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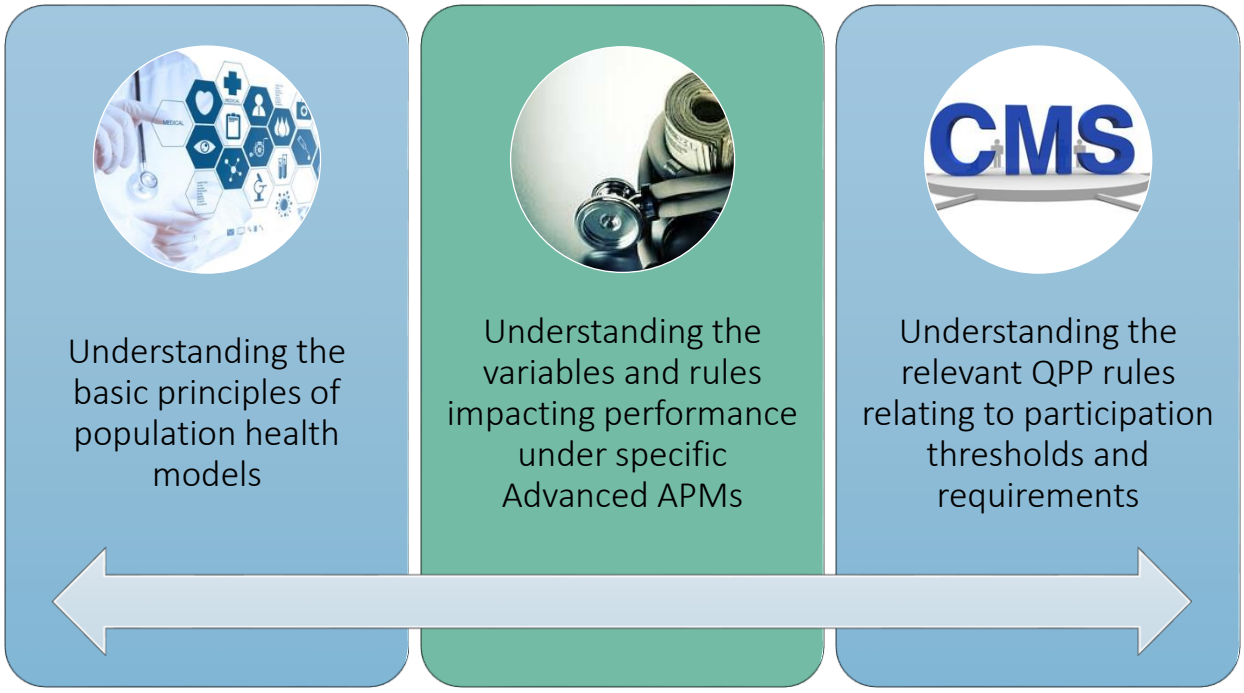
The Physicians Advocacy Institute's
Medicare Quality Payment Program (QPP)
Physician Education Initiative

Oncology Care Model (OCM) Overview

MEDICARE QPP PHYSICIAN EDUCATION INITIATIVE

Oncology Care Model Overview

An Advanced Alternative Payment Model (APM) is one of two pathways physicians can choose under the Quality Payment Program (QPP), which was established as part of the Medicare Access and CHIP Reauthorization Act (MACRA). Under the Advanced APM pathway, physicians may be exempt from participation in the Merit-based Incentive Payment System (MIPS) and be eligible to receive a 5% incentive payment. For successful participation in an Advanced APM, physicians need to consider three core building blocks:



This resource focuses on the second of these three building blocks: understanding the variables and rules impacting performance under specific Advanced APMs, specifically the Oncology Care Model (OCM). The OCM is a 5-year model focused on increasing the coordination of oncology care through financial and performance accountability for chemotherapy episodes of care.

Under the OCM, participation is at the practice level, and practices participating in the model commit to providing enhanced care coordination, navigation, and treatment guidelines for cancer patients receiving chemotherapy. While the OCM is a two-part model and engages with payers outside of Medicare, the focus of this overview is on the Medicare component of the model for the QPP Advanced APM pathway.

The OCM is structured as a 6-month episode-based payment model that begins when a patient receives a qualifying chemotherapy treatment, and includes the total care provided to the patient during that 6-month period, including non-oncology care. The model began on July 1, 2016, and runs through June 30, 2021. There are 190 practices[1] participating in the OCM. This resource provides an overview of the OCM, and additional information on the OCM is available on the CMMI website here.[2]

Goal of the OCM

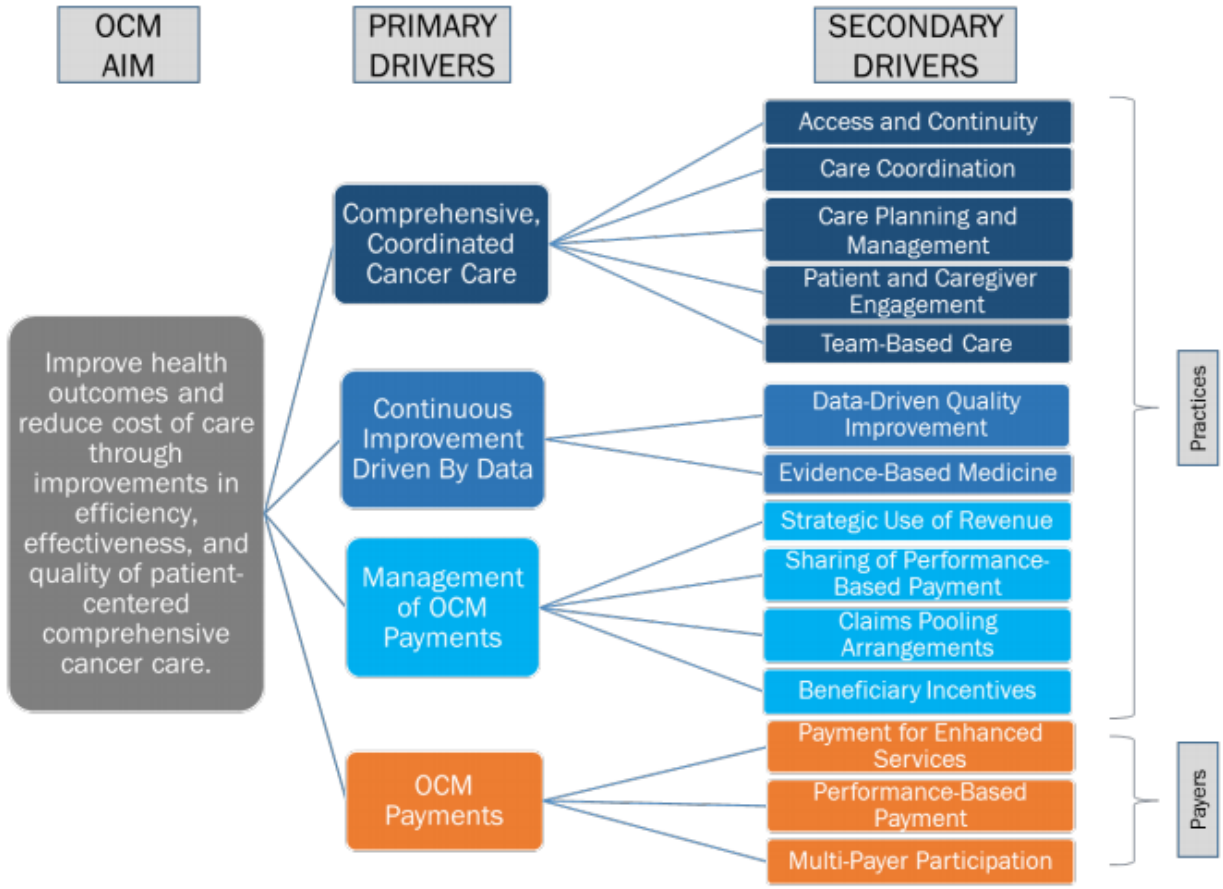
The goal of the OCM is to provide higher quality and coordinated oncology care. Through its financial incentives, the OCM encourages practices to work collaboratively with other clinicians to address the complex needs of cancer patients receiving chemotherapy.

To achieve this goal, CMS utilizes a "Key Drivers and Changes" framework for participating practices to use as an assessment tool for redesigning their care approach. There are two key components to this framework: primary drivers and secondary drivers.[3]

Primary Driver	Secondary Driver	Changes
Primary drivers identify the major areas of action necessary to achieve the desired aim.	Secondary drivers drill down further into the areas of action (or focus areas for improvement) that lead to the primary driver.	The changes thought to be necessary to achieve the results from a secondary driver are expressed in broad, conceptual terms (change concepts) and as specific tactics (change tactics) through which the change concepts are implemented.

The CMS diagram below provides a visual representation of how CMS intends for practices to use the Key Driver and Changes to meet the aim of the OCM.[4]

[1] https://data.cms.gov/Special-Programs-Initiatives-Speed-Adoption-of-Bes/Oncology-Care-Model/rxuj-d2br
[2] https://innovation.cms.gov/initiatives/oncology-care/
[3] https://innovation.cms.gov/Files/x/ocm-keydrivers-changepkg.pdf
[4] https://innovation.cms.gov/Files/x/ocm-keydrivers-changepkg.pdf



Application Process

The application process for practices to join the OCM closed on June 30, 2015. However, physicians and other clinicians can join practices participating in the OCM.

The application process included submitting a non-binding letter of intent followed by submitting the full OCM application. An archived version of the sample application template for providers can be found here[5] and an archived version of the request for applications (RFA) can be found here.[6]

[5] https://innovation.cms.gov/Files/x/ocmpracticeapp.pdf
[6] https://innovation.cms.gov/Files/x/ocmrfa.pdf

OCM Practice and Clinician Eligibility

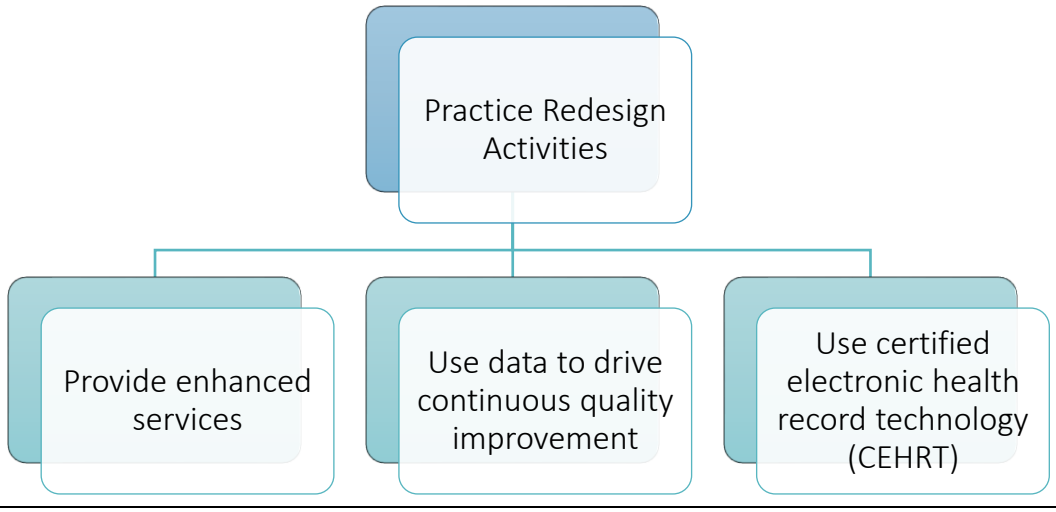
The following is a list of eligible practices that can participate in the OCM:

- Physician group practices and solo clinicians that furnish chemotherapies
- Multi-specialty practices that furnish chemotherapies
- Hospital-owned practices and provider-based departments that furnish chemotherapies (the hospital must be paid under Medicare outpatient or inpatient prospective payment system (OPPS or IPPS))
- Practices that partner with hospital outpatient departments for chemotherapy infusion services

The following is a list of those who are not eligible to participate in the OCM:

- Prospective payment system-exempt hospitals and affiliated practices
- Critical access hospitals (CAHs)
- Federally qualified health centers (FQHCs)
- Rural health clinics (RHCs)
- Maryland hospitals and physician practices

The program also encourages practice transformations by requiring participating practices to implement "practice redesign activities" to improve the quality of care being delivered. CMS lists the following services and functions that OCM practices must be able to provide to be able to participate in the model.



Providing enhanced services includes the following:

- Core functions of patient navigation
- Care plan containing the 13 Institute of Medicine (IOM) Care Management Plan components[2]
- 24/7 patient access; clinician must have real-time access to medical records, and
- Therapy treatments consistent with nationally recognized guidelines

OCM Patient Eligibility

Not all of a practice's patients will automatically be considered as part of the OCM 6-month episode. Only those patients who meet the following criteria will be included in the episode:

- Are enrolled in Medicare Parts A and B
- Do not have end-stage renal disease (ESRD)
- Have Medicare fee-for-service (FFS) as their primary payer
- Are not covered under United Mine Workers
- Receive an included chemotherapy treatment for cancer under management of an OCM participating practice, and
- Have at least one evaluation and management (E&M) visit with an included cancer diagnosis[7] during the 6 months of the episode

OCM Qualifying Treatment Episodes

A patient's care episode begins on the date of an initial Medicare Part B or Part D chemotherapy claim; it does not include services provided prior to that date. Once the episode begins, it includes all Medicare Part A and Part B services and costs that the patient receives during the 6-month episode period. Furthermore, certain Part D expenditures are also included in the total cost of care for the episode. A full list of qualifying chemotherapy drugs can be found in Appendix D of the RFA.[8]

A single episode of care, for purposes of the OCM, ends 6 months after the patient first begins chemotherapy. If the patient receives chemotherapy after the end of the episode (after the 6-month period), that will begin a new 6-month episode for the OCM.

[7] Please see Oncology Care Model Cancer Code List for a full list of the cancer diagnosis included in the OCM, available on the CMMI website: https://innovation.cms.gov/initiatives/oncology-care/.
[8] https://innovation.cms.gov/Files/x/ocmrfa.pdf

A hospital inpatient chemotherapy claim (billed under the OPPS) will not initiate an OCM care episode. Additionally, **cancer types treated exclusively with surgery, radiation, or topical chemotherapy are excluded from the model**.

Payment Mechanisms

During their participation in the OCM, practices will continue to be paid through Medicare FFS, but they will receive a two-part payment. The two-part payment includes a per-beneficiary-per-month (PBPM) payment, known as the Monthly Enhanced Oncology Services (MEOS) payment, and a performance-based payment (PBP).

MEOS Payment	PBP
• A flat payment of $160 per-beneficiary-per-month or $960 per six-month episode. • Provided to the OCM practice for managing and coordinating the patient's care.	• Calculated retrospectively on a semi-annual basis. • Based on a practice's OCM quality measure performance and how much money it saves relative to a target price established by CMS.

Performance Based Payment

There are three components to the PBP: a benchmark, target price, and quality performance. CMS calculates a benchmark episode for each OCM practice based on its risk-adjusted historical data. This benchmark is then discounted to arrive at a target price for the OCM episodes. The amount of the discount applied is determined by the risk arrangement chosen by the practice (discussed in further detail below): one-sided risk arrangement practices receive a 4% discount, while two-sided risk arrangement practices receive a 2.5% discount.

There are 9 performance periods used for the PBP, each generally lasting about 6 months each. Following the end of one of the 9 performance periods, the actual expenditures are calculated and then compared to the target amount. The difference between the target amount and the actual expenditures are then multiplied by the performance multiplier, calculated based on a quality performance (discussed in detail below). The performance multiplier allows for practices to receive 0%, 50%, 75%, or 100% of the difference between the target and actual expenditures. More detailed information about these calculations can be found here.[9]

[9] https://innovation.cms.gov/Files/slides/ocm-performancemethod-slides.pdf

PBP Performance Periods

Performance Period	Episodes Beginning	Episodes Ending
1	7/1/16 – 1/1/17	12/31/16 – 6/20/17
2	1/2/17 – 7/1/17	7/1/17 – 12/31/17
3	7/2/17 – 1/1/18	1/1/18 – 6/30/18
4	1/2/18 – 7/1/18	7/1/18 – 12/31/18
5	7/2/18 – 1/1/19	1/1/19 – 6/30/19
6	1/2/19 – 7/1/19	7/1/19 – 12/31/19
7	7/2/19 – 1/1/20	1/1/20 – 6/30/20
8	1/2/20 – 7/1/20	7/1/20 – 12/31/20
9	7/2/20 – 1/1/21	1/1/21 – 6/30/21

Risk Arrangements

The OCM features two risk arrangements: a one-sided risk option, and a two-sided risk option.

One-Sided Risk Model

- Medicare discount = 4%
- OCM practice receives a PBP if total actual expenditures for episodes are below the target price
- OCM practice not responsible if its total actual expenditures for the episodes exceed the target price
- Must qualify for PBP by mid-2019 to remain in the one-sided risk model

Two-Sided Risk Model

- Medicare discount = 2.5%
- OCM practice receives a PBP if total actual expenditures for episodes are below the target price
- OCM practice receives no PBP and the practice is responsible for total actual expenditures that exceed the target price
- Practices will have option to being participating in two-sided risk model beginning 2018

Under the two-sided risk model, if a practice's total actual expenditures exceed the target price, the practice must pay back to CMS the difference between the target price and the actual expenditures (called a recoupment). However, the recoupment is capped at 20% of the benchmark amount, adjusted for geographic variation, and reduced for sequestration. A performance multiplier is not applied to the recoupment.

To learn more about the OCM payment methodology and risk arrangements, please access the OCM Performance Period Payment Methodology files available on CMMI's website.[10]

Quality Measurement

Practices participating in the OCM will be evaluated on a series of 12 quality measures, across four National Quality Strategy Domains—communication and care coordination, person and caregiver-centered experience and outcomes, clinical quality of care, and patient safety—which will gradually be phased in across performance periods. A full list of the quality measures and their specifications are available here.[11]

Based on a practice's performance relative to the national performance standard for a particular measure, a practice can receive up to 10 points per measure. The score for a practice is then aggregated based on how many quality measures are implemented for a particular performance period. The performance multiplier is then determined by the percentage of how many points a practice has received compared to the maximum score. For example, if a practice receives a total of 50 points out of 120 possible points, then it will receive a performance multiplier of 50% because they received 42% of all possible points. The table below provides a summary of this calculation.

Table 6: Aggregate Quality Score Translated into Performance Multiplier

Aggregate Quality Score (% of maximum points available)	Performance Multiplier
75% - 100%	100%
50% - 74%	75%
30% - 49%	50%
Less than 30%	0%

[12]

OCM Participants and the Quality Payment Program

Under the QPP, only OCM practices participating in the two-sided risk arrangement are considered to be participating in an Advanced APM, while those practices participating in the one-sided risk arrangement are not considered to be participating in an Advanced APM. Physicians and other

[10] https://innovation.cms.gov/initiatives/oncology-care/
[11] http://www.healthcarecommunities.org/ResourceCenter.aspx?CategoryId=835658
[12] From CMS OCM Performance-Based Payment Methodology, available at: https://innovation.cms.gov/initiatives/oncology-care/.

eligible clinicians[13] on the Participant List for the two-sided risk arrangement practices can receive one of three Advanced APM determinations for their participation.

Qualifying Advanced APM Participant (QP)	Partially Qualifying Advanced APM Participant (PQ)	Neither a QP or PQ
•Eligible to receive a 5% incentive payment •Exempt from MIPS	•Not eligible to receive a 5% incentive payment •Exempt from MIPS (however, the APM Entity could elect to participate in MIPS using the MIPS APM scoring standard and be eligible to receive a positive payment adjustment)	•Subject to MIPS participation using the MIPS APM scoring standard

Unlike QPs, PQs would not be eligible to receive a 5% incentive payment for their participation, but they would be exempt from MIPS participation. However, the practice may elect to participate in MIPS using the MIPS APM scoring method. Under the MIPS APM scoring method option, all physicians and other eligible clinicians in the practice would be evaluated as a group in two of the four MIPS categories: advancing care information would be 75% of the MIPS score, and improvement activities would be 25% of the MIPS score. The cost and quality categories are reweighted to 0% because physicians are already subject to cost and quality performance assessment under the OCM.

To learn more about the MIPS APM scoring methodology, please see PAI QPP tutorial #5 on MIPS APMs, available on PAI's website.

While the QP and PQ determinations apply at the individual level, they are determined at the APM Entity level. In this case the APM Entity is the OCM practice, and all physicians and other eligible clinicians on the practice's Participant List must collectively meet the thresholds for becoming a QP or PQ.

[13] For 2017, eligible clinicians are defined as physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse anesthetists.

Qualifying Advanced APM Participant (QP)	Partially Qualifying Advanced APM Participant (PQ)	Neither a QP or PQ
•Receive 25% of their Medicare Part B payments through the Advanced APM, OR •See 20% of their Medicare Part B patients through the Advanced APM	•Receive 20% of their Medicare Part B payments through the Advanced APM, OR •See 10% of their Medicare Part B patients through the Advanced APM	•Receive less than 20% of their Medicare Part B payments through the Advanced APM, AND •See less than 10% of their Medicare Part B patients through the Advanced APM

Where can I go for more information?

For additional information on the QPP requirements for Advanced APM participation, please see the QPP Advanced APM Overview resource, available on PAI's website under the Advanced APM page, as well as PAI QPP Tutorial #4 on Advanced APMs available on the video library page.

Additional resources are available on CMMI's OCM website: https://innovation.cms.gov/initiatives/oncology-care/.