CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Oncology Care Model (OCM)
Practice Application Template

Instructions

Thank you for your interest in participating in the CMS Innovation Center's Oncology Care Model (OCM).

The PDF version of this application is for reference only. Applicants that submit a complete, timely LOI will be sent an authenticated web link and password with which to access and submit the electronic version of this application. Only those practices submitting a complete, timely LOI will be eligible to submit an application. Submission of the PDF version of this application will not be accepted.

Each complete application will be reviewed by a panel of experts from the Department of Health and Human Services, as well as other experts in the areas of provider payment policy, care improvement and coordination, and oncology care.

Complete practice applications will include:

- Signed Electronic Application Form
- Implementation Plan Narrative
- Financial Plan Narrative
- Diverse Populations Narrative
- Letters of Support from other payers or explanation of payer support, as applicable

Refer to the Request for Applications (RFA) on the Innovation Center website http://innovation.cms.gov/initiatives/Oncology-Care/ for further details regarding practice requirements and application scoring criteria.

ALL APPLICATIONS ARE DUE BY 5:00pm Eastern Daylight Time ON JUNE 30, 2015.

For questions regarding the application process, email OncologyCareModel@cms.hhs.gov

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Application Template

Contact Information

Practice Name:

Practice TIN:

Is the practice TIN a Social Security Number [yes/no]? Organizational TIN [yes/no]?

Point of Contact (POC) Name:

POC Title:

POC Address:

POC City:

POC State:

POC Phone: Extension:

POC Email:

Fiscal Year Start Date: Fiscal Year End Date:

Practice and Patient Information

1. In what setting(s) do patients under the care of the practice receive chemotherapy? Check all that apply, including sites to which the practice refers patients for chemotherapy.

    - Hospital outpatient department (on campus)
    - Hospital outpatient department (off campus, including all facilities and organizations with provider-based status)
    - Hospital inpatient unit
    - Physician's office
    - Patient self-administered
    - Other

    If other, list the setting(s) where patients under the care of the practice receive chemotherapy

If chemotherapy is administered or billed in any of the settings above under a TIN or CMS Certification Numbers (CCN) other than the applicant's, please specify the TIN(s) or CCN(s) below. Please also describe the circumstances under which the chemotherapy would be administered or billed under each TIN or CCN.

For example, CMS understands that certain physician practices partner with hospital-based entities for the administration of IV chemotherapy and/or may have alternative billing arrangements for physician and chemotherapy infusion services aside from billing these services under the applicant's TIN. Such arrangements should be described below.

2. a. Under what TIN/CCN do practitioners at the applicant practice bill E&M codes? Check all that apply.
   - Applicant TIN
   - Other TIN(s)
   - Facility CCN(s)

   b. If you selected more than one response for question 2a above, please describe the circumstances under which an E&M code would be billed under each selected option.

3. OCM aims to primarily target transformation of physician-led practices. For hospital-owned or affiliated practices, including provider-based departments, please describe how the applicant practice is a unique entity within the larger institution.

4. How many physicians and non-physician practitioners (NPPs) are in the practice, and what are their primary specialty designations as enrolled in Medicare?

5. All physicians and non-physician practitioners under the applicant TIN who prescribe chemotherapy for cancer or provide outpatient cancer care to patients receiving chemotherapy must be included in OCM. Please list all individual NPIs meeting these criteria.

   All NPIs should be re-assigned to the applicant TIN prior to submission of the application.

6. Where is the practice located?

   If the practice has more than one location, provide the city and state of all locations.

7. List the practice locations that are in a Health Provider Shortage Area (HPSA), as of application date. Provide the number and percentage of the practice's patients that receive care at the practice(s) in a HPSA.

If the practice does not have locations in a HPSA, skip this question.

City_____ State _____ Patients _____#_____%
City_____ State _____ Patients _____#_____%
City_____ State _____ Patients _____#_____%

Additional spaces will be provided in the online application.

8. Indicate whether the practice requests to have its data pooled with other applicant practices for purposes of benchmarking and performance payment, and with which other practices the applicant practice is requesting to have its data pooled for these purposes. The ability to pool with other practices is dependent on their selection for OCM-FFS participation. Practices may request a change to their benchmarking pool prior to the start of the first performance year (at a date that will be specified in the participant agreement).

   If the practice is not requesting to have its data pooled with that of other participating practices, skip this question.

   If the practice is requesting to have its data pooled, list the practices with which the practice is requesting to have its data pooled. Include all practice TINs.

   Why did the practice choose to pool with the listed practice(s) for benchmarking purposes?

9. Provide the following demographic information about practice's current patients (aggregate for all payers).

   - Dual eligible(Medicare-Medicaid) _____%

   - Percentage of all patients by race and ethnicity. Patients may be included in more than one category.

     Alaska Native or Native American _____%
     Asian_____%
     Black or African American _____%
     Hispanic or Latino _____%
     Native Hawaiian or other Pacific Islander _____%
     White _____%
     Unknown _____%

   - Percentage of all patients by primary language spoken

     English_____%
     Spanish_____%
     Other_____%

10. Provide information in the following tables about the practice's patients and revenue by payer for the practice's fiscal years 2012, 2013, and 2014. List all revenue (insurance and copayments) generated by services furnished to patients. Complete for only the practice's top 10 payers, based on percent of total practice gross revenue. Active patients are defined as those who received a billed service from the practice in the specified year. Do not count patients for more than one primary payer.

    Use the practice's billing system or billing vendor to generate this information. Indicate whether the practice is applying to OCM in participation with each payer, other than Medicare Fee-For-Service (FFS), and whether the practice is including a letter of support from each payer.

    Complete the following table for each payer, including:

    - Medicare FFS (not managed care)
    - Medicaid/CHIP FFS
    - Commercial Payers
    - TRICARE
    - Self-Pay Patients

Blank	Total number of active patients	Number of active cancer patients	Number of active cancer patients treated with chemotherapy	Percent of total practice revenue
2012				
2013				
2014				

Is the practice applying to participate in OCM with this payer? Yes/No

If yes, attach a letter or explanation of support from this payer here.

11. Complete the below table with information specific to any and all sanctions, penalties, or corrective action plans imposed against the OCM applicant, and any and all investigations of applicant. Provide information from the previous three years.

Federal or State Agency or Accrediting Body (e.g., DOJ, OIG, The Joint Commission, State Survey Agencies)	Provider at Issue	Description of Infraction (including date)	Status (including relevant dates)

Additional space will be available in the online application.

Implementation Information

- Explain the nature of any financial relationships the practice has or expects to have with other health care providers and suppliers related to its participation in OCM.

- Describe any items or services outside of standard Medicare FFS benefits that the practice may wish to offer OCM-FFS beneficiaries during the model performance period.

- Are there quality measures not already included in the RFA that are particularly useful in documenting cancer care and therefore should be incorporated into OCM-FFS? If so, explain.

- Are there risk adjustment factors that should be included in this model that are not captured in Medicare claims data? If so, explain.

Application Checklist and Signature Package

- ☐ Complete Electronic Application Form
- ☐ Attach Implementation Plan Narrative, as described in Table 1 of the RFA (limit 15 pages)
- ☐ Attach Financial Plan Narrative, as described in Table 1 of the RFA(limit 4 pages)
- ☐ Attach Diverse Populations Narrative, as described in Table 1 of the RFA (limit 2 pages)
- ☐ Attach Letters of Support or explanations of support from each other payer with which the practice is applying to participate.

APPLICATION CERTIFICATION:

I have read the contents of this application. By submitting this application, I certify that I am legally authorized to bind the applicant. I further certify that the information contained herein is true, accurate, and complete, and I authorize the Centers for Medicare & Medicaid Services (CMS) to verify this information. If I become aware that any information in this application is not true, accurate, or complete, I will notify CMS of this fact immediately.

Signature:_____