

# WELCOME – ONCOLOGY CARE MODEL WEBINAR

- Welcome, everyone! We will get started promptly at 3:00 PM EST. The webinar is scheduled for 90 minutes.
- All attendee phone lines are in a listen-only mode.
- You may submit questions during the event using the Q & A box to the right of your webinar screen, or after the event to [OCMSupport@cms.hhs.gov](mailto:OCMSupport@cms.hhs.gov)

# **ONCOLOGY CARE MODEL**

## **OCM PERFORMANCE-BASED PAYMENT METHODOLOGY WEBINAR**

**Speakers: Ms. Lara Strawbridge, Ms. Laura Mortimer, Mr. Dan Muldoon,  
Dr. Andy York (CMMI)**

**April 20, 2016**

# WELCOME

Some initial housekeeping before we start..

- All attendee phone lines have been placed in a listen-only mode. The slides and transcript from this event will be distributed to participants after this event.
- There will be a question and answer period during this event. We encourage you to submit any questions you might have into the Q & A box to the right of your webinar screen. All questions will be reviewed. You may also email your questions to [OCMSupport@cms.hhs.gov](mailto:OCMSupport@cms.hhs.gov) following this event.
- A web-based call will be held for payers on Tuesday, April 26, 3:00-4:00 P.M. EDT.
- Office Hours for practices will be held on Thursday, April 28, 3:00-4:00 P.M. EDT.
- If you have any technical questions or issues during this event, please submit a question in the Q & A box and we will be happy to assist you. You may also contact Adobe Connect Customer Support at 1-800-422-3623, select #1.

# PRESENTATION GOALS

Provide guidance on billing the OCM Monthly Enhanced Oncology Services (MEOS) payment

Provide a general understanding of the approach for calculating the OCM performance-based payments

# AGENDA

- Brief Overview of OCM
- Monthly Enhanced Oncology Services (MEOS) Guidance
- Steps to calculate Performance-Based Payments (PBPs)
- Q&A
- Next Steps
- Upcoming Office Hours and Webinars

# OVERVIEW OF OCM

- Launches July 1, 2016, and runs through June 30, 2021
- Goal of OCM: achieve better health, improved care, and smarter spending for individuals with cancer who receive chemotherapy through appropriately aligned financial incentives and practice redesign activities (e.g., use of certified EHR technology, 24/7 access to a clinician, patient navigation)
- Multi-payer – Medicare FFS and others
- Episodes of cancer care: payment model targets chemotherapy and related care during a 6-month period following the initiation of chemotherapy treatment

# TWO-PRONGED PAYMENT APPROACH

FFS payments continue as usual to participating practices

1. Monthly Enhanced Oncology Services (MEOS) payment: \$160
2. Semi-annual potential for performance-based payment for savings compared to a risk-adjusted target amount  
(One-sided risk and two-sided risk arrangements available)

# Monthly Enhanced Oncology Services (MEOS) Payment

# MEOS PAYMENT

- Monthly payment for enhanced services for Medicare FFS beneficiaries with cancer who receive chemotherapy
  - Enhanced services include: 24/7 clinician access, patient navigation, care planning, and use of clinical guidelines
- OCM practices are eligible to bill the MEOS for each month of the 6-month episode, unless the beneficiary enters hospice or dies
  - Only NPIs submitted on the practice's OCM Practitioner List may bill the MEOS
- MEOS payments will be included in the practice's total cost of care for the purposes of calculating the performance-based payment

# HOW TO BILL THE MEOS PAYMENT

- G9678 (OCM MEOS Payment) on the Medicare Physician Fee Schedule (MPFS) was created specifically for OCM participants
- May be billed once per month for each Medicare FFS beneficiary with cancer who receives chemotherapy
  - Must be billed using a professional claims form (CMS-1500 or 837B)
  - Rendering NPI must have been submitted to CMS on the OCM Practitioner List, and billing TIN must be the OCM Participant TIN
  - Date of Services (DOS) on the claim should be first day of the month
- Participating practices should bill for any Medicare FFS beneficiaries who they believe will be attributed to them as part of the OCM
  - i.e., practices should bill for Medicare FFS beneficiaries for whom they are the primary manager of the patient's medical oncology services

# BILLING RESTRICTIONS

- OCM practitioners cannot bill for the following care coordination service payments for OCM beneficiaries for the months that they bill the MEOS:
  - Chronic Care Management (CCM)
  - Transitional Care Management (TCM)
  - Home Health Care Supervision
  - Hospice Care Supervision
  - End Stage Renal Disease (ESRD)

*Note that non-OCM practitioners may bill for these services for OCM beneficiaries during months that OCM practitioners bill the MEOS*
- The MEOS cannot be billed after beneficiaries have died or entered hospice

# RECOUPMENT OF INCORRECT MEOS PAYMENTS

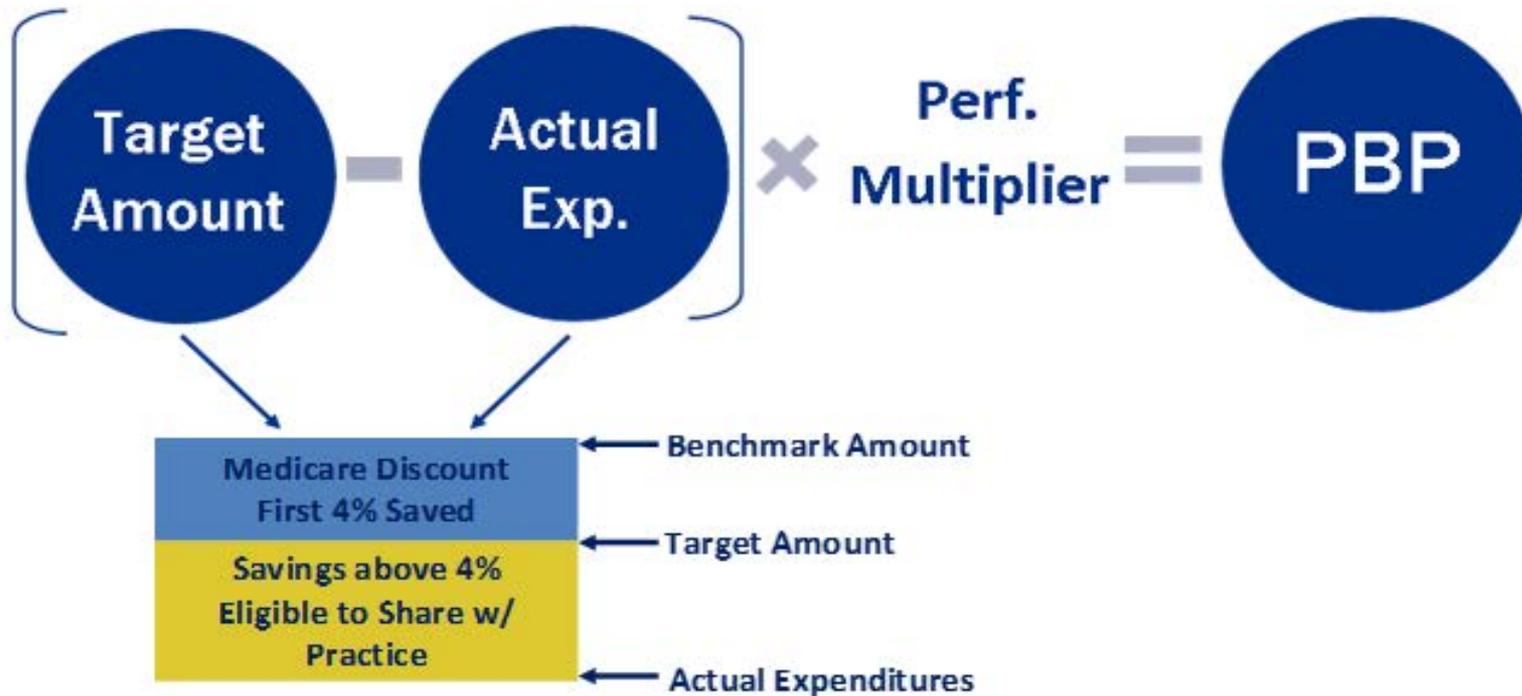
- CMS plans to recover MEOS payments that were billed for beneficiaries in the following circumstances:
  - The MEOS claim has a date of service after the beneficiary elects hospice or dies;
  - The OCM practice billed the MEOS payment for a beneficiary that is not attributed to the practice;
  - CMS determines that the practice has failed to provide enhanced services; or
  - The practice bills the MEOS payment after termination of the practice agreement

# Performance-Based Payment

# OCM PERFORMANCE PERIODS

Performance Period	Episodes Beginning	Episodes Ending
1	7/1/16 – 1/1/17	12/31/16 – 6/30/17
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
.	.	.
.	.	.
.	.	.
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

# PBP CALCULATION OVERVIEW



The PBP calculation will occur for each of OCM's nine performance periods.

# TO CALCULATE THE PERFORMANCE-BASED PAYMENT:

1. Identify baseline episodes
2. Calculate baseline expenditures
3. Calculate the risk-adjusted target amount
4. Identify performance period episodes
5. Calculate actual episode expenditures
6. Calculate the performance multiplier
7. Calculate the performance-based payment

# 1. IDENTIFY BASELINE EPISODES

- Step 1: Identify episodes
  - Step 1A: Identify potential trigger events
  - Step 1B: Determine episode eligibility
  - Step 1C: Assign cancer type
- Step 2: Attribute episodes to practices

# STEP 1A: IDENTIFY TRIGGER EVENTS

- Each 6-month episode will begin on the date associated with a trigger event, which will be either:
  - The first observed Part B chemotherapy drug claim in the historical period with a corresponding cancer diagnosis on the claim OR
  - The first Medicare Part D chemotherapy drug claim with a corresponding Part B claim for cancer on the fill date or in the preceding 59 days.

# STEP 1B: DETERMINE EPISODE ELIGIBILITY

- For all 6 months of the episode (except after death), the beneficiary:
  - Was enrolled in Medicare Parts A and B
  - Did not receive the Medicare End Stage Renal Disease (ESRD) benefit
  - Had Medicare as the primary payer
  - Was not covered under Medicare Advantage or any other group health program
  - Had at least one Evaluation and Management (E&M) visit with a cancer diagnosis during the 6 months of the episode

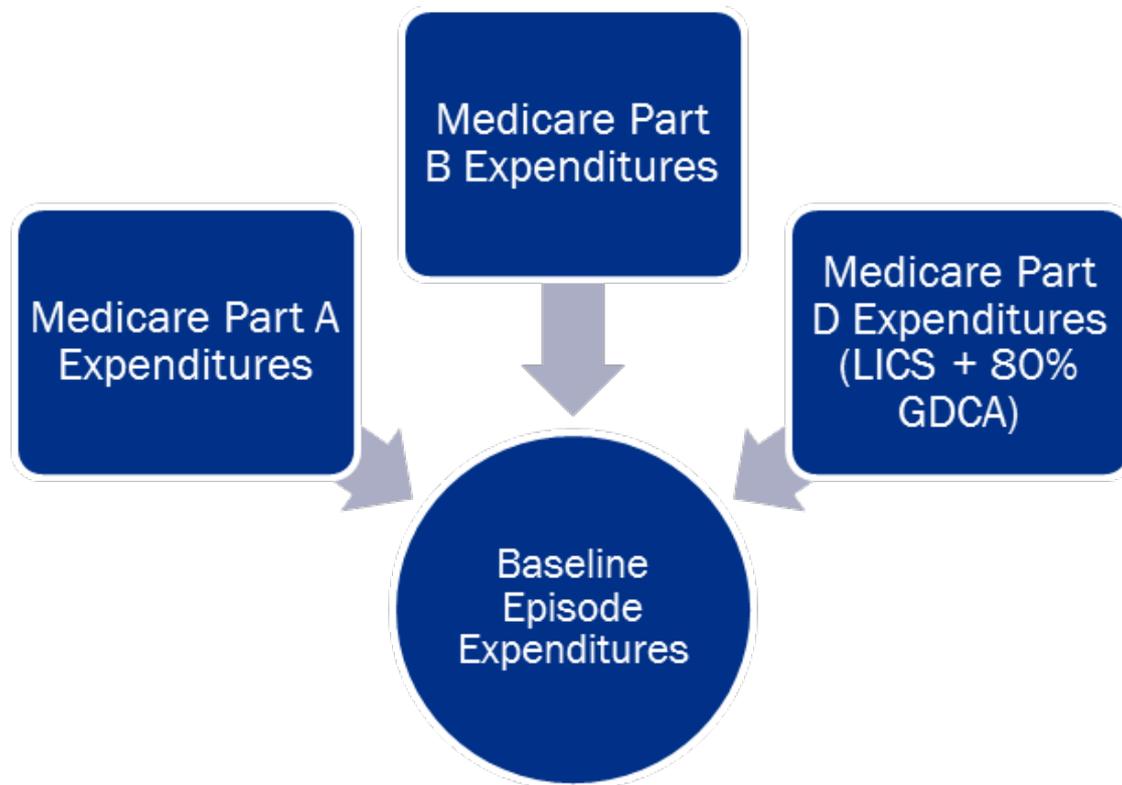
# STEP 1C: ASSIGN CANCER TYPE

- Each episode will be classified by cancer type (e.g., prostate, lymphoma, breast)
- The cancer type categories will be used for reporting, monitoring, and risk adjustment purposes
- Assigning cancer type to an episode:
  - First, each E&M visit during the episode is mapped to a cancer type
  - Then, the cancer type with the most E&M visits during the episode is the one assigned to the episode
- Lower-volume cancer types are excluded from the PBP calculation because there is not sufficient data on which to calculate target amounts.
  - 95% of episodes are expected to be included in PBP calculations.

# STEP 2: ATTRIBUTE EPISODES TO PRACTICES

- Each episode will be attributed to the practice that provided the most E&M visits with a cancer diagnosis during the episode (“plurality approach”)
- OCM and non-OCM practice are defined by the TIN used to bill for professional services

## 2. CALCULATE BASELINE EPISODE EXPENDITURES



# CALCULATION OF BASELINE EPISODE EXPENDITURES – SERVICE DATES

- For each episode, all the Medicare FFS expenditures incurred during the episode are summed.
- Those expenditures are identified using claims for which the *service date* is during the episode
  - For most claims, the service date is the date the beneficiary received the service
  - For inpatient and skilled nursing facility (SNF) claims, the service date is the date the beneficiary was admitted
  - For Part D claims, the service date is the date the prescription was filled

# BASELINE EXPENDITURE ADJUSTMENTS

<b>Model Overlap</b>	
Accountable Care Organizations (ACOs)	Bundled Payment for Care Improvement (BPCI)
<b>Sequestration</b>	
Beginning April 1, 2013	Approximately 2% adjustment ( $1/0.98 = 2.041\%$ )
Expenditures adjusted at claim level by date of service, to yield an amount equal to what the expenditures would have been in the absence of sequestration	
<b>Base Year Adjustment</b>	
Standardized to 6 <sup>th</sup> performance period of the historical baseline period	
<b>Outlier Adjustment (Winsorization)</b>	
Below 5%	Above 95%

# 3. CALCULATE THE RISK-ADJUSTED TARGET AMOUNT

- Step 1: Calculate the baseline price
- Step 2: Calculate the benchmark price
- Step 3: Calculate the target price
- Step 4: Calculate the risk-adjusted target amount

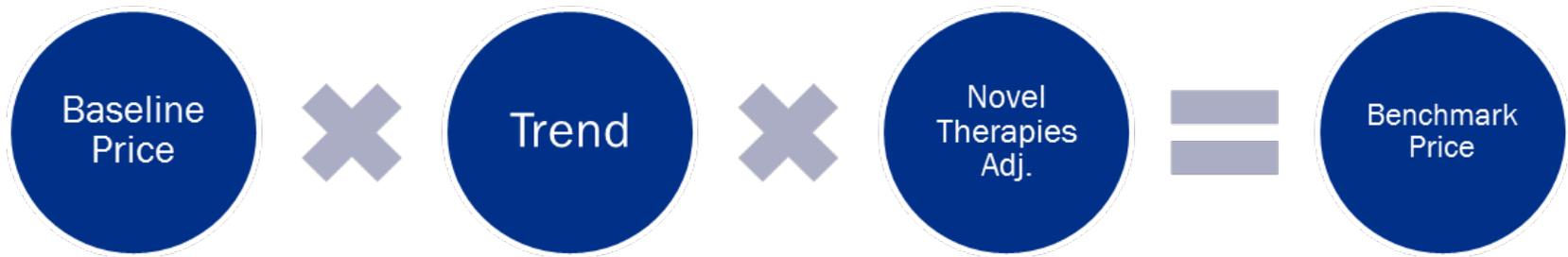
# STEP 1: CALCULATE THE BASELINE PRICE

- **Baseline price** = predicted baseline expenditures for an episode (based on beneficiary and episode characteristics) adjusted for the practice's/pool's own baseline experience



# STEP 2: CALCULATE THE BENCHMARK AMOUNT

- **Benchmark amount** = sum of benchmark prices for all episodes that are attributed to that practice and that have a cancer type that is reconciliation-eligible



# NOVEL THERAPIES ADJUSTMENT

- If a practice's/pool's new oncology drug expenditures as a percentage of its total episode expenditures is higher than that for episodes outside the OCM model, then an adjustment will be made based on 80 percent of the difference between the practice's/pool's proportion and the non-participating practices' proportion.
- The novel therapies adjustment may lead to a higher benchmark only; it will never lower a benchmark
- This adjustment only applies to certain oncology therapies.

# STEP 3: CALCULATE THE TARGET PRICE

- Target price = the benchmark price adjusted for the OCM discount



# STEP 4: CALCULATE THE RISK-ADJUSTED TARGET AMOUNT

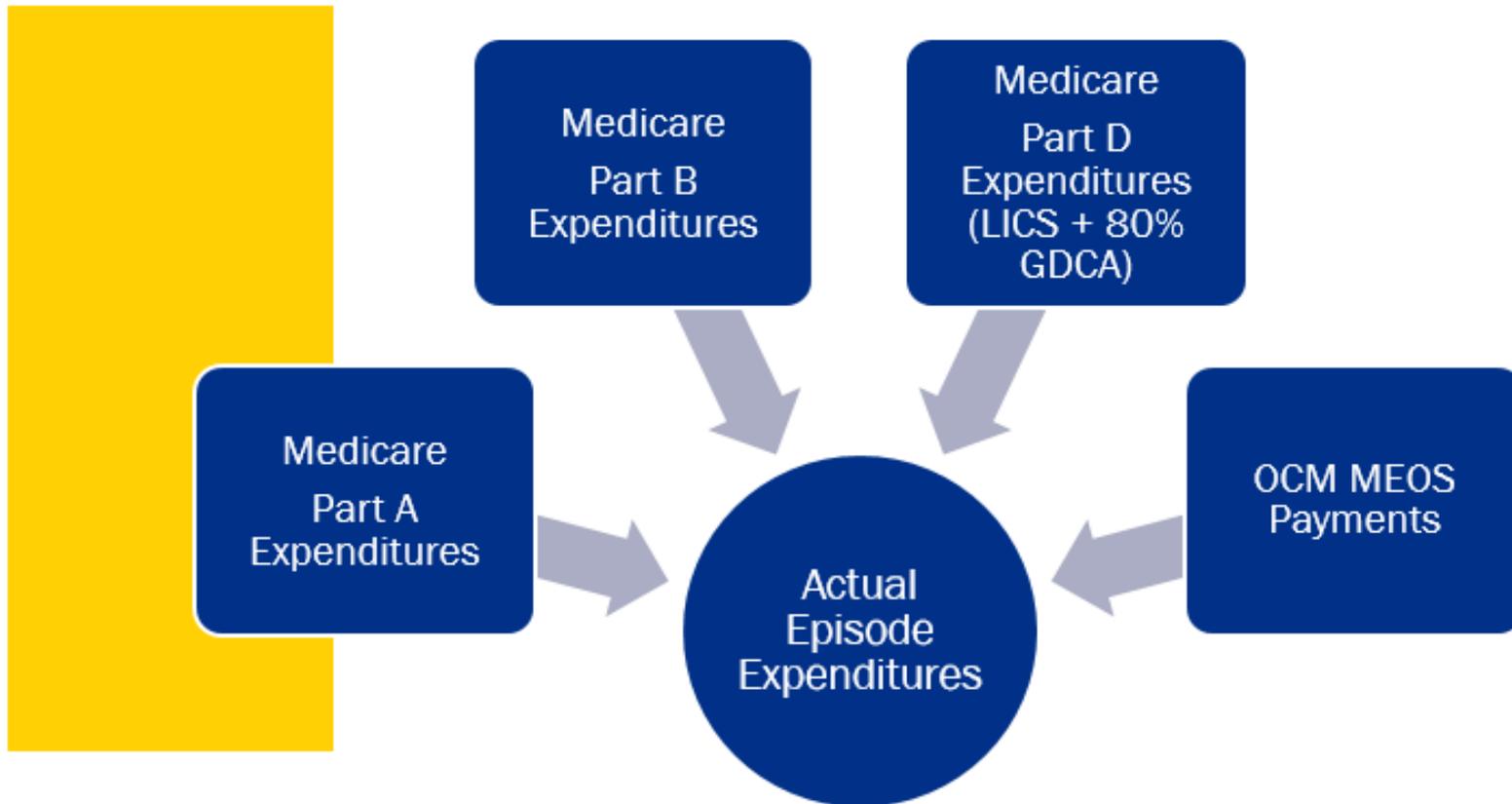
- Risk-adjusted target amount = sum of the target prices for all episodes attributed to practice for the performance period



# 4. IDENTIFY PERFORMANCE PERIOD EPISODES

- For each performance period, episodes will be identified and attributed to practices in the same way as for the baseline period, as previously described
- Recall that these were the steps involved
  - Step 1: Identify episodes
    - Step 1A: Identify potential trigger events
    - Step 1B: Determine episode eligibility
    - Step 1C: Assign cancer type
  - Step 2: Attribute episodes to practices

# 5. CALCULATE ACTUAL EPISODE EXPENDITURES



# 6. CALCULATE THE PERFORMANCE MULTIPLIER

- The performance multiplier will be based on the AQS constructed from each practice's or pool's performance on the quality measures, as shown here

Aggregate Quality Score	Performance Multiplier
75% - 100%	100%
50% - 74%	75%
30% - 49%	50%
Below 30%	0%

- The AQS equals the sum of the points earned on all 12 measures divided by the maximum number of points available.

# THE OCM QUALITY MEASURES

OCM Measure #	Measure Description	Source
OCM-1	Risk Adjusted proportion of patients with all-cause hospital admissions	Claims
OCM-2	Risk-adjusted proportion of patients with all-cause ED visits that did not result in a hospital admission	Claims
OCM-3	Proportion of patients who died who were admitted to hospice for 3 days or more	Claims
OCM-4	Pain assessment and management	Practice
OCM-5	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Practice
OCM-6	Patient-reported experience of care	Survey
OCM-7	Prostate cancer: Adjuvant hormonal therapy for high-risk beneficiaries	Practice
OCM-8	Timeliness of adjuvant chemotherapy for colon cancer	Practice
OCM-9	Timeliness of combination chemotherapy for hormone receptor negative breast cancer	Practice
OCM-10	Trastuzumab received by patients with AJCC stage I (T1c) to III Her2/neu positive breast cancer	Practice
OCM-11	Hormonal therapy for stage IC-IIIC estrogen receptor/progesterone receptor positive breast cancer	Practice
OCM-12	Documentation of current medication	Practice

# QUALITY POINTS

- In the first two performance periods there will be a mix of pay-for-reporting (P4R) and pay-for-performance (P4P) measures.

Measure Source	PP1	PP2	PP3
Claims-based	P4P	P4P	P4P
Practice-reported	P4R	P4R	P4P
Survey	Not included	P4P	P4P

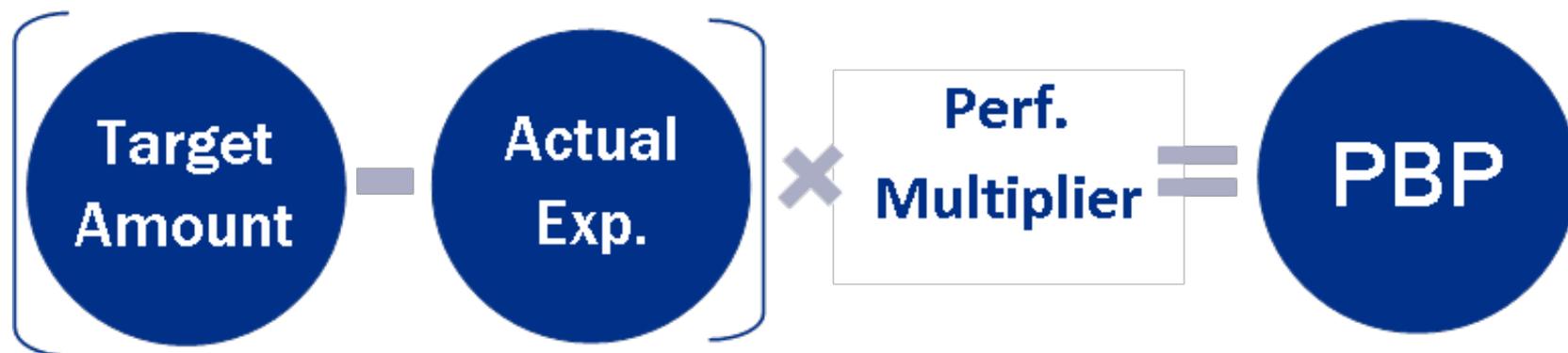
- Generally, each measure will have a maximum of 10 points available; the exception is in the first two performance periods, when the P4R measures will have a maximum of 2.5 points available for each.

## Maximum Points per Performance Period

PP1	PP2	PP3
50	60	120

# 7. CALCULATE THE PERFORMANCE-BASED PAYMENT

- **If actual episode expenditures are lower than the target amount:** The practice may be paid the full difference (up to a stop gain amount), contingent on quality performance
- **If actual episode expenditures are higher than the target amount:** No PBP will be made
  - If the practice has elected the two-sided risk sharing arrangement for the performance period, the practice must pay CMS back the difference (up to a stop loss amount), reduced for sequestration



# FINAL ADJUSTMENTS

- **Overlap with Medicare Accountable Care Organizations (ACOs)**
- **“Geographic Adjustment”**
- **Sequestration**

# REQUIREMENTS FOR RECEIVING A PERFORMANCE-BASED PAYMENT

**In order to receive a performance-based payment, a practice or pool must meet the following requirements:**

- Actual episode expenditures for the practice/pool must be lower than the target amount for the performance period.
- The practice/pool must have submitted the required data to the OCM data registry.
- The practice, or, in the case of a pool, each practice in the pool, implements all of the Practice Redesign Activities.
- The practice/pool must have achieved a minimum Aggregate Quality Score (AQS) of 30% (out of 100%).

# RECONCILIATION RESULTS

- We will carry out the reconciliation calculations for each 6-month performance period three times.
- Each reconciliation will use more claims run-out (that is, claims submitted after the end of the performance period) than the one prior.
- Differences between the current and previous reconciliations will be added to or subtracted from the current reconciliation amount.

# PERFORMANCE-BASED PAYMENT CALCULATION FOR POOLS

- Overall, PBPs for pools will be calculated using the same method as described above, with these modifications:
  - The target amount will be the sum of the target prices for all episodes attributed to the practices in the pool
  - The actual expenditures will be the sum of the expenditures for all episodes attributed to the practices in the pool
  - The performance multiplier will be based on the combined experience of all episodes attributed to the practices in the pool
  - One PBP will be calculated for the pool, and it will be paid to the pool's designated recipient

# QUESTIONS?

# IMPORTANT DATES AND UPCOMING EVENTS

Event	Date and Time
Web-Based Call for Payers	Tuesday, April 26, 3:00-4:00 P.M. EDT
Office Hours for Practices	Thursday, April 28, 3:00-4:00 P.M. EDT

- Event registration will be emailed to OCM participants and included with future Orientation Packet materials.
- Materials from each webinar session will also be emailed to OCM participants.

# OCM HELP DESK TEAM CONTACT INFORMATION

The OCM Help Desk Team provides phone and email support for technical and program related questions.

- Phone: 1-844-711-2664 (1-844-711-CMMI), press Option 2
- Email: [OCMSupport@cms.hhs.gov](mailto:OCMSupport@cms.hhs.gov)

## Hours of Business

- 8:30 A.M. to 6:00 P.M. Eastern Standard Time

## PII/PHI

- Please do not email any confidential information

# CLOSING

## Thank you, everyone!

- As a reminder, you may submit questions to the team at [OCMSupport@cms.hhs.gov](mailto:OCMSupport@cms.hhs.gov).
- Finally, today's presentation materials will be emailed to participants.
- We appreciate your feedback! Please complete our short, post-event survey. You can access the survey by clicking in the “Post Event Survey” box on your screen and selecting “Browse To”, or by posting this link into your browser:  
[https://www.surveymonkey.com/r/OCM\\_Methodology](https://www.surveymonkey.com/r/OCM_Methodology)