Oncology Care Model
External FAQs

GENERAL

What are the goals of the Oncology Care Model (OCM)?

The goals of OCM are to utilize appropriately aligned financial incentives to improve care coordination, appropriateness of care, and access to care for beneficiaries undergoing chemotherapy. The model encourages participating practices to improve care and lower costs through a model that incorporates a care coordination fee and episode-based payments. The Innovation Center expects that these improvements will result in better health outcomes, higher quality care, and lower Medicare costs. This is in accordance with the Department of Health and Human Services’ “Better, Smarter, Healthier” approach to improving our nation’s health care, setting clear, measurable goals and a timeline to move the Medicare program -- and the health care system at large -- toward paying providers based on the quality, rather than the quantity of care they give patients.

Are payers other than Medicare able to participate in OCM?

Yes. Commercial payers (including Medicare Advantage plans), state Medicaid agencies, and other governmental payers such as TRICARE, FEHBP, and state employee health plans may participate through the “Oncology Care Model - Other Payer” or OCM–OP arm of the model through a Memorandum of Understanding with the Innovation Center.

When will OCM start, and how long is the performance period?

OCM will start in spring 2016. The performance period for the model is five years. Episodes of care within the model are defined as six months of chemotherapy treatment.

How is an episode of care defined?

Episodes in OCM for Medicare Fee-For-Service beneficiaries (OCM-FFS) will initiate with either an initial chemotherapy administration claim or an initial Part D chemotherapy claim for cancer, and include all Medicare Parts A and B services that the OCM-FFS beneficiary receives during the six-month episode. Certain Medicare Part D expenditures will also be included. Services that OCM-FFS beneficiaries receive before the initial chemotherapy claim will not be included in the OCM-FFS episode. Subsequent episodes may occur if the beneficiary receives additional chemotherapy after the first six-month episode.

What cancer types will be included in OCM?

OCM-FFS includes nearly all cancers.
Participating practices will receive per beneficiary per month (PBPM) payments for Medicare FFS beneficiaries receiving an included chemotherapy during each month of an episode, regardless of cancer type. However, participating practices will only be eligible for performance-based payments for beneficiaries with high-volume cancers for which it is possible to calculate reliable benchmarks. The high-volume cancers which will be included in benchmarks cover an estimated 90 percent of Medicare FFS beneficiaries receiving chemotherapy. The Innovation Center will make this list of high-volume cancers publicly available prior to entering into participation agreements.

Can OCM-FFS beneficiaries trigger multiple episodes?

Yes. Beneficiaries who receive chemotherapy after the end of an episode may initiate a new episode. Reinitiation of chemotherapy after a gap in administration within an episode does not trigger a new episode.

Which chemotherapy drugs trigger an OCM-FFS episode?

Appendix D of the Request for Applications (RFA) lists drugs that trigger an OCM-FFS episode. The chemotherapy list excludes topical formulations of chemotherapy drugs as a trigger, such as fluorouracil cream, because the topical formulations do not require the intensive management associated with the systemic therapies. Topical formulations will still be included in the total cost of care if provided in conjunction with another cancer drug that triggers an OCM episode.

Are hormonal therapies that are used for cancer included in OCM-FFS?

Yes. Hormonal therapies used to treat a cancer diagnosis, such as aromatase inhibitors for breast cancer and anti-androgen therapy for prostate cancer, are included on the chemotherapy list for OCM-FFS and trigger episodes in the same manner as other chemotherapy drugs.

How will OCM be evaluated?

CMS will contract with an independent evaluator to determine the impact of OCM-FFS on costs, quality of care, and patient experience. The contractor will work within the statutory and regulatory limitations on individually identifiable health information data access (e.g. HIPAA). The OCM-FFS evaluation will seek to provide rapid-cycle feedback that can be used by participating practices to improve operations over the life of the model. The evaluation will include patient surveys to document patient experiences under the Oncology Care Model. It will involve analysis of both primary data collected under the terms of the model and secondary data such as claims and enrollment records. Both quantitative and qualitative analyses will be performed.

APPLICANT SELECTION

How do practices and payers apply to participate in OCM-FFS?
All practices and payers who wish to apply for participation in OCM-FFS must first submit a non-binding letter of intent. Letters of intent for interested payers are due by 5:00 pm EDT on March 19, 2015. Letters of intent for interested practices are due by 5:00 pm EDT on April 23, 2015. Letters of intent will only be accepted through the Oncology Care Model inbox at OncologyCareModel@cms.hhs.gov.

Practices and payers that submit timely, complete letters of intent (LOIs) will be eligible to submit applications. All applications must be submitted by 5:00 pm EDT on June 18, 2015. Applications must be completed online using an authenticated web link and password, which will be emailed to applicants upon submission of a complete LOI. Only those applicants submitting a timely, complete LOI will be eligible to submit an application. Submission of PDF versions of the applications will not be accepted.

More information can be found on the OCM website: http://innovation.cms.gov/initiatives/Oncology-Care/.

Where can interested parties access the Request for Applications?

The Request for Applications document, Letter of Intent forms, and application templates are available at the OCM website: http://innovation.cms.gov/initiatives/Oncology-Care/.

Who can participate in OCM-FFS?

Physician group practices and solo practitioners that furnish cancer chemotherapy may apply to participate in OCM-FFS. Eligible practices may be multi-specialty practices and do not need to solely consist of physicians that furnish cancer chemotherapies.

Must all practitioners in a participating practice be included in OCM-FFS?

All practitioners in the physician group practice who prescribe chemotherapy for cancer must be included in the practice’s participation in the model.

Are there any practices that cannot participate in this model?

Provider-based departments (whether on-campus or off-campus) of prospective payment system (PPS)-exempt cancer hospitals (section 1886(d)(1)(B)(v) of the Social Security Act) and other physicians not paid off of the Medicare Physician Fee Schedule for physician services may not participate in OCM.

How many practices will be selected to participate in OCM-FFS?

The number of practices selected will depend on several factors, including the size and geographic distribution of the practices that apply to participate in the Oncology Care Model. Applicants that best meet the selection criteria will be selected for participation.

When will practices be notified of their selection to participate in OCM-FFS?
Practices will be notified of their selection within six months of the application submission date.

Are practices required to engage with non-Medicare payers to participate in the Oncology Care Model?

No, but practices are strongly encouraged to do so. During the selection process, the Innovation Center will favor practices with higher proposed levels of participation with other payers. The Innovation Center will enter into participant agreements with physician practices and Memoranda of Understanding with other participating payers. Other participating payers will enter into agreements with practices separately.

Can practices participate in OCM and other CMMI models simultaneously?

Beneficiaries and practitioners participating in other CMS programs and models, including shared savings models such as Accountable Care Organizations (ACOs), are eligible for participation in OCM. Practitioners participating in the Transforming Clinical Practices Initiative are not eligible for participation in OCM.

How will practices and payers know which other parties are participating in OCM?

The Innovation Center will publicly post the list of payers who submit letters of intent and agree to public posting on March 26, 2015, and will post the list of practices that submit letters of intent and agree to public posting on April 30, 2015. These lists will appear on the Innovation Center webpage at http://innovation.cms.gov/initiatives/Oncology-Care/ to allow interested payers and practices to engage with one another and coordinate participation in the Oncology Care Model. The postings will include the names, locations, and points of contact for payers and practices. Potential practice and payer applicants are also encouraged to engage their current partners in discussions about the model.

**PRACTICE REQUIREMENTS**

**What requirements must practices meet to participate in OCM-FFS?**

Practices must meet the following requirements by the end of the first quarter of the first performance year to participate in OCM-FFS. More detail on each requirement may be found in the RFA.

1. Provide and attest to 24 hours a day, 7 days a week patient access to an appropriate clinician who has real-time access to practice’s medical records
2. Attestation and use of ONC-certified electronic health records (EHRs)
3. Utilize data for continuous quality improvement
4. Provide core functions of patient navigation
5. Document a care plan that contains the 13 components in the Institute of Medicine Care Management Plan
6. Treat patients with therapies consistent with nationally recognized clinical guidelines

Are participating practices required to hire patient navigators?

Practices are required to fulfill the core functions of patient navigation and care coordination as described in the RFA. Practices do not necessarily have to hire additional staff to perform these functions, but they should explain in their OCM applications how they will ensure that the core patient navigation requirements are met.

How often will practices be required to report data to CMS?

Practices are required to report data on OCM-FFS beneficiaries to CMS on a quarterly basis. To the extent possible, CMS will use existing data and reporting systems as part of its monitoring efforts, to minimize the reporting burden on practices, providers, and patients.

Do OCM-FFS quality measures align with Physician Quality Reporting System (PQRS) measures?

Several of the quality measures that OCM-FFS will monitor and evaluate are PQRS measures, such as the plan of care for pain and pain intensity, adjuvant hormonal therapy for high-risk beneficiaries, and population health measures. Additionally, many measures have support from entities such as the American Society of Clinical Oncology, the Community Oncology Alliance, the Institute of Medicine, the European Organization for Research and Treatment of Cancer, and the National Quality Forum.

What performance feedback and other data will practices receive from CMS?

The Innovation Center will issue quarterly monitoring reports to OCM-FFS practices describing their performance on measures that will be used for monitoring purposes and the measures that will be used as part of the performance-based payment calculation. Other payers may collect quality data and produce feedback reports differently.

How does OCM-FFS align with the CMS EHR Incentive Program?

Eligible professionals who are part of OCM-FFS practices may participate in and qualify to receive the incentive payments from the EHR Incentive Program, and may also be subject to downward payment adjustments under Medicare beginning in CY 2015 for failure to demonstrate meaningful use. The OCM requirements relating to meaningful use may be updated to align with future CMS rulemaking.

BENEFICIARY ENROLLMENT AND ATTRIBUTION

How can beneficiaries enroll in OCM-FFS?
Beneficiaries do not enroll themselves into OCM-FFS. Eligible beneficiaries who receive chemotherapy at participating practices will be automatically enrolled.

Are there specific eligibility requirements Medicare FFS beneficiaries must meet?

Yes. Medicare FFS beneficiaries must meet all of the following criteria in order to be eligible to participate in OCM-FFS:

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

How does enrollment in OCM affect beneficiaries’ access to care and choice of treatment?

OCM does not limit beneficiaries’ choice of provider or dictate from whom they seek cancer treatment; patients retain the ability to seek care wherever they choose. Further, the model does not dictate which drugs or services practitioners must provide. Participating practices are expected to use shared decision making techniques to work with beneficiaries in the model to develop the most appropriate course of treatment for each patient.

Is Part D coverage required for a Medicare FFS beneficiary to be enrolled in OCM-FFS?

No. If a beneficiary is not enrolled in Part D, the beneficiary will only initiate an episode if they receive Part B covered chemotherapy, and their benchmarked and actual expenditures will be based on only Parts A and B claims.

How will practices know which of their patients are enrolled in OCM-FFS?

All Medicare-FFS beneficiaries who receive chemotherapy at participating practices will be automatically enrolled in OCM-FFS. Practices are responsible for prospectively tracking which of their beneficiaries meet these criteria, and for billing for the monthly care management fee for these beneficiaries throughout each episode. CMS will perform retrospective attribution of beneficiaries to practices after the completion of each episode.

Can Medicare FFS beneficiaries opt out of OCM-FFS?

Because the oncology care model requires physician practices to undergo extensive practice improvements to participate, beneficiaries who do not wish to be part of OCM need to switch to providers in a non-participating practice. A beneficiary maintains complete freedom to visit any healthcare provider accepting Medicare at any time.

OCM emphasizes transformation at the practice level primarily through enhanced care coordination, so the systematic changes expected through the model should result in more coordinated, seamless services for beneficiaries. Medicare beneficiaries in OCM-FFS should
expect similar or better quality care than usual, as evidenced by enhancements such as increased shared decision-making, patient-centered communication, evidence-based care, beneficiary access to providers 24 hours per day, and coordination across providers and settings.

**FINANCIAL**

**How will practices’ benchmark expenditures be calculated in OCM-FFS?**

Benchmark expenditures for each OCM-FFS practice will be calculated based on Medicare claims data from a historical baseline period. Total Medicare expenditures for beneficiaries who meet OCM inclusion criteria in the historical period will be calculated and risk-adjusted based on several factors that affect cost of care as well as adjusted for geographic variation. These baseline expenditures will then be trended forward to calculate performance year benchmarks. Detailed methodologies for determining performance-based payments will be provided to practices prior to signing OCM-FFS participation agreements.

**What risk arrangements are offered in OCM-FFS?**

During the first two performance years all participants will be in a one-sided risk arrangement. In the one-sided risk arrangement, an OCM-FFS participant that generates reductions in expenditures below a target price will be eligible to receive a performance-based payment. If actual expenditures exceed target prices, the practice will not be financially responsible for the difference.

Beginning in the third model year, participants will have the option to switch to two-sided risk arrangements on a semiannual basis. Under two-sided risk, participants will be financially responsible for Medicare FFS expenditures that exceed the target price.

**Is two-sided risk mandatory in OCM-FFS?**

No.

**How will practices’ target spending prices be generated?**

Practice-specific benchmark expenditures will be trended forward to the performance period, and then discounted by four or 2.75 percent (under one or two-sided risk arrangements, respectively) to generate target prices. For example, if a practice’s benchmark expenditure for a given performance year is $10,000 per episode, and the practice has selected two-sided risk arrangement, the practice’s target price would be $9,725.

**What discount percentage will Medicare retain in the calculation of target prices?**

During the first two performance years all participants will be in a one-sided risk arrangement, where OCM-FFS applies a four percent discount to determine the target price for participants’ performance period episodes. Medicare will retain that four percent, and participants will be
eligible to retain a portion of the difference between the target price and actual expenditures. In the one-sided risk arrangement, an OCM-FFS participant that generates reductions in expenditures below a target price will be eligible to receive a performance-based payment. If actual expenditures exceed target prices, the practice will not be financially responsible for the difference.

Starting in performance year three, participants will have the option to select a two-sided risk arrangement, where OCM-FFS will apply a 2.75 percent discount to determine target prices. In the two-sided risk arrangement, a participant whose performance year actual expenditures exceed the target price would be financially responsible for the additional costs.

How will episode prices be adjusted to account for severity of disease, co-morbidities, and other factors which affect the intensity of intervention?

OCM-FFS will risk adjust target prices for characteristics that predict Medicare expenditures in the episode. In the first year, risk adjustment factors will include only those in Medicare administrative claims data. Examples may include: beneficiary characteristics, episode characteristics, disease characteristics, and types of services furnished. The Innovation Center will collect additional information from practices, including cancer staging information, to consider as risk adjustment factors in future performance years of OCM.

How will performance on quality measures affect practice payments?

OCM-FFS participants may receive up to the full difference between the target price and their performance year actual expenditures, based on their performance on a range of quality measures as measured by achievement or improvement. Participant performance across these metrics will be transformed into weighted scores that are summed to calculate a practice-specific performance multiplier. This multiplier will determine the amount of the performance-based payment a given participant can achieve. Final methodologies for determining performance-based payments will be provided to practices prior to signing OCM-FFS participation agreements.

Will practices continue billing Medicare fee-for-service (FFS) as usual during OCM?

Yes. Participating practices will continue billing traditional Medicare FFS claims throughout OCM episodes.

What is the amount of the PBPM payment that participating practices will receive?

The PBPM will be $160 for the duration of each six-month episode (totaling up to $960 per beneficiary per episode) and will remain constant for the entire five year performance period of the OCM.

Should practices still bill the PBPM for the duration of the six-month episode if a beneficiary stops receiving chemotherapy before the six-month time period is complete?
Yes. Practices should continue billing the PBPM for the duration of the six-month episode unless a beneficiary enters hospice.

**Can OCM practitioners bill the Chronic Care Management or Transitional Care Management codes during an OCM-FFS episode?**

OCM-FFS practices that bill for the OCM PBPM cannot also bill the Chronic Care Management or Transitional Care Management codes in the same month for the same beneficiary. Non-OCM practitioners could bill for CCM services for an OCM beneficiary, including during months when participating practices are billing the PBPM, if the practitioner meets criteria for CCM services without considering cancer one of the qualifying diagnoses.

**NON-MEDICARE PAYERS**

**What other payers may participate in OCM?**

Other payers may include commercial payers (including Medicare Advantage plans), state Medicaid agencies, and other governmental payers such as TRICARE, FEHBP, or state employee health plans.

**How will payers be selected for participation in the Oncology Care Model?**

Payers must submit letters of intent and applications to be considered for Oncology Care Model participation. Additionally, payers must be licensed to sell insurance in the state or states in which they implement the model and be in good standing with the health insurance regulator of that state or states and be committed to aligning with OCM. Priority will be given to payers that include cancer types that cover large majorities of beneficiaries.

The Innovation Center will enter into a Memorandum of Understanding with each payer to promote proper alignment with OCM. Additional payer requirements are listed in section III. A. of the RFA.

**With which components of OCM-FFS are other payers required to align?**

Other payers must agree to participate in the full five-year duration of the model, and to begin their performance period no later than 90 days after OCM-FFS’ performance period.

Other payers must financially incentivize the practice requirements as described in section IV. of the RFA. Financial incentives must be aligned with the payments in OCM-FFS in that the payments provide funding during the oncology episode for enhanced services (for example, advance payment or PBPM) and for actual performance (for example, retrospective lump sum or increased monthly payments).
Other payers are not required to use the same benchmarking, attribution, or payment methodologies as OCM-FFS, but they must share the methodologies they develop with the Innovation Center.

Payers must be willing to align with a core set of OCM-FFS quality measures to collect from and report back to practices. They may require practices to report on additional measures, as long as those measures do not conflict with OCM practice requirements or significantly increase practice reporting burden.

**Does the Oncology Care Model include Medicare Advantage plans?**

Medicare Advantage (Part C) plans may participate in the OCM – Other Payer arm of the model by submitting letters of intent and applications. The Innovation Center will enter into a Memorandum of Understanding with the plan. In addition, non-Medicare payers who offer Medicare Advantage plans may include those plans in their Oncology Care Model participation.

**Why should other payers partner with CMS and participate in OCM?**

Through participation in OCM, payers will work in tandem with Medicare FFS to leverage the opportunity to transform care for oncology patients across the population. In so doing, payers have the opportunity to improve care for their members, lower costs, and engage with quality and cost data that will inform changes to quality monitoring and payment delivery.