VerbalCare – Oncology Care Model Guide for Providers

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Abstract:

Scope: The Oncology Care Model aims to **improve effectiveness and efficiency of specialist oncology care** by using an episode-based payment model that will result in smarter spending and healthier people.

Goals: **Improve care coordination, appropriateness of care, and its availability for chemotherapy patients** through giving **financial incentives** to care providers, while lowering costs.

Performance: The model involves **multiple payors, including Medicare FFS** and other government-based payors. OCM-FFS incorporates a **two-part payment system** for practices: one monthly **per-beneficiary-per-month payment** for each 6-mo. episode, and another **performance-based payment** as incentive to lower care cost and improve its quality during treatment.

I. Scope and Approach of OCM

Every year, more than 1.6 million people in the United States are diagnosed with cancer.[1] As cancer patients are a medically complex and high-cost population, the Center for Medicare and Medicaid Innovation (CMMI) has developed a pay-for-performance model specific to cancer care . The Oncology Care Model (OCM) aims to improve the effectiveness and efficiency of specialist care with an episode-based payment model for oncology care. Through OCM, the Centers for Medicare & Medicaid (CMS), aims to further its three-pronged goals: higher quality care, smarter spending, and healthier populations.

The goal of OCM is to improve care coordination, appropriateness of care, and access to care for recipients of chemotherapy through the use of financial incentives for providers. With a care coordination fee and episode-based payments, the model encourages participating practices to improve care and lower costs. Additionally, practitioners in OCM are expected to rely on the **most current medical evidence** and **shared decision-making with patients** to guide their decision of whether the patient should receive chemotherapy treatment. Helping physician practices comprehensively address the care needs of their beneficiary population, OCM seeks to heighten the focus on furnishing services that will improve both the patient experience and their health outcomes.

OCM is intended to be a **multi-payor model** that includes **Medicare fee-for-service (FFS)** and other payors. Payors and physician practices must apply separately to participate in OCM. OCM-FFS incorporates a **two-part payment system** for participating practices: one is a monthly per-beneficiary-per-month (**PBPM**) payment for the duration of the episode (6 months), and the

other is a **performance-based** payment for associated episodes of cancer care. PBPM payments will help participating practices manage and coordinate care for oncology patients, while performance-based payments will serve as an appropriate incentive for practices to lower the total cost of care and improve care quality during treatment episodes.

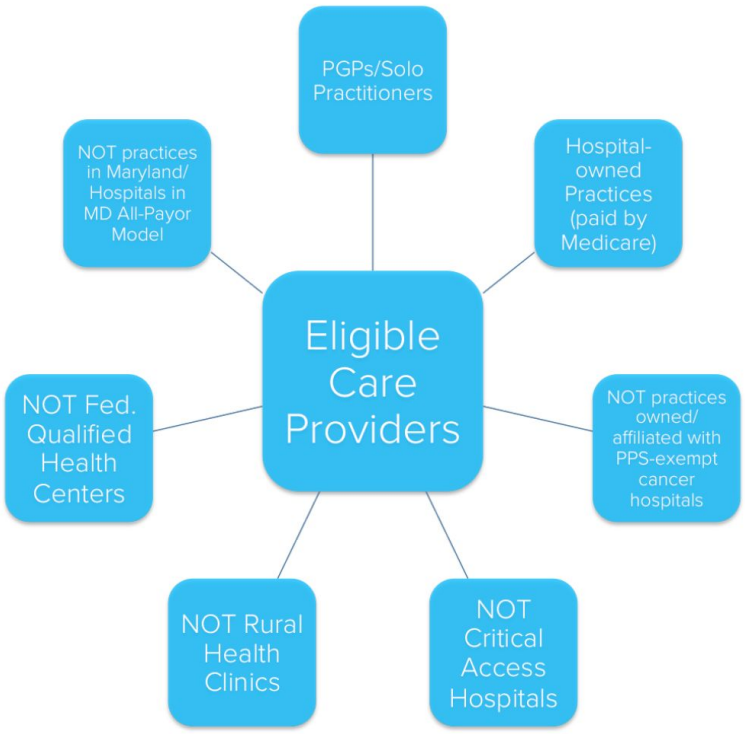
II. Eligibility Criteria

A. Eligible Practices

Physician group practices (PGPs) and solo practitioners that prescribe cancer chemotherapies and are currently enrolled in Medicare may apply for OCM-FFS. PGPs are defined as single legal entities operating primarily as physician medical groups and organized as partnerships, professional corporations, LLCs, foundations, not-for-profit corporations, faculty practice plans, or similar associations. Each PGP must employ/be owned by at least two physicians and/or non-physician providers. All physicians and NPPs in the PGP who prescribe chemotherapy for cancer are included in the PGP's participation in OCM-FFS. For billing reasons, however, they must reassign their national provider identifier to the PGP.

Hospital-owned practices may apply to participate in OCM if the hospital is paid by Medicare under the inpatient and outpatient Prospective Payment Systems (PPS). Since OCM is designed to transform independent physician-led practices, priority will be given to such practices in selecting participants for the model.

Practices owned by or formally affiliated with PPS-exempt cancer hospitals are ineligible. Critical Access Hospitals, Rural Health Clinics, and Federally Qualified Health Centers are also ineligible for OCM. PGPs that partner with such institutions for chemotherapy supply are also ineligible. Lastly, physician practices in the State of Maryland and hospitals participating in the Maryland All-Payor Model cannot participate in OCM.



B. Eligible Payors

Payors may be commercial insurers, Medicare Advantage plans, states (through Medicaid, state employees program, or another insurance purchasing entity), Medicaid-managed care plans, state/federal high-risk pools, self-insured businesses, or administrators of a self-insured group. Payors must be licensed to sell insurance in the state(s) in which they implement OCM and in good standing with the health insurance regulator of the state(s) in order to be eligible. Self-insured businesses need not meet this requirement but must follow all applicable federal laws and regulations.

Participation is possible only once the following requirements are met:

Operational Requirements
-Commitment to participation in OCM for its 5-year duration
-Sign a Memorandum of Understanding with CMMI
-Enter agreements with OCM practices requiring the provision of high quality care
-Share model methodologies with CMMI
-Provide payments to practices for enhanced services & performance as described in our guide
-Provide, at regular intervals, participating practices with aggregate & patient-level data about payment and utilization for patients receiving OCM care

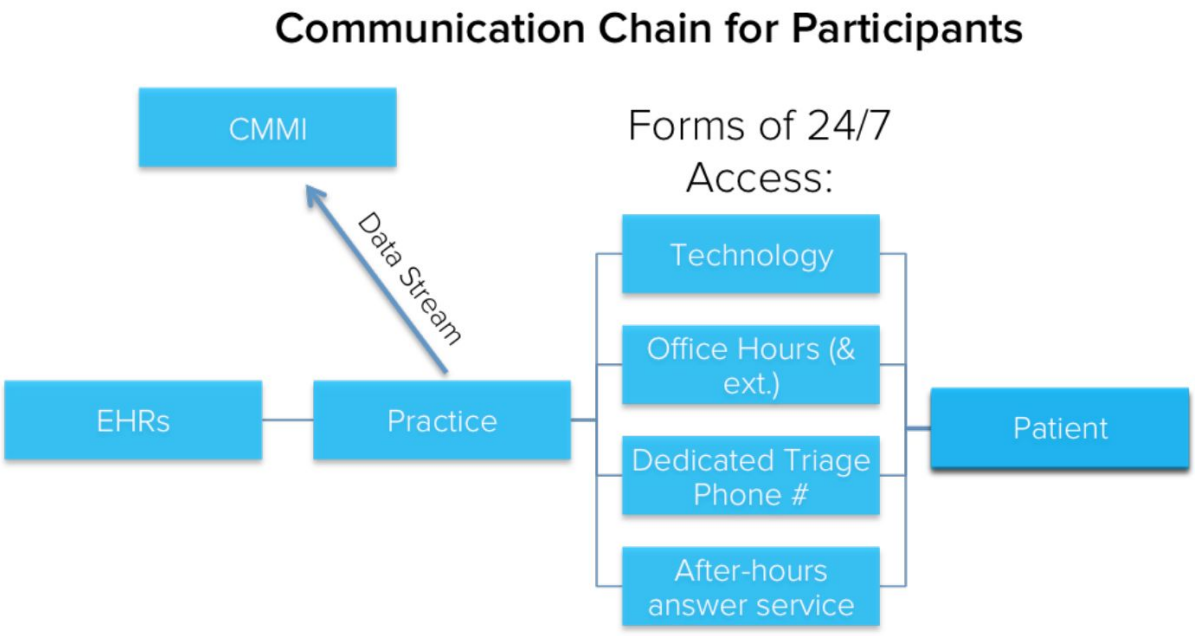
Quality Improvement Measures
-Align practice quality and performance measures with OCM-FFS

III. Practice Requirements

Participating care providers must meet the following requirements in order to participate and receive enhanced payment for care of their beneficiaries. Practices must meet all practice requirements by the end of the first quarter of the performance period to maintain participation eligibility. After the end of the first performance year, they must demonstrate that they have met each requirement fully.

1) **24/7 Patient Access.** Provide patients with round-the-clock access to a clinician with real-time access to patient medical records. Clinicians may be nurses, non-practicing physicians, or physicians who can access patient records through practices' EHRs. Care providers can better address patient needs related to chemotherapy, including side effects, and may reduce usage of the emergency department.

Solutions: Office Hours & Extended Office Hours; Dedicated Triage Phone Number; After-hours answer service to an on-call physician.



2) **Use of ONC-certified EHRs.** Practices must use an ONC-certified electronic health record and must pass stage one of Meaningful Use by the end of their first performance year and stage three by the end of their third. (Req.'s may be updated after future HHS rulemaking.)

For resources regarding transitioning to EHR and demonstrating MU, consult http://www.healthit.gov/providers-professionals/rec-highlights

3) **Quality Improvement Data.** Practices must collect and report data for continuous quality improvement. CMMI will leverage claims data and data reported by practices to provide practical feedback through regular monitoring reports. Practices are expected to utilize their own data for continuous performance improvement. **Webinars** will help practices analyze & utilize data given to practices to help better care quality.

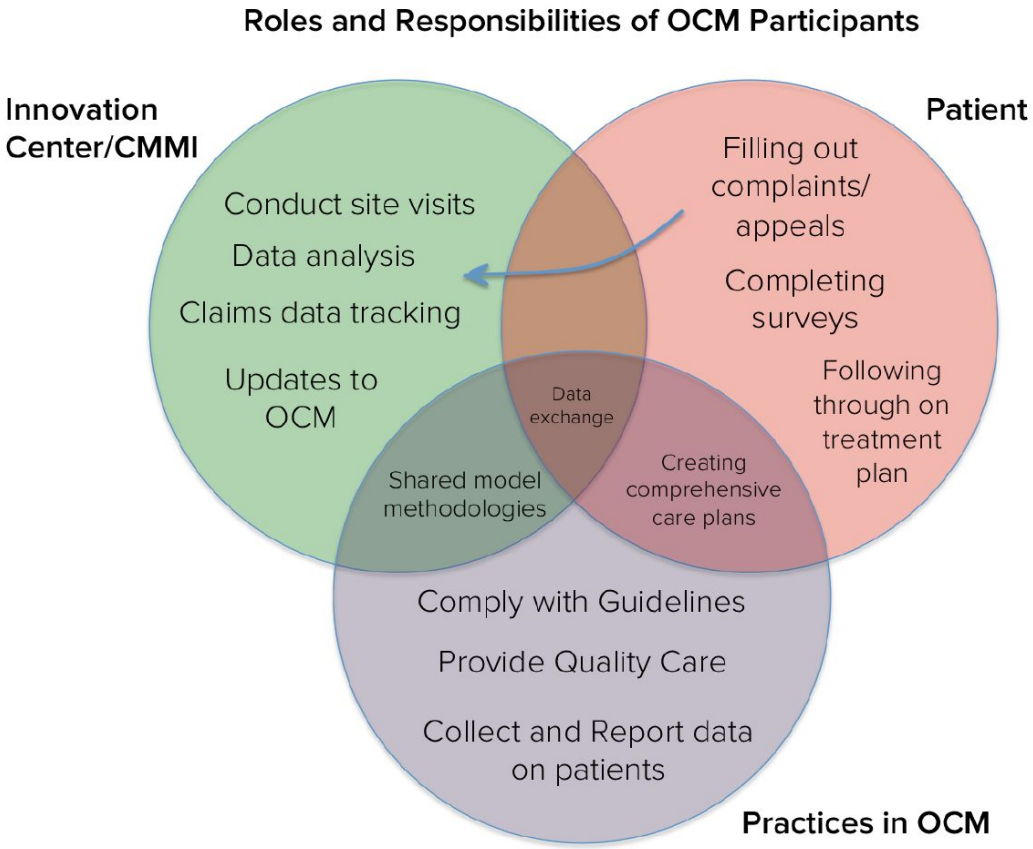
4) **Patient Navigation Services.*** Practices must provide the core functions of patient navigation and its services for all patients in the model. (This does not require the hiring of additional staff.)
Practices should also provide a written plan for meeting these requirements in their application Implementation Plan and must attest to follow this plan during the OCM performance period.

5) **Care Plans for OCM patients.*** Practices, with the active engagement of their patients, must document comprehensive care plans for all beneficiaries in the model. Each plan must include the thirteen elements identified in the Institute of Medicine's Report, Delivering High-Quality

Cancer Care: Charting a New Course for a System in Crisis. Patients should determine whether to initiate chemotherapy as a course of treatment.

6) **Following NCCN/ASCO guidelines.** Practices will treat patients with therapies consistent with either of these nationally-recognized clinical guidelines, and will report their adherence to such guidelines, unless they provide a rationale for not doing so (e.g. the patient is participating in a clinical trial). Practices may utilize pathways programs to fulfill this requirement, as long as pathways are based on nationally recognized clinical guidelines.

*See Appendix B for a list of patient navigation functions and for a list of the IOM's 13 elements.



IV. Description of the Model

A. Purpose and Overview

Beginning in Spring 2016, OCM is a five-year model that incentivizes efficient, high quality care by enhancing services for beneficiaries undergoing chemotherapy for a cancer diagnosis. The overarching goals of the model are to improve health outcomes for cancer patients, better the quality of their care, and reduce overall spending for cancer treatment.

Participants include physician group practices and solo practitioners that provide care for oncology patients undergoing chemotherapy. Selected practices must meet practice requirements and satisfy the model's quality/reporting requirements to be eligible for payments in OCM-FFS. We expect physician practices selected for participation in OCM will be able to fulfill the goals of the model, and allow for improved quality of care at a decreased cost to payors.

B. Multi-Payor Structure

On average, 50% of oncology practices' patients are Medicare beneficiaries.[2] Aligning financial incentives by engaging multiple payors as part of the model will transform care for oncology patients across a broader population.

Other payors will benefit from cost **savings**, **improved outcomes for beneficiaries**, and **increased information gathered about care quality**. They have the **flexibility to design their own payment incentives** that support beneficiaries through care improvement and cost reduction. They should financially incentivize the same practice requirements described in this guide. Payments should provide funding during the oncology episode for enhanced services (e.g. advance payment or PBPM) and for actual performance (e.g. retrospective lump sum or increased monthly payments).

Payors are encouraged to **include as many cancer types as possible** in order to incentivize true practice transformation. Priority will be given to payors that include cancer types covering majorities of beneficiaries. Payors include **commercial health insurers**, as well as **state Medicaid agencies**. Practices are favored based on the level of participation with other payors reflected in their application.

C. Definition of an Episode

OCM-FFS targets chemotherapy treatment of Medicare FFS beneficiaries during 6-month episodes, which will initiate with either an initial chemotherapy administration claim or an initial Part D chemotherapy claim. Beneficiaries who do not initiate chemotherapy will not trigger an OCM-FFS episode.

OCM-FFS episodes include all Medicare A and B services that OCM-FFS beneficiaries receive during the episode period. (Certain Part D expenditures will also be included.) Care services received by patients before an initial chemotherapy claim will not be included in the episode.

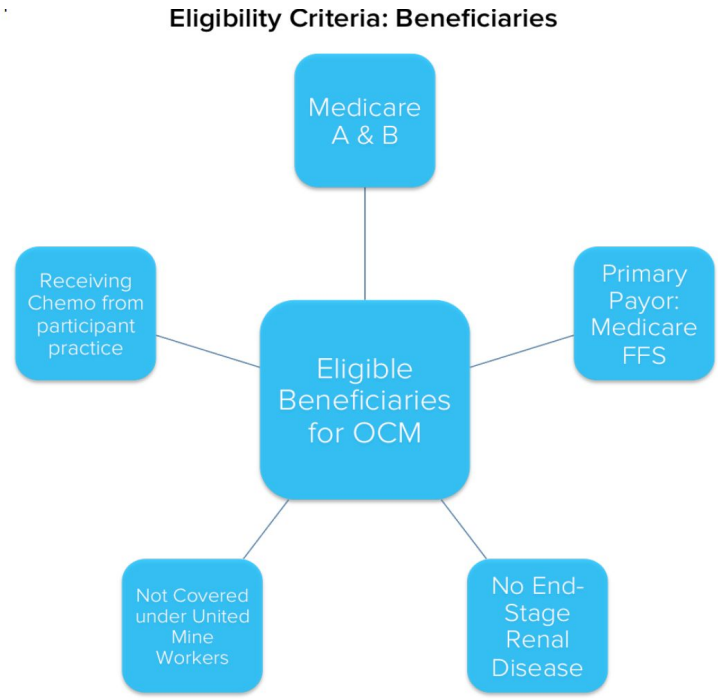
Cancer treatments that trigger an OCM-FFS episode are composed of a set of chemotherapy and “possible chemotherapy” drugs – the latter of which describes medication often used to treat cancer but that also serves other purposes, such as treatment of autoimmune diseases. The administration of either type of treatment to Medicare FFS beneficiaries with a diagnosed cancer will trigger an episode. Hormonal therapies used for cancer are included within the set of chemotherapy and “possible chemotherapy” drugs, but topical medications are not.

Regardless of whether a beneficiary receives treatment throughout the episode period, episodes will terminate six months after chemotherapy initiation. Reinitiating chemotherapy after a gap in administration within a single OCM-FFS episode does not trigger a new episode.

D. Beneficiary Alignment

Medicare beneficiaries must meet the following criteria to receive treatment through OCM:

- They are enrolled in Medicare Parts A and B
- They do not have end-stage renal disease
- They have Medicare FFS as their primary payor
- They are not covered under United Mine Workers
- They receive an included chemotherapy treatment under management of an OCM-participating practice



Enrollment in Medicare Part D is not required for eligibility in OCM. If a beneficiary is not enrolled in Part D, he/she will initiate an episode only if receiving Part B-covered chemotherapy, and his/her benchmarked & actual expenditures will be based on only Parts A & B claims. Beneficiaries in a Medicare-funded clinical trial, as well as those included in certain other CMS programs (ACO, MSSP, and MCCM) are eligible for OCM-FFS.

E. Benchmarking and Risk Adjustment

Risk-adjusted benchmark expenditures for each OCM-FFS-participating practice are calculated based on historical claims data. These claims are grouped into episodes and that data is adjusted for geographic variation in Medicare pricing.

Benchmarks will be risk-adjusted based on a variety of claims-based factors. Once fit within the context of the applicable performance period, the discount will be applied in order to determine a target price.

Each episode is evaluated to gauge the amount of spending that occurred, which amount is then reconciled against the target price. For instance, if actual spending were $9,000 during an episode (vs. a target price of $9,600), then the practice would be eligible for a performance-based payment of up to $600, depending on a range of quality measures.

Many factors can affect the cost of an episode of care. To determine a benchmark price per episode, **risk adjustments** will also be made. Risk adjustment in OCM performance year one will be based on information available in administrative claims data. Information solicited from OCM-FFS applicants regarding risk adjustment factors not captured in claims data may be incorporated into the OCM risk adjustment methodology in following performance years.

Factors under consideration include:

-Beneficiary characteristics, such as age, socioeconomic class, or comorbidities
-Episode characteristics (e.g. whether an episode is the first for a beneficiary)
-Disease characteristics (cancer type, etc.)
-Type of Service, such as radiation therapy or endocrine therapy, etc.

F. Model Payments

Performance-Based Payments

Standard Medicare FFS payments will continue during OCM-FFS episodes. After benchmark calculations, a 4 percent discount is applied to determine target price for the participant's performance period episodes. OCM sets a target price for each episode of chemotherapy.

Practices generating additional **reductions in expenditures under the target price** can receive a **semi-annual lump-sum performance-based payment** for up to the full difference between target and actual expenditures. Performance-based payments will **not** be made on behalf of **beneficiaries with low-volume cancers** for which it is not possible to calculate reliable benchmarks.

Performance Multiplier

Performance-based payments are adjusted based on participating practices' performance on a range of measures. **Participants are required to collect data** on quality measures including communication and care coordination, person- and caregiver- centered experience and outcomes, and clinical quality of care. Data will also be collected from **administrative claims**.

Participant performance across quality measures will be **converted to weighted scores** that are then summed to calculate the performance multiplier. Practices **must exceed a minimum quality score** in order to receive a performance-based payment.

OCM-FFS employs quality measures in order to verify clinical improvements, assess patient health outcomes and appropriate coordination of care, and ensure continued care quality. See Appendices for more information on specific measures.

Per-Beneficiary-Per-Month Payment (PBPM)

OCM-FFS practices will receive PBPM payments for beneficiaries with a diverse range of cancer types for each of the six months of the episode, even if the beneficiary does not receive chemotherapy during the episode. This monthly PBPM fee will pay for enhanced services driven by practice requirements, to help transform comprehensive, patient-centered, coordinated care.

The OCM PBPM is $160 per beneficiary per month for each six-month episode, and remains constant throughout the 5 year model. Practices are required to bill monthly using a G-code. Appropriate use of the G-code will be ensured and any inappropriate payments will be reconciled/recouped.

Payments for services during the episode (including PBPM) will be included in performance-based payment calculations. A participating practice will not receive performance-based payments until reductions in expenditures below target price exceed the amount of PBPM payments given to the practice. Practices that do not qualify for a performance-based payment by the end of year three will be removed from OCM-FFS. Additionally, both physicians and NPPs that participate cannot bill beneficiaries for chronic care management services in the same month they receive a PBPM payment.

G. Risk Arrangements

OCM-FFS features two risk arrangement options: **a one-sided risk arrangement for the duration of the model**, and a **phased-in two-sided risk arrangement** that features one-sided risk the first two performance years and **symmetric two-sided risk thereafter**.

One-Sided Risk
Any OCM-FFS participant that reduces expenditures below the target price is eligible for a performance-based payment. The practice is not financially responsible for expenditures over target price if no reductions below target price are achieved. Qualification for a performance-based payment by end of performance year three is necessary for cont. OCM-FFS participation.

Two-Sided Risk
Symmetric two-sided risk would require the participant to pay back expenditures over the target price. After year two, practices will be allowed to switch between the two arrangements

every six months. The discount percentage for episodes in the two-sided risk arrangement is 2.75%, lower than the 4% discount in the one-sided risk arrangement, enabling participants to earn more money though performance-based payments.

A maximum expenditure reduction percentage per practice limits the amount of the performance-based payments to provide a program safeguard by preventing practices from reducing care to unacceptable levels.

H. Monitoring and Reporting

CMMI will continuously monitor participating physician practices to ensure patient access to quality care, to confirm practices' infrastructure and capacity are fit for oncology care. Practices are required to report data on OCM-FFS beneficiaries to CMMI on a quarterly basis. Some measures tracked by the Center will be used to calculate a practice's performance-based payment. Monitoring includes, but is not limited to, the following:

1) **Tracking of claims data** to detect possible systematic stinting on care and to profile characteristics of OCM-FFS beneficiaries
2) **Patient surveys**
3) **Site Visits** to verify infrastructure improvements.
4) **Data Analysis** for quality measurements
5) Annual **reporting on use of OCM funds** and **practice's own investments**
6) Annual time-and-motion studies to document staff engagement in key model-related activity
7) **Medical record audits**; **patient complaint/appeal tracking**.

To inform evaluation of OCM, baseline data on certain measures may be collected before model implementation. CMMI will send quarterly monitoring reports to OCM-FFS practices describing their performance on general measures and those specific to performance-based payment calculations. Additionally, payors participating in OCM will send performance reports to practices to help them follow through on the model goals.

I. Evaluation

An OCM-FFS evaluation (rapid-cycle feedback) will be conducted through contract with an independent evaluator to determine the impact of the model on health outcomes, costs, quality of care, and patient experiences.

Participating Practices must agree to cooperate in an independent formal evaluation – includes sharing program data and making relevant staff available for site visits/phone calls

Practice Staff will be surveyed for their reactions to OCM implementation: how it has changed their approach to patient care, how satisfied they are with various aspects of the model

Patients will be given optional surveys, with the help of practices, to document their experiences under OCM. Surveys, if undertaken, will consist of analysis of primary data (monitoring/evaluation-specific) and secondary data (claims, enrollment records). (Involving quant. and qual. analyses.)

J. Learning System Participation

CMMI uses a Learning System with the aim of improving the likelihood of success of the OCM model. The dual objectives of the Learning System are to support learning and practice changes resulting in better care at lower cost, and to capture and spread operational knowledge that emerges from OCM and its participants. Through action-oriented learning and diffusion activities, the Learning System will create an environment of shared knowledge.

Faculty part of the OCM Learning System will work with practices to develop data-based case studies that will be used to determine successful ways to build and maintain engagement, understand best practices, and accelerate innovation and improvement.

OCM practices will be supported by:

- Topic-specific webinars led by faculty that offer opportunities for practices to learn from each other about what is working
- Action Groups in which practices work together online to explore critical topic areas and new ideas for delivering comprehensive oncology care
- In-person/virtual site visits to better understanding of service management, evidence-based care, and patient-centered care
- An online portal that supplants learning with shared resources, tools, ideas, discussions, data
- Coaching to support strategies for overcoming roadblocks to improvement

K. Interaction with Other Initiatives

OCM may overlap with future CMS models or initiatives. These will be determined on a case-by-case basis and will be communicated to participants. Please note that Medicare will not make duplicative payments for similar services for beneficiaries already paid for under the various CMS advanced primary care demonstration and other like initiatives.[3]

Medicare SSP and Pioneer ACOs, TCPI
Participating care providers may participate in a Medicare Shared Savings Program (SSP) or Pioneer ACO. OCM-FFS, SSP, and Pioneer ACO payments will account for such potential overlap to ensure that shared saving and performance-based payments are not made for the same saving for the same beneficiary. Dual participation in both Transforming Clinical Practices Initiative (TCPI) and OCM is not permitted.

CMS Quality Measures and PQRS
OCM depends on quality measures addressing person and caregiver-centered experience outcomes, communication, and care coordination in its evaluation of practice performance. (See Appendix C for a list of measures.) Many of the selected quality measures are from the Physician Quality Reporting System (PQRS), such as (1) Plan of Care for Pain and (2) Pain Intensity Quantified.

Medicare and Medicaid EHR Incentive Programs
Eligible professionals who are part of OCM practices and meet the EHR Incentive Program timeline[4] may be eligible to receive payments from the program. Additionally, they may be subject to downward payment adjustments for failure to demonstrate meaningful use.

L. Termination

CMMI may terminate a practice's/payor's participation in OCM or the model itself at any point during its five-year run after providing adequate notice. Specific reasons for termination, which are outlined in the participation practice agreement and payor MOU, include but are not limited to: poor performance, noncompliance with terms and conditions of participation, failure to qualify for a performance-based payment by the end of the third performance year, or sanctions and other program integrity matters.

M. Conclusion

This conclusion section should summarize the takeaways of the VerbalCare OCM guide and serve as a way to demonstrate the impact of the new care model. Needs to include analysis, not just summary of the facts presented.

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[1] American Cancer Society. Cancer facts and figures 2015. http://www.cancer.org/research/cancerfactsstatistics/cancerfactsfigures2015/

[2] https://innovation.cms.gov/Files/slides/OCMintro.pdf

[3] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

[4] The Medicare and Medicaid EHR Incentive Program provides incentive payments to eligible professionals, hospitals, and CAHs as they demonstrate meaningful use of certified EHR technology. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html