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

Oncology Care Model (OCM)
Request for Applications (RFA)
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Contents

I. Background/General Information

A. Scope

The Center for Medicare & Medicaid Innovation (Innovation Center) at the Centers for Medicare & Medicaid Services (CMS) aims to improve the effectiveness and efficiency of specialist care with an episode-based payment model for oncology care. More than 1.6 million people are diagnosed with cancer in the United States each year.[1] Cancer patients comprise a medically complex and high-cost population served by the Medicare program. Through the Oncology Care Model (OCM), the Innovation Center has the opportunity to further its three-part aim within oncology care: better care, smarter spending, and healthier people.

The Innovation Center is operating this model under the authority of section 1115A of the Social Security Act. This Request for Application (RFA) is directed to practices that provide oncology care as well as public and private health care payers. The Innovation Center hopes to engage at least 100 physician practices that, in aggregate, will furnish care for approximately 175,000 cancer care episodes for Medicare beneficiaries over the course of this 5-year model.

B. General Approach

The goal of OCM is to utilize appropriately aligned financial incentives to improve care coordination, appropriateness of care, and access to care for beneficiaries undergoing chemotherapy. OCM 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 care, smarter spending, and healthier people. Practitioners in OCM are expected to rely on the most current medical evidence and shared decision-making with beneficiaries to inform their recommendation about whether a beneficiary should receive chemotherapy treatment. OCM provides an incentive to participating physician practices to comprehensively and appropriately address the complex care needs of the beneficiary population receiving chemotherapy treatment, and heighten the focus on furnishing services that specifically improve the patient experience and/or health outcomes.

OCM is intended to be a multi-payer model that includes Medicare fee-for-service (FFS) and other payers. Payers and physician practices must separately apply to participate in OCM. Payers who participate share the Innovation Center's opportunity to improve care for their beneficiaries and realize cost savings while enabling practices to make broader changes. The Innovation Center expects the subset of OCM for Medicare FFS beneficiaries (OCM-FFS) may differ in certain model design aspects, such as selection of quality and performance measures, from OCM for beneficiaries of other payers (OCM-OP). However, OCM's approach to practice transformation as described in section IV. of this RFA will be consistent across payers.

[1] American Cancer Society. Cancer facts and figures 2014. Available at: http://www.cancer.org/research/cancerfactsstatistics/cancerfactsfigures2014/

OCM-FFS incorporates a two-part payment system for participating practices, creating incentives to improve the quality of care and furnish enhanced services for beneficiaries who undergo chemotherapy treatment for a cancer diagnosis. The two forms of payment include a monthly per-beneficiary-per-month (PBPM) payment for the duration of the episode, and a performance-based payment for associated episodes of cancer care. The PBPM enhanced care management payment will assist participating practices in effectively managing and coordinating care for oncology patients, while the performance-based payment will incentivize practices to lower the total cost of care and improve care for beneficiaries during treatment episodes.

C. Deadlines for Letter of Intent and Application

All practices and payers who wish to apply for participation in OCM-FFS must first submit a non-binding letter of intent (LOI). LOIs for interested payers are due by 5:00 pm EDT on **April 9, 2015**. LOIs for interested practices are due by 5:00 pm EDT on **May 7, 2015**. LOI forms are available for download on the Oncology Care Model website at http://innovation.cms.gov/initiatives/Oncology-Care/, and should be submitted by email to the Oncology Care Model inbox: OncologyCareModel@cms.hhs.gov.

Practices and payers that submit timely, complete LOIs will be eligible to submit applications. All applications must be submitted by 5:00 pm EDT on **June 30, 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. Templates of the applications are available for reference only on the Oncology Care Model website. Submission of the template versions of the applications will not be accepted.

II. Description of the Oncology Care Model

A. Purpose

The overarching aims of this model are to improve health outcomes for patients with cancer, improve the quality of cancer care, and reduce spending for cancer treatment. We expect that physician practices selected for participation in the model will be able to transform care delivery for patients undergoing chemotherapy, leading to improved quality of care for beneficiaries at a decreased cost to payers. Through this care transformation, practices participating in OCM-FFS can reduce Medicare expenditures while improving cancer care for Medicare FFS beneficiaries. Participating payers will have the opportunity to further these goals for their own beneficiaries who are cared for by practices participating in OCM.

The Innovation Center sees the following as key opportunities within OCM:

- Promote shared decision-making, patient-centered communication, evidence-based care, beneficiary access to care, and coordination across providers and settings.
- Reduce complications of cancer and cancer treatments, as well as associated costs, through advanced care planning, increased use of high-value treatments, and reduction of inappropriate payment incentives.

- Collect structured clinical data and integrate clinical trial enrollment into processes of care to facilitate quality improvement and accelerate clinical research.
- Support the development and reporting of meaningful outcome measures.
- Develop and monitor refined approaches to care delivery, which may improve the research infrastructure (for example, by facilitating improvement in the quality of evidence for existing therapies).
- Encourage delivery of care in the lowest-cost medically-appropriate setting.
- Refine a value-based payment system that encourages team-based care and workforce innovation.

B. Model Overview

OCM is a 5-year model, beginning in spring 2016, that creates incentives to furnish efficient, high quality care by enhancing services for beneficiaries undergoing chemotherapy for a cancer diagnosis. Participants will be physician group practices (PGP) and practitioners in solo practice (collectively referred to as "practices" for the purposes of this RFA) that provide care for oncology patients undergoing chemotherapy for cancer. Selected practices must meet practice requirements and satisfy the model's quality and reporting requirements to be eligible for payments in OCM-FFS.

The model emphasizes care coordination and enhanced patient care through practice transformation. Practices must meet certain requirements to participate in the model and to continue to receive enhanced payment for care of their beneficiaries, including effective use of electronic health records (EHR), 24-hour access to practitioners who can consult the patient's medical record in real time, comprehensive patient care plans, patient navigators, and continuous quality improvement. OCM offers practices the opportunity to improve the quality of care for their patients, lower costs, restructure their practice to provide more comprehensive care for oncology patients, and engage with quality and cost data that will inform their care redesign.

As in all Innovation Center models, participants are expected to fully engage in learning and diffusion, evaluation, and monitoring activities. The Innovation Center would consider limited model design changes following the release of this RFA if the design changes are appropriate and operationally feasible, do not have budgetary implications, and align with the model's goals of improving quality and health while lowering the cost of care for oncology patients. In addition, as the OCM is developed, CMS may incorporate a variety of program integrity or other safeguards to ensure that the model does not result in program or patient abuse.

C. Multi-Payer Structure

The Innovation Center is interested in testing models that engage multiple payers. Medicare FFS payments constitute only a share of any provider's revenue. Involving other payers in the model offers the opportunity to transform care on a larger scale by creating broader incentives for care transformation at the physician practice level. On average, about 50 percent of oncology practices' patients are Medicare beneficiaries. While this is a significant portion of oncology patients, aligned financial incentives that result from engaging multiple payers will leverage the opportunity to transform care for oncology patients across a broader population. Other payers would also benefit from savings, better outcomes for their beneficiaries, and information gathered about care quality. Payers who

participate will have the flexibility to design their own payment incentives to support their beneficiaries, while aligning with the Innovation Center's goals for care improvement and cost reduction. In order to incentivize true practice transformation, payers are encouraged to include as many cancer types as possible. Priority will be given to payers that include cancer types that cover large majorities of beneficiaries.

Other payers participating in the model could include commercial health insurers, as well as state Medicaid agencies. During the selection process, the Innovation Center will favor practices based on the level of participation with other payers that is reflected in the application. The Innovation Center will enter into participant agreements with physician practices. Other participating payers will enter into agreements with practices separately.

Other payers must financially incentivize the same practice requirements as described in section IV. of this 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).

A multi-payer model has important implications for the geographical distribution of target payer-provider markets in the model. The level of participation by other payers and the geographic reach of payers that apply to participate in the model will drive the target markets of the model. OCM will proceed as a Medicare FFS-only model in some or all markets in the event that other payer participation is lower than expected. The Innovation Center will identify payers and enter into a Memorandum of Understanding (MOU) with each to promote proper alignment with OCM.

D. Episode Definition

OCM-FFS targets chemotherapy treatment of Medicare FFS beneficiaries during 6-month episodes. Episodes in OCM-FFS will initiate with either an initial chemotherapy administration claim or an initial Part D chemotherapy claim. Practices' beneficiaries who do not initiate chemotherapy during the performance period 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. Services that OCM-FFS beneficiaries receive before the initial chemotherapy claim will not be included in the OCM-FFS episode.

Cancer therapies that trigger an OCM-FFS episode are composed of a comprehensive set of chemotherapy drugs, including possible chemotherapy drugs. The "possible chemotherapy" categorization describes chemotherapy drugs that are often used to treat cancer, but may have other important indications, such as treatment of autoimmune diseases. The inclusion of these possible chemotherapy drugs in OCM-FFS is based on the assumption that such drugs are being used to treat cancer when provided to beneficiaries who have been diagnosed with cancer. Administration of chemotherapy or possible chemotherapy drugs to Medicare FFS beneficiaries with a cancer diagnosis will trigger an episode. The chemotherapy lists exclude topical formulations of the chemotherapy drugs as a trigger, such as fluorouracil cream, because the topical formulations do not require the intensive management associated with the systemic therapies. Hormonal therapies used for cancer are included on the chemotherapy list for OCM-FFS, and trigger episodes in the same manner as other chemotherapy drugs. Preliminary lists of chemotherapy and possible chemotherapy drugs are in Appendix D.

OCM-FFS episodes terminate six months after chemotherapy initiation, regardless of whether the beneficiary receives chemotherapy treatment throughout the 6-month period of time or for a shorter period. Beneficiaries who receive chemotherapy after the 6-month episode may initiate a new 6-month episode. Reinitiation of chemotherapy after a gap in administration within an episode does not trigger a new episode.

E. Beneficiary Alignment

Medicare beneficiaries must meet each of the following criteria to be eligible for OCM-FFS:

- Beneficiaries are enrolled in Medicare Parts A and 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

A Medicare beneficiary must meet all of these eligibility criteria for the duration of the six-month episode to be included in OCM for that episode. Part D is not a requirement for beneficiary eligibility in OCM-FFS. 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.

Beneficiaries enrolled in a clinical trial for which Medicare pays routine costs would be included in OCM-FFS. Additionally, beneficiaries included in certain other CMS programs and Innovation Center models, including Pioneer Accountable Care Organizations (ACO), Medicare Shared Savings Program (MSSP), and the Medicare Care Choices model (MCCM), are also eligible for OCM-FFS. The implications of beneficiary alignment with multiple initiatives are further described in section II.L of this RFA.

OCM-FFS aligns eligible beneficiaries receiving chemotherapy to the OCM-FFS physician practice that is actively managing each beneficiary's cancer treatment.

F. Benchmarking and Risk Adjustment

Calculation of Participant Savings

Risk-adjusted benchmark expenditures for each OCM-FFS participating practice will be calculated based on data from a historical baseline period. Benchmarking includes the following steps:

1. Group claims from the baseline period into episodes of care for all Medicare beneficiaries who would satisfy inclusion criteria for the performance-based component of the model.
2. Calculate total Medicare expenditures for each baseline period episode identified in Step 1.

3. Adjust total Medicare expenditures for each baseline period episode for geographic variation.

4. Stratify baseline period episodes by combinations of risk-adjustment factors and trend episode expenditures within each combination from the baseline period to the performance year based on average expenditure growth of non-participants.

After assigning a benchmark episode expenditure to all performance year episodes, each OCM-FFS participant's total performance year benchmark expenditure will be calculated by first readjusting benchmark episode costs for geographic variation and then summing the adjusted benchmark episode costs across all performance year episodes at the participant. This risk-adjusted performance year benchmark expenditures would then be reduced by the set discount percentage (which would be retained as Medicare savings) to generate a target price.[2]

Performance year actual expenditures for each OCM-FFS participant will be calculated by summing total Medicare expenditures (including PBPM payments) for all performance year episodes included in the performance-based component of the model, as described in section II.G. of this RFA. The difference between the target price and the performance year actual expenditures would represent the maximum performance-based payment that the participant could achieve (which may be adjusted by the performance multiplier, as described below).

When participants have insufficient cases in the baseline period to calculate reliable target prices, the benchmarking methodology leverages regional or national data to increase precision. The Innovation Center also allows participating practices to elect to be benchmarked collectively (with cases pooled as though they were a single practice) to further increase benchmarking precision. Any participant may request to be pooled with other participating practices for benchmarking purposes. For the purposes of payment, pooled practices would indicate a single practice to receive performance-based payments on behalf of the pool. Payments or losses generated by an individual practice within a pool would be netted with those of other practices within the pool.

Other payers are not required to use the same benchmarking methodology. They will be required to share the methodology they develop with the Innovation Center.

Risk Adjustment and Outliers

The model risk adjusts for factors that affect episodic total cost of care, increasing or decreasing the performance year benchmark expenditures based on risk-adjustment factors. Risk adjustment factors will be calculated based on historical claims data from both participants and non-participants. While the specific risk adjustment factors have not yet been finalized, factors under consideration fall into the following categories:

- Beneficiary characteristics, such as age strata or comorbidities
- Episode characteristics, such as whether an episode is the first for that beneficiary
- Disease characteristics, such as cancer type

[2] The discount is 4 percent in the one-sided risk arrangement and 2.75 percent in the two-sided risk arrangement. See the Risk Arrangements section, II.H, for additional details.

- Types of services provided, such as provision of radiation therapy or initiation with an endocrine therapy

The list above includes examples of possible factors and is not exhaustive.

Risk adjustment in the first model performance year will be based solely on information available in administrative claims data. The Innovation Center is soliciting information from OCM-FFS applicants, as a part of this RFA, about risk adjustment factors that are not captured in claims data, such as stage of cancer at diagnosis, and will consider collecting this information from participants during the early part of the performance period. The Innovation Center will then consider incorporating these factors into the risk-adjustment methodology in later OCM-FFS performance years.

In addition to risk adjusting participant benchmarks, OCM-FFS mitigates risk by Winsorizing[3] the total Medicare expenditures within risk-adjustment categories. This minimizes the possible effect of extreme outliers.

G. Model Payments

Performance-Based Payments

The standard Medicare FFS payments will continue during OCM-FFS episodes. After calculating the benchmark for each OCM-FFS participant, the OCM-FFS applies a 4 percent discount to determine the target price for the participant's performance period episodes.[4] OCM sets a target price for chemotherapy episodes, which includes a discount (representing Medicare Trust Fund savings). Practices generating additional reductions in expenditures under the target price will be eligible for a semi-annual lump-sum performance-based payment for up to the full difference between target and actual expenditures. These payments will potentially be scaled down by participant-specific performance multipliers that are based on achievement and improvement on a range of quality measures, described below in the 'Performance Multiplier' section.

To limit instances in which the Innovation Center attributes savings or losses to participants based on random variation rather than actual participant performance, 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. Analysis of Medicare Chronic Condition Warehouse (CCW) data shows that more than 75 percent of Medicare FFS beneficiaries who initiated chemotherapy in 2010 had one of eight cancer types – breast, prostate, lung, colorectal, lymphoma, leukemia, ovarian, or pancreatic. The Innovation Center will expand this list of the highest volume cancers to cover at least 90 percent of Medicare FFS beneficiaries receiving chemotherapy, and will only make performance-based payments with respect to the treatment of Medicare beneficiaries receiving chemotherapy for one of these highest-volume cancer types. This list of high volume cancers will be available to selected OCM practices prior to entering into participation agreements.

[3] Winsorization is a method of adjusting statistics by trimming extreme values in the data to reduce the impact of pronounced outliers.

[4] The discount is 4 percent in the one-sided risk arrangement and 2.75 percent in the two-sided risk arrangement.

Performance Multiplier

OCM-FFS adjusts performance-based payments based on the participating practice's performance on a range of measures reflected in quality score. OCM-FFS participants are required to collect data on quality measures that span several domains of patient care, including communication and care coordination, person- and caregiver-centered experience and outcomes, and clinical quality of care.[5]

Data will also be collected from administrative claims. The selected quality measures balance the incentives for cost reduction by ensuring that participating practices meet the model's outcome goals and the process goals of patient-centered, coordinated, and clinically appropriate care. Similar to other Innovation Center models, participant performance across these quality measures, as measured by achievement and improvement relative to either other participants or national benchmarks, will be transformed into weighted scores that are summed to calculate the performance multiplier. A practice must exceed a minimum quality threshold for the practice to be eligible to receive a performance-based payment.

Quality measures are one key mechanism the Innovation Center uses to verify clinical improvements, assess patient health outcomes and appropriate coordination of care, and ensure continued quality of care for beneficiaries. The Innovation Center will provide selected practices with more information regarding the methodology for quality scoring before they enter participant agreements with the Innovation Center to participate in OCM-FFS. Appendix C of this RFA includes a preliminary set of quality measures that will be used for the performance multiplier in the performance-based payment calculation. The measures may change throughout the implementation period. Participants will be notified in advance of any adjustments to the performance measures.

Per-Beneficiary-Per-Month Payment

OCM-FFS practices will receive PBPM payments for beneficiaries with nearly all cancer types for each of the six months of the episode, even if the beneficiary does not receive chemotherapy for the duration of the episode. The monthly PBPM fee is intended to pay for the enhanced services driven by the practice requirements, aimed at transforming practices towards comprehensive, patient-centered, and coordinated care. The OCM PBPM is $160 per OCM-FFS beneficiary per month for the duration of each 6-month episode, and remains constant for the 5-year model.

Practices are required to bill monthly for the PBPM payment for each OCM-FFS beneficiary using a HCPCS G-Code created specifically for this purpose. Through ongoing monitoring, the Innovation Center will ensure that the PBPM G-Code is used appropriately for participating practices and OCM-FFS beneficiaries, and will reconcile and recoup any inappropriate payments.

Payments for services during the episode, including the PBPM payment, will be included in the performance-based payment calculations. A participating practice will not receive performance-based payments until reductions in expenditures below the target price exceed the amount of PBPM payments

[5]These domains are National Quality Strategy (NQS) domains, domains which represent the Department of Health and Human Services' NQS priorities for health care quality improvement. The full list of NQS domains is: Patient Safety; Person and Caregiver-Centered Experience and Outcomes; Communication and Care Coordination; Clinical Quality of Care; Population Health; Efficiency and Cost Reduction.

paid to the practice. Practices that do not qualify for a performance-based payment by the end of the third performance year would be removed from OCM-FFS.

In the CY 2014 Physician Fee Schedule final rule with comment period, CMS created codes for separately billable chronic care management (CCM) services starting in CY 2015.[6] OCM-FFS beneficiaries may be patients with chronic conditions that qualify for CCM services as defined in the Physician Fee Schedule. Since OCM practices receive a PBPM payment for OCM-FFS beneficiaries, physicians and non-physician practitioners (NPPs) that participate in OCM cannot bill for CCM services for the same beneficiary in the same month in which they receive a OCM-FFS PBPM payment. 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.

H. Risk Arrangements

OCM-FFS features two options for risk arrangements. The first is a one-sided risk arrangement for the duration of the model, in which any OCM-FFS participant that reduces expenditures below the target price will be eligible to receive a performance-based payment. If no reductions below the target price are achieved, then the practice will not be financially responsible for expenditures over the target price. Continued participation in OCM-FFS will be contingent upon qualifying for a performance-based payment by the end of the third performance year.

The second track is a phased-in two-sided risk arrangement that features one-sided risk in the first two performance years and symmetric two-sided risk thereafter, which would require the participant to pay back expenditures over the target price. After year two, participating entities will be allowed to elect to switch between the two arrangements on a semiannual basis. The discount percentage for episodes in the two-sided risk arrangement is 2.75 percent, lower than the 4 percent discount in the one-sided risk arrangement, enabling participants to earn more money through performance-based payments.

There is a maximum expenditure reduction percentage per practice that limits the amount of the performance-based payments. This is not meant to limit earnings by participating practices, but rather meant to provide a program safeguard to prevent practices from reducing care to unacceptable levels. The maximum expenditure reduction percentage is set at 20 percent of the benchmark before taking the CMS discount. A maximum loss percentage of 20 percent is also applied to the two-sided risk model as a stop-loss (such that participating practices are not required to pay Medicare back for losses over 20 percent).

I. Monitoring and Reporting

The Innovation Center will continuously monitor physician practices participating in this initiative to ensure that access to care and quality of care are not being compromised, that practices have built the capacity and infrastructure to deliver comprehensive oncology care, and that the Innovation Center is receiving data from practices demonstrating their engagement in continuous improvement.

[6] CY 2014 PFS final rule with comment period (78 FR. 74418-19, Dec. 10, 2013).

Practices are required to report data on OCM-FFS beneficiaries to the Innovation Center on a quarterly basis. To the extent possible, the Innovation Center will use existing data and reporting systems as part of its monitoring efforts, to minimize the reporting burden on practices, providers, and patients. Certain metrics, such as stage of cancer when diagnosed, are not collected on Medicare claims, but will be reported by the participating practices in OCM.

Some measures tracked by the Innovation Center will be used to calculate a practice's performance-based payment. In addition, some metrics will be tracked by the Innovation Center for monitoring purposes that will not be incorporated in the calculation of the performance-based payment. See Appendix C for a preliminary list of measures.

Monitoring includes, but is not limited to, the following activities:

1. Tracking of claims data to detect possible systematic stinting on care, and to profile characteristics of OCM-FFS beneficiaries (both process and outcome measures will be examined)
2. Patient surveys
3. Site visits to verify infrastructure improvements
4. Analysis of data reported by participating practices under the model for quality measurement
5. Annual reporting on use of model funds (through OCM PBPM and enhanced payments from other participating payers) and practice's own investments to implement infrastructure enhancements required for model participation
6. Annual time-and-motion studies to document practice staff time engaging in key model-related activities, including care coordination
7. Other activities, such as medical record audits and tracking patient complaints and appeals

In order to inform the model's evaluation, baseline data on certain measures may be collected prior to model implementation. 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. These reports can assist practices in continuous improvement and the most effective participation in the model. Payers that participate in OCM will provide practices with performance reports to assist practices in achieving the goals of the model. Other payers may collect and produce reports on a different set of measures.

J. Evaluation

CMS will contract with an independent evaluator to determine the impact of OCM-FFS on health outcomes, costs, quality of care, and patient experiences. The OCM-FFS evaluation will seek to provide rapid-cycle feedback that can be used by participating practices to improve operations during the course of model implementation. Participating practices must agree to cooperate in an independent formal evaluation of the demonstration by the evaluation contractor, including sharing program data and making relevant staff of participating organizations available for site visits and/or phone calls conducted by the Innovation Center and/or its contractor. Additionally, practice staff will be surveyed to obtain their reactions to OCM's implementation, how it has changed their approach to patient care, and their satisfaction with various aspects of the model. The evaluation will also include patient surveys to

document patient experiences under OCM. Participating practices will be expected to assist in facilitating the survey process. All patient surveys will be strictly voluntary. The evaluation will involve analysis of both primary data collected under the terms of the model (which may include data collected for monitoring purposes, as well as evaluation-specific data), and secondary data such as claims and enrollment records. Both quantitative and qualitative analyses will be performed.

K. Learning System Participation

The Innovation Center is utilizing a Learning System aimed at improving the likelihood of success to reinforce OCM[7]. The OCM Learning System is a continuous process with two objectives: (1) support rapid learning and practice changes resulting in improved quality of care at lower cost; and (2) capture and spread operational learning emerging from the model and participating practices. The Learning System creates an environment of shared learning through a set of action-oriented learning and diffusion activities. Data reported by participating practices and collected from Medicare FFS claims will be used to monitor performance and to guide the learning community.

OCM-FFS practices are expected to participate in the results-driven learning community comprised of both didactic and peer-based learning opportunities. The OCM Learning System supports participating practices' efforts to transform their practice using rapid-cycle improvement methods guided by data. OCM Learning System faculty will work with practices to develop data-based case studies, which will identify successful approaches to further build and maintain excitement and engagement, reinforce the desire to change, understand best practices, and accelerate innovation and improvement.

The pool of faculty will include subject matter experts and, importantly, the OCM practices themselves who will be working together to share and adapt effective models, and serve as peer-faculty for areas in which they have the strongest capabilities. Practices are expected to complete baseline assessment and periodic reports, which will provide data to analyze strengths and areas for improvement for achieving the OCM goals.

Participating OCM practices will be supported through learning communities with:

- Topic-specific, action-oriented webinars facilitated by faculty and offering an opportunity for practices to learn from each other what is working to reach the program aims.
- Topic specific Action Groups in which practices work together in on-line communities to explore critical topic areas, new ideas and build capability to deliver comprehensive oncology care.
- In-person and virtual site visits to better understand how practices manage services, use evidence-based care, and practice patient-centered care.
- Use of an on-line portal to support learning through shared resources, tools, ideas, discussions, and the sharing of novel approaches supported by data.
- Virtual or in-practice coaching intended to support and offer strategies for overcoming barriers to improvement.

[7] The OCM Driver Diagram can be found in Appendix E.

L. Interaction with Other Initiatives

Medicare Shared Savings Program ACOs and Pioneer ACOs

While providers participating in a CMS model, program, or demonstration involving a shared savings component may not additionally participate in a Medicare Shared Savings Program (SSP) ACO,[8] participation in OCM would not preclude participation in an SSP or Pioneer ACO. As such, the potential for overlap between OCM and SSP ACO or Pioneer ACO providers and beneficiaries exists. OCM-FFS, SSP, and Pioneer ACO payment methodologies will account for such potential overlap to ensure that shared savings and performance based payments are not made for the same savings for the same beneficiary.

The OCM-FFS performance-based payments will be eligible for inclusion in SSP ACO and Pioneer ACO shared savings calculations. Neither SSP nor Pioneer ACO Model calculations will take into account OCM-FFS discount amounts, which represent Medicare savings. Thus, the Innovation Center will perform separate calculations to identify these amounts. If a portion of the OCM-FFS discount is paid out as shared savings to an ACO under SSP or the Pioneer ACO Model, the Innovation Center will recoup the portion from OCM participants who are part of that SSP or Pioneer ACO.

Transforming Clinical Practices Initiative (TCPI)

Contemporaneous dual participation in both TCPI and OCM would not be allowed. Participants must choose between participating in one model or the other.

CMS Quality Measures and Physician Quality Reporting System (PQRS)

OCM-FFS incorporates quality measures that address person- and caregiver-centered experience outcomes, communication and care coordination in its evaluation of practice performance. See Appendix C for a preliminary list of quality measures. A number of the quality measures that OCM-FFS may monitor and evaluate are PQRS measures, such as the Plan of Care for Pain and Pain Intensity Quantified (NQF #2100) measures. CMS plans to work with external stakeholders to identify a reasonable set of quality measures to ensure that a focus on quality of care is a primary consideration in the model.

Medicare and Medicaid EHR Incentive Programs

Participants in OCM must be committed to the effective use of health IT prior to participation. As part of OCM, participants must attest to meaningful use of ONC-certified EHR technology that will support Stage 2 meaningful use.[9] Eligible professionals who are part of OCM practices may be eligible to participate and receive the payments from the EHR Incentive Program if they meet the Incentive

[8] § 1899(b)(4)(A) of the Social Security Act

[9] The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms/.

Program timeline, and may also be subject to downward payment adjustments under Medicare beginning in CY 2015 for failure to demonstrate meaningful use.

By the end of the first performance year, practices would be required to use certified EHR technology that can support Stage 2 of meaningful use. By the end of the first performance year, eligible professionals in the practice would be required to attest to Stage 1 of meaningful use, with the intention of attesting to Stage 2 of meaningful use by the end of the third performance year. The OCM requirements related to meaningful use may be updated to align with any future CMS modifications to the program.

Future Initiatives

OCM may overlap with future Innovation Center models or CMS initiatives. Additional overlap methodologies will be developed on a case-by-case basis and communicated to OCM participants.

M. Waivers

The authority for this model is section 1115A of the Social Security Act (SSA). Under section 1115A(d)(1) of the SSA, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b). For this model and consistent with this standard, the Secretary may consider issuing waivers of certain fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the SSA. Waivers of sections 1848(a)(1), 1833(a)(1)(N), and 1833(b) will be necessary in order to make the PBPM payments and performance-based payments out of the Part B Trust Fund. Waivers are not being issued in this document; waivers, if any, would be set forth in separately issued documentation. Thus, notwithstanding any other provision of this RFA, individuals and entities must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued specifically for OCM pursuant to section 1115A(d)(1). Any such waiver would apply solely to OCM and could differ in scope or design from waivers granted for other programs or models.

N. Termination

The Innovation Center may terminate the model or a practice's or payer's participation in the model at any point during the five performance years. Reasons for termination could include but are not limited to poor performance, non-compliance with the terms and conditions of participation, failure to qualify for a performance-based payment by the end of the third performance year, sanctions and other program integrity matters, or if otherwise required under section 1115A(b)(3)(B) of the Social Security Act. The Innovation Center will provide adequate notice prior to termination. Specific reasons and procedures for termination will be clearly outlined in the practice participation agreement and payer MOU.

III. Eligibility Criteria for Practices and Payers

A. Eligible Payers

Payers may be commercial insurers, Medicare Advantage plans, states (through the Medicaid program, state employees program, or other insurance purchasing entity), Medicaid managed care plans, state or federal high-risk pools, self-insured businesses, or administrators of a self-insured group (Third Party Administrator (TPA)/Administrative Service Only (ASO)).

To be eligible for OCM, payers must be licensed to sell insurance in the state or states in which they implement the model and in good standing with the health insurance regulator of that state or states. Self-insured businesses do not need to meet this requirement, but must comply with all applicable federal laws and regulations.

To participate, payers must meet the following requirements:

Operational

- Commit to participation in OCM for its 5-year duration
- Sign a Memorandum of Understanding with the Innovation Center
- Enter into agreements with OCM practices that include requirements to provide high quality care
- Share model methodologies with the Innovation Center
- Provide payments to practices for enhanced services and performance as described in this RFA

Quality Improvement Measures

- Align practice quality and performance measures with OCM-FFS, when possible

Data Sharing

- Provide participating practices with aggregate and patient-level data about payment and utilization for their patients receiving care in OCM, at regular intervals

B. Eligible Practices

Physician group practices (PGPs) and solo practitioners that prescribe cancer chemotherapies and are currently enrolled in Medicare may apply for OCM-FFS. For OCM-FFS, the Innovation Center defines a PGP as a single legal entity operating primarily for the purpose of being a physician medical group and organized as a partnership, professional corporation, limited liability company, foundation, nonprofit corporation, faculty practice plan, or similar association. The single legal entity must employ or be owned by at least two physicians and/or NPPs.

All physicians and NPPs in the PGP, as defined above, who prescribe chemotherapy for cancer are included in the PGP's participation in OCM-FFS. All physicians and NPPs within the PGP who prescribe chemotherapy for cancer must reassign their individual national provider identifier (NPI) to the PGP for billing purposes.

Hospital-owned practices, including on- and off-campus provider-based departments, may apply to participate in OCM if the hospital is paid by Medicare under the inpatient and outpatient Prospective Payment Systems (PPS). However, as OCM is designed to primarily target transformation of independent physician-led practices, priority will be given to non-hospital-based entities in the event that CMS receives many more applications from practices than can be accepted in the model.

Practices owned by or formally affiliated with PPS-exempt cancer hospitals (section 1886(d)(1)(B)(v) of the Social Security Act) are not eligible to apply. Critical Access Hospitals, Rural Health Clinics, and Federally Qualified Health Centers also cannot apply. Additionally, PGPs that partner with these institutions for the provision of chemotherapy may not participate in OCM. Finally, Maryland hospitals participating in the Maryland All-Payer Model and any physician practice located in the state of Maryland are excluded.

Applicants will be screened to determine an applicant's eligibility to participate in this model. In addition, CMS may deny an application on the basis of information found during a program integrity review regarding the applicant, its affiliates, or any other relevant individuals or entities. Applicants are required to disclose any sanctions, investigations, probations or corrective action plans that have been imposed on the applicant in the last three years.

The Innovation Center will enter into participation agreements with each participating practice that will provide further detail about participation in the model. A practice may not participate without signing a participation agreement with the Innovation Center. Group or solo practices may apply to be grouped together with other practices for benchmarking purposes, but are individual participants in the model with individual agreements with the Innovation Center.[10]

IV. Practice Requirements

Participating practices must meet certain requirements to participate in the model and to continue to receive enhanced payment for care of their beneficiaries. All of the practice requirements must be met by the end of the first quarter of the performance period for a practice to maintain eligibility to participate in OCM. Practices must demonstrate their intent to meet EHR standards prior to participation, but they do not need to demonstrate that they have met the full requirement until the end of the first performance year. OCM practice requirements are as follows:

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

[10] For the purposes of payment, pooled practices would indicate a single practice to receive performance-based payments on behalf of the pool

Participating practices are required to provide OCM beneficiaries with 24 hours/7 days per week access to a clinician who has real-time access to patients' medical records. Clinicians may be nurses, NPPs, or physicians who can access patients' records through practices' EHRs. This may be in the form of remote access, including telephone access. This allows the managing practice to better address patient needs related to chemotherapy treatment, including side effects, and potentially reduces utilization of the emergency department (ED). Practices must attest to providing this round-the-clock clinical support during the model performance period.

2. Attestation and use of ONC-certified EHRs

Participating practices must demonstrate an increasing commitment to using electronic health records (EHR) throughout the performance years. Prior to the start of the first performance year, participating practices are required to demonstrate their intent to meaningfully use EHR technology certified under ONC's HIT Certification Program. By the end of the first performance year, eligible professionals in the practice must attest to Stage 1 of meaningful use, with the intention of attesting to Stage 2 of meaningful use by the end of the third performance year. The OCM requirements related to meaningful use may be updated to align with future CMS rulemaking.

The Certified Health IT Product List (CHPL) can be found at http://www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl. For resources regarding transitioning to EHR and demonstrating MU, consult Regional Extension Centers resources at http://www.healthit.gov/providers-professionals/rec-highlights.

3. Utilize data for continuous quality improvement

In order to promote and advance best practices, participating practices are required to collect and report data on several metrics. The Innovation Center will leverage claims data and the data reported by practices to provide actionable feedback in the form of regular monitoring reports to participating practices to support continuous quality improvement. Practices are also expected to utilize their own data along with the data in the monitoring reports to continuously improve their performance and achieve the goals of OCM.

4. Provide core functions of patient navigation

Participating practices are required to provide the core functions of patient navigation for all OCM beneficiaries. A sample list of activities associated with patient navigation from the National Cancer Institute is included in Appendix B.[11] Practices should provide a written description in their application Implementation Plan for how they will meet these requirements and must attest to following this plan during the model performance period.

5. Document a care plan that contains the 13 components in the Institute of Medicine Care Management Plan

[11] National Cancer Institute Center to Reduce Cancer Health Disparities. What are Patient Navigators? Available at: http://crchd.cancer.gov/pnp/what-are.html

Participating practices are required to document comprehensive cancer care plans for all of the patients in the model. The care plans must include the 13 elements identified in the Institute of Medicine Report, *Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis* (see Appendix A).[12] Patients should be engaged in the development of a care plan, including the decision of whether to initiate chemotherapy as a course of treatment. Initially, practices must attest to fulfilling this requirement. Practice agreements with CMS will include a timeline for moving towards more specific reporting for this requirement over the course of the model.

6. Treat patients with therapies consistent with nationally recognized clinical guidelines

Participating practices are encouraged to consult and use nationally recognized clinical guidelines for OCM beneficiaries. Practices will report when care is either consistent with clinical guidelines of the American Society of Clinical Oncology (ASCO) or the National Comprehensive Cancer Network (NCCN). When care is not in accordance with these guidelines due to specific clinical decision-making for a particular patient, practices must provide explanations for their treatment decisions. A patient's participation in a clinical trial may be one reason for deviating from clinical guidelines.

Practices may utilize pathways programs to fulfill this requirement, as long as the pathways are based on nationally recognized clinical guidelines. Practices should include their use (or proposed use) of oncology pathways programs in their OCM applications.

V. Submission of Letters of Intent and Applications

All practices and payers who wish to apply for participation in OCM-FFS must first submit a non-binding letter of intent (LOI). LOIs for interested payers are due by 5:00 pm EDT on **April 9, 2015**. LOIs for interested practices are due by 5:00 pm EDT on **May 7, 2015**. LOI forms are available for download on the Oncology Care Model website at http://innovation.cms.gov/initiatives/Oncology-Care/, and should be submitted by email to the Oncology Care Model inbox: OncologyCareModel@cms.hhs.gov.

Practices and payers that submit timely, complete LOIs will be eligible to submit applications. All applications must be submitted by 5:00 pm EDT on **June 30, 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. Templates of the applications are available for reference only on the Oncology Care Model website. Submission of the template versions of the applications will not be accepted.

Payers must submit their LOIs before practices to serve two purposes. The first is to allow the Innovation Center to determine the level of interest from payers and the geographic spread of the multi-payer model. The second is to publicly release information about which payers may participate in the model to inform prospective practice applicants. Information about which payers may participate may be useful to practices in determining whether to apply.

[12] Institute of Medicine Report. Levit L, Balogh E, Nass S and Ganz P, ed. Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis. 2013.

The Innovation Center will publicly post the list of payers who submit LOIs and agree to public posting on April 16, 2015, and will post the list of practices who submit LOIs and agree to public posting on May 14, 2015. These lists will appear on the OCM website at http://innovation.cms.gov/initiatives/Oncology-Care/ to allow interested payers and practices to engage with one another and coordinate participation in OCM. The postings will include the names, locations, and points of contact for payers and practices.

Complete payer applications will include:

- Signed Electronic Application Form
- Implementation Plan Narrative

Complete practice application 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

Questions

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

VI. Application Review and Selection Process

The Innovation Center will only consider applications for OCM-FFS from practices and payers that have submitted an LOI and application by the deadlines listed above. Each complete and eligible practice 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. CMS will select practices and payers to participate in OCM from among the most highly qualified applicants. In the event that CMS receives many more applications from practices than can be accepted into the model, priority will be given to independent physician-led practices. In addition to the criteria outlined in Table 1, CMS will seek to have a representative sample of participants in terms of size, geographic location, and other characteristics.

Practice application selection criteria are listed in the table below. The four selection criteria are worth a total of 100 points:

- Implementation Plan (40 points)
- Financial Plan (25 points)
- Participation with Other Payers (30 points)
- Diverse Populations (5 points)

Table 1 includes the practice selection criteria and information to include in the practice application for each section.

Table 1: Practice Selection Criteria

Selection Criteria	Information to Include in the Application	Points
Implementation Plan: Presentation of a realistic, sound, comprehensive OCM implementation plan that is based on current practice capabilities and addresses necessary changes to meet OCM objectives.	**Include in the Implementation Plan Narrative:** ❖ Full description of the practice's implementation plan for the first two performance years of OCM, including but not limited to: • Current uses of the following or other tools to achieve better outcomes, better care, and reduced expenditures for Medicare FFS beneficiaries. The practice's plans to continue to utilize or make changes to utilize these and other tools for the first two performance years in OCM-FFS to achieve the model objectives: o care coordination within the practice o care coordination with other health care providers o care coordination with relevant social services o patient navigator(s)/care coordinator(s) o extended hours o care plans o clinical decision support o compliance with ASCO or NCCN clinical guidelines o quality measurement and feedback o patient engagement o patient outreach and education o shared decision making, taking into account patient preferences o supporting health information technology infrastructure o other interventions • Practice requirements in section IV. of the RFA that the practice already meets, and its plans to meet the other practice requirements in OCM along with a clear and realistic timeline for meeting each requirement by the end of the first quarter of performance year one, including changes in necessary workflow, creation of new partnerships with other entities (for example, hospitals, primary care practices, other specialty physician practices, etc.), hiring and training of appropriate personnel, extending hours of access to care, etc. ❖ The likelihood that the practice's implementation plan will achieve savings for Medicare within the practice's OCM-FFS beneficiaries.	40

Selection Criteria	Information to Include in the Application	Points
Financial Plan: Demonstration of practice stability and soundness, as well as presentation of a realistic, sound, comprehensive OCM financial plan based on expected financial resources to support the implementation plan.	**Include in the Electronic Application Form:** ❖ Presentation of practice's percent revenues from the practice's top 10 payers over the preceding three years. **Include in the Financial Plan Narrative:** ❖ Description of any known or expected changes to practice revenue during the OCM performance years. If no changes are expected, the practice should indicate why in their description of their financial stability. ❖ Full description of the practice's financial plan to support the implementation plan for the first two performance years of OCM, including but not limited to: • OCM-FFS PBPM payments o Description of how these payments will be used to support the practice's implementation plan including practice transformation and meeting OCM practice requirements • Expected OCM-FFS performance-based payments (not paid until approximately 18 months into the performance period) o Realistic assessment of expected OCM-FFS performance-based payments based on current practice capabilities and expected changes in order to achieve OCM objectives • Expected enhanced and performance-based payments from other payers o Description of expected revenue from other payers participating in OCM-OP and how these payments will be used to support the practice's implementation plan • Practice investments o Description of how these payments will be used to support the practice's implementation plan • Other sources of revenue o Description of how these payments will be used to support the practice's implementation plan	25

Selection Criteria	Information to Include in the Application	Points
Participation with Other Payers: Demonstration of significant, realistic expected multi-payer participation in OCM covering a significant fraction of the practice's patients receiving chemotherapy.	**Include in the Electronic Application Form:** ❖ Presentation of the practice's chemotherapy patients that will be included in the model through participation in OCM with Medicare FFS and other payers. **Include Other Payers Letters of Support:** ❖ Attach a letter of support from each payer, other than Medicare FFS, with which the practice is applying to participate in OCM. • Letters of support should include a description of the payer's level of commitment to participate in OCM and to support the transformation of partnering practices. • If the practice is unable to obtain a letter of support from a payer, provide a narrative justification for not including a letter of support, including an explanation of how the practice is pursuing participation with the payer and why that payer's beneficiaries should be included in the application.	30
Diverse Populations: Demonstration that the practice manages care for diverse populations and populations with limited access to health care services and has a realistic, sound, comprehensive OCM plan for engaging these populations to address their needs.	**Include in the Electronic Application Form:** ❖ Information about practice locations in a Health Professional Shortage Area (HPSA) ❖ Patient demographics **Include in the Diverse Populations Narrative:** ❖ The practice's plan to treat and engage diverse and/or underserved populations during the course of OCM ❖ The practice's plan to treat and engage dual eligible beneficiaries during the course of OCM	5

Appendix A: Components of the Institute of Medicine Care Management Plan[13]

1. Patient information (e.g., name, date of birth, medication list, and allergies)
2. Diagnosis, including specific tissue information, relevant biomarkers, and stage
3. Prognosis
4. Treatment goals (curative, life-prolonging, symptom control, palliative care)
5. Initial plan for treatment and proposed duration, including specific chemotherapy drug names, doses, and schedule as well as surgery and radiation therapy (if applicable)
6. Expected response to treatment
7. Treatment benefits and harms, including common and rare toxicities and how to manage these toxicities, as well as short-term and late effects of treatment
8. Information on quality of life and a patient's likely experience with treatment
9. Who will take responsibility for specific aspects of a patient's care (e.g., the cancer care team, the primary care/geriatrics care team, or other care teams)
10. Advance care plans, including advanced directives and other legal documents
11. Estimated total and out-of-pocket costs of cancer treatment
12. A plan for addressing a patient's psychosocial health needs, including psychological, vocational, disability, legal, or financial concerns and their management
13. Survivorship plan, including a summary of treatment and information on recommended follow-up activities and surveillance, as well as risk reduction and health promotion activities

Appendix B: National Cancer Institute Sample Patient Navigation Activities [14]

1. Coordinating appointments with providers to ensure timely delivery of diagnostic and treatment services
2. Maintaining communication with patients, survivors, families, and the health care providers to monitor patient satisfaction with the cancer care experience
3. Ensuring that appropriate medical records are available at scheduled appointments
4. Arranging language translation or interpretation services
5. Facilitating financial support and helping with paperwork
6. Arranging transportation and/or child/elder care
7. Facilitating linkages to follow-up services
8. Community outreach
9. Providing access to clinical trials, and
10. Building partnerships with local agencies and groups (e.g., referrals to other services and/or cancer survivor support groups).

[13] Institute of Medicine Report. Levit L, Balogh E, Nass S and Ganz P, ed. Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis. 2013.
[14] National Cancer Institute Center to Reduce Cancer Health Disparities. Patient Navigator Research Program. Available at: http://www.cancer.gov/aboutnci/organization/crchd/disparities-research/pnrp

Appendix C: Preliminary List of Quality and Performance Measures

Purpose	Quality Domain	Recommended practice requirement or quality measurement	NQF #/ Federal Programs	Source
Practice Requirements		Percentage of beneficiaries who are treated with therapies consistent with nationally recognized clinical guidelines		Reported by Practice
		Provide and attest to 24 hour, 7 days a week patient access to appropriate clinician who has real-time access to practice's medical record		Reported by Practice
		Attestation and Use of ONC certified EHRs		Collected by CMS
		Participating practices must submit all quality measures required by the program team, including those for quality monitoring and performance-based payment listed below.		N/A
		Provide core functions of patient navigation		Reported by Practice
		Electronically document a care plan that contains the 13 components in the IOM Care Management Plan		Reported by Practice
Performance-based payment	Communication and Care Coordination	Number of emergency department visits per attributed OCM-FFS beneficiary per OCM-FFS episode (Risk adjusted)		National Claims Data
		Number of hospital admissions per attributed OCM-FFS beneficiaries per OCM-FFS episode for (Risk adjusted)		National Claims Data
		Percentage of all Medicare FFS beneficiaries managed by a practice who are admitted to hospice for less than 3 days in the last 30 days of life	#0216	National Claims Data
		Percentage of all Medicare FFS beneficiaries managed by a practice who experience more than one emergency department visit in the last 30 days of life	#0211	National Claims Data
	Person-and Caregiver- Centered Experience and Outcomes	Percentage of OCM-FFS beneficiary face-to-face visits to the participating practice in which there is a documented plan of care for pain AND pain intensity is quantified	#2100/MU Stage 2, PQRS	Reported by Practice

Purpose	Quality Domain	Recommended practice requirement or quality measurement	NQF #/ Federal Programs	Source
Performance-based payment	Person-and Caregiver-Centered Experience and Outcomes	Score on patient experience survey (CAHPS as modified by the evaluation contractor)		Collected by CMS
		Percentage of OCM-FFS beneficiary face-to-face visits in which the patient is assessed by an approved patient-reported outcomes tool. This would include a minimum of the PROMIS tool short forms for anxiety, depression, fatigue, pain interference, and physical function		Reported by Practice
		Percentage of OCM-FFS beneficiaries that receive psychosocial screening and intervention at least once per OCM-FFS episode		Reported by Practice
Quality Monitoring	Communication and Care Coordination	Percentage of OCM-FFS beneficiaries with least one palliative care consultation per OCM-FFS episode		Reported by Practice
		Mortality rates of OCM-FFS beneficiaries, risk adjusted		National Claims Data
		Number of emergency department visits per OCM-FFS beneficiary in the 6 months following the OCM-FFS episode		National Claims Data
		Number of hospital admissions per OCM-FFS beneficiary in the 6 months following the OCM-FFS episode		National Claims Data
		Number of hospital readmissions per OCM-FFS beneficiary during the OCM-FFS episode and the following 6 months	#1789/ Hospital Inpatient Quality Reporting	National Claims Data
		Number of ICU admissions per OCM-FFS beneficiary during the OCM-FFS episode and the following 6 months		National Claims Data
		Proportion of all Medicare FFS beneficiaries managed by a practice not admitted to hospice	#0215	National Claims Data
		Proportion of all Medicare FFS beneficiaries managed by a practice receiving chemotherapy in the last 14 days of life	#0210	National Claims Data

Purpose	Quality Domain	Recommended practice requirement or quality measurement	NQF #/ Federal Programs	Source
Quality Monitoring	Communication and Care Coordination	Percentage of attributed OCM-FFS beneficiaries that receive a follow-up visit from the participating practice within 7 days after discharge from any inpatient hospitalization		National Claims Data
		Percentage of face-to-face encounters between an attributed OCM-FFS beneficiary and a participating practice which include medication reconciliation		Reported by practice
	Clinical Quality of Care	Breast Cancer: Hormonal therapy for Stage IC-IIIC (ER/PR) Positive Cancer in OCM-FFS beneficiaries	#0387/ MU Stage 2, PQRS	Reported by practice
		Breast Cancer: Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or Stage III hormone receptor negative breast cancer in OCM-FFS beneficiaries	#0559/ PPS-Exempt Hospital Reporting	Reported by practice
		Colon Cancer: Chemotherapy for Stage IIIA through Stage IIIC OCM-FFS beneficiaries with colon cancer	#0385/MU Stage 2, PQRS	Reported by practice
		Colon Cancer: Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to OCM-FFS beneficiaries under the age of 80 with AJCC III (lymph node positive) colon cancer	#0223/ PPS-Exempt Hospital Reporting	Reported by practice
		Prostate Cancer: Adjuvant hormonal therapy for high-risk OCM-FFS beneficiaries	#0390/ PQRS	Reported by practice
		Percentage of OCM-FFS beneficiaries with documented ECOG, Karnofsky, or WHO performance status assessment prior to OCM-FFS episode initiation and at episode conclusion		Reported by practice
	Population Health	Percentage of OCM-FFS beneficiaries that receive tobacco screening and cessation intervention at least once per OCM-FFS episode	#0028/ MU Stage 2, PQRS	Reported by Practice
		Percentage of OCM-FFS beneficiaries that have an Influenza Immunization	#0041/ MU Stage 2, PQRS	National Claims Data

Purpose	Quality Domain	Recommended practice requirement or quality measurement	NQF #/ Federal Programs	Source
Quality Monitoring	Population Health	Number of OCM-FFS beneficiaries enrolled in clinical trials at any point during an OCM-FFS episode		National Claims Data
	Efficiency and Cost Reduction	Prescription drug utilization under Medicare Part B and Part D		National Claims Data
		Radiation utilization by OCM-FFS beneficiaries		National Claims Data
		Imaging utilization by OCM-FFS beneficiaries		National Claims Data
		Post-acute provider utilization by OCM-FFS beneficiaries		National Claims Data
		Therapy service utilization by OCM-FFS beneficiaries		National Claims Data
		Home health services utilization by OCM-FFS beneficiaries		National Claims Data

Appendix D: Preliminary List of Chemotherapy Drugs

Chemotherapy Drugs

Standardized Drug Active Ingredient Name
ABIRATERONE
ADO-TRASTUZUMAB
AFATINIB
ALDESLEUKIN
ALTRETAMINE
ANASTROZOLE
ANTINEO, NOC
ARSENIC TRIOXIDE
ASPARAGINASE
AXITINIB
AZACITIDINE
BELINOSTAT
BENDAMUSTINE
BEXAROTENE
BLEOMYCIN
BLINATUMOMAB
BORTEZOMIB
BOSUTINIB
BRENTUXIMAB
BUSULFAN
CABAZITAXEL
CABOZANTINIB
CAPECITABINE
CARBOPLATIN
CARFILZOMIB
CARMUSTINE
CERITINIB
CETUXIMAB
CHEMO, NOC
CISPLATIN
CLADRIBINE
CLOFARABINE
CRIZOTINIB
CYCLOPHOSPHAMIDE
CYTARABINE
DABRAFENIB
DACARBAZINE

Standardized Drug Active Ingredient Name
DACTINOMYCIN
DASATINIB
DAUNORUBICIN
DECITABINE
DEGARELIX
DENILEUKIN
DOCETAXEL
DOXORUBICIN
ENZALUTAMIDE
EPIRUBICIN
ERIBULIN
ERLOTINIB
ESTRAMUSTINE
ETOPOSIDE
EXEMESTANE
FLOXURIDINE
FLUOROURACIL
FLUTAMIDE
FULVESTRANT
GEMCITABINE
GOSERELIN
HISTRELIN
IBRITUMOMAB
IBRUTINIB
IDARUBICIN
IFOSFAMIDE
IDELALISIB
IMATINIB
IPILIMUMAB
IRINOTECAN
IXABEPILONE
LANREOTIDE
LAPATINIB
LETROZOLE
LEUPROLIDE
LOMUSTINE
MECHLORETHAMINE
MELPHALAN
MITOMYCIN
MITOTANE
NELARABINE
NILUTAMIDE

Standardized Drug Active Ingredient Name
NIVOLUMAB
OBINUTUZUMAB
OFATUMUMAB
OLAPARIB
OMACETAXINE
OXALIPLATIN
PACLITAXEL
PALBOCICLIB
PANITUMUMAB
PAZOPANIB
PEGASPARGASE
PEMBROLIZUMAB
PEMETREXED
PENTOSTATIN
PERTUZUMAB
POMALIDOMIDE
PONATINIB HYDROCHLORIDE
PORFIMER SODIUM
PRALATREXATE
PROCARBAZINE
RAMUCIRUMAB
REGORAFENIB
ROMIDEPSIN
RUXOLITINIB
SORAFENIB
STREPTOZOTOCIN
SUNITINIB
TEMOZOLOMIDE
TEMSIROLIMUS
TENIPOSIDE
THIOTEPA
TOPOTECAN
TOREMIFENE
TRAMETINIB
TRASTUZUMAB
TRIPTORELIN
VALRUBICIN
VANDETANIB
VEMURAFENIB
VINBLASTINE
VINCRISTINE
VINORELBINE

Standardized Drug Active Ingredient Name
VISMODEGIB
VORINOSTAT

Possible Chemotherapy Drugs

Standardized Drug Active Ingredient Name
BEVACIZUMAB
BICALUTAMIDE
CHLORAMBUCIL
DIETHYLSTILBESTROL
EVEROLIMUS
HYDROXYUREA
INTERFERON ALFA-2B,RECOMB.
INTERFERON, ALFA-2A
LENALIDOMIDE
LEUCOVORIN
MERCAPTOPURINE
METHOTREXATE
MITOXANTRONE
NILOTINIB
PEGINTERFERON ALFA-2B
RITUXIMAB
TAMOXIFEN CITRATE
THALIDOMIDE
THIOGUANINE
TRETINOIN
ZIV-AFLIBERCEPT

*For the purposes of triggering a chemotherapy episode, the list of chemotherapies excludes topical formulations, such as fluorouracil and tretinoin cream.
**The “possible chemotherapy” categorization describes chemotherapy drugs that are often used to treat cancer, but may have other important indications, such as treatment of autoimmune diseases.

Appendix E: Driver Diagram