Act of 2009”.

6 **SEC. 2. FINDINGS.**

7 Congress finds the following:

1 (1) In order to ensure the delivery of quality,
2 cost-efficient medical care, Medicare must transform
3 the payment system to one based on evidence-based
4 guidelines and demonstrated quality delivery of care.

5 (2) An Institute of Medicine report entitled
6 “Ensuring Quality Cancer Care” recommends that
7 the following items are essential components in qual-
8 ity cancer care delivery:

9 (A) An agreed-upon treatment plan that
10 outlines the goals of care.

11 (B) Access to clinical trials.

12 (C) Policies to ensure full disclosure of in-
13 formation about appropriate treatment options
14 to patients.

15 (D) A mechanism to coordinate services.

16 (3) Additionally, the report notes the impor-
17 tance of ensuring quality of care at the end of life,
18 in particular, the management of cancer-related pain
19 and timely referral to palliative and hospice care.

20 (4) According to the Institute of Medicine, the
21 quality of cancer care must be measured by using a
22 core set of quality measures. Cancer care quality
23 measures should be used to hold providers, including
24 health care systems, health plans, and physicians,

1 accountable for demonstrating that they provide and
2 improve quality of care.

3 (5) Although two of the critical components of
4 cancer care are treatment planning and end-of-life
5 care, none of the 153 quality measures in the Cen-
6 ters for Medicare & Medicaid Services (CMS) 2009
7 Physician Quality Reporting Initiative (PQRI) ad-
8 dresses overall treatment planning or end-of-life care
9 for cancer patients.

10 (6) The medical literature suggests that adher-
11 ence to quality metrics and evidence-based guidelines
12 help lower costs by reducing use of physician serv-
13 ices, hospitalizations, and supplemental and expen-
14 sive drugs.”

15 **SEC. 3. MEDICARE QUALITY CANCER CARE DEMONSTRA-**
16 **TION PROJECT.**

17 (a) ESTABLISHMENT.—The Secretary of Health and
18 Human Services (in this section referred to as the “Sec-
19 retary”) shall establish a quality cancer care demonstra-
20 tion project under this section (in this section referred to
21 as the “QCCD project”) for the purpose of establishing
22 quality metrics and aligning Medicare payment incentives
23 in the areas of treatment planning and end-of-life care for
24 Medicare beneficiaries with cancer.

1 (b) TEST METRICS AND REPORTING SYSTEMS
2 THROUGH A PAY-FOR-REPORTING INCENTIVE PRO-
3 GRAM.—Under the QCCD project, the Secretary shall do
4 the following:

5 (1) Identify and address gaps in current quality
6 measures related to the areas of active treatment
7 planning and end-of-life care by refining the per-
8 formance measures described in paragraphs (1) and
9 (2) of subsection (d) relating to active treatment
10 planning and end-of-life care for clinician-level re-
11 porting.

12 (2) Explore the potential to report quality data
13 through registries or other electronic means for
14 treatment planning and end-of-life care data, includ-
15 ing identifying data elements necessary to measure
16 quality of treatment planning and end-of-life care
17 and determine how those elements could be collected
18 through claims data or registries or other electronic
19 means.

20 (3) Test and validate identified treatment plan-
21 ning and end-of-life quality measures through a pay-
22 for-reporting program with oncologists, which pro-
23 gram—

1 (A) ensures that oncologists are able to ac-
2 curately report on measures through simple
3 HCPCS coding mechanisms; and

4 (B) tests processes of submitting treat-
5 ment planning and end-of-life measures through
6 registries or other electronic means.

7 (c) INCENTIVE PAYMENT.—

8 (1) IN GENERAL.—Under the QCCD project,
9 the Secretary shall provide for a separate payment
10 under section 1848 of the Social Security Act (42
11 U.S.C. 1395w-4), to be divided into a baseline pay-
12 ment amount and an additional payment amount, as
13 specified by the Secretary, for a treatment planning
14 code and for an end-of-life code. The amount of such
15 payments under the project shall be designed to
16 total \$300,000,000 each year. Payments under the
17 project shall be designed to be paid on an ongoing
18 basis as claims are submitted.

19 (2) REQUIREMENT TO SATISFY BASELINE MAN-
20 DATORY MEASURES TO RECEIVE BASELINE PAY-
21 MENT.—In order for a physician to receive any pay-
22 ment under the QCCD project for treatment plan-
23 ning or end-of-life care, a physician must report in
24 a manner specified under the project that all of the
25 baseline mandatory measures described in paragraph

1 (1)(A) or (2)(A), respectively, of subsection (d) were
2 satisfied.

3 (3) REQUIREMENT TO SATISFY ALL MEASURES
4 TO RECEIVE ADDITIONAL PAYMENT.—In order for a
5 physician to receive the additional payment amount
6 described in paragraph (1) under this subsection for
7 treatment planning or end-of-life care, a physician
8 must report in a manner specified under the project
9 that all of measures described in paragraph (1) or
10 (2), respectively, of subsection (d) were satisfied.

11 (d) MEASURES.—

12 (1) TREATMENT PLANNING MEASURES.—The
13 specific measures related to treatment planning and
14 any subsequent modifications described in this para-
15 graph are as follows:

16 (A) BASELINE MANDATORY MEASURES.—

17 (i) Documented pathology report.

18 (ii) Documented clinical staging prior
19 to initiation of first course of treatment.

20 (iii) Performed treatment education
21 by oncology nursing staff.

22 (iv) Provided the patient with a writ-
23 ten care plan for patients in active treat-
24 ment, which advises patient of relevant op-
25 tions.

1 (B) AUGMENTED.—

2 (i) Implemented practice-endorsed
3 treatment plan consistent with nationally
4 recognized evidence based guidelines.

5 (ii) Documented clinical trial dis-
6 cussed with the patient, or that no clinical
7 trial available.

8 (iii) Documented discussion or coordi-
9 nation with other physicians involved in
10 the patient's care.

11 (2) END-OF-LIFE CARE MEASURES.—The spe-
12 cific measures related to end-of-life care described in
13 this paragraph are as follows:

14 (A) BASELINE MANDATORY.—

15 (i) Documented advanced care plan-
16 ning session with the patient.

17 (ii) Symptoms assessed and ad-
18 dressed.

19 (iii) Recommended the patient to hos-
20 pice program, whether for institutional or
21 home-based hospice care.

22 (B) AUGMENTED.—

23 (i) Documented no acute care hospital
24 admissions (including admission to an
25 emergency room or intensive care unit but

1 excluding admission to a hospice or pallia-
2 tive care unit) within 30 days of death.

3 (ii) Advanced directive discussion with
4 the patient documented in the physician's
5 records and, if agreed to, inclusion of an
6 advanced directive in such records.

7 (iii) Documented that no chemo-
8 therapy administered within 30 days of
9 death.

10 (e) DURATION OF PROJECT.—

11 (1) IN GENERAL.—The Secretary shall conduct
12 the demonstration project over a sufficient period (of
13 not less than 2 years) to allow for refinement of
14 metrics and reporting methodologies and for anal-
15 yses. The project shall continue, subject to para-
16 graph (2), to operate until the Secretary has devel-
17 oped and implemented under part B of the Medicare
18 program a payment system that relates payment
19 under such part for professional oncology services to
20 performance on measures developed and refined
21 under the demonstration project.

22 (2) TRANSITION.—The Secretary shall provide
23 for a transition period over the course of 2 years
24 during which oncologists are permitted to transition
25 from the payment system under the demonstration

1 project to the payment system described in para-
2 graph (1).

3 (f) PROJECT EVALUATION.—

4 (1) IN GENERAL.—The Secretary shall conduct
5 an evaluation of the QCCD project—

6 (A) to determine oncologist participation in
7 the project;

8 (B) to assess the cost effectiveness of the
9 project, including an analyses of the cost sav-
10 ings (if any) to the Medicare part A and B pro-
11 grams resulting from a general reduction in
12 physician services, hospitalizations, and supple-
13 mental care drug costs;

14 (C) to compare outcomes of patients par-
15 ticipating in the project to outcomes for those
16 not participating in the project;

17 (D) to determine the satisfaction of pa-
18 tients participating in the project; and

19 (E) to evaluate other such matters as the
20 Secretary determines is appropriate.

21 (2) REPORTING.—Not later than 90 days after
22 the completion of the second year following the com-
23 mencement of the QCCD project, the Secretary shall
24 submit to Congress a report on the evaluation con-
25 ducted under paragraph (1) together which such rec-

1 ommendations for legislation or administrative ac-
2 tion as the Secretary determines is appropriate.

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