Oncology Care Model Introductory Webinar

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SPEAKERS:
Laura Mortimer
Dan Muldoon
Andrew York
Ron Kline
Heidi Schumacher

PRESENTATION

Introduction:

L. Mortimer: Thank you for joining us today for the CMS Innovation Center's Oncology Care Model, or OCM, Introductory webinar hosted by the OCM program team. My name is Laura Mortimer and I'm joined by my colleagues Dan Muldoon and Andrew York. During this webinar, we'll provide an overview of OCM for both payers and physician practices and also explain the application process. Please refer to the RFA and other materials on our Innovation Center website for further details on the model. The webinar slides will be available after today on the website as well.

If you have questions during today's presentation, please submit them to the Q&A feature and we will address them following the presentation. To submit a question, click on the "Q&A" button located at the top of your screen, enter your question in the textbox and click "Send." All participants online will be muted during this webinar.

Following today's presentation, you will be asked to participate in a short survey regarding the presentation. Please take a moment to complete the survey to help inform future OCM webinars. Thank you again for joining us. We are very excited to share the Oncology Care Model with you and we look forward to working with you to improve cancer care for patients through this new model.

The CMS Innovation Center was established by the Affordable Care Act in 2010 to develop and test innovative healthcare payment and delivery models in Medicare, Medicaid, and CHIP. The center works with a broad range of stakeholders to create, implement, and evaluate new models. We currently have dozens of models in progress and are beginning to scale our most successful ones in order to expand healthcare innovation that works.

The Innovation Center's payment models promote the broader Health & Human Services goal recently outlined by Secretary Burwell: better care, smarter spending, and healthier people. Our models range in focus and scope and include Accountable Care Organizations, Primary Care Transformation, Bundled Payments, and now a new emphasis on specialty care. The center currently has two specialty care models in our portfolio: one for ESRD care and now one for oncology care.

The Specialty Care Model group at CMMI got significant input from many different stakeholders, including patient advocates, physicians, and

payers after we shared the OCM design paper publicly this past August. Since then, we've worked with many of these different groups to incorporate their feedback and fine-tuned the oncology model to best meet our goals. We look forward to continuing these conversations with OCM participants and working very collaboratively over the next few years.

We chose oncology care as our first specialty model area for several reasons. First and most importantly, cancer affects millions of American families. Over 1.6 million Americans are diagnosed with cancer every year and nearly half of those patients are over 65 and Medicare beneficiaries. As you all know, cancer is a very complex disease that can also be very expensive for patients and other payers. The Innovation Center sees a tremendous opportunity to promote its healthcare goals through an oncology payment model.

OCM is a five-year model that focuses on episodes of cancer care. The goals of the model are to appropriately align financial incentives to improve care coordination, appropriateness of care, and access for beneficiaries undergoing chemotherapy. In the model, these incentives encourage participating practices to work collaboratively to manage the complex care needs of their cancer patients and to use services and treatments that have shown to improve health outcomes.

OCM is an episode-based model that defines episodes as six-month periods of care following the initiation of chemotherapy. There is no limit to the number of episodes that beneficiaries may trigger during the model period. Practice transformation is key to this model. Participating physician practices will engage in transformation to improve the quality of care they deliver by meeting a defined set of OCM practice requirements.

Finally, OCM is a multi-payer model, meaning that commercial payers and others are invited to participate along with Medicare by aligning their payment models with the Innovation Center's. By engaging other payers, we increase the opportunity to transform care across the broader patient population by providing robust and aligned support to practices.

Participants in OCM are physician practices that are Medicare providers and furnish chemotherapy. We've received several questions so far regarding which physician practices may or may not participate in the model. We welcome and encourage all chemotherapy providers to participate, including those who practice at cancer centers. The primary exceptions here are practices that are owned or formally affiliated with PPS-exempt hospitals due to differences in their payments for services.

A key feature of the Oncology Care Model is our practice requirements. All practices are expected to engage in care transformation as

demonstrated through these six OCM requirements, which I'll outline here. The first is to provide patients in the model with 24/7 access to a clinician who has real-time access to those patients' medical records. Cancer patients' complex medical needs don't just arise during normal business hours, so we expect clinicians to be available to provide medical advice whenever patients need it.

The second requirement is that practices must use an ONC-certified electronic health record and attest to Stage 2 of meaningful use by the end of the third performance year. As a step towards this goal, practices must attest Stage 1 by the end of year one. Note that the meaningful use requirements may be updated based on future HHS rulemaking.

Third, practices must use data for continuous quality improvement. The Innovation Center will provide participating practices with quality and cost data throughout the model to aid in this improvement. Our Learning and Diffusion team will provide additional support services, collaboration opportunities, and webinars to help practices use the data we provide to improve the quality of care they deliver.

Requirement four is to provide the core functions of patient navigation. Practices are required to provide patient navigation services to all patients in the model. You can find a sample list of these activities from the National Cancer Institute outlined in the RFA. Participating practices are not required to hire additional staff to perform these functions, but they may do so if necessary.

Next, practices must create a care plan for OCM patients that contains the 13 components of the IOM Care Plan. Patients should be actively engaged in creating this plan. Please see the RFA for more details.

The final practice requirement is to treat patients with therapies consistent with nationally recognized clinical guidelines and to report which guidelines they follow. If practices do not follow NCCN or ASCO guidelines, they must provide a rationale for not doing so.

In addition to physician practices, non-Medicare payers may also participate in OCM. From this point forward in the webinar, we'll designate between OCM fee-for-service (OCM-FFS) and OCM for other payers. These other payers may include commercial payers, including Medicare Advantage plans, state Medicaid agencies and other governmental payers such as Tricare and state employee health plans.

The main goal of including these other payers in the model is to work with them to transform oncology care for patients across the population. We believe that a high level of collaboration between Medicare fee-for-service and other payers will allow OCM to drive comprehensive care

transformation and redesign at the practice level. To help practices and payers coordinate their OCM participation, we'll publish a list of payers and practices who submit Letters of Intent to participate on the OCM website in the next few months.

Payers will sign Memoranda of Understanding with CMS and are required to align with OCM fee-for-service on several operational and quality improvement measures. These alignment areas include participating in OCM for its full five years, implementing the same practice requirements as OCM fee-for-service, and using a payment approach which includes payments for enhanced services and for performance. Other payers must share their payment methodologies with the Innovation Center and also share other aggregate level data collected during the model.

The next several slides pertain only to OCM fee-for-service, which I'll just refer to as OCM, although other payers' models may share many of these same details. The target patient population of OCM is Medicare beneficiaries who have Medicare fee-for-service as their primary healthcare payer and receive chemotherapy treatment for cancer from a participating OCM practice. Additional detail, including some restricted patient populations, is listed here and also in the RFA.

We define "episodes" as six-month periods of care following the initiation of chemotherapy treatment for any type of cancer. A list of qualifying chemotherapy drugs is included in our RFA. OCM is a total cost of care model, meaning that the cost of all Medicare A and B services beneficiaries receive, as well as certain Part D expenditures, during this episode will be included in the cost of care of that episode. My colleague Dan will explain more about OCM's payment methodologies in the next few slides.

Beneficiaries may trigger more than one episode during OCM's five-year performance period, depending on their treatment needs and timing. For example, if a beneficiary triggers an episode by receiving chemotherapy on January 1, that episode will conclude on June 30th. If the beneficiary continued receiving chemo after that date, she would trigger a second episode. There may be breaks in between episodes if no chemotherapy services are being furnished.

Now I'd like to introduce my Innovation Center colleague Dan Muldoon who will discuss OCM payments.

OCM Payments:

D. Muldoon: Hi. Thanks, Laura, for introducing me. I'm going to talk a little bit more about the payment approach for OCM fee-for-service. During OCM, practices will continue to be paid regular Medicare fee-for-service payments, as will other providers that interact with beneficiaries throughout the course of their episodes. We will be layering two different payment approaches on to sort of the existing fee-for-service structure in an effort to realign incentives.

The first of those is a per-beneficiary-per-month payment (PBPM) of $160, and that payment is designed to cover the enhanced services that we require practices in OCM to perform as part of their participation of the model, things like the 24/7 patient access to a clinician who has access to the patients' medical records. Additionally, practices in OCM fee-for-service will be eligible to build the PBPM monthly for each month of the six-month episodes unless the beneficiary enters into hospice.

Now, in addition to that per-beneficiary-per-month payment we'll be including a performance-based payment as part of the model. So here the incentive is really to lower the total cost of care and to improve the quality of care for beneficiaries throughout the course of their six-month episode period through care redesign, increased care coordination, and other types of practice transformation. This performance-based payment will be a retrospective payment calculated based on historical medical expenditures to set a target price and then also a practice's achievement on selective quality measures. And so basically, CMS will incorporate quality into the payment as well.

Specifically, we'll be calculating a benchmark of episode expenditures for the practices. It will be based on historical data and then we'll risk adjust those expenditures. We'll also adjust for geographic variation that occurs simply because Medicare pays different prices in different parts of the country. Then we'll be trending that benchmark forward to the performance period.

At that time, when we have these benchmarks, we will apply a discount that represents the savings to Medicare to calculate a target price for episodes in OCM. In the example below, you'll see that we look at a benchmark of $100 per episode, again, a hypothetical benchmark. And then with the discount of 4%, we would take off $4 and the target price would be $96. Then when it came time to perform our retrospective reconciliation, we would look at the actual fee-for-service expenditures that occurred during an episode and sum those up to compare those to the target price.

For example, if actual expenditures during an episode were $90, the practice would be eligible to receive a performance-based payment of up to $6. If they perform well on the selected quality measures that we're incorporating into the payment, then the practices would be able to receive that full $6, although there is a possibility of a reduction if they do not perform as well on the quality measures.

In OCM fee-for-service, we'll be offering two risk arrangements that practices can opt for. The first is a one-sided risk arrangement in which participants would not be responsible for Medicare expenditures that exceed the target price for the duration of the five-year model. In this risk arrangement practices must qualify for a performance-based payment or achieve savings for at least one performance period by the end of the third year in the model.

Again, the way we would implement this one-sided risk is that within each performance period we would first make the calculations for each of the episodes that occurred at a practice and then net out the positive and negative reconciliation amounts across all those episodes, and then look at that final practice level figure. And if that figure were less than zero, then the practice would not be required to pay back Medicare.

The other option that we're allowing is a two-sided risk option, and in this option practices would be responsible for Medicare expenditures that exceed the target price. Again, we do that similar netting mechanism across episodes within a performance period at a participant.

The option to take this downside risk is only going to begin in year three, so there will be two years of one-sided risk for all participants in the model, regardless. And to incentivize practices to opt for the two-sided risk, we're going to take a lower discount for Medicare of 2.75%, so that offers the practices the ability to capture a larger performance-based payment if they take on some additional financial risk. Again, in this two-sided risk option there's still the requirement that the practice has qualified for at least one performance-based payment by the end of the third model year.

Now we'll talk a little bit more about benchmarking. So here we're going to be basing the benchmarking and setting our target prices on historical Medicare expenditure data. We're going to be basing those both on practice data as it's available, and when there's ample practice data. But we'll also be incorporating regional and national data as necessary to increase our precision and to allow us to incorporate a broader set of risk adjustment factors that we find correlate with episode expenditures and have some predictive capacity to explain variation in episode expenditures.

We will be risk adjusting these benchmarks and accounting also for geographic variation that just happens because of the way that Medicare pays for the same service in different parts of the country. Then we'll trend those target prices into the applicable performance period.

As mentioned on the previous slide, in the one-sided risk arrangement there will be a 4% discount that Medicare takes off the top to get to the target price. And in the two-sided risk option we'll be only taking a 2.75% discount, again, to give practices the opportunity to capture a larger portion of savings.

In both the benchmarks and also in episodes that occur during a performance period, we will include beneficiaries participating in clinical trials. So those beneficiaries will be included both for the purposes of setting benchmarks and for performance periods.

Additionally, we do want to insure that we incentivize appropriate use of new technologies that demonstrate significant improvement in efficacy or safety relative to existing therapies, so we're working to make sure that we have adequate measures in place so that we don't disincentivize practices from using those treatments when they really would be appropriate and in the beneficiary's best interest. So we'll be incorporating an adjustment for those new technologies into our benchmarking methodology as well.

Now we'll talk a little bit about some of the risk adjustment factors that we'll be looking to incorporate into our episodes. The first would be beneficiary characteristics, such as the beneficiary's age; comorbidities present at the onset of chemotherapy; and gender, to the extent that those types of characteristics correlate with episode expenditures. Also, we will look at episode characteristics – we expect that there will be different cost profiles associated with a beneficiary's first chemotherapy episode versus a secondary or tertiary episode.

Similarly, we'll be looking at disease characteristics, predominantly cancer type, especially in the first year. And then also some of the different types of services that are furnished during the episodes, such as radiation therapy or endocrine therapies that theoretically could or do affect the expenditures that occurred throughout an episode.

In the first year of the OCM fee-for-service, we'll be basing this risk adjustment solely on the information we have available in claims data here at Medicare. In later years in the model, we will be incorporating additional factors into a risk adjustment strategy that are not based on claims data, such as cancer staging. We're also seeking input from prospective applicants on different types of measures that they think would be important here for trying to risk adjust target prices. In the

application, there's a section where we solicit your input on the different types of measures that we could look to, to collect and then incorporate into how we set prices in Years 2 and onward in the model.

At this time, I'd like to introduce my colleague Andrew York and he's going to discuss quality measures and some other aspects that we'll be including in OCM.

Quality Measures:

A. York: Great. Thanks. Monitoring and quality are going to be important parts of the Oncology Care Model, especially because of the two-part payment method used by the model. Our quality strategy aligns with overall CMS and HHS quality strategies, and we're covering all six of the CMS quality domains with our measures.

The data that's going to be used to actually collect these quality measures, as well as to monitor the model itself, is going to include Medicare claims data, patient surveys, practice reported data, and this is actually going to be one of the first models out of CMMI, as Dan mentioned, that's going to be collecting clinical data. So we're going to be collecting staging and other clinical data as part of the model.

We have a tentative list of 32 quality measures; 8 of those measures are going to be used to adjust for performance payments, and 24 of them are going to be for overall quality monitoring. The important thing to note is that the majority are claims-based measures, so the number of measures shouldn't sound as overwhelming. Finally, this is a tentative list, so we're still looking for recommendations from all applicants on measures that should be either added or removed, should be considered in payment, or just used for monitoring. There's an opportunity for you to comment on that in your application.

I wanted to take some time to just go through the eight measures that we plan to use for the performance-based payment. Again, these are going to be the ones that can adjust for the savings that are achieved based on the benchmark.

So the first measure is going to be the number of ED visits per OCM fee-for-service beneficiary per episode. Second measure is going to be the number of hospital admissions per OCM fee-for-service beneficiary per episode. And then after that we have two end-of-life measures. One's going to be the percentage of Medicare fee-for-service beneficiaries managed by the practice admitted to hospice for less than three days. The next is percentage of Medicare fee-for-service beneficiaries managed by

the practice who experienced more than one ED visit in the last 30 days of life. The next is a PQRS measure where we look at the percentage of patients that have their pain intensity quantified and have a documented plan of care for pain as part of their experience.

Next is going to be a patient experience, which is going to be modeled similarly to the other CMMI models with modified CAHPS. Then next measure is the number of face-to-face encounters in which the patient is assessed by an approved patient-reported outcomes tool, and that will be clarified when the final list of measures comes out. The final measure is the percentage of patients that receive psychosocial screening and an intervention at least once per episode.

As I mentioned, these are going to go towards adjusting the performance-based payments. They're going to help calculate this performance multiplier that was mentioned in the RFA, and it's going to look similar to what's been done for the ACO and CPC models. Basically, the practices are going to get a score on a measure which is going to be compared to national data to set their percentile. Their percentile score is going to align them with quality points for each measure, and the quality points for each measure earned are going to be added up to create an aggregate quality score. That quality score is going to be mapped to the percentage of the performance-based payment that the practice will receive. For this methodology, the exact algorithm is going to be available before the practices sign practice agreements.

As you can see with all of the CMMI models, monitoring and evaluation is going to be an extremely important part of the model. We're going to be tracking claims data to look at any changes in care and also we're going to be using our patient surveys to see if there's any difference before the and after the model starts. We're going to have a number of site visits where we'll be looking at if the practice has been able to comply with care transformation. And we're also going to be looking at the quality measurement data to ensure the quality of care is being maintained throughout the model, and as we hope, possibly improving.

We will have time-in- motion studies, which are going to be analyzing the staff time associated with clinical care and the practice requirements required for practice transformation. And then finally, as part of our site visits, we'll also do medical record audits, tracking of patient complaints, and appeals. As I mentioned, a lot of the utilization measures are actually going to look at utilization, costs, and quality that can be attributed to the model. That's going to come out in a series of reports.

Learning and Diffusion is also going to be an important part. As you can see from our practice requirements, we're looking for a comprehensive

change from the practices. So, we're going to be hoping to find best practices among the practices to learn and help practices learn from each other as part of our learning and diffusion.

Also, we're going to have an online portal to support learning through shared resources, tools, and ideas. We're going to have action groups in which practices work together to explore critical topics and areas and build the capability to deliver the comprehensive care that we're targeting. Finally our Learning and Diffusion team will be coaching practices to help them overcome any barriers to improvement.

Practitioners and beneficiaries that are already enrolled in shared savings programs, such as the ACOs, are eligible to apply for OCM. Unfortunately, practices will not be able to concurrently be enrolled in both the Transforming Clinical Practice Initiative and OCM. . The good thing about that is we don't foresee a lot of overlap between them, but participants can't be enrolled in both of those programs.

Then finally, there are a number of care management fees that practitioners are eligible to receive under the Physician Fee Schedule. Practices that are participating in the Oncology Care Model will not be able to bill those fees for the same beneficiary during the same month that they bill the OCM per-beneficiary-per-month fee. With that, I will turn it back over to Laura to talk about the application process. Thanks.

L. Mortimer: Great. Thanks, Andy. These final two slides are about the OCM application process for both payers and practices. This process has two parts, both of which are entirely electronic. First, applicants must submit electronic Letters of Intent, or LOIs. LOI PDF forms may be downloaded from the OCM website, completed electronically, and then emailed to the Innovation Center as attachments. Payer LOIs are due by April 9th and practice LOIs are due May 7rh. Applicants who submit timely complete LOIs will be sent an authenticated web link and password to complete an electronic application.

Application templates are available now for anyone to view on the OCM website. Please do not submit these templates to the Innovation Center. They are for your reference only so that you can prepare application answers prior to receiving access to the actual application. Only applications submitted through the authenticated web link will be accepted.

The Innovation Center will publicly post lists of payers and practices who submit LOIs on the OCM website. Practices are strongly encouraged to participate in OCM with multiple payers to increase the opportunity for

successful practice transformation. Practices will receive additional points in the application review for applying with multiple payers.

We've listed the major components of the payer and practice applications here. Again, the electronic application forms are only acceptable through the web link, which applicants will receive after submitting LOIs. Please note that practices will need to submit letters of support for all payers with whom they apply for OCM participation. These application materials are explained in much more detail in Table 1 of our RFA, so please see that document for additional information.

That concludes our presentation, so now we'll just take a few minutes before responding to the many questions that have come in. Again, to submit a question, click on the "Q&A" box on your screen. And as a reminder, once the Q&A period ends, please take a second to complete the survey that appears on your screen. I know several have already asked whether the slides will be available from this presentation and they will indeed, along with a transcript. That will be available on the OCM website shortly. So, we will be back in a moment.

Questions and Answers:

H. Schumacher: Great, so we're going to take questions in a few cohorts. The first group of questions that we received around a similar theme was one, if we can clarify whether there's a maximum number of episodes that a given beneficiary can trigger within the five-year performance period. And secondly, what costs will be included in the total episode expenditures, whether it's truly total cost of care or just cancer-related costs. I'll let Dan answer those.

D. Muldoon: This is Dan Muldoon again. So on the first question, the number of episodes, in the earlier model design paper we had published we had been thinking about limiting the number of episodes to two per beneficiary. However, since then we've revised our thinking and are going to allow beneficiaries to continue to initiate episodes beyond the second episode. So, beneficiaries theoretically could initiate up to ten episodes in a five-year period, but we don't anticipate that. Based on our analytics we have seen that the number of episodes have severely dropped off sort of looking after the second and third episode that a beneficiary has. So while there's a possibility to initiate many episodes, we do not anticipate that we'll be seeing a lot of episodes occurring in the fifth, sixth, seventh episodes.

The second question that you posed to me was about the costs that we'll be including in the model. So there we are coming at this from a perspective of managing the total cost of care for all the Medicare services

that are paid under Parts A and B, as well as certain Part D expenditures, during a sixth-month period of an episode. I think cancer-related cost of care will comprise the bulk of the expenditures but we will be including all costs and expenditures that occur during the six-month episode.

H. Schumacher: I'm going to ask my colleagues a couple other questions related to the inclusion of particular types of cancers and certain types of practices. So several folks have asked what we mean by saying that "nearly all cancer types will be included," and I'm going to have my colleague Dr. Kline answer that.

R. Kline: This is Ron Kline from the OCM model team. The intent is to include all cancers in the model that are treated with non-topical chemotherapy. So if a diagnosis requires only surgery or only radiation therapy and does not require either IV or oral chemotherapy, then that diagnosis would be excluded. Diagnoses treated only with topical chemotherapy will also be excluded. All other cancer diagnoses will be included. The other point to make is that practices will not be able to choose which diagnoses are included. If a cancer diagnosis is treated with IV or oral chemotherapy, then that diagnosis will be automatically included as part of the model.

H. Schumacher: Then I'm going to look to some of my other colleagues to get a little bit more specific on the types of practices that can and cannot participate. There were some questions surrounding whether hospital-affiliated practices could participate and also some questions around the PPS-exempt cancer hospitals. So I'll look to my colleague Andrew York to answer those.

A. York: Hello; this is Andrew York. And as you'll see in the RFA, we intend for all practices that are paid on the prospective payment system to be able to participate in the model. We understand that there are a number of practices that are partnered with outpatient departments, so they'll provide the management services while an outpatient department will provide the chemotherapy, and we intend for these practices to be eligible. We're going to be updating the model website and materials with any additional information those practices would need to include as part of their application.

The primary exception will be practices that are a part of the 11 PPS-exempt cancer hospitals, and that's mainly due to the reconciliation process related to the PPS-exempt hospitals. It basically means that we can't calculate the performance-based payment for those practices.

H. Schumacher: And another attendee of the webinar asked whether all providers under a given TIN would be included in the model or whether only certain NPIs under the given practice would be included. I'll just share that we enroll

practices at the taxpayer ID number level, and all providers that prescribe chemotherapy for cancer under that taxpayer ID number or TIN would be included. So practices would be required to include all medical oncologists and other providers that may prescribe chemotherapy for cancer in the model.

The next set of questions related to some technical details about payments in the model. One, how the PBPM or per-beneficiary-per-month would be billed, and whether that was something that would be prospectively billed or retrospectively paid. I'll look to Laura Mortimer to answer that.

L. Mortimer: So the PBPM payment is a prospective payment that practices who are participating in the model will bill Medicare for in the same way they bill other claims. So they will bill the PBPM for each beneficiary for each month throughout the entirety of the six-month episode, except after a beneficiary enters hospice.

H. Schumacher: Then to my colleague Dan Muldoon, can you respond to some questions related to benchmark or target prices, and how or if those will be updated over the course of the model?

D. Muldoon: Yes, so those target prices that we set will be updated over the course of the model first through trending those to the applicable performance period, based on the treatments that are occurring for different types of episodes more broadly nationally as time progresses. So in doing that, that trending mechanism will naturally account for some of the changes in practice patterns and even some of the new technologies that are widely adopted as the model proceeds and progresses. However, for some of the new technologies that may come out in the future that may only affect certain subpopulations, we're working through the mechanism to make sure that we are able to set prices in a way that accurately reflects maybe some of the additional costs of those new technologies. And so we're working to make sure that we do have a mechanism there and we'll be sharing further details there with applicants and practices prior to when they have to sign agreements for the model.

H. Schumacher: We can just add, in general, insofar as some methodologies are nearly finalized but haven't been included in our model materials to date, all methodologies relevant to payment, attribution, and other technical details of the model will be available to practices prior to signing agreements. Dan, I'm going to ask you one more question. We had an attendee ask how drugs will be paid for during the model. Are they still paid at ASP plus 6 or is there another mechanism through which drugs will be paid?

D. Muldoon: The drugs will all continue to be paid at the ASP plus 6 and then for Part D drugs, those will be paid as they are. So all the services that oncologists

and other practitioners provide to beneficiaries in an episode will be paid through the existing Medicare fee-for-service payment system. Then we will be doing a retrospective reconciliation against the target price to compare whether or not the actual expenditures fell below or exceeded the target price to calculate our performance base. So the drugs will continue to be paid as they are now.

H. Schumacher: Great.

So the next cohort of questions relates to the application process. We received several questions wondering whether the Letters of Intent are binding and what the relationship is between the submission of a Letter of Intent and an application. So I'm going to let Laura Mortimer answer those.

L. Mortimer: Thanks. The Letter of Intent process is neither binding nor competitive. Everyone, payers and practices, are invited to submit Letters of Intent. And again, you can download those forms on the website. They are PDFs; they're available now. You email the form as an attachment and then all applicants who submit LOIs will be sent a web link after the LOI submission period has ended with which they can access and complete and submit the actual applications.

As the LOIs are non-binding, just because you submit an LOI does not mean that you have to submit an application. The main reason why we have the LOI is so that practices and payers can see who else is interested in participating in the model in their markets and plan their participation in OCM. So again, we encourage practices and payers to visit our website after we've posted these lists and coordinate with the practices and payers in your respective markets.

H. Schumacher: Laura, can you clarify at what date folks should anticipate having the list publicly available of practices and payers respectively who have submitted LOI's?

L. Mortimer: Sure. That would be March 26th for the payer LOIs and April 30th for the practice LOIs. They'll be posted on our website then.

H. Schumacher: And those represent one week after the respective LOI submission deadlines?

L. Mortimer: Yes, they do.

H. Schumacher: Okay. Great. Thank you. Laura, I'll look to you to—several folks have asked about the numbers of practices that we anticipate enrolling and whether there's a particular goal of types of practice that we enroll or types of providers or types of cancer types.

L. Mortimer: We expect to enroll around 100 practices in the model. And as we've said, we are open to include nearly all cancer types in the model and expect to have a variety of practices in the model as well. We also will look for geographic diversity and diversity in patient populations. And practices can highlight this diversity in their applications in the Diverse Populations narrative. .

H. Schumacher: Laura, I'll look to you again for one final question. We've had several questions on whether practices must participate for the entire five years of the model or whether they can enroll at a later time.

L. Mortimer: Practices must participate for the entire five-year period. If they don't achieve savings by the end of the third performance year, then they will be disenrolled from the model. But other than that, practices do have to participate for the full five years.

H. Schumacher: Great.

Several folks have asked about the multi-payer aspect of the model, and specifically what is the benefit to another payer in participating in the oncology model? Laura, do you want to help us answer that one?

L. Mortimer: Sure. In addition to savings that other payers could achieve through the model, similar to Medicare there, we believe that a high level of collaboration between Medicare and other payers will really allow this model to drive care transformation on a broader scale. So, ideally we would have all of the payers that a participating practice accepts participating in the model. The more payers that a practice participates with, the better.

H. Schumacher: Laura, can you clarify whether a practice gets to choose which payers they participate with or whether the model at CMS decides that?

L. Mortimer: So that would be up to practices and payers to decide. They will apply separately, but practices will need to submit letters of support for each payer in their market that also participate in the model, just to demonstrate that they have coordinated this participation and the payers are on board with the practices.

H. Schumacher: Okay. And some folks have asked whether practices will sign separate agreements with other payers if other payers do participate in the model and partner with the practices. Laura, can you give us some insight on what the expectation of the partnership would be between a practice and another payer?

L. Mortimer: Sure. So other payers will sign agreements with practices, and those agreements will include the payment methodologies, practice

requirements, and other details of the payers' models. Again, we do expect payers to align their models with the Innovation Center's model, particularly around the two-part payment approach. Payers will sign memoranda of understanding with the Innovation Center.

H. Schumacher: Great. The next set of questions, and I know we're running somewhat short on time—several folks have asked about what the data collection process will look like in terms of the quality measures that we ask practices to report on and what that feedback might look like back to the practices. So, my colleague Andy has done a lot of our work related to the collection of those data and I'll let him take those.

A. York: So as we mentioned, the model is a six-month episode and we're expecting quarterly reporting on quality data primarily to be able to update practices with kind of like a midpoint standing before the final quality score is calculated for the episode. Right now we try to align with a lot of the work that's already done within CMS. We anticipate creating a platform that can receive direct exports from EHRs as well as a web portal for manual data entry for practices to submit both manually and through electronic export.

H. Schumacher: Andy, can you clarify when practices would get more information on the data collection platform and what their specific responsibilities would be?

A. York: We will share a finalized list of quality measures in the practice agreements for practices to review. So once we have the final list of quality measures, we'll have the entire process mapped out for how you will submit data for each of those quality measures.

H. Schumacher: Great. So we are just about at time. The last question that we'll take as a group is whether these slides will be available in an archived fashion and also whether there are any other webinars that we anticipate giving. At this stage, we can say definitively, yes, these slides will be available on the Oncology Care Model website, which is listed on the current slide. We may well have other webinars in the future and if we do those, they will be posted to the Oncology Care Model website. Again, we will look through the questions that have been posed by many of the attendees that we didn't have time to reach today, and as we find trends across attendees' questions we will be updating our model materials, in particular our Frequently Asked Questions document, which is available on the Oncology Care Model website.

So with that, we close our webinar today. Thank you so much for your interest in the CMS Oncology Care Model and for your attention and patience with some of the audio issues today. We hope that you will all, as you leave this webinar, will be willing to complete a survey and in that

survey you actually have the opportunity to clarify any further questions that you hope we'll be able to answer in our model materials.

So thank you again so much for your interest and we hope you have a great day.