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Oncology Care Model
Overview and Application Process

Centers for Medicare & Medicaid Services Innovation Center (CMMI)

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Innovation at CMS

Center for Medicare & Medicaid Innovation (Innovation Center)

- Established by section 1115A of the Social Security Act (as added by Section 3021 of the Affordable Care Act)
- Created for purpose of developing and testing innovative health care payment and service delivery models within Medicare, Medicaid, and CHIP programs nationwide

Innovation Center priorities:

- Test new payment and service delivery models
- Evaluate results and advancing best practices
- Engage a broad range of stakeholders to develop additional models for testing

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Innovation Center Models

Goals of Innovation Center models:

- Better care
- Smarter spending
- Healthier people

Models range in focus, including:

- Accountable Care Organizations
- Primary Care Transformation
- Bundled Payments for Care Improvement
- New emphasis on specialty care models

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Oncology Care Background

- One specialty practice area where the Innovation Center aims to improve effectiveness and efficiency is oncology care.
- More than 1.6 million people are diagnosed with cancer in the United States each year. Approximately half of those diagnosed are over 65 years old and Medicare beneficiaries. Cancer patients comprise a medically complex and high-cost population served by the Medicare program.
- About 50% of patients in oncology practices are Medicare beneficiaries
- The Innovation Center has the opportunity to further its goals of better care, smarter spending, healthier people through an oncology payment model.

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Oncology Care Model (OCM)

- The Innovation Center's Oncology Care Model (OCM) focuses on an episode of cancer care, specifically a chemotherapy episode of care
- The goals of OCM are to utilize appropriately aligned financial incentives to improve:
    1) Care coordination
    2) Appropriateness of care
    3) Access for beneficiaries undergoing chemotherapy
- Financial incentives encourage participating practices to work collaboratively to comprehensively address the complex care needs of beneficiaries receiving chemotherapy treatment, and encourage the use of services that improve health outcomes.

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OCM Overview

Episode-based

Payment model targets chemotherapy and related care during a 6-month period following the initiation of chemotherapy treatment

Emphasizes practice transformation

Physician practices are required to engage in practice transformation to improve the quality of care they deliver

Multi-payer model

Includes Medicare fee-for-service and other payers working in tandem to leverage the opportunity to transform care for oncology patients across the population

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Participants: Physician Practices

Physician practices that are Medicare providers and furnish chemotherapy may apply to participate in OCM.

Practices are expected to engage in practice transformation to improve the quality of care they deliver. This transformation is driven by OCM's 6 practice requirements:

1) Provide 24/7 patient access to an appropriate clinician who has real-time access to patient's medical records

Aim to better meet patients' needs by providing around-the-clock access to a clinician who can provide real-time, individualized medical advice

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Practice Requirements

2) Use an ONC-certified EHR and attest to Stage 2 of meaningful use (MU) by the end of the third model performance year

OCM Practices must demonstrate progress by attesting to MU Stage 1 by end of the first model performance year

3) Utilize data for continuous quality improvement

The Innovation Center will provide participating practices with rapid cycle data feedback reports to aid in quality improvement. Practices are expected to use this data to continuously improve OCM patient care management.

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Practice Requirements cont.

4) Provide core functions of patient navigation

Practices are required to provide patient navigation to all OCM patients. The National Cancer Institute provides a sample list of patient navigation activities (see Appendix B of the RFA)

5) Document a care plan for every OCM patient that contains the 13 components in the Institute of Medicine Care Management Plan

Plan components include treatment goals, care team, psychosocial support, and estimated patient out-of-pocket cost (see Appendix A of the RFA for full list)

6) Treat patients with therapies consistent with nationally recognized clinical guidelines

Practices must report which clinical guidelines (NCCN or ASCO) they follow for OCM patients, or provide a rationale for not following the clinical guidelines.

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Participants: Payers

OCM covers Medicare fee-for-service (OCM-FFS) and other payers (OCM-OP)

- Other payers may include commercial payers (including MA plans), state Medicaid agencies, or other governmental payers (including Tricare, FEHBP, and state employee health plans)

Payer participation will drive the geographical scope of the model

- The Innovation Center will publish lists of payers and practices who submit letters of intent to participate in OCM, and expects other payers to plan for OCM participation with their associated practices

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Payer Requirements

Operational

- Commit to participation in OCM for its 5-year duration, and begin performance period within 90 days of OCM-FFS' performance period
- Sign a Memorandum of Understanding with the Innovation Center
- Enter into agreements with OCM practices that include requirements to provide high quality care
- Share model methodologies with the Innovation Center
- Provide payments to practices for enhanced services and performance as described in the RFA

Quality Improvement Measures

- Align practice quality and performance measures with OCM, when possible

Data Sharing

- Provide participating practices with aggregate and patient-level data about payment and utilization for their patients receiving care in OCM, at regular intervals

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Target Beneficiary Population: OCM-FFS

Medicare beneficiaries who meet each of the following criteria will be included in OCM-FFS.

- Are eligible for Medicare Part A and enrolled in Medicare Part B
- Have Medicare FFS as their primary payer
- Do not have end-stage renal disease
- Are not covered under United Mine Workers
- Receive an included chemotherapy treatment for cancer under management of an OCM participating practice

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Episode Definition: OCM-FFS

Types of cancer

- OCM-FFS includes nearly all cancer types

Episode initiation

- Episodes initiate when a beneficiary starts chemotherapy
- The Innovation Center has devised a list of chemotherapy drugs that trigger OCM-FFS episodes, including endocrine therapies but excluding topical formulations of drugs

Included services

- All Medicare A and B services that Medicare FFS beneficiaries receive during episode
- Certain Part D expenditures will also be included

Episode duration

- OCM-FFS episodes extend six months after a beneficiary's chemotherapy initiation.
- Beneficiaries may initiate multiple episodes during the five-year model performance period

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Two-Part Payment Approach: OCM-FFS

During OCM, participating practices will be paid Medicare FFS payments.

Additionally, OCM has a two-part payment approach:

(1) Per-beneficiary-per-month (PBPM) payment

- $160 PBPM payment for enhanced services required by OCM that is paid during the chemotherapy episode
- OCM-FFS practices are eligible for the PBPM monthly for each month of the 6-month episode, unless beneficiary enters hospice

(2) Performance-based payment

- Incentive to lower the total cost of care and improve quality of care for beneficiaries over the 6-month episode period
- Retrospective payment that is calculated based on the practice's historical Medicare expenditures and achievement on selected quality measures

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Performance-Based Payment: OCM-FFS

1) CMS will calculate **benchmark** episode expenditures for participating practices
    - Based on historical data
    - Risk-adjusted, adjusted for geographic variation
    - Trended to the applicable performance period
2) A discount will be applied to the benchmark to determine a **target price** for OCM-FFS episodes
    - Example: Benchmark = $100 → Discount = 4% → Target Price = $96
3) If **actual** OCM-FFS episode Medicare expenditures are **below target** price, the practice could receive a performance-based payment
    - Example: Actual = $90 → Performance-based payment up to $6
4) The amount of the performance-based payment may be reduced based on the participant's achievement and improvement on a range of **quality measures**

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Risk Arrangement Options: OCM-FFS

One-Sided

- Participants are NOT responsible for Medicare expenditures that exceed target price
- 5-year model duration
- Medicare discount = 4%
- *Must qualify for performance-based payment by end of Year 3*

Two-Sided

- Participants are responsible for Medicare expenditures that exceed target price
- Option to take downside risk, beginning in Year 3 (one-sided risk for Years 1 and 2)
- Medicare discount = 2.75%
- *Must qualify for performance-based payment by end of Year 3*

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Benchmarking: OCM-FFS

- Benchmarking will be based on **historical Medicare expenditure data**
  - Based on both practice data and regional/national data as necessary to increase precision
  - Risk adjusted, adjusted for geographic variation
  - Trended to applicable performance period

- Participants in the same risk arrangement structure will all receive the same **discount** (4% in one-sided risk; 2.75% in two-sided risk)

- **Clinical trial** participants will be included

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Risk Adjustment: OCM-FFS

OCM-FFS will risk adjust for several factors that affect episodic expenditures. Possible risk adjustment factors include:

1) **Beneficiary characteristics** (such as age strata or comorbidities)
2) **Episode characteristics** (such as whether an episode is the first for that beneficiary)
3) **Disease characteristics** (such as cancer type)
4) **Types of services furnished** (such as provision of radiation therapy or initiation with an endocrine therapy)

Risk adjustment in Year 1 will be based solely on information available in claims data. Risk adjustment in subsequent years may incorporate additional factors not captured in claims data, such as cancer staging.

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Quality Measures: OCM-FFS

Quality measure domains:

1) Clinical quality of care
2) Communication and care coordination
3) Person and caregiver centered experience and outcomes
4) Population health
5) Efficiency and cost reduction
6) Patient safety

Data sources:

1) Practice-reported
2) Medicare claims
3) Patient surveys

List still in progress – will be finalized prior to practices signing agreements

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Quality Measures: Performance-Based Payment Subset

See Appendix F of the RFA for full list of preliminary quality measures

Quality Domain	Recommended practice requirement or quality measurement	NQF #	Source
Communication and Care Coordination	# of ED visits per OCM-FFS beneficiary per episode		Claims data
Communication and Care Coordination	# of hospital admissions per OCM-FFS beneficiary per episode		Claims data
Communication and Care Coordination	% of all Medicare FFS beneficiaries managed by the practice admitted to hospice for < 3 days	#0216	Claims data
Communication and Care Coordination	% of all Medicare FFS beneficiaries managed by the practice who experience ≥1 ED visit in the last 30 days of life	#0211	Claims data
Person-and Caregiver-Centered Experience and Outcome	% of OCM-FFS beneficiary face-to-face encounters with the participating practice in which there is a documented plan of care for pain AND pain intensity is quantified	#2100	Reported by practice
Person-and Caregiver-Centered Experience and Outcome	Score on patient experience survey (modified CAHPS)		Administered by CMS contractor
Person-and Caregiver-Centered Experience and Outcome	% of OCM-FFS beneficiary face-to-face encounters in which the patient is assessed by an approved patient-reported outcomes tool		Reported by practice
Person-and Caregiver-Centered Experience and Outcome	% of OCM-FFS beneficiaries that receive psychosocial screening and intervention at least once per episode		Reported by practice

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Monitoring and Evaluation: OCM-FFS

Participant monitoring activities may include:

- Tracking of claims data
- Patient surveys
- Site visits
- Analysis of quality measurement data
- Time and motion studies
- Medical record audits, tracking of patient complaints, and appeals

OCM will employ a non-randomized research design using matched comparison groups to detect changes in utilization, costs, and quality that can be attributed to the model

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Learning and Diffusion (L&D)

The OCM Learning System will provide:

- Topic-specific webinars that allow OCM participants to learn from each other
- An online portal to support learning through shared resources, tools, ideas, discussions, and data-driven approaches to care
- Action Groups in which practices work together virtually to explore critical topic areas and build capability to deliver comprehensive oncology care
- Site visits to better understand how practices manage services, use evidence-based care, and practice patient-centered care
- Coaching to help practices overcome barriers to improvement

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Program and Payment Overlap

Shared Savings Programs

- Participation in shared savings programs and OCM is allowed
- Examples of shared savings programs are: Pioneer Accountable Care Organizations (ACOs), Medicare Shared Savings Program (MSSP), Comprehensive Primary Care (CPC)

Other Models

- Transforming Clinical Practice Initiative (TCPI): Significant overlap between TCPI and OCM is not expected, and dual participation in both TCPI and OCM is not allowed

Care Management Services

- Chronic Care Management (CCM) and Transitional Care Management (TCM) services: Practices that bill the OCM PBPM cannot also bill for CCM or TCM services in the same month for the same beneficiary.

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Application Process Overview

- All interested practices and payers must submit a Letter of Intent (LOI) by 5pm EDT on April 9, 2015 (payers) or May 7, 2015 (practices)

  All LOIs must be emailed to OncologyCareModel@cms.hhs.gov.

  Applicants who submit timely, complete LOIs will be sent an authenticated web link and password to complete an electronic application.

  Application instructions and materials available on the OCM website: http://innovation.cms.gov/initiatives/oncology-care

- Innovation Center will publicly post lists of payers and practices who submit LOIs
- All applications due 5pm EDT on June 18, 2015
- Participants notified of selection late 2015; OCM begins spring 2016

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Application Materials

PAYER applications will include:

1) Signed Electronic Application Form
2) Implementation Plan Narrative

PRACTICE applications will include:

1) Signed Electronic Application Form
2) Implementation Plan Narrative
3) Financial Plan Narrative
4) Diverse Populations Narrative
5) Letters of Support from other payers or explanations of payer support, as applicable

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Contact Information

Oncology Care Model

CMMI Patient Care Models Group

OncologyCareModel@cms.hhs.gov

http://innovation.cms.gov/initiatives/Oncology-Care/

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