Common Terms Used in Oncology Care Delivery

Welcome to the *Common Terms Used in Oncology Care Delivery*

In the field of health care, and especially cancer care, there is an extensive and evolving library of terms and acronyms to learn and understand.

As a result, the Community Oncology Alliance (COA) and Novartis Oncology have collaborated to create a resource-specific guide to provide clarity and context around common terms encountered by fellows, early career physicians, and others involved in the cancer continuum. The terms included in this glossary are categorized to provide definitions for key terms and concepts the teams will encounter day-to-day and are more business versus clinically focused.

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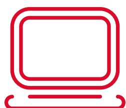

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The content herein reflects generally accepted terminology and concepts, but does not necessarily reflect the views or opinions of Novartis or COA.

Chapter 1: Payer Terms

Health care professionals will encounter a variety of terms when evaluating and processing health insurance coverage for their patients. This section covers common terms related to health insurance coverage and payer policies.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act is a comprehensive health care reform law enacted in March 2010, and is commonly known as the Affordable Care Act. The goal of the ACA is to make affordable health insurance available to more people, expand Medicaid to cover more adults, and support innovative medical care delivery models designed to lower costs of health care.[1]

Allowed Amount: The maximum amount a health insurance plan will pay for a particular medical service.[2]

Balance Billing: When a provider bills the patient for the balance remaining on the bill that the patient's health insurance plan doesn't cover. This amount is the difference between the provider's charge and the allowed amount. Balance bill costs are in addition to what is paid out of pocket for out-of-network services according to each health plan. An in-network, or preferred, provider may not balance bill for covered services.[2,3]

Average Manufacturers Price (AMP): The average price paid by wholesalers for drugs distributed to the retail class of trade. Medicaid uses AMP data to determine the rebate amount for a drug.[4]

Average Sales Price (ASP): A manufacturer's average price to all purchasers, net of applicable discounts, chargebacks, and rebates for drugs. ASP is used as the basis for Medicare reimbursement of medication administered in the outpatient setting.[4]

Average Wholesale Price (AWP): A price point published by third-party sources of pricing data originally intended to convey benchmark pricing information to third-party payers, including government prescription drug programs, but does not represent an actual price paid.[5]

Biosimilar: A type of biological product that is licensed (approved) by the US Food and Drug Administration (FDA) because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product.[6]

Bundled Payment System: This is a system in which different health care providers treating a patient for the same or related condition coordinate their care and are then paid an overall sum for treatment. This structure rewards collaboration and also reduces unnecessary or duplicate tests and treatments.[7]

Business Associate Agreement (BAA): This is a method to assure entities are protecting patient information when they are working on a common project. A business associate is directly liable under the HIPAA Rules and may use or disclose protected health information only as permitted or required by its business associate contract or as required by law.[8]

Carve Outs: These are items or services which are paid separately when a hospital or practice has fixed pricing like capitation from their payers. If a patient needs an additional service, the payment would not come out of the physician's capitated payment and instead would be paid fee-for-service.[9]

Co-pay Accumulator: Health insurance plans and PBMs utilize co-pay accumulators to prevent manufacturer co-pay assistance from counting toward the patient's deductible and maximum out-of-pocket costs. These programs are not always disclosed to beneficiaries and have potential to impact patient adherence to specialty pharmaceutical products. As of June 2023, 19 states have banned the use of co-pay accumulators by state-regulated insurance plans.[10,11]

Co-pay Maximizer: Plans that use co-pay maximizers require patients to sign up, and set the patient out-of-pocket maximum amount equal to the maximum value of a manufacturer's co-pay assistance program for a particular product. Patients are still responsible for meeting the total out-of-pocket maximum outlined in their benefits.[11]

Coinsurance: A percentage that may be required for services after any health insurance plan allowed amounts are paid.[2]

Commercial Insurance: Health insurance issued by private companies or nongovernmental organizations is considered commercial health insurance. Employer-provided group health insurance policies are commercial, as are individual policies people can buy if they do not receive employer or government insurance benefits.[12]

Compendia: A collected body of information on the standards of strength, purity, and quality of drugs.[13]

Copayment: A copayment is usually a set amount paid for a medical service, like a doctor's visit or prescription drug. The amount billed is dependent on how much of the deductible was paid off at the time of billing.[2]

HIPAA, Health Insurance Portability and Accountability Act of 1996; PBM, pharmacy benefit manager.

Cost Sharing: A system where patients pay for a portion of health care costs not covered by health insurance. This generally includes deductibles, coinsurance, and copayments (or similar charges), but not premiums, balance billing amounts for non-network providers, or the cost of non-covered services.[2,14]

Current Procedural Terminology Codes (CPT® codes): The standard for how medical professionals document and report medical, surgical, radiology, laboratory, anesthesiology, and evaluation and management services. This standard is maintained and updated by the CPT Editorial Panel. All health care providers, payers, and facilities use CPT codes. The 5-character CPT codes are used by insurers to help determine the amount of reimbursement that a practitioner will receive for services provided. CPT is a registered trademark of the American Medical Association.[15]

For more information about CPT codes, visit https://www.ama-assn.org/practice-management/cpt

Deductible: The amount paid for health care or prescriptions before a prescription drug plan or other insurance begins to pay. The deductible is a patient out-of-pocket expense and varies based on the health insurance plan or prescription drug plan.[2]

Diagnosis Related Group Codes (DRG codes): A system to classify inpatient hospital cases into one of approximately 500 groups, also referred to as DRGs, which group together patients with similar clinical needs for payment on these groups. DRG codes are used to reimburse hospitals a set amount per patient based on the payment weight assigned to each grouping.[16,17]

Drug Tier: Many plans offering prescription drug coverage place drugs into different "co-pay tiers" on their formularies. Each plan can divide its tiers in different ways with varying impact on patient out-of-pocket costs.[18]

Essential Health Benefits: Ten health benefits that all plans participating in the ACA must provide with no dollar limits. These include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services.[19]

ACA, Affordable Care Act.

Explanation of Benefits (EOB): This is a summary sent to the patient for charges from a recent medical visit. This document is not a bill, and typically includes the charges for health care services received, as well as the amount the insurance plan and the patient will pay.[2]

Federal Poverty Level (FPL): The federal poverty level is a measure of income used to determine patient eligibility for certain programs or benefits, such as Medicaid. The FPL is updated and published annually by the Department of Health and Human Services (HHS).[20]

Federally Qualified Health Center (FQHC): FQHC is a reimbursement designation from the Bureau of Primary Health Care and the CMS. FQHCs are community-based organizations that provide comprehensive primary and preventive care, including oral, mental health, and substance abuse services to persons of all ages, regardless of their ability to pay or health insurance status.[21,22]

Fee-for-Service (FFS): A payment model in which each service is paid for separately.[23]

Formulary: A list of drugs covered by an insurance plan.[24]

Health Insurance Marketplace: Organizations that facilitate structured and competitive markets for purchasing health insurance coverage. The Health Insurance Marketplace, or "Exchange," offers standardized health insurance plans to individuals, families, and small businesses.[25]

Health Maintenance Organization (HMO): HMOs are health plans that typically limit members to using health care providers contracted with the HMO.[26]

Healthcare Common Procedure Coding System (HCPCS): HCPCS is a collection of standardized codes produced by CMS that represent medical procedures, supplies, products, and services. HCPCS is divided into 2 subsystems: Level I (CPT codes) and Level II (products, supplies, and services not included in CPT).[27]

HIPAA: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that standardized procedures to protect sensitive patient health information from being shared without the patient's consent. The HIPAA Privacy Rule was introduced to implement the requirements of HIPAA.[28]

ICD-10-CM: The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) is used to code and classify mortality data, and is owned and published by the World Health Organization (WHO). The ICD-10, Clinical Modification (ICD-10-CM) is a clinical modification of the ICD-10 used in the United States. The list contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.[29,30]

CMS, Centers for Medicare & Medicaid Services; CPT, Current Procedural Terminology.

Non-Formulary Drugs: Drugs not on a drug coverage plan's approved drug list.[31]

Out-of-Pocket (OOP) Costs: These costs are the portion that the patient has to pay for health care services that are not covered by their insurance.[32]

Payers/Payors: In health care, a payor is a person, organization, or entity that pays for the care services administered by a health care provider. This term most often refers to health insurance companies, which provide customers with health plans that offer cost coverage and reimbursements for medical treatment and care services. Employers often sponsor commercial health insurance plans available to their employees.[33]

Pharmacy Benefit Manager (PBM): A third-party administrator of prescription drug programs for commercial health plans, self-insured employer plans, Medicare Part D plans, the Federal Employees Health Benefits Program, and state government employee plans. PBMs act as intermediaries between pharmacies, plan sponsors, pharmaceutical manufacturers and drug wholesalers, handling claims processing, making decisions about formulary placement and negotiating rebates.[34]

Pharmacy Benefit Plan: Prescription drug programs for commercial health plans, self-insured employer plans, Medicare Part D plans, the Federal Employees Health Benefits Program, and state government employee plans.[34,35]

Pre-Existing Condition: A health problem a patient had before signing up for a health insurance plan. Under the Affordable Care Act (ACA), patients cannot be denied coverage due to pre-existing conditions, except in cases of "grandfathered" health plans, which are health insurance policies purchased on or before March 23, 2010.[36,37]

Preferred Provider Organization (PPO): A managed care plan that contracts with networks or panels of providers to furnish services that are paid for on a negotiated fee schedule. Enrollees are offered a financial incentive to use providers on the preferred list, but may use non-network providers as well.[38]

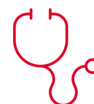
Prompt Pay: Discounted payment terms that drug manufacturers may offer to drug wholesalers to induce payment within a certain time frame.[39]

Qualified Health Plan (QHP): A major medical health insurance plan that covers all the mandatory benefits of the ACA. A qualified health plan is also eligible to be purchased with an ACA subsidy, also known as a premium tax credit.[40]

Site of Care: The location in which health care is delivered. The most common locations are hospital inpatient, hospital outpatient, and physician office-based care. The cost of care and reimbursement amounts will vary by the site of care.[41,42]

Hospital Outpatient (HOP)

This term is used most often in relation to the site of care, as in HOP (hospital outpatient) care.[43]



Physician Office Visit (POV)

This term is used most often in relation to the site of care, as in POV (physician office visit) based care.[43]

Underinsured: Not having proper or sufficient health insurance to cover medical expenses related to the diagnosis and treatment of an illness or injury.[44]

Uninsured: A person without health insurance coverage.[2]

Value-Based Purchasing (VBP): VBP links payment to providers from payers based on improved performance. VBP attempts to identify and reward the best-performing providers by holding them accountable for both the cost and quality of care they provide.[45]

Value Framework: An assessment of the value of new cancer therapies based on clinical benefit, side effects, and improvements in patient symptoms or quality of life in the context of cost.[46]

Wholesale Acquisition Cost (WAC): WAC represents the manufacturer's list price for a drug to wholesalers or direct purchasers, but does not include discounts or rebates.[47]

Chapter 2: Patient Access and Fulfillment

This section covers the common terms used during the process of getting patients access to medication, from prescription through fulfillment.

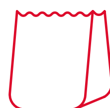
Appeal: A request for a health insurer or plan to review a decision or a grievance in order to gain the appropriate payment. Usually, appeals address treatment appropriateness or medical necessity.[48,49]

Letter of Appeal: A letter of appeal can be drafted and sent to the health insurance plan when coverage for a treatment has been denied.[50]

Bagging: This occurs when a payer supplies a drug through their own or another specialty pharmacy. [51]

White bagging occurs when a specialty pharmacy (usually an outside specialty pharmacy) ships medication directly to the prescriber's office, hospital, or clinic for administration.[51]

Clear bagging occurs when the health system's specialty pharmacy delivers medication to the prescriber's office, hospital, or clinic.[51]



Brown bagging occurs when the specialty pharmacy delivers medication to the patient, who then brings the medication to the prescriber's office, hospital, or infusion clinic.[51]

Gold bagging occurs when the prescription is filled at the health-system–owned specialty pharmacy by their own pharmacy staff, then packaged and delivered to the final place of administration, which is usually on the same campus as the hospital, office, or infusion clinic.[51]

Benefits Investigation: A benefits investigation is often conducted by a practice to find out what a patient's health insurance will cover in regard to a particular treatment or procedure.[35]

Buy and Bill: The buy and bill process is where pharmaceutical products are first purchased by the provider practice, then billed for reimbursement under medical benefit after the product is administered to the patient.[52]

Dispensing Pharmacy: A pharmacy that provides prescription drugs and supports patient safety and compliance through counseling when the drugs are dispensed.[53]

Dispensing Physician: Oncologists whose patient care includes providing direct access to oral cancer drugs through an in-practice dispensing pharmacy. Practice staff can provide greater continuity of care by managing all aspects of drug therapy – from initial dispensing to completion of therapy. Some states do not allow physician dispensing. This decision is made by the state's Board of Pharmacy.[54]

Employee Retirement Income Security Act of 1974 (ERISA): ERISA is a federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals. This includes requirements such as including important information about plan features and funding, minimum standards for participation, vesting, benefit accrual and funding, fiduciary responsibilities for those managing the plans, and more.[55]

Financial Toxicity: Financial toxicity describes problems a patient has related to the cost of treatment. This can be a devastating issue with cancer patients. It refers to the negative impact medical expenses can have on patients' health-related quality of life. Financial toxicity can cause negative mental and physical effects as well as, in some cases, bankruptcy. Financial toxicity is often caused by out-of-pocket costs that are not covered by health insurance.[56,57]

Health Equity (HE): Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Community Oncology Alliance (COA), via its member practices, is working to bring HE pilots to community practice.[58,59]

Medical Benefit: A medical benefit is what most people know simply as their "insurance" or what they have to cover their health care costs. Depending on how the provider acquires specialty medications, they may be covered by this benefit.[35]

Pharmacy Benefit: Health plans will apply pharmacy benefit coverage for medications that can be self-administered at home or administered at a provider's office or facility, based on how the medication is delivered. Medications covered under this benefit include oral treatments, self-injectables, infusions, or topical medications.[35]

Prior Authorization (PA): Health insurance plans will sometimes require a PA to be submitted before approving a particular treatment or service. PA criteria will vary by plan and often require a specific form to be submitted, along with other relevant documentation. PAs do not guarantee payment; they only authorize treatment.[60]

Specialty Distributors: Specialty distributors, also sometimes known as specialty wholesalers, supply specialty medication directly to physicians and pharmacies.[61]

Specialty Pharmacy: A pharmacy that manages the handling and service requirements of specialty pharmaceuticals, including dispensing, distribution, reimbursement, case management, and other services specific to patients with rare and/or chronic diseases. Specialty pharmacies deliver medication directly to the patient.[62,63]

Statement of Medical Necessity: A physician can draft and submit a letter of medical necessity when submitting a prior authorization request to an insurance plan. Along with the proper clinical documentation, this letter can attest to why a patient needs a particular treatment.[64]

Step Therapy: As part of prior authorization criteria, health insurance plans may suggest a patient to try and fail (or "step through") an alternative product before the prescribed product.[65]

Utilization Management: Utilization management, such as prior authorization or step therapy, is part of the cost management approach that health insurance plans use to review and assess appropriateness of health care services and treatment, which may result in changes to drug treatment selection.[66,67]

Vertical Integration: As it relates to health care, vertical integration involves a combination of businesses across the health care value chain, such as insurance companies, pharmacy benefit managers, and other entities or middlemen within the health care sector. Simply put, it is when a company owns its own supply chain.[68]

Example: CVS, in addition to operating thousands of pharmacies and MinuteClinics throughout the United States, is also the parent company of a major health insurer (Aetna) and a pharmacy benefit manager (CVS Caremark).[69,70]

- CVS/Caremark owns 33% of market share
- Cigna/Evernorth/Express Scripts owns 24% of market share
- UnitedHealthcare/OptumRx owns 22% of market share

Chapter 3: Medicare and Health Care Policy

This section provides more information about the common terms you may encounter with Medicare patients and health care policies.

Accountable Care Organizations (ACO): Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.[71]

Ambulatory Payment Classifications (APCs): Sometimes known as APCs, these are the government's method of paying facilities for hospital outpatients under the Medicare program. APC payments can apply to services or drugs.[72]

Centers for Medicare & Medicaid Services (CMS): The federal agency within the Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid.[73,74]

Center for Medicare and Medicaid Innovation (CMMI): CMMI was created as part of the Affordable Care Act (ACA) to develop, test, and evaluate innovative payment and delivery system models that improve quality of care and lower costs in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).[75]

Direct and Indirect Remuneration (DIR) Fees: Fees, payments, or payment adjustments made after the point-of-sale that change the cost of Part D covered drugs for Part D sponsors or PBMs that must be reported to CMS as DIR. Manufacturer rebates comprise a significant share of all DIR reported to CMS. The final plan payments by CMS are based on the costs actually incurred by Part D sponsors.[76]

The term DIR was originally advanced by CMS in the drug price reporting context to ensure that Medicare Part D sponsors and PBMs accurately report rebates and other price concessions from manufacturers or other third parties which could not be reasonably determined at the point-of-sale. PBMs have used the concept of DIR to impose additional fees against pharmacies.[77]

PBM, pharmacy benefit manager.

Donut Hole: Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (called a "donut hole"). This means that after a patient and their drug plan have spent a certain amount of money for covered drugs ($5030 in 2024), the patient enters the coverage gap. Once a patient has reached the out-of-pocket spending threshold ($8000 in 2024), they exit the coverage gap and enter the catastrophic coverage phase. Starting in 2024, the patient will not have to pay anything for the rest of the year once they reach catastrophic coverage.[78,79]

Dually Eligible Individuals: Patients who have insurance coverage from both Medicare and Medicaid are considered dually eligible.[80]

Enhancing Oncology Model (EOM): The Enhancing Oncology Model, designed and implemented by Centers for Medicare & Medicaid Services (CMS), aims to drive transformation and improve care coordination in oncology care by preserving and enhancing the quality of care furnished to beneficiaries undergoing treatment for cancer while reducing program spending under Medicare fee-for-service. Under EOM, participating oncology practices will take on financial and performance accountability for episodes of care surrounding systemic chemotherapy administration to patients with common cancer types.[81]

Geographic Practice Cost Index (GPCI): The Medicare Physician Fee Schedule amounts are adjusted to reflect the variation in practice costs from area to area. A geographic practice cost index has been established for every Medicare payment locality for each of the 3 components of a procedure's relative value unit (work, practice expense, and malpractice). This index is intended to take into account geographic cost of living differences.[82]

Hospital Outpatient Physician Fee Schedule: The reimbursement rates established for the professional services of physicians and nonphysician practitioners provided in hospital outpatient departments. This Medicare Physician Fee Schedule is updated annually by CMS.[83,84]

Inflation Reduction Act: The Inflation Reduction Act (IRA), passed by Congress in 2022, requires the Secretary of HHS to negotiate prices with drug companies for certain prescription drugs. In addition to Medicare drug price negotiation, the IRA also requires drug manufacturers to pay rebates for price increases above inflation, and caps out-of-pocket spending for Medicare Part D beneficiaries.[85]

Low-Income Subsidy (LIS): The Low-Income Subsidy program, also known as "Extra Help," is available under the Medicare Part D prescription drug program. Patients who meet income requirements receive assistance paying for their prescription drug coverage, including monthly premium, deductibles, and co-pays.[86,87]

Maximum Out-of-Pocket (MOOP): The MOOP is the annual maximum amount patients are expected to pay out of pocket for Medicare services. Once patients reach this limit, they will not be responsible for cost-sharing (deductibles, coinsurance, and copayments) on covered services for the rest of the year.[88]

Medicaid: A health care program that assists low-income families or individuals in paying for long-term medical and custodial care costs. Medicaid is a program that is funded jointly by the federal government and states, and run at the state level, where coverage may vary.[80]

Medicaid Expansion: This is a provision in the Affordable Care Act (ACA) that calls for expanding Medicaid eligibility to cover more Americans with low income. Under Medicaid Expansion, eligibility is extended to adults under the age of 65 with incomes up to 138% of the federal poverty level. As of July 2023, 38 states and Washington DC have expanded Medicaid.[89]

Medicare: The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant). Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance).[90,91]

A

Medicare Part A covers inpatient hospital stays, as well as skilled nursing facility, hospice, and some home health care.[90]

B

Medicare Part B covers medical services for patients, including doctor visits, outpatient care, and medical supplies.[90]

C

Medicare Part C allows patients to sign up with private health insurance companies as an alternative to Original Medicare for health and drug coverage. These private health plans are known as Medicare Advantage Plans, and sometimes offer benefits not offered by Original Medicare, such as vision, hearing, and dental care.[90,91]

D

Medicare Part D is the Medicare prescription drug benefit that subsidizes the cost of prescription drugs. Plans have different monthly premiums in addition to the cost of drugs. How much a patient pays for each drug depends on which plan they choose.[90]

Medicare Fee-for-Service (FFS): Medicare FFS is a program that pays physicians, hospitals, and other health care facilities based on established payment systems, most of which are updated annually.[92]

Medigap: Medicare Supplemental Insurance, known as Medigap, is extra insurance patients can buy from a private company that helps pay their share of costs for Original Medicare.[91]

MedPAC (Medicare Payment Advisory Commission): An independent congressional agency established by the Balanced Budget Act of 1997 to advise the US Congress on issues affecting the Medicare program. The Commission's 17 members bring diverse expertise in the financing and delivery of health care services.[93]

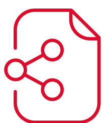
Oncology Care Model (OCM): A payment and care delivery model designed to improve the effectiveness and efficiency of specialty care. Under the OCM, which was active from 2016-2022, physician practices, hospitals, teaching and academic centers, and payers entered into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients.[94,95]

Open Enrollment: The open enrollment period for Medicare is October 15 - December 7, every year. Medicare health plans and drug plans may change annually, including cost, coverage, and in-network providers and pharmacies. Patients with Medicare have the option to change their Medicare health plans and prescription drug coverage for the following year during this period to ensure the plans meet their needs.[96]

Oral Parity: State and federal legislation by which oral chemotherapeutic agents are provided under no less favorable financial terms than intravenous (IV) chemotherapy. As of June 2023, 43 states have oral parity laws, and the Cancer Drug Parity Act of 2023 was presented before Congress to reintroduce the oral parity legislation.[97]

Physician Fee Schedule: The reimbursement rates established for services provided by physicians to patients covered by Medicare. The Physician Fee Schedule is updated annually by the Centers for Medicare & Medicaid Services (CMS).[98]

Resource-Based Relative Value Scale (RBRVS): A common scale for pricing most physicians' services under Medicare Part B. This method is used to evaluate the relative costs of the resources needed to deliver services and procedures and to use those costs to determine and standardize the pricing of physicians' services. Many other payers use RBRVS relative values to pay physicians.[99]



Relative Value Units (RVUs): Established by the RBRVS system, this is the method for assessing the value of and paying for the services of health care providers within Medicare Part B.[99]

Sequestration: The automatic across the board cuts to federal government spending that were implemented as an austerity fiscal policy as part of the Budget Control Act of 2011. The cuts reduced the reimbursement rate for all cancer drugs purchased on behalf of Medicare patients.[100,101]

Site Parity: The move to make cancer care costs equal regardless of the site of care. The 2 sites usually considered in site parity are privately-owned physician offices and hospital outpatient departments.[102]

Social Determinants of Health (SDOH): Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH can be grouped into 5 domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.[103]

Stark Law/Physician Self Referral Law: The Physician Self-Referral Law, commonly referred to as the Stark Law, prohibits physicians from referring patients for certain "designated health services" payable by Medicare or Medicaid to entities with which the physician or an immediate family member has a financial relationship, such as ownership, investment, or compensation, unless an exception applies.[104,105]

Sunshine Act: A portion of the Affordable Care Act (ACA) that requires the manufacturers of drugs, medical devices, and biologicals that are participating in US federal health care programs to report payments and items of value given to physicians and teaching hospitals.[106]

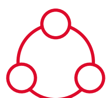
For more information about Medicare, visit cms.gov

Chapter 4: Practice Management

Practice management involves daily management of clinical and operational efficiencies as well as performance measurement and benchmarking. This section covers the care models, programs, and other aspects that affect practice management and payment.

340B Drug Pricing Program: A federal government program created in 1992 that requires drug manufacturers to provide outpatient drugs at significantly reduced prices to eligible health care organizations and covered entities.[107,108]

Alternate Payment Models (APMs): A payment approach that rewards providers for delivering high-quality and cost-efficient care.[109]



Advanced Alternative Payment Models (AAPMs): A subset of APMs that let practices earn more rewards in exchange for taking on risks related to expenditures and patient outcomes.[109]

Cancer Care Delivery System: The system of the various sources of cancer care available including physician-owned practices (commonly referred to as community oncologists), hospital-based oncologists and cancer care centers, and academic or teaching institutions.[110]

Clinically Integrated Network (CIN): CINs represent a model of health care that integrates larger organizations like hospitals with a network of specialists and independent physicians.[111]

Community Oncologist: An oncologist working in private practice, alone or as part of a group, that is privately owned, and not part of a hospital-based, corporately owned, or academic institution.[112]

Electronic Health Record (EHR): An electronic version of a patient's medical history that is maintained by the provider and includes all of the key administrative clinical data relevant to that patient's care.[113]

Exempt Cancer Hospitals: The hospitals excluded from payment under the Inpatient Prospective Payment System. CMS has designated 11 hospitals as PPS-Exempt Cancer Hospitals or Medicare PPS-Excluded Cancer Hospitals.[114]

CMS, Centers for Medicare & Medicaid Services; PPS, prospective payment system.

In-House Dispensing Pharmacy: A pharmacy within a medical practice that provides prescription drugs and supports patient safety and compliance through counseling when the drugs are dispensed. Typically, this type of pharmacy limits its drug dispensing to patients of the practice.[115]

In-House Retail Pharmacy: A pharmacy within a medical practice that provides prescription drugs and supports patient safety and compliance through counseling when the drugs are dispensed. Typically, this type of pharmacy dispenses drugs to patients as well as the general public.[116]

Integrated Clinical Pathways: Task-oriented care plans detailing essential steps of a patient's care referring to a specific clinical problem with a patient's expected clinical course.[117]

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): MACRA replaces the previous Medicare reimbursement schedule with a new pay-for-performance program that is focused on quality, value, and accountability. Physicians can choose between two Medicare payment tracks (MIPS and APMs) that adjust provider payments based on specific performance categories related to cost and quality.[118,119]

Merit-Based Incentive Payment System (MIPS): A CMS program that, based on a composite performance score, eligible professionals may receive a payment bonus, a payment penalty, or no payment adjustment. The composite performance score is based on 4 performance categories: Quality, Improvement Activities, Promoting Interoperability, and Cost.[120]

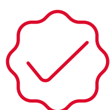
National Cancer Treatment Alliance (NCTA): The National Cancer Treatment Alliance is a clinically integrated network (CIN) of leading oncology practices and pharmacies across the country. Its unique structure allows NCTA community oncology practices to work together and directly with health plan sponsors to ensure patients receive high-quality, patient-centered, and lower-cost cancer care.[121]

National Comprehensive Cancer Network (NCCN) Guidelines®: The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) are the recognized standard for clinical direction and policy in cancer care. These guidelines are frequently updated and provide sequential management decisions and interventions that currently apply to 97% of cancers affecting patients in the United States.[122]

CHIP, Children's Health Insurance Program; CMS, Centers for Medicare & Medicaid Services.

Oncology Medical Home – ASCO Certified Patient-Centered Cancer Care Certification Program: Innovations in alternative payment models need complementary innovations in care delivery in order to achieve meaningful savings and improve quality. These include 7 Domains: (1) Patient Engagement, (2) Availability and Access to Care, (3) Evidence-Based Medicine, (4) Equitable and Comprehensive Team-Based Care, (5) Quality Improvement, (6) Goals of Care and Palliative and End-of-Life Discussions, and (7) Chemotherapy Safety. These innovations collectively become patient-centered cancer care.[123-125]

This certification program is powered by the Community Oncology Alliance (COA)/ American Society of Clinical Oncology (ASCO) standards including site surveys consisting of care delivery, chemotherapy safety (QOPI® Certification Program) standards, policy, process, medical record review, communication to the entire provider team, and ongoing oversight.[123-125]



Electronic Patient-Reported Outcomes (ePROs): ePROs expands a layer in the Oncology Medical Home (OMH), identifying and reporting upon direct-to-patient queries during various junctures of the cancer treatment journey. At a time when quality and value matter more than ever, obtaining sequential and timely reporting from the patient in active care, is invaluable.[126,127]

Prospective Payment System (PPS): A method of reimbursement in which Medicare payment is established in advance.[128]

Ryan White HIV/AIDS Program (RWHAP): RWHAP provides a comprehensive system of care that includes primary medical care, medication, and essential support services for people living with HIV who are uninsured or underinsured. The program works with cities, states, and local community-based organizations to provide HIV care and treatment services to more than half a million people each year. The program reaches more than half of all people diagnosed with HIV in the United States.[129]

USP 797 – Pharmaceutical Compounding – Sterile Preparations: A set of enforceable sterile compounding standards issued by the United States Pharmacopeia (USP). USP 797 describes the guidelines, procedures, and compliance requirements for compounding sterile preparations and sets the standards that apply to all settings in which sterile preparations are compounded. The mixing of chemotherapy drugs is covered by USP 797.[130,131]

USP 800 – Key Changes and Additions to USP 797: Updates to USP 797 fell short due to a lack of guidance for non-parenteral products. USP 800 is a set of guidelines addressing the shortfall and deals with hazardous drug handling in health care settings.[132]

QOPI, Quality Oncology Practice Initiative.

Visas

H-1B Visa: The H-1B visa allows an H-1B visa holder to work temporarily at a sponsoring US employer. The H-1B visa may be preferable to the J-1 visa because it carries no 2-year J-1 Home Residence Requirement. The H-1B visa is for eligible physicians entering the United States to teach, perform research, or provide direct patient care. Initial validity is 3 years. The H-1B visa is renewable for up to 6 years but may be valid for longer in some circumstances.[133,134]

Immigrant Visa: An immigrant visa, also known as a green card or permanent resident status, permits a foreign citizen to permanently remain in the United States.[133]

J-1 Visa: The J-1 visa is a non-immigrant exchange visitor visa and is often used by International Medical Graduates (IMGs) pursuing a medical residency or fellowship training in the United States. The J-1 visa allows holders to remain in the United States until they complete their Graduate Medical Education.[133,134]

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COA is a non-profit 501(c)(6) organization dedicated to advocating for community oncology practices, the patients they serve, and the preservation of access to local, affordable care. COA is the only organization dedicated solely to community oncology where the majority of Americans with cancer are treated.

COA supports oncology patients and practices through a variety of initiatives, including COA Fellows Initiative, Community Oncology Pharmacy Association (COPA), COA Patient Advocacy Network (CPAN), and COA Administrators' Network (CAN).

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For more information, visit novartis.com/us-en/hcpresources or coafellows.org

The content herein reflects generally accepted terminology and concepts, but does not necessarily reflect the views or opinions of Novartis or COA.

References: 1. About the Affordable Care Act. US Department of Health and Human Services. https://www.hhs.gov/healthcare/about-the-aca/index.html **2.** No surprises: health insurance terms you should know. Centers for Medicare & Medicaid Services. Accessed February 29, 2024. https://www.cms.gov/files/document/nosurpriseactfactsheet-health-insurance-terms-you-should-know508c.pdf **3.** Balance billing - surprise bills. Centers for Medicare & Medicaid Services. Accessed February 29, 2024.https://www.cms.gov/glossary/balance-billing-surprise-bills **4.** US Department of Health and Human Services. Medicaid drug price comparison: average sales price to average wholesale price. June 2005. Accessed February 29, 2024. https://oig.hhs.gov/oei/reports/oei-03-05-00200.pdf **5.** Gencarelli DM. Average wholesale price for prescription drugs: is there a more appropriate pricing mechanism? National Health Policy Forum. NHPF Issue Brief No. 775. June 2022. Accessed February 29, 2024. https://www.ncbi.nlm.nih.gov/books/NBK561162/pdf/Bookshelf_NBK561162.pdf **6.** Review and approval. US Food & Drug Administration. Updated December 13, 2022. Accessed February 29, 2024. https://www.fda.gov/drugs/biosimilars/review-and-approval **7.** Payment bundling. HealthCare.gov. Accessed February 29, 2024. https://www.healthcare.gov/glossary/payment-bundling/ **8.** Business associate contracts. US Department of Health and Human Services. January 25, 2013. Updated on June 16, 2017. Accessed February 29, 2024. https://www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html **9.** Center for Healthcare Quality and Payment Reform. Healthcare payment glossary. Accessed February 29, 2024. https://glossary.chqpr.org/#Carve_Out **10.** State copay accumulator bans will affect 19% of US commercial lives. Avalere. May 13, 2022. Updated June 22, 2023. Accessed February 29, 2024. https://avalere.com/insights/state-copay-accumulator-bans-impact-11-of-us-commercial-lives **11.** Fein AJ. Copay accumulator and maximizer update: adoption plateaus as insurers battle patients over copay support. Drug Channels.net. February 22, 2023. Accessed February 29, 2024. https://www.drugchannels.net/2023/02/copay-accumulator-and-maximizer-update.html **12.** What is commercial health insurance? MedicalBillingandCoding.org. Accessed February 29, 2024. https://www.medicalbillingandcoding.org/health-insurance-guide/commercial-health-insurance/ **13.** Legal recognition - standards categories. The United States Pharmacopeia. Accessed February 29, 2024. https://www.usp.org/about/legal-recognition/standard-categories **14.** Cost sharing. HealthCare.gov. Accessed February 29, 2024. https://www.healthcare.gov/glossary/cost-sharing/ **15.** CPT® overview and code approval. American Medical Association. Accessed February 29, 2024. https://www.ama-assn.org/print/pdf/node/34456 **16.** US Department of Health and Human Services. Medicare hospital prospective payment system: How DRG rates are calculated and updated. August 2001. Accessed February 27, 2024. https://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf **17.** Lopez E, Claxton G, Schwartz K, Rae M, Ochieng N, Neuman T. Comparing private payer and Medicare payment rates for select inpatient hospital services. KFF. July 7, 2020. Accessed February 29, 2024. https://www.kff.org/report-section/comparing-private-payer-and-medicare-payment-rates-for-select-inpatient-hospital-services-methods/ **18.** What Medicare Part D drug plans cover. Medicare.gov. Accessed February 29, 2024. https://www.medicare.gov/drug-coverage-part-d/what-medicare-part-d-drug-plans-cover **19.** What Marketplace health insurance plans cover. HealthCare.gov. Accessed February 29, 2024. https://www.healthcare.gov/coverage/what-marketplace-plans-cover/ **20.** Federal poverty level (FPL). HealthCare.gov. Accessed February 29, 2024. https://www.healthcare.gov/glossary/federal-poverty-level-fpl/ **21.** Federally qualified health centers: an overview. Center for Healthcare Research & Transformation. Accessed February 29, 2024. https://chrt.sites.uofmhosting.net/wp-content/uploads/2013/07/CHRT_Federally-Qualified-Health-Centers-An-Overview-.pdf **22.** Medicare federally qualified health center advanced primary care practice demonstration. Centers for Medicare & Medicaid Services. October 24, 2011. Accessed February 29, 2024. https://www.cms.gov/newsroom/fact-sheets/medicare-federally-qualified-health-center-advanced-primary-care-practice-demonstration **23.** Fee for service. HealthCare.gov. Accessed February 29, 2024. https://www.healthcare.gov/glossary/fee-for-service/ **24.** Formulary. HealthCare.gov. https://www.healthcare.gov/glossary/formulary/ **25.** Health Insurance Marketplace®. HealthCare.gov. https://www.healthcare.gov/glossary/health-insurance-marketplace-glossary/ **26.** Health Maintenance Organization (HMO). HealthCare.gov. Accessed February 29, 2024. https://www.healthcare.gov/glossary/health-maintenance-organization-hmo/ **27.** HCPCS (HCPCS - Healthcare Common Procedure Coding System) - synopsis. National Library of Medicine. Accessed February 29, 2024. https://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/HCPCS/index.html **28.** Health Insurance Portability and Accountability Act of 1996 (HIPAA). Centers for Disease Control and Prevention. Updated June 27, 2022. Accessed February 29, 2024. https://www.cdc.gov/phlp/publications/topic/hipaa.html **29.** International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). Centers for Disease Control and Prevention. Accessed February 29, 2024. https://www.cdc.gov/nchs/icd/icd-10-cm.htm **30.** ICD-10-CM official guidelines for coding and reporting FY 2022. Centers for Medicare & Medicaid Services. Updated April 1, 2022. Accessed February 29, 2024. https://www.cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines-updated-02012022.pdf **31.** What's a formulary and how do they work? UnitedHealthcare. Accessed February 29, 2024. https://www.uhc.com/communityplan/dual-special-needs-plans/benefits/medicare-medicaid-formulary-drug-list **32.** Out-of-pocket costs. HealthCare.gov. Accessed February 29, 2024. https://www.healthcare.gov/glossary/out-of-pocket-costs/ **33.** Payor. Definitive Healthcare. Accessed February 29, 2024. https://www.definitivehc.com/resources/glossary/payor **34.** Drug spending glossary. The Pew Charitable Trusts. September 20, 2017. Updated November 30, 2017. Accessed February 29, 2024. https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2017/09/drug-spending-glossary **35.** The importance of a thorough benefits investigation to help navigate medical vs pharmacy benefit. National Association of Medication Access & Patient Advocacy. Accessed February 29, 2024. https://www.namapa.org/medical-vs-pharmacy-benefit **36.** Pre-existing conditions. US Department of Health and Human Services. Accessed February 29, 2024. https://www.hhs.gov/healthcare/about-the-aca/pre-existing-conditions/index.html **37.** Grandfathered health plan. HealthCare.gov. Accessed February 29, 2024. https://www.healthcare.gov/glossary/grandfathered-health-plan/ **38.** Lane SG, Longstreth E, Nixon V, Kane NM. A community leader's guide to hospital finance: evaluating how a hospital gets and spends its money. National Academy for State Health Policy. Updated 2020. Accessed February 29, 2024. https://www.nashp.org/wp-content/uploads/2020/07/A-Community-Leaders-Guide-to-Hospital-Finance2.pdf **39.** Report to the Congress: Medicare and the Health Care Delivery System. Chapter 3: Part B drug payment policy issues. MedPAC. June 2015. Accessed February 29, 2024. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-3-part-b-drug-payment-policy-issues-june-2015-report-.pdf **40.** What is a qualified health plan? Healthinsurance.org. Accessed March 1, 2024. https://www.healthinsurance.org/glossary/qualified-health-plan/ **41.** Chernew ME. Disparities in payment across sites encourage consolidation. *Health Serv Res*. 2021; 56(1):5-6. doi: 10.1111/1475-6773.13612. **42.** Hematology/Oncology Pharmacy Association. Site of care issue brief. Accessed March 1, 2024. https://www.hoparx.org/documents/61/Site_of_Care_Issue_Brief_10.20.22_V.4.pdf **43.** Milliman. Site of service cost differences for Medicare patients receiving chemotherapy. October 19, 2011. Accessed March 1, 2024. https://us.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/health-published/site-of-service-cost-differences.ashx **44.** Collins SR, Haynes LA, Masitha R. The State of U.S. health insurance in 2022: findings from the Commonwealth Fund Biennial Health Insurance Survey. The Commonwealth Fund. Accessed March 1, 2024. https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey **45.** Value-based purchasing (VBP). HealthCare.gov. Accessed March 1, 2024. https://www.healthcare.gov/glossary/value-based-purchasing-vbp/ **46.** Value in cancer care. American Society of Clinical Oncology. Accessed March 1, 2024. https://old-prod.asco.org/news-initiatives/current-initiatives/cancer-care-initiatives/value-cancer-care **47.** Mattingly J. Understanding drug pricing. U.S. Pharmacist. June 20, 2012. Accessed March 1, 2024. https://www.uspharmacist.com/article/understanding-drug-pricing **48.** Appealing a health plan decision. Internal appeals. HealthCare.gov. Accessed March 1, 2024. https://www.healthcare.gov/appeal-insurance-company-decision/internal-appeals/ **49.** Appealing a health plan decision. How to appeal an insurance company decision. HealthCare.gov. Accessed March 1, 2024. https://www.healthcare.gov/appeal-insurance-company-decision/appeals/ **50.** Things to include in your appeal letter. Patient Advocate Found. Accessed March 1, 2024. https://www.patientadvocate.org/explore-our-resources/insurance-denials-appeals/things-to-include-in-your-appeal-letter/ **51.** Emerging pharma trends. Hospital System Owned Pharmacy Alliance. Accessed March 1, 2024. https://hospalliance.org/gold-bagging-is-the-newest-emerging-terminology-in-the-system-owned-specialty-pharmacy-arena/ **52.** Werble, C. Medicare Part B. Health Affairs Health. August 10, 2017. Accessed March 1, 2024. doi: 10.1377/hpb20171008.000171 **53.** New Jersey Administrative Code, Title 13. Law and Public Safety, Chapter 39, State Board of Pharmacy. N J Division of Consumer Aff. Updated October 17, 2022. Accessed March 1, 2024. https://www.njconsumeraffairs.gov/regulations/chapter-39-state-board-of-pharmacy.pdf **54.** Association of Community Cancer Centers. Dispensing pharmacy: a value proposition for oncology practices. Accessed March 1, 2024. https://www.accc-cancer.org/docs/projects/pdf/dispensing-pharmacy-a-value-proposition-for-oncology-practices **55.** Employee Retirement Income Security Act (ERISA). US Department of Labor. Accessed March 1, 2024. https://www.dol.gov/general/topic/retirement/erisa **56.** Hussaini SMQ, Gupta A, Dusetzina SB. Financial toxicity of cancer treatment. *JAMA Oncol.* 2022;8(5):788. doi:10.1001/jamaoncol.2021.7987. **57.** Joszt L. Addressing financial toxicity with patients and health systems. AJMC. July 23, 2021. Accessed March 1, 2024. https://www.ajmc.com/view/addressing-financial-toxicity-with-patients-and-health-systems **58.** What is health equity? Centers for Disease Control and Prevention. Accessed March 1, 2024. https://www.cdc.gov/healthequity/whatis/index.html **59.** COA Patient Advocacy Network. The impact of health equity on cancer care. Accessed March 1, 2024. https://coaadvocacy.org/events/the-impact-of-health-equity-on-cancer-care/ **60.** Pestaina K and Pollitz K. Examining prior authorization in health insurance. KFF. Published May 20, 2022. Accessed March 1, 2024. https://www.kff.org/policy-watch/examining-prior-authorization-in-health-insurance/ **61.** McCain J. Connecting patients with specialty products. Part 1: Distribution models for biologics and other specialty pharmaceutical products. *Biotechnology Healthcare*. 2012;9(2):8-13. Accessed March 1, 2024. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3411231/pdf/bh0902008.pdf **62.** DeLoach LA, Leonard CE, Galdo JA. Specialty pharmacy: what's the impact on community practice? Published May 17, 2016. Accessed March 1, 2024. U.S. Pharmacist. Ahttps://www.uspharmacist.com/article/specialty-pharmacy-whats-the-impact-on-community-practice **63.** What's so special about specialty pharmacy? A user's guide to specialty pharmacies. Patient Advocate Foundation. Accessed March 1, 2024. https://www.patientadvocate.org/wp-content/uploads/Specialty-Pharmacy.pdf **64.** Nice Rx Health. What is a letter of medical necessity? Accessed March 1, 2024. https://www.nicerx.com/blog/letter-of-medical-necessity/ **65.** Jenkins NB, Nichols DE. Varied use of step therapy among Medicare Advantage plans. *Am J Manag Care*. 2023;29(9):464-468. doi: 10.37765/ajmc.2023.89426. **66.** Giardino AP, Wadhwa R. Utilization management. National Library of Medicine. Updated July 10. 2023. Accessed March 1, 2024. https://www.ncbi.nlm.nih.gov/books/NBK560806 **67.** Edwards ML, Yin PT, Kuehn M, et al. Physician perceptions of drug utilization management: results of a national survey. *PLoS One*. 2022;17(9):e0274772. doi: 10.1371/journal.pone.0274772. **68.** Hanna J. Vertical integration in health care: the next stairway to heaven? Pharmacy Times. A Published July 16, 2019. Accessed March 1, 2024. https://www.pharmacytimes.com/view/vertical-integration-in-health-care-the-next-stairway-to-heaven **69.** Fein AJ. The top pharmacy benefit managers of 2022: market share and trends for the biggest companies. Drugchannels.com.

Published May 23, 2023. Accessed March 1, 2024. https://www.drugchannels.net/2023/05/the-top-pharmacy-benefit-managers-of.html **70.** Landi H. With Oak Street Health deal, CVS pushes healthcare ambitions as investment in value- based care heats up. Fierce Healthcare. Published February 9, 2023. Accessed March 1, 2024. https://www.fiercehealthcare.com/providers/oak-street-health-deal-cvs-doubled-down-healthcare-strategy-investment-value-based-care **71.** Accountable Care Organizations (ACOs): general information. Centers for Medicare & Medicaid Services. Accessed March 1, 2024. https://www.cms.gov/priorities/innovation/innovation-models/ACO **72.** APC (Ambulatory Payment Classifications) FAQ. American College of Emergency Physicians. Accessed March 1, 2024. https://www.acep.org/administration/reimbursement/reimbursement-faqs/apc-ambulatory-payment-classifications-faq **73.** About CMS. Centers for Medicare & Medicaid Services. Accessed March 1, 2024. https://www.cms.gov/about-cms **74.** HHS agencies & offices. US Department of Health and Human Services. Accessed March 1, 2024. https://www.hhs.gov/about/agencies/hhs-agencies-and-offices/index.html **75.** Innovation center strategy refresh. Centers for Medicare & Medicaid Services. Accessed March 1, 2024. https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper **76.** Medicare Part D – Direct and Indirect Remuneration (DIR). Centers for Medicare & Medicaid Services. January 19, 2017. Accessed February 27, 2024. https://www.cms.gov/newsroom/fact-sheets/medicare-part-d-direct-and-indirect-remuneration-dir **77.** Frier Levitt. DIR fees. Accessed March 1, 2024. https://www.frierlevitt.com/what-we-do/pharmacy-law/dir-fees/ **78.** Cubanski J, Neuman T. Changes to Medicare Part D in 2024 and 2025 under the Inflation Reduction Act and how enrollees will benefit. KFF. April 20, 2023. Accessed March 1, 2024. https://www.kff.org/medicare/issue-brief/changes-to-medicare-part-d-in-2024-and-2025-under-the-inflation-reduction-act-and-how-enrollees-will-benefit/ **79.** Donut hole (Medicare prescription drug). HealthCare.gov. Accessed March 1, 2024. https://www.healthcare.gov/glossary/donut-hole-medicare-prescription-drug/ **80.** Dually eligible individuals - categories. Centers for Medicare & Medicaid Services. Accessed March 1, 2024. https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/downloads/medicaremedicaidenrolleecategories.pdf **81.** Enhancing oncology model. Centers for Medicare & Medicaid Services. Accessed March 1, 2024. https://www.cms.gov/priorities/innovation/innovation-models/enhancing-oncology-model **82.** Documentation and files. Centers for Medicare & Medicaid Services. Accessed March 1, 2024. https://www.cms.gov/medicare/physician-fee-schedule/search/documentation **83.** Medicare payment primers: the hospital outpatient prospective payment system. PYA. May 2, 2023. Accessed March 1, 2024. https://www.pyapc.com/insights/medicare-payment-primers-hospital-outpatient-prospective-payment-system-part-6/ **84.** CY 2024 Medicare hospital outpatient prospective payment system and ambulatory surgical center payment system final rule (CMS 1786-FC). Centers for Medicare & Medicaid Services. November 2, 2023. Accessed March 1, 2024. https://www.cms.gov/newsroom/fact-sheets/cy-2024-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0 **85.** Cubanski J, Neuman T, Freed M. Explaining the prescription drug provisions in the Inflation Reduction Act. KFF. Published January 24, 2023. Accessed March 1, 2024. https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/ **86.** What to do if you no longer automatically qualify for extra help with Medicare drug costs. Medicare.gov. September 2022. Accessed March 1, 2024. https://www.medicare.gov/publications/11215-extra-help-not-automatically-qualify.pdf **87.** Low income subsidy for Medicare prescription drug coverage. Centers for Medicare & Medicaid Services. Accessed March 1, 2024. https://cms.gov/medicare/enrollment-renewal/part-d-plans/low-income-subsidy **88.** What you'll pay in out-of-pocket Medicare costs in 2024. National Council on Aging. October 13, 2023. Accessed March 1, 2024. https://www.ncoa.org/article/what-you-will-pay-in-out-of-pocket-medicare-costs-in-2024 **89.** What is Medicaid expansion? HealthInsurance.org. Accessed March 1, 2024. https://www.healthinsurance.org/glossary/medicaid-expansion/ **90.** What's Medicare? Medicare.gov. Accessed March 1, 2024. https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare **91.** Parts of Medicare. Medicare.gov. Accessed March 1, 2024. https://www.medicare.gov/basics/get-started-with-medicare/medicare-basics/parts-of-medicare **92.** Congressional Research Service. Finding Medicare Fee-For-Service (FFS) payment system rules: schedules and resources. Updated June 28, 2023. Accessed March 1, 2024. https://crsreports.congress.gov/product/pdf/R/R46797 **93.** What we do. MedPAC. Accessed March 1, 2024. https://www.medpac.gov/what-we-do/ **94.** Kline R, Adelson K, Kirshner JJ, et al. The Oncology Care Model: perspectives from the Centers for Medicare & Medicaid Services and participating oncology practices in academia and the community. *Am Soc Clin Oncol Educ Book*. 2017;37:460-466. doi: 10.1200/EDBK_174909. **95.** Oncology Care Model. Centers for Medicare & Medicaid Services. Accessed March 1, 2024. https://www.cms.gov/priorities/innovation/innovation-models/Oncology-Care **96.** Medicare open enrollment. Centers for Medicare & Medicaid Services. Accessed March 1, 2024. https://www.cms.gov/priorities/key-initiatives/medicare-open-enrollment-partner-resources **97.** Patient and provider advocates applaud Senate reintroduction of the Cancer Drug Parity Act. International Myeloma Foundation. June 16, 2023. Accessed March 1, 2024. https://www.myeloma.org/news-events/multiple-myeloma-news/patient-provider-advocates-applaud-Senate-reintroduction-Cancer-Drug-Parity-Act **98.** Fee schedules - general information. Centers for Medicare & Medicaid Services. Accessed March 1, 2024. https://www.cms.gov/medicare/payment/fee-schedules **99.** Buntin MB, Escarce J, Goldman D, et al. Appendix A, Payment for Physicians' Services Under the Resource Based Relative Value Scale. Accessed March 1, 2024. https://www.ncbi.nlm.nih.gov/books/NBK43875/ **100.** Community Oncology Alliance. The financial impact of the sequester cut to Medicare Part B drug reimbursement in community oncology. AJMC. August 29, 2018. Accessed March 1, 2024. https://www.ajmc.com/view/the-financial-impact-of-the-sequester-cut-to-medicare-part-b-drug-reimbursement-in-community-oncology **101.** Weidner S, Diaz M, Schaedig C, Gordan L. Observations regarding the average sales price reimbursement methodology. AJMC. 2021;27(4):SP156-SP160. Accessed March 1, 2024. https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care **102.** Equalizing Medicare payments regardless of site-of-care. Committee for a Responsible Federal Budget. February 23, 2021. Accessed March 1, 2024. https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care **103.** Hinnant L, Hairgrove S, Kane H, Williams J, Cance JD. Social determinants of health: a review of publicly available indices. Research Triangle Park (NC): RTI Press. Published online December 2022. doi:10.3768/rtipress.2022.op.0081.2212. **104.** Physician self-referral. Centers for Medicare & Medicaid Services. Accessed March 1, 2024. https://www.cms.gov/medicare/regulations-guidance/physician-self-referral **105.** Fraud & abuse laws. US Department of Health and Human Services. Accessed March 1, 2024. https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/ **106.** Physician Payment Sunshine Act. American Psychiatric Association. Accessed March 1, 2024. https://www.psychiatry.org/psychiatrists/practice/sunshine-act **107.** American Hospital Association. The 340B Program: how it delivers value to patients and providers. Accessed March 1, 2024. https://www.aha.org/system/files/media/file/2023/05/the-340b-program-how-it-delivers-value-to-patients-and-providers.pdf **108.** Desai SM, McWilliams JM. The 340B Drug Pricing Program and hospital provision of uncompensated care. *Am J Manag Care*. 2021;27(10):432-437. doi:10.37765/ajmc.2021.88761. **109.** US Department of Health and Human Services. Common Alternative Payment Model (APM) approaches: reference guide. January 2021. Accessed March 1, 2024. https://aspe.hhs.gov/sites/default/files/private/aspe-files/207901/common-apms-reference-guide-2021.pdf **110.** Bosserman LD, Cianfrocca M, Yuh B, et al. Integrating academic and community cancer care and research through multidisciplinary oncology pathways for value-based care: a review and the city of hope Experience. *J Clin Med*. 2021;10(2):188. doi:10.3390/jcm10020188. **111.** About us. Henry Ford Health. Accessed March 1, 2024. https://www.henryford.com/hcp/hfpn/about-us **112.** Desch CE, Blayney DW. Making the choice between academic oncology and community practice: the big picture and details about each career. *J Oncol Pract*. 2006;2(3):132-136. doi:10.1200/jop.2006.2.3.132. **113.** Electronic health records. Centers for Medicare & Medicaid Services. Accessed March 1, 2024. https://www.cms.gov/priorities/key-initiatives/e-health/records **114.** PPS-exempt cancer hospitals (PCHs). Centers for Medicare & Medicaid Services. Accessed March 1, 2024. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/pps-exempt-cancer-hospitals-pchs **115.** In-house dispensing for primary care medicine: a guide for doctors. ProficientRx. November 8, 2022. Accessed March 1, 2024. https://proficientrx.com/in-house-dispensing-primary-care-medicine-guide/ **116.** In-sourcing retail pharmacy. Deloitte. Accessed March 1, 2024. https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/insourcing-retail-pharmacy-performance-improvement-series.html **117.** Ardito C, Caivano D, Colizzi L, Dimauro G, Verardi L. Design and execution of integrated clinical pathway: a simplified meta-model and associated methodology. Information. 2020;11(7):362. Accessed March 1, 2024. https://doi.org/10.3390/info11070362 **118.** What's MACRA? Centers for Medicare & Medicaid Services. Updated September 6, 2023. Accessed March 1, 2024. https://www.cms.gov/medicare/quality/value-based-programs/chip-reauthorization-act **119.** Hussey PS, Liu JL, White C. The Medicare Access and CHIP Reauthorization Act: effects on Medicare payment policy and spending. *Health Aff* (Millwood). 2017;36(4):697-705. doi:10.1377/hlthaff.2016.0559. **120.** Merit-Based Incentive Payment System (MIPS). American Academy of Physical Medicine and Rehabilitation. Accessed March 1, 2024. https://www.aapmr.org/quality-practice/quality-reporting/merit-incentive-payment-system **121.** About NCTA. National Cancer Treatment Alliance. Accessed March 1, 2024. https://nctacancer.com/about-ncta/ **122.** About clinical practice guidelines. National Comprehensive Cancer Network. Accessed March 1, 2024. https://www.nccn.org/guidelines/guidelines-process/about-nccn-clinical-practice-guidelines **123.** Woofter K, Kennedy EB, Adelson K, et al. Oncology Medical Home: ASCO and COA standards. *JCO Oncol Pract*. 2021;17(8):475-492. doi:10.1200/OP.21.00167. **124.** What is the Oncology Medical Home? Oncology Medical Home. Accessed March 1, 2024. https://medicalhomeoncology.org/about/ **125.** The seven domains of the OMH standards. Oncology Medical Home. Accessed March 1, 2024. https://medicalhomeoncology.org/key-domains/the-seven-domains-of-the-omh-standards/ **126.** Pritchett JC, Patt D, Thanarajasingam G, Schuster A, Snyder C. Patient-reported outcomes, digital health, and the quest to improve health equity. *Am Soc Clin Oncol Educ Book*. 2023:43:e390678. doi:10.1200/EDBK_390678. **127.** Rocque GB, Dent DN, Ingram SA, et al. Adaptation of remote symptom monitoring using electronic patient-reported outcomes for implementation in real-world settings. *JCO Oncol Pract*. 2022;18(12):e1943-e1952. doi:10.1200/OP.22.00360. **128.** Prospective payment systems - general information. Centers for Medicare & Medicaid Services. Accessed March 1, 2024. https://www.cms.gov/medicare/payment/prospective-payment-systems **129.** Health Resources & Services Administration. Ryan White HIV/AIDS Program biennial reports. Accessed March 1, 2024. https://ryanwhite.hrsa.gov/data/biennial-reports **130.** Prosper C. USP <797> Updated guidelines. Drug Topics Journal. 2023;167(8). April 3, 2023. Accessed March 1, 2024. https://www.drugtopics.com/view/usp-797-updated-guidelines **131.** General chapter <797>. Pharmaceutical Compounding – Sterile Preparations. United States Pharmacopeia. Accessed March 1, 2024. https://www.usp.org/compounding/general-chapter-797 **132.** USP: key changes and additions to USP. Pharmacy Practice in Focus: Health Systems. 2016;5(4). Page MR. Accessed March 1, 2024. https://www.pharmacytimes.com/view/usp-800-key-changes-and-additions-to-usp-797 **133.** Immigration information for international medical graduates. American Medical Association. Accessed March 1, 2024. https://www.ama-assn.org/education/international-medical-education/immigration-information-international-medical-graduates **134.** International Medical Graduates (IMG) toolkit: Types of visas & FAQs. American Medical Association. Accessed March 1, 2024. https://www.ama-assn.org/education/international-medical-education/international-medical-graduates-img-toolkit-types-visas

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