ONCOLOGY CARE MODEL

OCM QUALITY MEASURES GUIDE

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CMS
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Note: This version of the OCM Quality Measures Guide is effective beginning with the release of this document. If an updated version of this document is released, this version will be used for reporting until the release of the new version.

Revision History

Version	Date	Description of Changes
1.0	6/6/2016	Initial "OCM Clinical Data and Quality Measures Guide"
1.1	8/17/2016	Updated Section 1.1 to indicate that detailed specifications for claims-based measures are available on OCM Connect. Revised Section 2.1 to clarify that patients not meeting the OCM FFS Beneficiary criteria should not be reported. Updated Figure 2 to clarify that the beneficiary is not covered under a group health plan. Revised Section 2.2 "Note" for correct diagnosis codes to be used for Practice-Level Patient identification. Expanded on clinical data for patient-level reporting in Sections 3.2.1 and 3.2.2. Added additional documents to Section 6; re-directed all supporting document hyperlinks to OCM Connect. Revised OCM-8 and OCM-9 population definitions, and OCM-10 measure title, description and population definitions in Tables 2, 3 and A-1. Updated introductory paragraph of Appendix A to clarify that beneficiary-level data should only be reported for OCM FFS Beneficiaries.
1.2	1/9/2017	Revised PP1 reporting requirements and added PQRS and eCQM (CMS) measure numbers to applicable Measure Names in Tables 2 and 3. Added information on composite scoring to footer of Table 2. Updated OCM-2 and OCM-6 Measure Names in Tables 2 and A-1. In Section 2.2, clarified that aggregate reporting applies only to OCM participating providers. Added additional reporting periods to Table 4. Updated examples in Sections 3.1, 3.4.1 and 3.4.2. Removed Race and Ethnicity from Section 3.2.1. Added reporting requirement and updated list of clinical data in Section 3.2.2. In Section 4, removed distribution date of the first attributed beneficiary list to the OCM Participants. Added new Section 6.3 Oncology Care Model Cancer Code List.
1.3	2/13/2017	Added reference to "OCM Performance-Based Payment Methodology" in Sections 2 and 3.1. Added "cancer-related" to E&M visit in Section 2.1 step 3e and to Figure 2. Updated Section 3.22 to add "Equivocal" for HER2 amplification and updated the Lung Cancer Histology options. Updated the descriptions in Sections 6.3, 6.4, 6.11 and 6.12. Added Sections 6.13 – 6.17.

Version	Date	Description of Changes
1.4	5/15/2017	Updated population descriptions in Table A-1 to make all consistently summary level. Throughout document, updated references from quarterly reporting periods to semiannual measurement periods. Removed references to pay-for-reporting and pay-for-performance timeframes, as this information will be communicated via other methods. PQRS has been updated to MIPS throughout the document. Removed reference to outdated "OCM Included Cancer Diagnoses and Cancer Types" document. Updated Sections 6.5 and 6.6 to reflect the Measure Flows are being incorporated into the Measure Specifications documents. Renamed Section 6.2 to "OCM Cancer Type Mapping," and clarified that detailed diagnosis codes are located in the "OCM Staging and Clinical Data Specifications." Updated OCM-4a and OCM-4b in Table A-1. Updated OCM-8, OCM-9 and added Denominator Exclusion for OCM-24 in Table A-1.
1.5	7/10/2017	Removed "Patient Date of Death" from Section 3.2.1. Removed list of clinical data from Section 3.2.2. Updated the submission methods in Section 3. Renamed Section 6.15 from "OCM Data Registry Staging Paper Tool" to "OCM Data Registry Staging Abstraction Tool," and noted that the tool may be used for upload to the OCM Data Registry. Added new Sections 6.16 "OCM Data Registry Staging Abstraction Tool Sample File" and 6.17 "OCM Data Registry Staging Template."
2.0	1/1/2018	Renamed Section 6.2 to "OCM Cancer Type Mapping and Codes". Updated throughout to reflect updated reporting requirements and changes made to the measure specifications. Removed information specific to reporting Staging and Clinical Data, as that is documented in the OCM Staging and Clinical Data Overview.
2.1	4/16/2018	Added NQF disclaimer language and removed Section 4.0. Updated throughout to reflect the reporting requirement change to no longer require aggregate measure result updates after attribution information is available.
2.2	5/28/2018	Removed Section 3.2 "OCM FFS Beneficiary Patient Level Reporting – Staging and Clinical Data" and subsections; this information has been moved to the "OCM Staging and Clinical Data Overview" document. Updated Figure 1 to remove Staging and Clinical Data section. Added a disclaimer footnote to Table 1, Table 2, and Table A-1 indicating measures that were adapted from an NQF-endorsed measure, but NQF has not reviewed or approved the OCM measure specifications. Removed sections 4.1, 4.2, 4.3 and 4.4.

Version	Date	Description of Changes
2.3	10/29/2018	Updated Section 1 to remove "Clinical Quality of Care" domain. Removed references to Practice-Level (all Payer) measures OCM-8, OCM-9, OCM-10, OCM-11, except in Table 1. Updated Table 1 to reflect OCM-1, OCM-8, OCM-9, OCM-10 and OCM-11 were retired, added OCM-24 and OCM-30, and added a footnote to indicate OCM FFS Beneficiary measures OCM-12, 24 and 30 are optional for 7/1/2018 and retired for 1/1/2019, and Claims-based measure OCM-1 is retired for 1/1/2019; updated the eCQM (CMS) measure number for OCM-5, OCM-12, and OCM-30. Removed Table 2 as monitoring measures are transitioning to pay-for-reporting and pay-for-performance. Renumbered Table 3 to be Table 2 and added submission deadlines. Removed Section 3.3 "Reporting of Practice-Level (all Payer) Quality Measure Results". Removed Appendix A (added to the OCM Measure List document).
2.4	4/15/2019	Updated Table 1 to reflect OCM-1, OCM-12, OCM-24 and OCM-30 are retired. Removed references to these measures throughout the rest of the document.
2.5	7/8/2019	Removed "Patient Safety" from Section 1. Updated Table 1 to remove the retired measures. Updated Section 2.1, Identification of Potential OCM FFS Beneficiaries, to match the PBP document.
2.6	10/14/2019	Updated Section 2.1 to refer to requirements found in Sections 3.3.1 and 3.3.2. Updated Sections 3.3.1 and 3.3.2 to incorporate additional OCM-specific reporting rules previously contained within OCM FAQs. Added new Section 5.10 "OCM FAQ."
2.7	1/20/2020	Updated Table 1 for OCM-5 and OCM-4b. Updated Section 2.1 Number 3 to match PBP Methodology. Added Example 2 in Section 3.3.1.
2.8	7/13/2020	Added information about COVID-19 flexibilities throughout the document.
2.9	1/1/2021	Added information regarding OCM COVID-19 flexibilities extended to PP10 throughout the document. Table 2 updated to reflect the addition of PP10 and PP11.
2.10	6/7/2021	Added information regarding OCM COVID-19 flexibilities extended to PP11 throughout the document. Table 1 updated to remove "NQF 0418e" from the "Measure Name" and to remove "*" from the "OCM Measure Number" from OCM-5.

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COVID-19 PHE Notes:
In response to COVID-19, aggregate quality measure reporting will be optional for PP7, PP8, PP9, PP10, and PP11. If a practice has elected to not report aggregate quality measure results for OCM-4a, OCM-4b, ***AND*** *OCM-5 for the affected measurement periods, the practice must manually enter the value of "8888" in the denominator and numerator (and denominator exclusions and exceptions, if applicable) for each measure in the OCM Data Registry to indicate non-reporting by the submission deadline for the measurement period. Practices must report* ***all three measures*** *if they elect to report for a measurement period, otherwise the practice-reported measures will not be used for AQS.*

If a practice participating in one or two-sided risk elects not to report aggregate measure results for either of the measurement periods used to determine the AQS in PP7, PP8, PP9, PP10, and PP11, the practice's AQS and Performance Multiplier will be based on claims-based and patient survey measures only. Refer to Table 7 in the OCM PBP Methodology document which shows the measurement periods that will be used in the scoring of the practice-reported measures for each performance period.

Introduction

The Oncology Care Model (OCM) is a payment model designed to test the effect of better care coordination, improved access to practitioners, and appropriate clinical care on health outcomes and costs of care for Medicare fee-for-service (FFS) beneficiaries with cancer who receive chemotherapy. OCM encourages participating practices (OCM Participants) to improve care and lower costs through episode-based payments that financially incentivize high-quality, coordinated care. CMS expects that when OCM Participants make these changes, it will result in better care, smarter spending, and healthier people.

OCM targets physician group practices that prescribe chemotherapy for cancer and is centered on six-month episodes of care triggered by receipt of a qualifying cancer therapy. OCM incorporates a two-part payment system for OCM Participants as follows:

1. Monthly Enhanced Oncology Services (MEOS) payment to assist OCM Participants with effectively managing and coordinating care for oncology patients during episodes of care (see your OCM Participation Agreement for additional information on MEOS payments).
2. Potential retrospective performance-based payment for episodes of chemotherapy care to incentivize OCM Participants to lower the total cost of care and improve the quality of care for beneficiaries (additional information on performance-based payments is available in the "OCM PBP Methodology" document).

Episodes of chemotherapy care are organized by performance periods, which are six-month periods of time during which a group of episodes terminate (additional information on performance periods is available in the "OCM PBP Methodology" document). Calculation of performance-based payments will occur semiannually and will include all episodes ending in a given performance period.

Quality measures are one key mechanism that CMS uses to verify clinical improvements, assess patient health outcomes and appropriate coordination of care, and ensure continued quality of care for

beneficiaries. Quality measures are a component of the OCM performance-based payment calculation. OCM adjusts performance-based payments for each performance period based on the OCM Participant's or pool's performance on a range of quality measures.

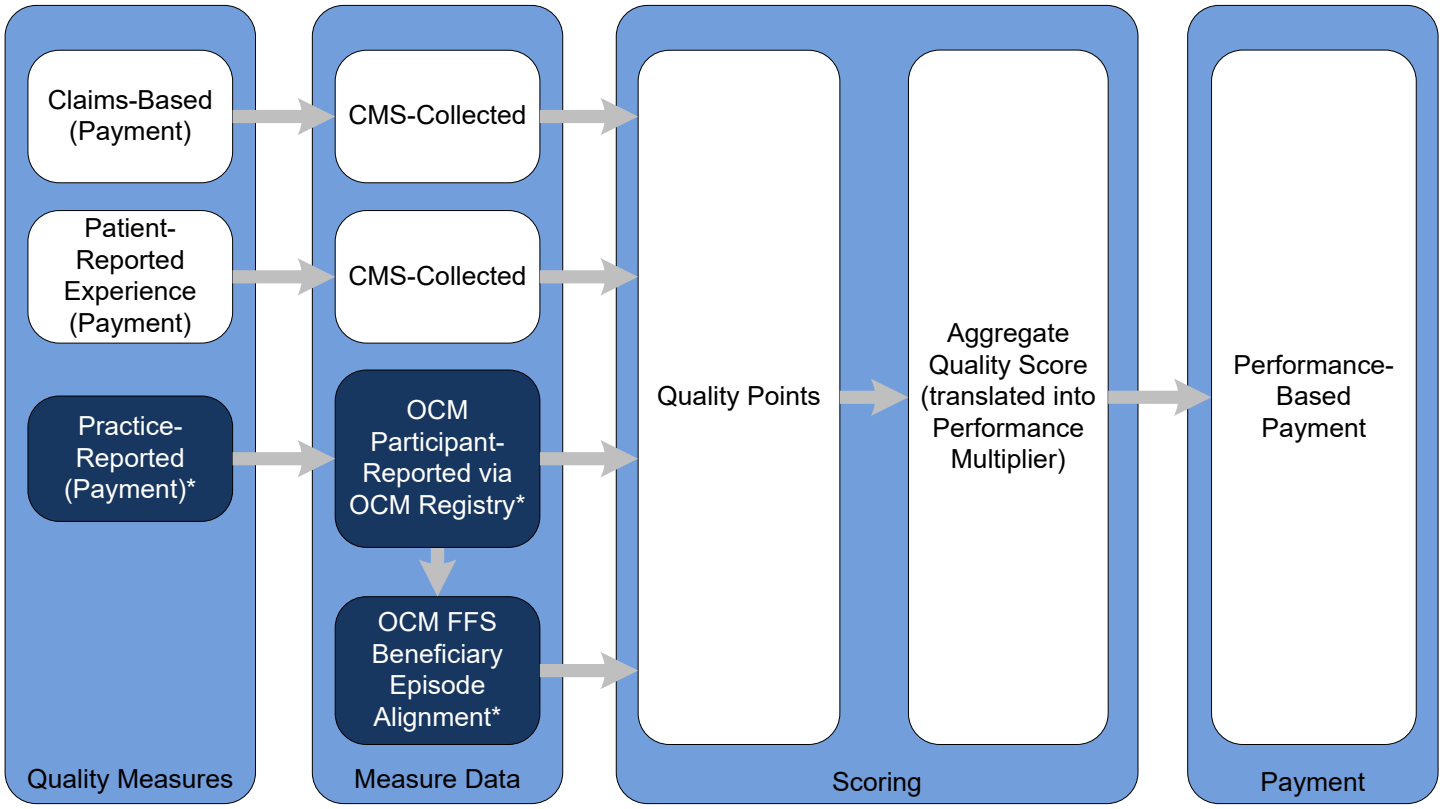
The quality measures selected by CMS for OCM span two domains of patient care. These measures balance the incentives for cost reduction by ensuring that OCM Participants meet the model's outcome goals of improving patient care and lowering costs while ensuring continued focus on patient-centered, coordinated, and clinically appropriate care. Similar to other CMS models, participant performance across these quality measures is measured by achievement relative to national benchmarks or, in cases where national benchmarks are not available, compared to other OCM Participants.

This guide provides OCM Participants with the information described below:

- A high-level overview of the measures selected for OCM is provided in Section 1. This section provides foundational information that will be built upon in subsequent sections, including measures that are reported by OCM Participants, as well as measures that are administered or calculated by CMS.
- Section 2 and Section 3 specifically provide guidance on OCM Participant responsibilities related to the reporting of quality measure results.
    - Section 2 directs practices regarding how to identify qualifying patients and episodes for OCM quality measure reporting.
    - Section 3 provides OCM Participants direction regarding quality measure results that are required to be reported via the OCM Data Registry for each measurement period.
- Section 4 gives a high-level overview of how quality measure results are used as part of the performance-based payment, including the application of the performance multiplier.
- Section 5 provides an overview of OCM supporting documents related to quality measures, as well as links to the documents.
- Section 6 contains additional OCM program resources for quality measure reporting, including links to relevant web sites and contact information for support.

An overview of the OCM quality measures that will be covered in this guide is provided in Figure 1.

Figure 1: OCM Quality Measures Overview



* The OCM Participant is responsible for reporting these items.

Section 1: OCM Quality Measures Overview

CMS has selected a set of quality measures for OCM that cross two of the National Quality Strategy (NQS) domains to be used for payment. These quality measures were chosen after an extensive literature review, a review by a Technical Expert Panel, and consideration of alignment with other quality reporting efforts. Selected quality measures represent the following NQS domains:

- Communication and Care Coordination
- Person and Caregiver-Centered Experience and Outcomes

OCM Participant performance will be calculated and monitored using OCM quality measure data derived from Medicare administrative claims, a patient experience survey, and measure results reported by OCM Participants via a centralized data registry contracted by CMS (OCM Data Registry). To the extent possible, OCM utilizes existing data such as claims data and data collected for other CMS programs as part of its performance-based payment to reduce burden on OCM Participants. Additional information regarding these data sources is provided in Section 1.1, Section 1.2, and Section 1.3.

1.1 Claims-Based Measures

CMS selected a set of claims-based measures to be used in pay-for-performance. Table 1 provides an overview of the quality measures, the source of data utilized for each measure, and the reporting requirements associated with each measure.

Performance rates for claims-based measures used in pay-for-performance are calculated by CMS using only Medicare administrative data and scored based on performance compared to national benchmarks. The detailed specifications are available on OCM Connect.

OCM Participants are not responsible for reporting any data related to these quality measures, as CMS uses claims data to monitor OCM Participant performance and calculate the performance rates.

1.2 Patient-Reported Experience Measure

CMS will use a multi-item survey to assess patients' experience with chemotherapy care at each participating practice. Survey items used in the calculation of the patient-reported experience measure for the performance-based payment will be based on items recommended in the first Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Cancer Care field test report. Additional survey items will be drawn from various validated instruments (e.g., CanCORS) to support evaluation of OCM, but these items will not be used for scoring purposes.

Performance rates for the patient-reported experience measure will be calculated for pay-for-performance using aggregated composite-level scores to create one summary score of "patient experience of care." The survey data will be collected by the Evaluation Contractor.

1.3 Practice-Reported Measures

COVID-19 PHE Notes:

*In response to COVID-19, aggregate quality measure reporting will be optional for PP7, PP8, PP9, PP10, and PP11. If a practice has elected to not report aggregate quality measure results for OCM-4a, OCM-4b, **AND** OCM-5 for the affected measurement periods, the practice must manually enter the value of "8888" in the denominator and numerator (and denominator exclusions and exceptions, if applicable) for each measure in the OCM Data Registry to indicate non-reporting by the submission deadline for the measurement period. Practices must report **all three measures** if they elect to report for a measurement period, otherwise the practice-reported measures will not be used for AQS.*

If a practice participating in one or two-sided risk elects not to report aggregate measure results for either of the measurement periods used to determine the AQS in PP7, PP8, PP9, PP10, and PP11, the practice's AQS and Performance Multiplier will be based on claims-based and patient survey measures only. Refer to Table 7 in the OCM PBP Methodology document which shows the measurement periods that will be used in the scoring of the practice-reported measures for each performance period.

CMS selected a set of practice-reported measures to be used for pay-for-reporting and pay-for-performance (Table 1). **All practice-reported measures are reported at the aggregate-level.** The aggregate measure results are reported semiannually to the OCM Data Registry, as described in Section 3. The practice-reported OCM FFS Beneficiary measures are OCM-4a, OCM-4b and OCM-5.

OCM FFS Beneficiary measures are reported for all qualifying OCM FFS Beneficiaries, as identified in Section 2. For OCM FFS Beneficiary measure results, OCM Participants must include each potentially qualifying OCM FFS Beneficiary with an episode that begins within or overlaps with any part of the semiannual measurement period who meet the denominator-qualifying criteria of the measure. The OCM Participant must continue to include that patient through the end of the episode, which may span multiple measurement periods.

Table 1: OCM Quality Measures for Determination of Performance-Based Payment

Measure Name*	OCM Measure Number	NQS Domain	Measure Source	Reporting Requirement
Risk-adjusted proportion of patients with all-cause ED visits or observation stays that did not result in a hospital admission within the 6-month episode	OCM-2	Communication and Care Coordination	Claims	Calculated by CMS using administrative data
Proportion of patients who died who were admitted to hospice for 3 days or more	OCM-3	Communication and Care Coordination	Claims	Calculated by CMS using administrative data
Oncology: Medical and Radiation – Pain Intensity Quantified (MIPS 143, NQF 0384)	OCM-4a[δ^]	Person and Caregiver-Centered Experience and Outcomes	Registry (practice-reported)	OCM-FFS Beneficiary
Oncology: Medical and Radiation – Plan of Care for Pain (NQF 0383)	OCM-4b[δ^]	Person and Caregiver-Centered Experience and Outcomes	Registry (practice-reported)	OCM-FFS Beneficiary
Preventive Care and Screening: Screening for Depression and Follow-Up Plan (CMS 2v11.0)	OCM-5	Person and Caregiver-Centered Experience and Outcomes	Registry (practice-reported)	OCM-FFS Beneficiary
Patient-Reported Experience of Care	OCM-6	Person and Caregiver-Centered Experience and Outcomes	Survey	CMS-Acquired Data

* The OCM Quality Measures may change throughout the implementation period. OCM Participants will be notified in advance of any adjustments to the quality measures.

^ Please note that this measure was adapted from an NQF-endorsed measure; the measure specifications were changed for use in the Oncology Care Model. NQF has not reviewed or approved the revised measure specifications.

δ A composite score will be calculated for OCM-4a and OCM-4b; additional information on composite scoring is available in the "OCM-4 Measure Calculation" document on OCM Connect.

Section 2: Episode Identification for Quality Reporting

COVID-19 PHE Notes:
In response to COVID-19, aggregate quality measure reporting will be optional for PP7, PP8, PP9, PP10, and PP11. If a practice has elected to not report aggregate quality measure results for OCM-4a, OCM-4b, **AND** OCM-5 for the affected measurement periods, the practice must manually enter the value of "8888" in the denominator and numerator (and denominator exclusions and exceptions, if applicable) for each measure in the OCM Data Registry to indicate non-reporting by the submission deadline for the measurement period. Practices must report ***all three measures*** if they elect to report for a measurement period, otherwise the practice-reported measures will not be used for AQS.

If a practice participating in one or two-sided risk elects not to report aggregate measure results for either of the measurement periods used to determine the AQS in PP7, PP8, PP9, PP10, and PP11, the practice's AQS and Performance Multiplier will be based on claims-based and patient survey measures only. Refer to Table 7 in the OCM PBP Methodology document which shows the measurement periods that will be used in the scoring of the practice-reported measures for each performance period.

OCM Participants are required to report quality measure results on a semiannual basis at the aggregate-level for potential OCM FFS Beneficiaries, for "applicable patients" (patients who qualify for a particular quality measure).

- **OCM FFS Beneficiaries** are Medicare FFS beneficiaries who meet all OCM beneficiary eligibility criteria and are in an OCM episode of care which is triggered by receipt of a qualifying cancer therapy.

There are several criteria that must be assessed to identify patients that qualify for aggregate-level reporting. These criteria are outlined in Figure 2, and detailed in Section 2.1.

Note: Refer to the "OCM PBP Methodology" document for additional information on episode identification.

2.1 Identification of Potential OCM FFS Beneficiaries

OCM Participants are required to report quality measure results on a semiannual basis. Therefore, to meet the semiannual reporting requirements, OCM Participants should use the below criteria to identify potential OCM FFS Beneficiaries. Patients seen at the OCM practice who meet these criteria should be included in the OCM FFS Beneficiary measure results.

To identify potential OCM FFS Beneficiaries with an associated qualifying episode, OCM Participants must:

1. Identify patients that have a qualifying cancer diagnosis code.

   Note: A general list of qualifying ICD-10-CM diagnosis codes utilized within the OCM program for episode identification is located in the "OCM Cancer Type Mapping and Codes" document. Each document includes cancer types (bundles) that are both eligible and ineligible for performance-based payments. OCM Participants are required to report on all cancer types included in the table, regardless of payment eligibility. Detailed lists of all diagnosis codes are located in the "OCM Staging and Clinical Data Specifications" document.

2. Of the patients identified above with a qualifying cancer diagnosis code, identify those that have a qualifying initiating cancer therapy code. Receipt of this qualifying initiating cancer therapy code triggers the beginning of an episode. Once an episode has begun, it will last for six calendar months. If a beneficiary enters hospice during the episode, the OCM Participant is only required to include the beneficiary in quality measure results through the initiation of hospice. If the beneficiary leaves hospice before the six-month episode has ended, the OCM Participant is required to resume reporting.

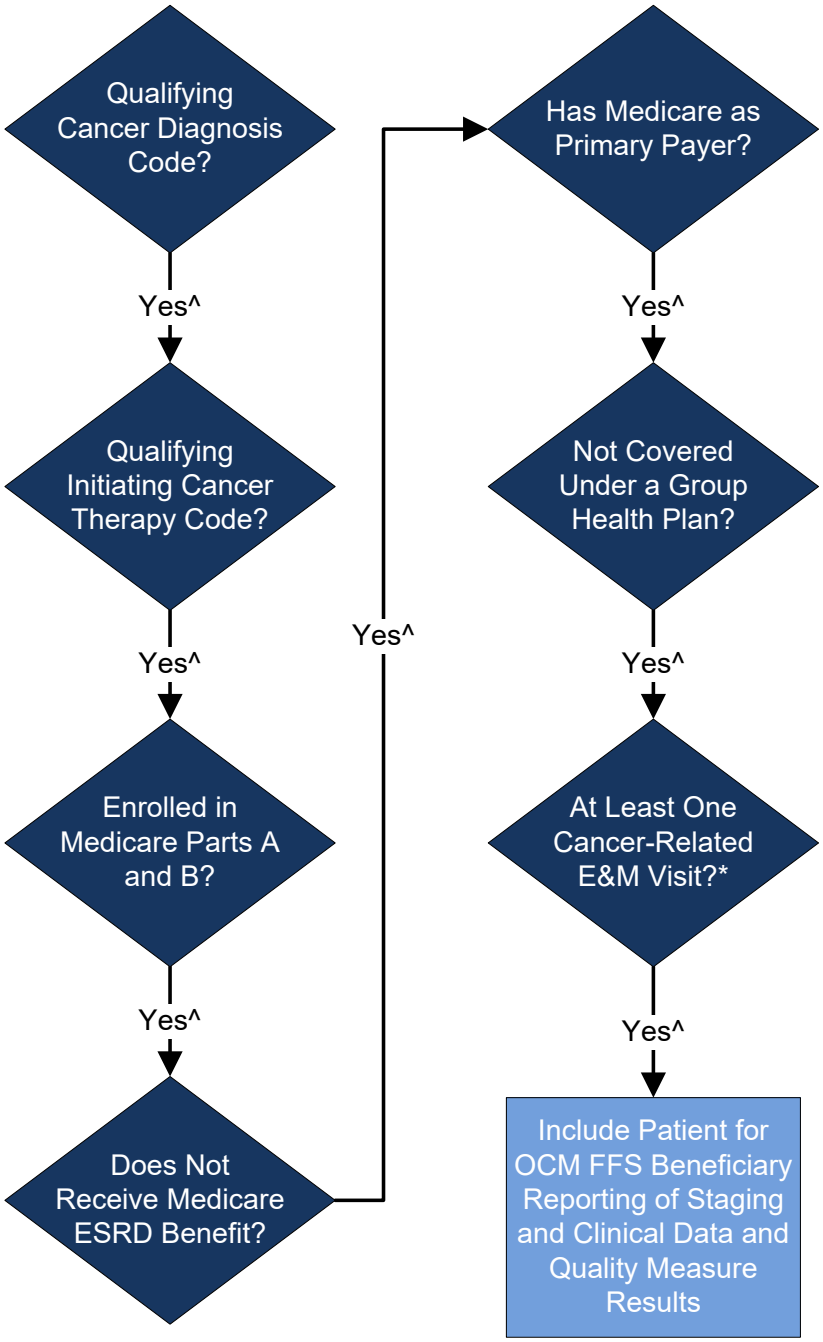
   Note: A list of Healthcare Common Procedure Coding System (HCPCS) codes and National Drug Codes (NDCs) which have been identified as qualifying initiating cancer therapy codes is located in the "OCM Initiating Cancer Therapies and Codes" document.

3. Of the patients identified above with a qualifying cancer diagnosis code and a qualifying initiating cancer therapy code, identify those that meet the following criteria:

   a. Beneficiary is enrolled in Medicare Parts A and B;
   b. Beneficiary does not receive the Medicare End Stage Renal Disease (ESRD) benefit;
   c. Beneficiary has Medicare as his or her primary payer;
   d. Beneficiary is not covered under Medicare Advantage or any other group health program;
   e. Beneficiary received chemotherapy treatment for cancer;
   f. Beneficiary has at least one qualifying Evaluation & Management (E&M) visit during the 6 months of the episode. A qualifying E&M visit is defined as having a HCPCS code in the ranges 99201-99205 or 99211-99215, a cancer diagnosis included in the document "OCM Cancer Type Mapping and Codes," and billed by a TIN with at least one oncology provider in the performance period. Oncology providers are those with a specialty code of Hematology/Oncology, Medical Oncology, Surgical Oncology, Radiation Oncology, and/or Gynecological/Oncology.
      Note: The goal is that the practice which primarily manages the oncology care of the OCM FFS Beneficiary is the practice that will report on the patient.

Episodes in which a beneficiary dies or elects hospice care before the end of 6 months are considered eligible; death will be the only case in which an episode will be shorter than 6 months. While the original measure specifications for OCM-4a, OCM-4b and OCM-5 are applicable to a broader population than cancer patients eligible for OCM, OCM Participants must only include patients meeting the OCM FFS Beneficiary criteria above. Additional OCM-specific reporting requirements applicable to the patient-based and encounter-based measures can be found in Section 3.3.1 and Section 3.3.2.

Figure 2: Identification of Potential OCM FFS Beneficiaries



* The practice which primarily manages the oncology care of the patient is the practice that will report on the patient.
^ If any of these criteria is answered "No," the patient does not qualify as an OCM FFS Beneficiary.

Section 3: OCM Data Registry for Quality Measure Practice Reporting

COVID-19 PHE Notes:
In response to COVID-19, aggregate quality measure reporting will be optional for PP7, PP8, PP9, PP10, and PP11. If a practice has elected to not report aggregate quality measure results for OCM-4a, OCM-4b, ***AND*** *OCM-5 for the affected measurement periods, the practice must manually enter the value of "8888" in the denominator and numerator (and denominator exclusions and exceptions, if applicable) for each measure in the OCM Data Registry to indicate non-reporting by the submission deadline for the measurement period. Practices must report* ***all three measures*** *if they elect to report for a measurement period, otherwise the practice-reported measures will not be used for AQS.*

If a practice participating in one or two-sided risk elects not to report aggregate measure results for either of the measurement periods used to determine the AQS in PP7, PP8, PP9, PP10, and PP11, the practice's AQS and Performance Multiplier will be based on claims-based and patient survey measures only. Refer to Table 7 in the OCM PBP Methodology document which shows the measurement periods that will be used in the scoring of the practice-reported measures for each performance period.

OCM Participants are required to utilize a centralized data registry (OCM Data Registry) for aggregate quality measure result submission. CMS has contracted with CORMAC, Premier, and Deloitte to provide the OCM Data Registry, which is a web-based data submission and collection tool. A separate user manual for the OCM Data Registry is available to guide OCM Participants through the detailed process of reporting data to the OCM Data Registry by manually entering aggregate quality measure results. The intent of Section 3 is to educate OCM Participants on the measurement periods and the requirements for reporting aggregate quality measure results to the OCM Data Registry. OCM Participants are required to report data semiannually, as outlined in Section 3.2.

3.1 OCM Measurement Periods

Each measurement period is six months in duration, as shown in Table 2. OCM Participants will have three months from the last day of each measurement period to report quality measure results to the OCM Data Registry for that measurement period.

Table 2: Planned OCM Measurement Periods and Submission Deadlines

Measurement Periods	Planned Aggregate Measure Result Submission Deadline
7/1/2016 – 12/31/2016	March 31, 2017
1/1/2017 – 6/30/2017	September 30, 2017
7/1/2017 – 12/31/2017	March 31, 2018
1/1/2018 – 6/30/2018	September 30, 2018
7/1/2018 – 12/31/2018	March 31, 2019
1/1/2019 – 6/30/2019	September 30, 2019
7/1/2019 – 12/31/2019	March 31, 2020
1/1/2020 – 6/30/2020	September 30, 2020
7/1/2020 – 12/31/2020	March 31, 2021
1/1/2021 – 6/30/2021	September 30, 2021
7/1/2021 – 12/31/2021	March 31, 2022
1/1/2022 – 6/30/2022	September 30, 2022

Example 1

Consider the following potential OCM FFS Beneficiary where the cancer diagnosis and initial cancer therapy drug claim occur after the start of the 7/1/2019 measurement period, and the episode spans two measurement periods:

- Cancer diagnosis: 8/2/2019
- Encounters:
  - Initial cancer therapy drug claim: 8/23/2019
    - This triggers the start of the six-month episode (Episode A), which will run from 8/23/2019 to 2/22/2020.
  - Subsequent encounters included in Episode A (with or without cancer therapy):
    - 9/25/2019, 10/27/2019, 11/30/2019, 12/28/2019, 1/31/2020
  - Cancer therapy drug claim following completion of Episode A: 3/1/2020
    - This claim occurs after the end of the initial six-month episode (Episode A) and will therefore initiate a new six-month episode (Episode B), which will run from 3/1/2020 to 8/31/2020.
  - Subsequent encounters included in Episode B (with or without cancer therapy):
    - 4/1/2020, 5/2/2020, 6/5/2020

Based on Episode A with a beginning date of 8/23/2019:

- The potential OCM FFS Beneficiary must be included in aggregate quality measure results reported via the OCM Data Registry for the following measurement period:
    - 7/1/2019 – 12/31/2019
    - 1/1/2020 – 6/30/2020

Based on Episode B with a beginning date of 3/1/2020:

- The potential OCM FFS Beneficiary must be included in aggregate quality measure results reported via the OCM Data Registry for the following measurement periods:
    - 1/1/2020 –6/30/2020
    - 7/1/2020 – 12/31/2020
        - **Note:** Episode B extends through 8/31/2020. OCM Participants will still be required to include potential OCM FFS Beneficiaries in aggregate quality measure results, as required in each individual measure specification.

Example 2

Consider the following potential OCM FFS Beneficiary where the diagnosis begins prior to the start of the 7/1/2019 measurement period:

- Cancer diagnosis: 6/17/2019
- Encounters:
    - Initial cancer therapy drug claim: 7/2/2019
        - This triggers the start of the six-month episode (Episode A), which will run from 7/2/2019 to 1/1/2020.
    - Subsequent encounters (with or without cancer therapy) (included in Episode A):
        - 7/9/2019, 7/23/2019, 8/11/2019, 8/25/2019, 9/9/2019, 9/23/2019, 10/10/2019, 10/26/2019, 11/9/2019, 11/24/2019, 12/10/2019, 12/24/2019

Based on Episode A with a beginning date of 7/2/2019:

- The potential OCM FFS Beneficiary must be included in aggregate quality measure results reported via the OCM Data Registry for the following measurement periods:
    - 7/1/2019 –12/31/2019
    - 1/1/2020 – 6/30/2020
        - **Note:** Episode A extends through 1/1/2020. OCM Participants will still be required to include potential OCM FFS Beneficiaries in aggregate quality measure results, as required in each individual measure specification.

3.2 Reporting of Potential OCM FFS Beneficiary Quality Measure Results

OCM Participants are required to report aggregate quality measure results for potential OCM FFS Beneficiaries, which are used for performance payment determination (pay-for-reporting and pay-for-performance).

For the quality measures reported for potential OCM FFS Beneficiaries, as indicated in Table 1, OCM Participants are required to report aggregate measure results for OCM-4a, OCM-4b and OCM-5 for each measurement period. OCM Participants are required to:

- Report the denominator for each measure
- Report the denominator exclusion (if applicable) for each measure
- Report the numerator for each measure
- Report the denominator exception (if applicable) for each measure

OCM Participants have access to detailed specifications which will provide information on all clinical data required for quality measure calculations. The detailed specifications are located in the "OCM Measure Specifications" and the data elements and corresponding codes/criteria are located in the "OCM Tech Spec Value Set" document.

3.3 Measure-Specific Reporting Requirements

OCM quality measures encompass both patient-based (Section 3.3.1) and encounter-based (Section 3.3.2) measures as outlined below.

3.3.1 Patient-Based Measures

Measures that evaluate the care of a patient over a period of time and assign the patient to membership in one or more measure populations are called patient-based measures. One of the OCM practice-reported measure specifications is patient-based (OCM-5). **All of the information in the patient record referenced in the measure must be considered when calculating a patient-based measure for each semiannual measurement period**. This includes consideration of care which occurred within the measurement period, but outside the patient episode. It also includes care provided by any clinician at the practice, regardless if the clinician is an OCM Practitioner. The criteria for inclusion of a patient in a measure population may require that information from multiple encounters during that measurement period be considered, but the patient should only be included in the denominator once per semiannual measurement period. Patient-based measures may evaluate encounters prior to the start of the patient's episode or after the end date of the patient's episode to capture all care provided during the measurement period.

In a patient-based measure, the patient criteria for measure inclusion is identified in the Initial Population or Denominator. The requirement to report measure results once per measurement period may result in reporting on Initial Population/Denominator eligible patients prior to completion of a measure's specified time frame to complete the appropriate care. Timeframes for delivery of clinically appropriate, high quality care are addressed in each individual measure specification based on nationally recognized clinical guidelines. The requirement to report measure results for each measure semiannually does not change the timeframes in which high quality clinical care may be provided.

Example 1 Effective 7/1/2019 - 12/31/2019

OCM-5 includes patients aged 18 years and older screened during the measurement period for depression on the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen. In this example, the first measurement period used to evaluate the patient is 7/1/2019 – 12/31/2019. A male patient aged 68 years, meeting the OCM FFS Beneficiary criteria, with a qualifying provider encounter on 8/1/2019 would be included in the denominator for the measure. The patient does not have an active diagnosis of depression or bipolar disorder during the qualifying provider encounter. The patient meeting the denominator criteria on 8/1/2019 is included in the denominator during the 7/1/2019 – 12/31/2019

measurement period. The patient will be included in the numerator if there is documentation of the most recent depression screening reviewed and addressed during the qualifying provider encounter, and the result is either negative, or if positive there is a follow-up plan documented on the same day as the depression screening. The OCM Participant must continue to include that patient through the end of the potential qualifying episode, which may span multiple measurement periods.

Example 2 Effective 1/1/2020

OCM-5 includes patients aged 18 years and older screened during the measurement period for depression on the date of the encounter or up to 14 days prior to the date of the encounter, using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen. In this example, the first measurement period used to evaluate the patient is 1/1/2020 – 6/30/2020. A male patient aged 68 years, meeting the OCM FFS Beneficiary criteria, with a qualifying provider encounter on 4/1/2020 would be included in the denominator for the measure. The patient does not have an active diagnosis of depression or bipolar disorder during the qualifying provider encounter. The patient meeting the denominator criteria on 4/1/2020 is included in the denominator during the 1/1/2020 – 6/30/2020 measurement period. The patient will be included in the numerator if there is documentation of the most recent depression screening reviewed and addressed during the qualifying provider encounter, and the result is either negative, or if positive there is a follow-up plan documented on the same day as the depression screening. The OCM Participant must continue to include that patient through the end of the potential qualifying episode, which may span multiple measurement periods.

3.3.2 Encounter-Based Measures

Measures that evaluate the care during a patient-provider encounter and assign the encounter to one or more populations are called encounter-based measures. Two of the OCM practice-reported measure specifications are encounter-based (OCM-4a and OCM-4b). In an encounter-based measure, the encounter is identified in the Initial Population or Denominator, and each qualifying encounter during the semiannual measurement period is to be reported separately for that patient. Please reference the detailed code lists available in the "OCM Tech Spec Value Set" for specific qualifying encounter codes for each encounter-based measure.

To support quality measurement of OCM Practitioners and the care that occurred for OCM FFS Beneficiaries during their OCM episode, the following reporting requirements have been established:

- OCM practices are not required to evaluate encounters during the measurement period that are prior to the episode start date or after the episode end date for the encounter-based measures.
- In addition, practices should only report encounters with OCM Practitioners (i.e., practitioners on the practice's OCM Practitioner List with effective dates which overlap with the measurement period) in the OCM measure results for the encounter-based measures.

Example

OCM-4a includes patient visits (encounters) with a diagnosis of cancer receiving chemotherapy or radiation therapy in which pain intensity is quantified. A patient with a qualifying cancer diagnosis receiving chemotherapy or radiation therapy would be included in the denominator for the measure for each qualifying provider encounter. The patient with encounters meeting the denominator criteria on 8/1/2019

and 11/1/2019 is included in the denominator during the 7/1/2019 – 12/31/2019 measurement period. Both the 8/1/2019 and 11/1/2019 encounters are included in the aggregate denominator count. The patient encounters will be included in the aggregate numerator count if pain intensity was quantified during the measurement period. The OCM Participant must continue to include that patient through the end of the potential qualifying episode, which may span multiple measurement periods.

Section 4: Determination of Performance-Based Payment

COVID-19 PHE Notes:
In response to COVID-19, aggregate quality measure reporting will be optional for PP7, PP8, PP9, PP10, and PP11. If a practice has elected to not report aggregate quality measure results for OCM-4a, OCM-4b, ***AND*** *OCM-5 for the affected measurement periods, the practice must manually enter the value of "8888" in the denominator and numerator (and denominator exclusions and exceptions, if applicable) for each measure in the OCM Data Registry to indicate non-reporting by the submission deadline for the measurement period. Practices must report* ***all three measures*** *if they elect to report for a measurement period, otherwise the practice-reported measures will not be used for AQS.*

If a practice participating in one or two-sided risk elects not to report aggregate measure results for either of the measurement periods used to determine the AQS in PP7, PP8, PP9, PP10, and PP11 the practice's AQS and Performance Multiplier will be based on claims-based and patient survey measures only. Refer to Table 7 in the OCM PBP Methodology document which shows the measurement periods that will be used in the scoring of the practice-reported measures for each performance period.

Detailed information regarding calculation of performance rates and performance-based payment is located in the "OCM PBP Methodology" document. This guide provides only a high-level overview of these topics.

OCM quality measure data derived from claims, aggregate measure results reported to the OCM Data Registry, and patient experience survey data, are utilized to determine the quality score used in calculation of the performance multiplier. Scoring, or the process of assigning quality points to each quality measure, is based on the OCM Participants' reporting of quality measure data and/or quality performance relative to set thresholds. Once quality points are assigned, an Aggregate Quality Score (AQS) will be calculated and translated into a performance multiplier. This performance multiplier is used as part of the performance-based payment calculation.

Section 5: OCM Quality Measure Reporting Supporting Documents

This section provides an overview of several OCM supporting documents that are used to:

- Explain the methodology used to calculate OCM performance-based payments
- Identify qualifying patients and episodes for OCM quality measure reporting
- Assist OCM Participants with reporting quality measure data at the aggregate level to the OCM Data Registry

These documents are located on OCM Connect.

5.1 OCM PBP Methodology

This document includes technical details for the methodology used to calculate OCM performance rates and performance-based payment.

5.2 OCM Cancer Type Mapping and Codes

This document includes a general list of OCM-qualifying ICD-10-CM cancer diagnosis codes. This information will be used to:

- Identify patients that have a qualifying cancer diagnosis code

Note: Please reference OCM Connect for the version of this document specific to each performance period. For a detailed list of all OCM-qualifying diagnosis codes, please refer to the "OCM Staging and Clinical Data Specifications."

5.3 OCM Initiating Cancer Therapies and Codes

Please refer to the timeframe-appropriate version of this document, which includes a list of Healthcare Common Procedure Coding System (HCPCS) codes and National Drug Codes (NDCs) that have been identified as qualifying initiating cancer therapy codes. This information will be used to:

- Identify patients that have a qualifying initiating cancer therapy code

5.4 OCM Measure List

This quick-reference document provides a list of all OCM quality measures, including details on which measures are practice-reported, reporting requirements and other information.

5.5 OCM Measure Specifications

Each individual OCM measure specifications document includes Description, Guidance, Numerator and Denominator definitions, and where applicable, Denominator Exclusion and Denominator Exception definitions. These narrative descriptions of the population criteria represent the data that will be used to calculate these measures. The codes and value sets/code sets that make up the population criteria for the measures can be found in the "OCM Tech Spec Value Set" document. Each OCM measure flow provides a flow chart representation of the individual OCM Measure Specifications.

5.6 OCM Quality Measure Calculations and Definitions

This document provides definitions of the measure populations included in the OCM quality measures and explains how these populations are used to calculate the measure performance rate.

5.7 OCM Tech Spec Value Set

This document includes the codes/criteria that make up the population criteria in each of the practice-reported OCM measures. This document will be used to determine which population(s) each patient fits into. The "Data Element Names" tab includes a list of all data elements included in the OCM Measure Specifications, and the measure(s) they are used for.

Each of the practice-reported measures is represented on a tab in this document. Each tab includes the data elements from the measure specifications and an indicator of which population criteria(s) the data element is used for in the measure. Each data element is made up of codes or criteria, and those are included as well as the code description (when available). The source documentation indicates the

measure specification that was leveraged for the OCM model. When the source documentation is "eCQM" there will be an Object Identifier (OID) included as well. The code system and version columns include reference information.

5.8 OCM Staging and Clinical Data Specifications

This document includes the specific data elements and codes for the clinical data that will be collected for each cancer bundle.

5.9 OCMR Quality Measure Abstraction Tool

This is an optional Excel tool available to assist with collecting data and calculating aggregate measure results prior to manual entry of the aggregate measure results in the OCM Data Registry.

5.10 OCM FAQ

This document includes frequently asked questions from OCM Participants regarding all aspects of OCM. The FAQ document contains sections specific to OCM staging and clinical data and quality measures reporting. Many of these FAQs provide guidance to OCM Participants regarding specific clinical scenarios and questions related to quality measures interpretation and reporting.

Section 6: OCM Quality Reporting Program Resources

OCM Connect:

- https://app.innovation.cms.gov/OCMConnect

OCM Data Registry:

- https://portal.cms.gov

OCM Support:

- OCMSupport@cms.hhs.gov
- 1-844-711-2664 (1-844-711-CMMI), Option 2

Section 7: Acronyms and Abbreviations

Table 3: Acronyms and Abbreviations

Acronym	Literal Translation
AQS	Aggregate Quality Score
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
E&M	Evaluation and Management
eCQM	Electronic Clinical Quality Measure
ESRD	End Stage Renal Disease
FFS	Fee-for-Service
HCPCS	Healthcare Common Procedure Coding System
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
MIPS	Merit-based Incentive Payment System
MEOS	Monthly Enhanced Oncology Services
NDC	National Drug Code
NQF	National Quality Forum
NQS	National Quality Strategy
OCM	Oncology Care Model