Oncology Care Model Frequently Asked Questions and Application Overview Webinar

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PRESENTATION

<u>Introduction:</u>

K. Cox: Thank you for joining us today for the CMS Innovation Center's Oncology Care Model Frequently Asked Questions and Application Overview Webinar, hosted by the OCM program team. My name is Katie Cox, and I'm joined by my colleagues Laura Mortimer and Dr. Heidi Schumacher.

During this webinar, we'll address several Frequently Asked Questions (FAQs) and provide an overview of the OCM application process. If you have any questions during today's webinar, please submit them through the Q&A feature and we will address them following the presentation. To submit a question, click on the "Q&A" button located on the top of your screen, enter your question in the text box, and click "Send."

Following the Q&A you will be asked to participate in a short survey regarding today's webinar. Please take a moment to complete the survey to help inform future OCM webinars. As a reminder, additional information is available on the OCM website including the updated Request For Applications, or RFA, Fact Sheet, and FAQs page. Additionally, the slides and a transcript of today's presentation will also be posted to the website within a week.

So I'll start with a quick overview of the model. The goals of OCM are to appropriately align financial incentives to improve care coordination, appropriateness of care, and access for beneficiaries undergoing chemotherapy. Practice transformation is really key to this model and is supported through the OCM practice requirements that are described in detail in the RFA. We will also be discussing those requirements in more detail later in the webinar.

OCM is an episode-based payment model, and the episodes are defined as six-month periods that are initiated by chemotherapy. They include the total cost of care that the beneficiary receives during the six-month episode.

Finally, OCM is a multi-payer model, and CMS has invited other payers to participate, along with Medicare, by aligning their own payment models with the Innovation Center's.

Frequently Asked Questions:

So we will begin today's discussion of the frequently asked questions by addressing practice eligibility and participation. This will include a list of the entities that are not eligible to participate in OCM as well as information to consider while planning your LOI submission.

I'll start with **practice eligibility**. Eligible OCM participants are physician group practices or solo practitioners who furnish chemotherapy to Medicare beneficiaries. This includes multi-specialty practices. Please note that in the LOI, we ask how many physicians are in the practice – applicants should include all physicians in this response, no matter their specialty. However, for OCM, only those practitioners who administer chemotherapy for cancer will actually trigger an OCM episode. The application thus asks for a list of those specific NPIs that prescribe chemotherapy for cancer.

We have also received several questions regarding the eligibility of hospital-owned or provider-based departments. These entities are eligible to participate in OCM. This also includes practices that partner with these entities for the infusion of chemotherapy. One important thing to note here is that these examples of the hospital-based departments must be paid under the Medicare outpatient and inpatient prospective payment systems (OPPS/IPPS) to be eligible to participate in OCM.

We have also added information on practice eligibility to our FAQs document, which can be seen on the OCM website.

Building off the previous slide, these are all examples of **entities that are not eligible to participate in OCM**. The biggest takeaway here is that these entities are not eligible because they're all paid on an alternative payment system other than the OPPS/IPPS. This also applies to physician practices that are formally affiliated with these excluded entities or partner with them for the provision of chemotherapy.

Some examples include the PPS-exempt cancer hospitals, Critical Access Hospitals, Federally Qualified Health Centers, Rural Health Clinics, and both Maryland hospitals and Maryland physician practices. These groups are ineligible for OCM participation because of the differences in their payment structures, as they are not paid under Medicare's outpatient and inpatient prospective payment system.

Something important to remember is while these entities are not eligible to participate in OCM, if a beneficiary that is primarily managed and treated by an OCM practice is admitted to or receives services from one of these

ineligible entities during their six-month episode, then the associated cost would still be included in the total cost of care.

In terms of practice eligibility, we've had many larger practices ask about the participation of **multi-site practices** or practices operating in multiple locations. The answer here is yes. All sites that bill under the applicant's tax identification number, or TIN, must participate. This is because we're enrolling participating practices at the TIN level, and so all sites that bill under the applicant's single TIN must also participate in OCM. If the practice wants to include other sites or locations that bill under a different TIN, these practices can participate separately. So they would need to submit their own LOIs in a separate application.

Of note, selected practices that are applying separately are able to elect to pool with other practices. This would allow them to partner together and to be benchmarked collectively. More information on pooling for practices that might be interested is included in the RFA, and we'll also be providing more information when we discuss applications.

Practices that are interested in or are already participating in certain shared savings programs such as Pioneer ACOs, the Medicare Shared Savings Program, and the Comprehensive Primary Care Initiative are still eligible to participate in OCM. However, OCM practices may not participate in both OCM and the new Transforming Clinical Practice Initiative, or TCPI.

Practices will not be allowed to bill both the OCM per-beneficiary-per-month (PBPM) payment and the chronic care management (CCM) or transitional care management (TCM) in the same month for the same beneficiary. Any overlap issues regarding participation in additional CMS programs will be worked out with OCM participants on a case-by-case basis.

So, now we'll move on to a discussion of **OCM episodes**. Many of the questions we've received regarding episodes have focused on their definition as well as what is included or excluded in the episode. So, we'll start now with how episodes are triggered.

OCM episodes are triggered with a Part B chemotherapy administration claim or a Part D chemotherapy claim and a diagnosis for cancer. Because OCM targets physician practices, only outpatient chemotherapy will trigger a new OCM episode. Something to remember here is that while inpatient chemotherapy will not trigger an episode, if an OCM beneficiary receives inpatient chemotherapy at some point during their six-month episode, then these costs will still be included in the total cost of care.

Another question includes how episodes will be triggered when the model's performance period begins. When the model starts, beneficiaries

who may have already been receiving chemotherapy treatment from a participating practice will still be included in the model. The first administration of an included chemotherapy after the model begins is what will trigger the first episode for that beneficiary.

We also understand that beneficiaries may receive chemotherapy treatments for periods, both shorter and longer, than the OCM's six-month episode. Because of this variation, beneficiaries may initiate multiple episodes during the five-year performance period. So for example, if a beneficiary is receiving chemotherapy continuously for the entire period of the model, then they would trigger ten consecutive episodes.

By far, the most common questions regarding episodes are, **"What services are included or excluded?"** So, I really want to emphasize that episodes include the total cost of care for the beneficiary during the six-month period, which means that no services furnished to the beneficiary during that episode will be excluded. This includes all Medicare Part A, Part B, and certain Part D expenditures and is not limited to just services for cancer care. Below is a list of some examples of services that would be included in an OCM episode, but again, all services that a beneficiary receives during that episode will be included.

OCM includes nearly all cancer types and focuses on all cancers that are treated with non-topical chemotherapy. Appendix D of the RFA includes a full list of the drugs that will trigger an OCM episode. I want to mention that this list does also include hormonal therapies used to treat a cancer diagnosis.

Because OCM is focused on chemotherapy treatment, all cancers that are treated with surgery, radiation, or topical chemotherapy are excluded from OCM. This means that participating practices can build a PBPM for Medicare beneficiaries receiving one of the included chemotherapies during each month of an episode, regardless of the cancer type. This is different from the performance-based payment where participating practices will be eligible for payments for beneficiaries with high-volume cancers for which it's possible to calculate a reliable benchmark. Laura will be discussing the OCM payments and answering questions in more detail later in this webinar.

Moving on we'll be discussing the **OCM practice requirements**. A complete list of these requirements is included in the RFA for you to review. The updated FAQs page on the OCM website also answers some specific questions in more detail, but I'll review some of the high-level points for meeting these requirements on the next slide.

So, here is a list of the six practice requirements that all OCM practices will be required to meet by the end of the first quarter of the first performance year. Practices will be expected to explain in their application both their plan for meeting these requirements as well as a realistic timeline for implementation. I'll touch on a few of the common questions we've received, but, again, feel free to continue submitting questions through the Q&A feature.

The first requirement is for practices to provide 24/7 access to a clinician that has access to the patient's medical records. To clarify, this clinician providing the 24/7 access for patients may be nurses, non-physician practitioners (NPPs), or physicians. The main requirement here is that these clinicians must be able to access the patients' records in real time through the practices electronic health records and also have the ability to escalate concerns to the appropriate physician or NPP as needed and in a timely fashion.

For number two, practices will be required to use EHRs that have been certified by the Office of National Coordinator for Health Information Technology or the ONC Certification Program.

The practice requirements also include the use of data for quality improvement. Practices will be working closely with CMS throughout the model to better understand their data, and this will be done through the OCM learning system.

Number four: Practices are required to fulfill the core functions of patient navigation and care coordination, which are described in the RFA. Also in Appendix B, we've provided the National Cancer Institute sample patient navigation activities for your reference. Something to note here is that practices do not necessarily have to hire additional staff to perform these functions. We're asking practices to explain in their application how they will ensure that the core patient navigation requirements are met.

For number five, the documentation and use of the IOM Care Plan, participating practices can use care management plans other than the IOM plan as long as the care plan documents all 13 elements of the IOM plan within the patient's EHRs at least once during each OCM episode.

Finally, the requirement to use chemotherapy that is consistent with clinical guidelines. Initially practices must attest to treating patients with therapies consistent with nationally recognized clinical guidelines such as ASCO or the National Comprehensive Cancer Network, NCCN. Practices will also be required to provide an explanation in cases where they do not follow the guidelines. CMS will provide guidance on more detailed reporting as the model progresses.

So, a little more on reporting data to CMS. Using data for quality improvement as well as for the monitoring and evaluation of the model are really key. Under OCM, practices will be required to report data back to CMS on a quarterly basis. To the extent possible, CMS will be using any existing data reporting system to try to minimize the reporting burden on practices and providers. The Innovation Center will be issuing quarterly monitoring reports to practices describing their performance on measures that will be used for monitoring purposes as well as the measures that will be used as part of their performance-based payment calculation.

And at this point, I'll turn it over to my colleague, Laura Mortimer, who will discuss OCM payments and the application process in more detail.

OCM Payments and Application Overview:

L. Mortimer: Thanks, Katie. Hello, everyone. This is Laura Mortimer. I'll be discussing questions around OCM payments and then payer participation in the model, and lastly, the application itself.

So, by now, hopefully, many of you have had a chance to read our RFA or participate on one of our previous webinars. So, we'll go through these next few slides somewhat quickly and focus on specific questions that we've received so far related to **OCM payments**.

During OCM episodes, providers will continue to bill standard Medicare Fee-for-Service payments for beneficiaries. In addition, OCM includes a $160 per-beneficiary-per-month (PBPM) payment for enhanced care management services, as well as a retrospective performance-based payment. Providers will bill Medicare for the PBPMs using a new G code, so those payments don't happen automatically. Think of the PBPMs as you would any other fee-for-service payment; the chronic care management claim payment is a good example of this type of care management payment.

We'll provide instructions to participating practices on exactly how and when to bill the code, including dates of service to list on the claim. Again, this payment should support the enhanced care management services that Katie noted in the practice requirements that practices will be providing for OCM beneficiaries. So, it can be put towards hiring patient navigators, EHR upgrades, 24/7 clinician access, and other model services.

The performance-based payments will be made semi-annually to participating practices that earn these payments. Practices will not bill for

these payments; rather, CMS will calculate the payment amount after the OCM episodes have ended and pay practices directly.

We've gotten several questions about the **benchmark prices** that will be used to calculate performance-based payments. As noted in the RFA, benchmarks will be practice specific and based on historical Medicare claims data. These benchmarks will be risk adjusted and trended forward to each model performance year. We're still finalizing our **risk adjustment methodology**, which will include factors such as geographic location, patient population, and cancer type.

Many of you have asked whether we'll include cancer staging in our risk adjustments, and while we won't include it during the first model performance year since it's not available on Medicare claims data, we'll likely collect staging information from practices to use in later OCM performance years. CMS will make benchmarking methodologies used to calculate those prices available to selected practices prior to their signing agreements.

This next slide should look familiar to those of you who've attended past OCM webinars. Here we show the basic steps for how OCM performance-based payments are calculated. So starting with the risk-adjusted benchmark price, we'll trend the price to the relevant performance period and then take a 4% discount to arrive at practice-specific target prices for episodes. If the actual episode expenditures fall below that target, then the practice could earn up to the difference between the actual and target prices as a performance-based payment. The amount of that difference that the practice receives is based on their performance on quality measures. So, we'll use the performance multiplier to essentially translate quality measure scores to payment amounts. Once again, we've not yet finalized that methodology, but we will make it available to practices prior to signing agreements. The subset of quality measures used to determine OCM performance payments is highlighted in Table 1 of the RFA, so please see that document for more details.

We know that many of you are wondering how these OCM target prices and payments will account for the cost of **new drugs and technologies** that become available during the model and, thus, were not included in the historical pricing data used for benchmarking. We at CMS are very aware of the high cost of many of these breakthrough therapies and understand that including those costs in OCM episodes could make it difficult for practices to reduce their expenditures below their target prices.

We don't want to penalize practitioners for providing state-of-the-art care, but also seek to incentivize practitioners to select high-value, cost-effective therapies when clinically appropriate. We continue to welcome

public feedback on this methodology. And, of course, we'll share our methodology for including new drug costs into the model with selected practices prior to their signing agreements.

This next slide contains information on the two **risk arrangements** that are offered in the oncology model. All OCM practices will be in a one-sided risk arrangement during the first two model performance years. That means that participants are not responsible for repaying Medicare in case they exceed their target prices.

Starting in Year 3, participants will have the option of assuming financial risk but also of having a lower discount of 2.75%, which should make it easier for practices to meet the target prices than with the 4% discount in the one-sided risk model. So, while you assume financial risk in the two-sided arrangement, the lower discount makes it easier to achieve performance-based payments. Regardless of the risk track, all practices must have met or come in below their target prices, thus, qualifying for performance-based payment by the end of model Year 3. If not, then those practices would be terminated from the model, and we certainly do not want that to happen.

Now we'll transition to talking about the **application process** including other payer participation in OCM. As you know, OCM is a multi-payer model, meaning that Medicare will not be the only payer participating. We invite, as Katie said, other payers to participate by aligning their cancer payment models with the Innovation Center's Medicare Fee-for-Service model in certain key ways. For more details on payer participation, please check out our RFA, Frequently Asked Questions, and also the slides from the March 23rd Payer Participation webinar, all of which are posted on our website.

We are very excited to share that 48 payers submitted letters of intent to participate in OCM, and most of those payers agreed to public posting. So, their names and contact information are currently posted on our website. You'll see from the list and also from the map on the next slide that those payers represent a considerable range of geographic areas and they've also indicated that they'd like to include many different lines of business in their OCM participation, including several Medicare Advantage plans, Medicaid Managed Care, and Fee-for-Service Medicaid. A number of other commercial plans may also participate.

So, we strongly encourage practices and payers to communicate during the upcoming application period and coordinate their participation in the model. As I'll discuss in a few more slides, practices are required to submit letters of support from the payers with whom they participate in OCM. We posted payers' contact information on our website and we'll

soon post practice information as well, once those LOIs are due, and that's to help facilitate the coordination between payers and practices. So please take advantage of that opportunity.

This slide shows where the payers that submitted letters of intent are located. Again, we encourage practices to go onto our website, check out this payer list, and be in touch with any payers in your area that have expressed interest. While the deadline for payers to submit letters has passed, it's not too late for payers to change their proposed participation areas. So, it's fine for practices to reach out to payers that submitted LOIs but may not have included those practices' specific areas and encourage them to expand or change their OCM participation areas.

Medicare Fee-for-Service beneficiaries will be included in every OCM practice's participation, and while participation with other payers is not a requirement for practices, it's very strongly recommended. As you know, the main goal of the model is to incentivize practice-wide transformation in oncology care, not just to improve care coordination for Medicare Fee-for-Service beneficiaries but for patients across a practices' population.

Practices will need the support of other payers in order to do that, which is why participation with other payers is worth 30 out of the 100 points in the OCM application scoring criteria. It is possible for practices to apply to participate in OCM with only Medicare Fee-for-Service if no other payers in their markets participate, but those practices that apply with no other payers may have a harder time achieving the necessary points on their applications. So, please, be in touch with one another, if you're not already, and start thinking about the kind of support for payers that you will need as practices to succeed in this model.

Next, to clarify, both payers and practices that are applying for OCM must first submit letters of intent. The payer letter was due April 9th, and the practice LOI deadline is May 7th. As I mentioned on the last slide, practices that agree to public posting will also have their LOI contact info posted on the OCM website along with payers, and that will happen a week or so after the practice LOI deadline. Once again, LOI forms are available on our website, so please download them, complete them electronically, and then email them to the OCM inbox (OncologyCareModel@cms.hhs.gov).

Practices and payers that submit timely, complete letters of intent will be emailed a web link and password that they can use to access and complete the online OCM applications. Payers and also practices that have already submitted letters by now will receive those emails on or around April 30th. Practices that submit letters between now and the May 7th deadline will be emailed their application links around May the 14th. Please notify us

immediately through the OCM inbox if the point of contact information listed in your letter changes before the June 18th application deadline. We certainly don't want anyone to miss the application link or have other problems because of incorrect email addresses or other point of contact changes.

As a reminder, application templates are available on the OCM website for reference and to help applicants start preparing their responses prior to receiving the application link. Just like with the LOIs, payers and practices will complete their applications separately though they'll note their planned participation with one another in their applications.

These next several slides show **screenshots of the web-based OCM practice application** just to provide some framework ahead of time for the actual application. The sample application here demonstrates the same questions asked in the practice application template on our website, but in the web-based form. The web-based payer application will appear similarly, but will instead ask the questions shown in the payer application template currently available on the OCM website.

You will notice on this general information page here, once again, that practices apply with a taxpayer ID number or TIN level, and as Katie mentioned, each TIN will need to submit a separate letter of intent and application.

We know that applicants may administer chemotherapy in various settings. Some may partner with hospitals for chemo infusion services, and others may do everything in the physician's office. So, applications ask in this section of application to note all the different settings where their patients receive chemotherapy. Likewise, in this next tab, applicants will specify the TINs or CMS certification numbers, CCNs, for the locations where their patients receive chemotherapy. So practices will need to have that information ready to include in the applications.

The last section under the Care Setting tab asks the applicants to specify under what TIN or CCN they bill E&M codes. We ask for this information for attribution purposes since, you'll remember from an earlier slide, we anticipate attributing episodes to the practice that primarily manages the patient's cancer care.

Here applicants are asked to indicate whether they wish to have their data pooled with other specific practices for the purposes of benchmarking performance-based payments. Practices can choose to pool in order to increase the accuracy of their benchmarks

In this section of the application, practices are asked to report their revenue data for the past three fiscal years, 2012 through 2014.

Applicants should complete these revenue tables for their top ten payers, including Medicare Fee-for-Service. We ask for this information to gain a more complete picture of who our applicants are and the financial structures of their practices.

Reviewers will use the tables here to help provide context for scoring the payer participation section of the OCM application. So if, for example, Dr. Kline notes in his practice application that 50% of his oncology practice revenue comes from Medicare Fee-for-Service and 40% comes from payer X, reviewers looking at that application would know that a significant portion of Dr. Kline's patients were covered in OCM if payer X also applies to participate in the model.

Applicants will answer these implementation information questions directly in the text boxes you see here. And again, these questions are available on the application template that's currently on our website so that applicants can prepare their responses ahead of time and cut and paste into these text boxes if they wish.

Finally, practice applicants will attach their narrative documents in PDF form to the application here. Page limits for these narratives are noted on the slide and also in the application template. Applicants may use whatever formatting, including line spacing and font, they prefer in their narrative, as long as they stay within the page limits.

Application scoring categories and selection criteria for practices are listed on this slide. Panels of reviewers with expertise in oncology care, nursing, care coordination, payment, and health policy will review and score all practice applications. In addition to panel review, CMS reserves discretion to ensure a broad range of practice types, sizes, geographic distribution, and a diversity of patients participating in the model. Payer applications will be reviewed internally by CMS staff. The OCM program team, as well as CMMI leadership, will also be jointly determining the final selection of payers and practices.

CMS will notify payers and practices of their selection to participate in late 2015 or early 2016.

That concludes the presentation part of the webinar, so we will just take one minute or so to gather some of the questions that have been entered, and we'll be right back.

Questions and Answers:

H. Schumacher: Thanks, everybody, for your patience. This is Heidi Schumacher, another one of the folks on the OCM team at the Innovation Center. We've gotten excellent questions so far, and we'll take them in batches to try to cohort topics together.

The first question we received was a question about episode triggers, specifically whether an episode is triggered automatically by the administration of chemotherapy for cancer or whether it relates to the billing of the PBPM. Laura, I'll have you answer that one.

L. Mortimer: Sure. So, billing the G code for the PBPM does not trigger an episode. Only a chemotherapy claim with an ICD-9 code for cancer will trigger an episode.

H. Schumacher: Great. Thank you. And then Laura, one more question for you. A couple listeners have written wondering whether a practice must trigger a minimum number of episodes or have a certain number of patients receiving chemotherapy for cancer in order to be selected for the model.

L. Mortimer: No. There's not a minimum threshold of episodes or patients required to apply or be selected for OCM.

H. Schumacher: Great. So even a small practice with only one physician who triggers maybe 50 episodes a year is eligible to apply and encouraged to do so.

So, I'll look to my colleague, Andrew York, to answer a few questions about the practice requirements. One person asked whether the Institute of Medicine Care Management Plan needs to be documented once per episode or every single visit.

A. York: Thanks, Heidi. So, the IOM Care Plan is meant to be a living document. So, it'd only have to be documented once per episode, though we would expect that if things change within the care plan it would be updated within the medical records. So, for example, things like patient information are going to stay the same throughout, so you'd only need to document that once. But if things such as treatment goals or the actual treatment itself changes, we would expect to see that reflected in the care plan. If we do a site visit or a medical record review, and it looks like the care plan is from multiple episodes ago, or the beginning of the episode and things have changed, that would not meet the requirement.

H. Schumacher: Great. Thank you. And then another person asked a question about the clinical guidelines requirements, specifically whether the use or some of the clinical pathways programs would meet that requirement.

A. York:	Yes. The use of clinical pathways does count as representation of following cancer guidelines.
H. Schumacher:	So as long as the pathway is reputable and based on clinical guidelines that would meet the requirement?
A. York:	Correct.
H. Schumacher:	Great. And then finally, one last question on the practice requirements. One person wrote in wondering whether additional funding would be available to help practices implement the practice requirements.
A. York:	The per-beneficiary-per-month payment is meant to pay for increased patient management and overall practice transformation. So we would expect that the payments that you collect through that monthly per-beneficiary-per-month management fee would also go towards infrastructure changes and overall practice transformation.
L. Mortimer:	Perfect. And also, keep in mind if you come in with other payers you'll be getting enhanced payments for services from those payers as well. And so the expectation is that the PBPM and other payments for enhanced services plus any practice investments can be combined together for these types of infrastructural investments.
H. Schumacher:	Great. Okay. Please keep the questions coming. We've had really, really good questions. If we don't get to your question today, we have a record of the questions that are being asked so we will be updating our Frequently Asked Questions accordingly.

For the next section we'll be talking a lot about payments. So, the first set of these questions—I'll have Laura Mortimer answer—relate to the per-beneficiary-per-month or PBPM payment. So first, Laura, can you clarify whether there will be any patient cost sharing with the PBPM? |
| **L. Mortimer:** | There will not. |
| **H. Schumacher:** | Great. So the whole $160 will come from CMS, no patient cost sharing with the PBPM.

Laura, is there consent required for the billing of the PBPM similar to what practitioners need to do to bill the CCM or chronic care management code? |
| **L. Mortimer:** | No, there's not. Beneficiaries will not need to fill out consent forms, but participating practices will need to let beneficiaries know that they may be included in the model. |

H. Schumacher:	Great. And then, Laura, if a practice participates in the model but has some patients that, for example, are only treated with radiation or surgery, aren't getting chemotherapy, and, thus, are not in an OCM episode, can that practice continue to bill for the chronic care management and transitional care management codes for those non-OCM beneficiaries?
L. Mortimer:	Yes. They can. The only restriction there is for beneficiaries for whom the practice is billing the PBPM. The practice cannot also bill the CCM or TCM codes. But for beneficiaries not in the model, the practice can bill those codes.
H. Schumacher:	Perfect. And then if a practice is in a partnership with another entity for the infusion of chemotherapy—say for example, an independent physician group practice manages the patients, sees the patients in their office, and prescribes chemotherapy, but the chemotherapy is actually infused at a hospital outpatient department, does the practice bill for the PBPM or would the hospital outpatient department bill for it?
L. Mortimer:	That's a good question and one that I've gotten a few times. The answer is that the practice itself would bill the PBPM. So the practice or the entity that is primarily managing the patient's care is the one that should be billing for those payments for enhanced services.
H. Schumacher:	Great. And then the last question on the PBPM. Is the $160 payment each month during the episode included in the total cost of care and, therefore, subject to reconciliation at the end of the episode?
L. Mortimer:	Yes it is.
H. Schumacher:	Great. All right, so we will transition now; the next group of questions is about benchmarking and how we calculate our benchmark prices. So, Dan Muldoon is an economist with our group who will answer those questions.
	So first, a couple folks asked what our baseline period will be for the calculation of practice-specific benchmarks.
D. Muldoon:	Yes. So, we haven't finalized what the baseline period will be exactly, but it will likely be episodes that occur during a recent three-year period. So perhaps episodes that occur between the beginning of 2012 and the end of 2014 or possibly mid-2012 and mid-2015.
	That baseline data will serve as the historical claims data for setting the baseline – and then ultimately benchmark and target – prices.
H. Schumacher:	So basically, we pretend that the baseline period were in the model and construct episodes in the same way as we would in the performance period?

D. Muldoon:	Right, exactly. So we'll go in and group all claims into what would be episodes had OCM been occurring, attribute those to practices, group them together, and then apply our risk adjustment methodology. We actually use those episodes and their characteristics to construct a basis for the risk adjustment methodology that will then apply to the performance period episodes that occur during each of the periods during the actual model.
H. Schumacher:	Great. And then another person asked how practices' practice-specific data and regional and national data will be combined, and whether a practice can choose to be benchmarked only against regional or national data.
D. Muldoon:	Practices are not able to select to be compared only against the regional or national data. The thrust of using the regional or national data is really to identify the types of beneficiary or episode characteristics where commonalities exist in the expenditure patterns that go across practices. Even if each individual practice is relatively high or relatively low cost, there are some characteristics that still are indicative of overall how expensive an episode is or isn't, and we thus try to identify those areas where we can leverage regional or national data and make it so we have more precise, better estimates of what we think an episode will actually cost.
H. Schumacher:	Great. And will benchmarks be recalculated or "rebased" annually or do we use one benchmark that we trend forward throughout the performance period?
D. Muldoon:	We'll keep the baseline period set, so the years that comprised the baseline period won't change. We don't use model years in the baseline period, even later in the model, as we don't want to disadvantage practices that are able to achieve performance-based payments.

However, the benchmark and target prices that we set will change throughout the model because we'll be using the historical period with atrend factor applied to the prices to trend the predicted amounts from that historical period into each of the applicable performance periods. We will be using changes in episode expenditures at non-participating practices to account for inflation in cancer treatment expenditure costs. |
| **H. Schumacher:** | Great. The next question we got was, again, related to the availability of CMS sharing claims data with potential participants. Several folks have asked whether all applicants who submitted LOIs can have claims data available now to help them gauge their opportunity for savings. |
| **D. Muldoon:** | We will be providing baseline data to selected practices upon their selection to participate in the model, but are unable to provide that data to all practices submitting LOIs. For the data we do share with selected |

	practices, we are not sure yet whether that will take the form of raw claims data versus processed data that comes in some sort of report or Excel workbook, both of those, or another combination. We're trying to get a feel for how much capacity different types of practices have for analyzing data presented at different levels of granularity, and trying to accommodate as many of those different setups as we can.
H. Schumacher:	Okay. And then the last question on benchmarks and claims data is, "Will practices be able to receive regular feedback from CMS on their claims and their payments throughout their performance period if selected, and if so, how often will that happen?"
D. Muldoon:	So, yes, we will be giving out data. Again, we haven't figured out exactly what form that data will take. But, we do anticipate quarterly feedback reports to practices, as well as semi-annual reconciliations. For the quarterly feedback reports, the data will be based on preliminary data on the beneficiaries who are in potential OCM episodes although, for a variety of reasons, sometimes those potential episodes may not materialize into an official episode of reconciliation.
H. Schumacher:	Great. Thank you.
	So, the last set of questions we will answer, and we acknowledge that there are many really good questions that have come in under the Q&A feature that we haven't had time to answer. We will do our best to answer as many of those as we can in our Frequently Asked Questions document which we will update on our website, but please do feel free to reach out to us at the email address listed on this slide as well (OncologyCareModel@cms.hhs.gov).
	So, to Katie and Laura, a few application-specific questions. Katie, you had mentioned at the beginning that the LOI should include all providers regardless of whether they prescribe chemo or not, that the application should be more specific. Can you clarify that instruction?
K. Cox:	Sure. Just to clarify, in the LOI, we are trying to get a sense for the high-level view of the practice as a whole. Thus, in the LOI, we're asking for the total number of all the physicians that are in the practice, regardless of whether they provide cancer care or not. In the actual application, we're looking for more specific information on which providers would actually trigger episodes in the model; thus, we ask for the list of all the individual practitioners' NPIs who prescribe chemotherapy for cancer within the practice.
H. Schumacher:	Next question is, "If practices or payers choose to not have their name posted publicly if they submit an LOI, does that have any implication for the likelihood they'll be selected?"

L. Mortimer:	This is Laura. No, it does not affect their actual application scoring. It's not part of the scoring criteria, but not having the information posted might make it more difficult for payers and practices to contact each other and coordinate their participation in the model during the application period. So, we post that information so that practices and payers can work with each other to plan their OCM participation.
H. Schumacher:	Great. And the next question about applying with other payers—Laura, can you clarify for us whether if a practice and a payer anticipate or hope to participate jointly in the model whether they submit one combined application or whether they each need to submit separate applications?
L. Mortimer:	They should submit separate LOIs and applications. And again, practices should have letters of support or explanations of support from the payers with whom they plan to participate in OCM, and, likewise, payers will note on their applications and their implementation plans the practices with which that they plan to participate. But they do have to do separate applications.
H. Schumacher:	Great. And keep in mind, both of the templates for both of those applications are posted on the OCM website, and any payer and any practice that submits an LOI will be sent a link with which to access their respective online application.
	Another question for you, Laura. If a practice is interested in participating but there are no payers in that practice's region that have submitted an LOI, how likely is it that that practice will be selected?
L. Mortimer:	That depends on a number of factors, starting with the number of practices that apply to participate. But it also depends on the quality of the rest of the practice's application. So, as you know, payer participation is worth 30 out of 100 points. So, if the practice doesn't apply to participate with any other payers then they would not receive those points, but they could have a great application otherwise and still score pretty well.
	So depending on how the scores are distributed, that practice applicant may still have a good chance of participating in the model. And so, we still strongly encourage practice applicants to apply even if there are not payers in their particular areas. And again, payers may change their specific geographic participation areas. So if you see a payer listed on the payer LOI submission list that you know is operating in your area and that your practice accepts, but they haven't specifically listed that area, you can reach out to that payer and ask them to consider expanding their OCM participation area.
H. Schumacher:	Great. And then one final practice application question on the revenue streams by payer. Are we asking about billed charges or paid charges

when we ask about the revenue by each payer, for the top ten payers in the application?

K. Cox: Those are paid charges ("collections").

H. Schumacher: Great. We do know that sometimes the billed charges and paid charges can be quite different, so we want to get a sense for what money actually comes in the door to your practice and what percentage each of your top 10 payers provide to your total revenue.

With that, we will conclude today's session. We thank you, again, greatly for your time today in participating and for your really excellent questions. You can anticipate a copy of our slides to be posted to the same OCM webinar page soon as well as an audio transcript of the presentation within the next week or so, and our Frequently Asked Questions will be updated within the next few weeks as well. So, thanks again for your participation, and for your interest in OCM.