# September 22 CMS Quality Vendor Workgroup

September 22, 2016
12:00 – 1:30 p.m. ET

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

# Agenda

| Topic | Speaker |
|---|---|
| **Inpatient Rehabilitation Facility and Long-Term Care Hospital Preview Reports** | **Kathleen Johnson on behalf of Amanda Barnes**<br>*Division of Chronic and Post-Acute Care (DCPAC),CMS* |
| **Working to Improve Cyber Security** | **Mikki Smith**<br>*Office of the Chief Privacy Officer (OCPO), ONC* |
| **Medicare & Medicaid EHR Incentive Programs Update** | **Kathleen Johnson**<br>*Division of Health Information Technology (DHIT), CMS* |
| **Ransomware and Breach** | **Nick Heesters**<br>*Office for Civil Rights (OCR), HHS* |
| **Hospital Inpatient Quality Reporting Program (HIQR)** | **Artrina Sturges**<br>*Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR), CMS* |
| **Oncology Care Model** | **Andrew York and Katie Cox**<br>*Division of Ambulatory Care Models, CMMI* |
| Questions | |

# Inpatient Rehabilitation Facility and Long-Term Care Hospital Preview Reports

Kathleen Johnson on behalf of Amanda Barnes

*Division of Chronic and Post-Acute Care (DCPAC),CMS*

# Inpatient Rehabilitation Facility and Long-Term Care Hospital Preview Reports

*IRF and LTCH QRP Provider Preview Reports Now Available*

- IRF and LTCH QRP Provider Preview Reports are available until **September 30, 2016.**

- Review your performance data on each quality measure prior to public display on the IRF or LTCH Compare websites.

- Corrections to the underlying data will not be permitted during this time. However, you can request a CMS review during the 30-day preview period if you believe the data are inaccurate.

# Inpatient Rehabilitation Facility and Long-Term Care Hospital Preview Reports

*For More Information*

- IRF Quality Public Reporting webpage and Preview Report Access Instructions
- LTCH Quality Public Reporting webpage and Preview Report Access Instructions
- IRF QRP Help Desk - IRF.questions@cms.hhs.gov
- LTCH Help Desk - LTCHQualityQuestions@cms.hhs.gov

# Working to Improve Cyber Security

Mikki Smith

*Office of the Chief Privacy Officer (OCPO), ONC*

# October is Cyber Security Month

- ONC working to improve security in the Cyberhood
  - **Why:**
    - In an ***interoperable, interconnected health system***, an intrusion in one system could allow intrusions in other systems
    - ***volume, timeliness, and quality***
    - ***Better information yields better prevention***
  - **How:**
    - Grants to expand threat sharing
    - HHS Healthcare Cyber Information Sharing Task Force

# Working to Improve Cyber Security

*For More Information*

To contact the HHS Healthcare and Public Health Coordinating Council (HPH), e-mail Steve Curren at Steve.curren@hhs.gov.

# Medicare & Medicaid EHR Incentive Programs Update

Kathleen Johnson

*Division of Health Information Technology (DHIT), CMS*

# Medicare & Medicaid EHR Incentive Programs Update

*Frequently Asked Questions about 2016 EHR Incentive Program Requirements*

- Last month CMS hosted webinars for eligible professionals (EPs), and eligible hospitals and critical access hospitals (CAHs) to explain the requirements providers must meet to successfully participate in the EHR Incentive Programs in 2016, based on the October 2015 final rule.

- The following slides provide clarification on a few of the most common questions we received on the August webinars.

- Visit the EHR Events page on the CMS website to view each webinar.

# Medicare & Medicaid EHR Incentive Programs Update

*Frequently Asked Questions about 2016 EHR Incentive Program Requirements*

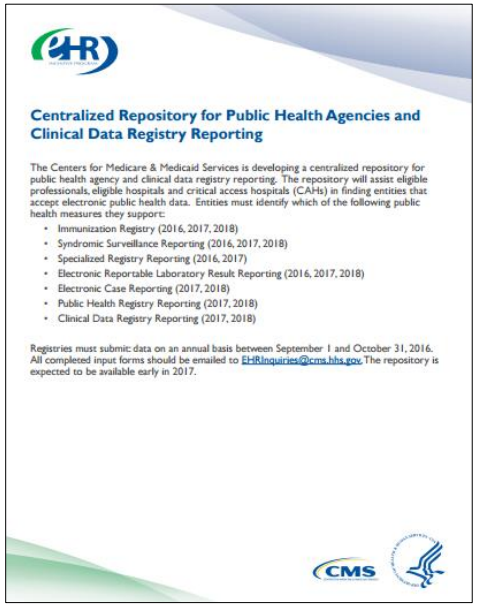
- Q1: What type of providers are considered first-time attesters?
- Q2: When is the attestation period for first-time participants in the EHR Incentive Programs?
- Q3: What are the exclusions and alternate exclusions for the Public Health Reporting objective?
- Q4: If a provider reports on clinical quality measures (CQMs) using the Physician Quality Reporting System (PQRS), do they also have to report on CQMs via attestation to meet the EHR Incentive Program requirements?
- Q5: Is Stage 3 of the EHR Incentive Programs going away?

# Medicare & Medicaid EHR Incentive Programs Update

*Centralized Repository for Public Health Agencies and Clinical Data Registry reporting*

- The Centers for Medicare & Medicaid Services (CMS) is developing a centralized repository for public health agency (PHA) and clinical data registry (CDR) reporting to assist providers in finding entities that accept electronic public health data.

- CMS is asking registries to declare their readiness to receive electronic data by completing the Centralized Repository for Public Health Agencies and Clinical Data Registry Reporting Input Form.



**Centralized Repository for Public Health Agencies and Clinical Data Registry Reporting**

The Centers for Medicare & Medicaid Services is developing a centralized repository for public health agency and clinical data registry reporting. The repository will assist eligible professionals, eligible hospitals and critical access hospitals (CAHs) in finding entities that accept electronic public health data. Entities must identify which of the following public health measures they support:

- Immunization Registry (2016, 2017, 2018)
- Syndromic Surveillance Reporting (2016, 2017, 2018)
- Specialized Registry Reporting (2016, 2017)
- Electronic Reportable Laboratory Result Reporting (2016, 2017, 2018)
- Electronic Case Reporting (2017, 2018)
- Public Health Registry Reporting (2017, 2018)
- Clinical Data Registry Reporting (2017, 2018)

Registries must submit data on an annual basis between September 1 and October 31, 2016. All completed input forms should be emailed to EHRInquiries@cms.hhs.gov. The repository is expected to be available early in 2017.

# Medicare & Medicaid EHR Incentive Programs Update

*Centralized Repository for Public Health Agencies and Clinical Data Registry reporting*

Registries must identify which of the following public health measures they support by **October 31, 2016**:

- Immunization Registry
- Syndromic Surveillance Reporting
- Specialized Registry Reporting
- Electronic Reportable Laboratory Result Reporting
- Electronic Case Reporting
- Public Health Registry Reporting
- Clinical Data Registry Reporting

All completed input forms should be emailed to EHRInquiries@cms.hhs.gov.

# Medicare & Medicaid EHR Incentive Programs Update

*2016 National Health IT Week*

National Health IT Week is **September 26-30, 2016**. This year's theme: "Expanding the Value of Health IT."

Use the **#NHITWeek** hashtag to participate in the conversation on social media and visit the National Health IT Week website for a list of events and more information on ways you can get involved.

NATIONAL HEALTH IT WEEK
*Expanding the Value of Health IT*

ENGAGE

Event Hashtag: #NHITWeek

# Medicare & Medicaid EHR Incentive Programs Update

*For More Information*

For more information about the EHR Incentive Programs, visit the CMS website or e-mail CMS at EHRInquiries@cms.hhs.gov.

# Ransomware and Breach

Nick Heesters

*Office for Civil Rights (OCR), HHS*

Agenda:

- Ransomware
- Ransomware Prevention
- Ransomware Recovery
- Breach Review
- Ransomware and Security Incidents
- Ransomware and Breaches
- Resources

- Ransomware is a type of malware (malicious software) that denies access to data by encrypting the data with a key known only to the attacker who deployed the ransomware.
- After a user's data is encrypted, the ransomware directs the user to pay a ransom (usually in a cryptocurrency, such as Bitcoin) in order to receive the key to decrypt the user's data.
- Even if ransom is paid, the ransomware attacker may not provide the key to decrypt the data or may increase ransom demands.
- As of September 1, 2016 one Bitcoin was worth approximately $570.

Ransomware Prevention:

- Security awareness and training
  - Processes are in place to detect/guard against malicious software
  - Train workforce how to detect and report malicious software
- Risk analysis
  - Identify the risks and vulnerabilities to the confidentiality, integrity, and availability of all ePHI entities create, receive, maintain, or transmit
- Risk management
  - Implement security measures sufficient to reduce identified threats and vulnerabilities to a reasonable and appropriate level
- Access controls
  - Ensure access rights granted are not excessive
- Business Associate Agreements
  - Define processes, including responsibilities, to prevent, manage and report security incidents and breaches

Ransomware Recovery:

- Security incident response
  - Prepare for security incidents ahead of time
    - Define teams and activities
  - Detect and conduct initial analysis of incident
    - Identify scope of incident
    - Determine origination (who/what/where/when)
    - Determine if incident has concluded or is ongoing
    - Determine how incident occurred
  - Contain the impact and propagation of the incident
  - Eradicate the incident and vulnerabilities which may have permitted its ingress and/or propagation
  - Recover from incident (restore lost data, return to business as usual)
  - Post-incident activities which could include responding to regulatory and/or contractual obligations as a result of breach

Ransomware Recovery:

- Contingency plans
  - Data backup plans
  - Disaster recovery plans
  - Emergency operations mode plans
  - Testing and revision procedures
    - Conduct test restorations to verify the integrity of backed up data and provide confidence in data restoration capabilities
    - Testing contingency plans to ensure organizational readiness and provide confidence that contingency plans would be effective
    - Revise contingency plans if tests show areas which would be ineffective
  - Application and data criticality analysis
    - Ensure all critical applications and data are accounted for as part of the contingency plans

- Breach

  The acquisition, access, use, or disclosure of PHI in a manner not permitted by the HIPAA Privacy Rule which compromises the security or privacy of the PHI.

- Presumption

  The breach is presumed and requires notification to individuals and HHS (and to the media for large breaches) unless the entity demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment.

# Breach Risk Assessment:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person who used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed; and
- The extent to which the risk to the protected health information has been mitigated.

# Security Incident:

- A security incident under the HIPAA Rules is "…the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system." See 45 C.F.R. 164.304.
- The presence of ransomware on a covered entity's or business associate's computer systems is a security incident.
- If a ransomware attack is detected the affected entity should immediately activate its security incident response plan, which should include measures to isolate the infected computer systems in order to halt propagation of the attack.

# Breach:

- A breach under the HIPAA Rules is "…the acquisition, access, use, or disclosure of PHI in a manner not permitted under the [HIPAA Privacy Rule] which compromises the security or privacy of the PHI."

- When ePHI is encrypted as the result of a ransomware attack, a breach has occurred because the ePHI encrypted by the ransomware was acquired (i.e., unauthorized individuals have taken possession or control of the information), and thus is a "disclosure" not permitted under the HIPAA Privacy Rule.

# Breach Notification:

- Unless the covered entity or business associate can demonstrate that there is a "…low probability that the PHI has been compromised," based on the factors set forth in the Breach Notification Rule, a breach of PHI is presumed to have occurred.
- The entity must then comply with the applicable breach notification provisions, including notification to affected individuals without unreasonable delay, to the Secretary of HHS, and to the media (for breaches affecting over 500 individuals) in accordance with HIPAA breach notification requirements. See 45 C.F.R. 164.400-414

# Breach Documentation:

- The breach risk assessment must be thorough, completed in good faith and reach conclusions that are reasonable given the circumstances.
- Covered entities and business associates must maintain supporting documentation sufficient to meet their burden of proof (see 45 C.F.R. 164.414) regarding the breach risk assessment – and if applicable, notification process including:
  - documentation of the risk assessment demonstrating the conclusions reached;
  - documentation of any exceptions determined to be applicable (see 45 C.F.R. 164.402(1)); and
  - documentation demonstrating that all notifications were made, if a determination was made that the impermissible use or disclosure was a reportable breach.

# Ransomware and Breach

*For More Information*

Ransomware Guidance

- http://www.hhs.gov/sites/default/files/RansomwareFactSheet.pdf

Breach Notification/Reporting Resources

- http://www.hhs.gov/hipaa/for-professionals/breach-notification/index.html
- http://www.hhs.gov/hipaa/for-professionals/breach-notification/breach-reporting/index.html
- https://ocrportal.hhs.gov/ocr/breach/wizard_breach.jsf

# Ransomware and Breach

*For More Information*

App Developer Portal

- http://hipaaqsportal.hhs.gov/

HIPAA Security Rule Resources

- http://www.hhs.gov/hipaa/for-professionals/security/guidance/

HIPAA FAQs

- http://www.hhs.gov/hipaa/for-professionals/faq

Privacy and Security ListServ

- http://www.hhs.gov/hipaa/for-professionals/list-serve/

# Hospital Inpatient Quality Reporting (HIQR) Update

Artrina Sturges, EdD

*Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)*

*Outreach and Education Support Contractor (SC)*

# Hospital Inpatient Quality Reporting (HIQR) Update

*CY 2016 CMS Data Receiving System Updates*

**Test** Quality Reporting Document Architecture (QRDA) Category I Files

- Receiving system currently accepting test files
- System will remain open until at least February 28, 2017

**Production** QRDA Category I Files

- Receiving system opens October 1, 2016
- System will remain open until at least February 28, 2017

# Hospital Inpatient Quality Reporting (HIQR) Update

*Pre-Submission Validation Application (PSVA) Tool Updates*

The PSVA Tool is:

- Available to process both test and production QRDA Category I files through at least February 28, 2017
- In current version 1.1.2
- Scheduled to Update (detailed tool) as 1.2 for late September 2016

# Hospital Inpatient Quality Reporting (HIQR) Update

*September 2016 ListServe Distributions*

- 9/1/16 − eCQM Receiving System Accepting Production Files Beginning October 1, 2016
- 9/12/16 − QRDA Category I File Errors – CONF CMS_0060 and CONF CMS_0062
- 9/13/16 − Updated Pre-Submission Validation Application (PSVA) Tool Available late September 2016
- 9/14/16 − Upgrading Java Version in preparation for Updated Pre-Submission Validation Application (PSVA) Tool Available Beginning September 21, 2016

To ensure you're receiving program updates, please visit the QualityNet.org website and locate the 'Join Listserves' tab on the left side of the main page

# Hospital Inpatient Quality Reporting (HIQR) Update

*Frequently Asked Question #1 − Expectations for Submitting Rejected Production Files*

**Question:**

- If 800 QRDA Category I files were submitted and accepted as production files into the warehouse, satisfying the definition of successful submission, and if 75 of the files were rejected, would those 75 be required to be re-submitted? Or, is the re-submission of those files optional for the CY 2016 reporting requirement to the IQR and Medicare EHR Incentive Programs?

**Answer:**

- CMS expects that eCQM reporting is reflective of the total patient population. In this scenario, if the 75 rejected QRDA Category I files meet the criteria to be included for reporting, the errors should be addressed, and the corrected files should be resubmitted to fulfill quality reporting activities.

# Hospital Inpatient Quality Reporting (HIQR) Update

*Frequently Asked Question #2 – JAVA Language Argument Exception using the PSVA Tool*

**Question:**

- When I attempt to validate our QRDA Category I file in the PSVA tool, we receive an error message regarding validation, “JAVA language argument exception.” I am unable to locate this error message in the user manual. What does this mean and how do I correct it?

**Answer:**

- This error occurs when the submitter is attempting to pre-validate a zip file that contains a subdirectory. The most likely scenario occurs when the submitter places the QRDA files into a file folder and then zips the folder. To remedy this error, we suggest removing the files from the zip and re-zip the QRDA files without the file folder. If you have additional questions, please contact the QualityNet Help Desk (Qnetsupport@hcqis.org 1-866-288-8912).

# Hospital Inpatient Quality Reporting (HIQR) Update

*Frequently Asked Question #3 – Troubleshooting Data Type Validation Error*

**Question:**

- If we have an ERROR that *QualityNet* has not provided a CONF#, but only has the following: (Rule: validate_ST). What is the suggested action? The error is: "ERROR: Data types of ST SHALL either not be empty or have @nullFlavor (Rule: validate_ST)."

**Answer:**

- There are several other Schematron data type validation rules similar to this that are not documented in the 2016 CMS Implementation Guide. However, the CMS QRDA HQR 2017 Implementation Guide , available on the CMS eCQM Library, provides a table in an appendix that lists the "Null Flavor Validation Rules for Data Types" with a little more information. To help you troubleshoot any data type validation error similar to this (e.g., Channel Definition (CD), Coded Element (CE), etc.), please contact the *QualityNet* Help Desk (qnetsupport@hcqis.org or 1-866-288-8912) and include the file submitted and any reports you may have run.

# Hospital Inpatient Quality Reporting (HIQR) Update

*Frequently Asked Question #4 – Patient Data Section Conformance Error*

**Question:**

- We have been receiving the error "SHALL contain exactly one [1..1] text (CONF:67-3867)." Can you elaborate on what this might be?

**Answer:**

- This error is from the Patient Data Section of the QRDA Category I. The HL7 specification requires the presence of a <text> element. However, no validation is performed on the actual content provided. The examples provided in the QRDA Supplementary Implementation Guide for 2016, the QRDA Appendix, and sample files describe how the table would be created with headings, rows, columns, and borders to be displayed. For testing purposes, you could supply an empty tag, such as “<text></text>” to get through validation. For additional information, please reference the HL7 CDA® R2 Implementation Guide: Quality Reporting Document Architecture - Category I (QRDA I) DSTU Release 3 (US Realm) on the HL7 website.

# Hospital Inpatient Quality Reporting (HIQR) Update

*Frequently Asked Question #5 – Penalty for Failing to Meet IQR Reporting Requirements*

**Question:**

- What is the penalty for not reporting eCQMs to the Hospital IQR Program for CY 2016?

**Answer:**

- Hospitals that do not participate, or participate but fail to meet Hospital IQR Program requirements, receive a one-fourth reduction in the applicable percentage increase on their Annual Payment Update (APU) for the applicable payment year. Please visit the Qualitynet.org website to help ensure that you are fulfilling all the requirements for the IQR Program. IQR Program and Policy questions can be addressed by two methods: https://cms-ip.custhelp.com or by phone 1-866-800-8765 or 1-844-472-4477.

# Hospital Inpatient Quality Reporting (HIQR) Update

*FY 2017 IPPS/LTCH PPS Final Rule Presentations*

- FY 2017 IPPS/LTCH PPS Final Rule – August 29, 2016
- FY 2017 IPPS/LTCH PPS Final Rule: IQR-EHR Incentive Program Requirements – September 12, 2016

The http://www.qualityreportingcenter.com/ website contains archived webinar materials, helpful tools, and information on upcoming presentations.

# Hospital Inpatient Quality Reporting (HIQR) Update

*For More Information*

***QualityNet* Help Desk – PSVA and Data Upload**

- Qnetsupport@hcqis.org
- 1-866-288-8912, 7 AM - 7 PM CT, Monday through Friday

**eCQM General Program Questions – IQR Program & Policy**

- https://cms-ip.custhelp.com
- 1-866-800-8765 or 1-844-472-4477, 7 AM–7 PM CT Monday through Friday (except holidays)

**EHR (Meaningful Use) Information Center – EHR Incentive Program**

- 1-888-734-6433, 7:30 AM – 6:30 PM, CT Monday through Friday

**JIRA – Office of the National Coordinator for Health Information Technology (ONC) Project Tracking System**

- http://oncprojectracking.org
- Resource to submit questions and comments regarding:
  - Issues identified with eCQM logic
  - Clarification on specifications
  - The QRDA IG for the applicable year

# Oncology Care Model Overview

Andrew York and Katie Cox

*Division of Ambulatory Care Models, CMMI*

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# Oncology Care Model Overview

*Centers for Medicare & Medicaid Services Innovation Center (CMMI)*

*September 2016*

# Innovation at CMS

## Center for Medicare & Medicaid Innovation (Innovation Center)

- Established by section 1115A of the Social Security Act (as added by Section 3021 of the Affordable Care Act)
- Created for purpose of developing and testing innovative health care payment and service delivery models within Medicare, Medicaid, and CHIP programs nationwide

## Innovation Center priorities:

- Test new payment and service delivery models
- Evaluate results and advance best practices
- Engage a broad range of stakeholders to develop additional models for testing

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# Innovation Center Models

**Goals of Innovation Center models:**

- Better care
- Smarter spending
- Healthier people

**Models range in focus, including:**

- Accountable Care Organizations
- Primary Care Transformation
- Bundled Payments for Care Improvement
- State-Based Innovation

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# Oncology Care Model Background

- The Innovation Center also focuses on specialty care, including improving the effectiveness and efficiency of oncology care.
- In 2016, more than 1.6 million new cases of cancer will be diagnosed, and cancer will kill an estimated 600,000 Americans in 2016. A significant proportion of those diagnosed are over 65 years old and Medicare beneficiaries.
- According to the NIH, based on growth and the aging of the U.S. population, medical expenditures for cancer in the year 2020 are projected to reach at least $158 billion (in 2010 dollars) – an increase of 27 percent over 2010.
- The Innovation Center is pursuing the opportunity to further its goals of better care, smarter spending, healthier people through an oncology payment model.

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# Oncology Care Model (OCM)

- The Innovation Center's Oncology Care Model (OCM) focuses on episodes of cancer care that include chemotherapy
- The goals of OCM are to utilize appropriately aligned financial incentives to improve:
    1) Care coordination
    2) Appropriateness of care
    3) Access for beneficiaries undergoing chemotherapy
- Financial incentives encourage participating practices to work collaboratively with other providers to comprehensively address the complex care needs of beneficiaries receiving chemotherapy treatment, and encourage the use of services that improve health outcomes.

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# OCM Overview

**Episode-based**

Payment model targets chemotherapy and related care during a 6-month period that begins with receipt of chemotherapy treatment

**Emphasizes practice transformation**

Physician practices are required to implement “practice redesign activities” to improve the quality of care they deliver

**Multi-payer model**

Includes Medicare fee-for-service and other payers working in tandem to leverage the opportunity to transform care for oncology patients across the practice’s population

**Timeline: July 1, 2016-June 30, 2021**

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# Practice Redesign Activities

1) **Provide Enhanced Services**
   - Provide OCM Beneficiaries with 24/7 access to an appropriate clinician who has real-time access to the Practice's medical records
   - Provide the core functions of patient navigation to OCM Beneficiaries
   - Document a care plan for each OCM Beneficiary that contains the 13 components in the Institute of Medicine Care Management Plan
   - Treat OCM Beneficiaries with therapies that are consistent with nationally recognized clinical guidelines

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# Practice Redesign Activities (cont.)

**2) Use certified electronic health record technology (CEHRT)**

OCM Practices must use CEHRT in a manner sufficient to meet the requirements of an "eligible alternative payment entity" under the MACRA rule implementing the Quality Payment Program.

**3) Utilize data for continuous quality improvement**

Practices must collect and report clinical and quality data to the Innovation Center. In addition, the Innovation Center will provide participating practices with feedback reports for practices to use to continuously improve OCM patient care management.

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# OCM Practices

- Nearly 200 oncology practices are participating in OCM.
- OCM Practices:
  - Medicare-enrolled physician groups identified by a single Taxpayer Identification Number (TIN)
  - Composed of one or more physicians who treat Medicare beneficiaries diagnosed with cancer
  - Cover urban, suburban and rural areas
  - Range in size from solo oncologists to large practices with hundreds of providers

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# OCM Payers

- 17 commercial insurers are supporting OCM practices in their practice transformation efforts; payers include regional and national organizations
- The goal of multi-payer participation is to provide aligned financial support and quality measurement across a practice's patient population, in order to facilitate whole practice change
- CMS and the OCM payers will convene regularly throughout the model to share lessons learned on engaging in alternative payment model work that supports oncology practice transformation

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# OCM Payer Alignment

- OCM payers are aligning their models with the Medicare FFS arm of OCM (OCM-FFS) in the following ways:
  - Provide payments for enhanced services and for performance
  - Include patients receiving chemotherapy as a focus of the model
  - Require similar practice requirements
  - Share data with participating practices
  - Align with CMS on a core quality measure set

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# OCM-FFS Beneficiary Population

Medicare beneficiaries who meet each of the following criteria for the entire 6-month episode are included in OCM-FFS:

- Enrolled in Medicare Parts A and B;
- Does not receive the Medicare End Stage Renal Disease (ESRD) benefit;
- Medicare as his or her primary payer;
- Not covered under Medicare Advantage or any other group health program;
- Received an included chemotherapy treatment for cancer; and
- Has at least one Evaluation & Management (E&M) visit with an included cancer diagnosis during the 6 months of the episode.

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# OCM-FFS Episode Definition

## Types of cancer

- OCM-FFS includes nearly all cancer types (see Cancer Code List on website)

## Episode initiation

- Episodes initiate when a beneficiary receives a qualifying chemotherapy drug
- The list of qualifying chemotherapy drugs that trigger OCM-FFS episodes includes endocrine therapies but excludes topical formulations of drugs

## Included services

- All Medicare A and B services that Medicare FFS beneficiaries receive during the episode
- Certain Part D expenditures are also included: the Low Income Cost Sharing Subsidy (LICS) amount and 80 percent of the Gross Drug Cost above the Catastrophic (GDCA) threshold

## Episode duration

- OCM-FFS episodes extend six months after a beneficiary's triggering chemotherapy claim
- Beneficiaries may initiate multiple episodes during the five-year model

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# OCM-FFS Two-Part Payment Approach

During OCM, participating practices continue to be paid Medicare FFS payments.

Additionally, OCM has a two-part payment approach:

**(1) Monthly Enhanced Oncology Services (MEOS) Payment**

- Provides OCM practices with financial resources to aid in effectively managing and coordinating care for Medicare FFS beneficiaries
- The $160 payment for OCM enhanced services can be billed for OCM FFS beneficiaries for each month of their 6-month episodes, unless they enter hospice or die

**(2) Performance-Based Payment (PBP)**

- The potential for a PBP encourages OCM practices to improve care for beneficiaries and lower the total cost of care during the 6-month episodes
- The PBP is calculated retrospectively on a semi-annual basis based on the practice's achievement on quality measures and reductions in Medicare expenditures below a target price

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# OCM-FFS Performance-Based Payment

1) CMS calculates **benchmark** episode expenditures for OCM practices
    - Based on historical data
    - Risk-adjusted and adjusted for geographic variation
    - Trended to the applicable performance period
    - Includes a novel therapies adjustment
2) A discount is applied to the benchmark to determine a **target price** for OCM-FFS episodes
    - Example: Benchmark = $30,000 → Discount = 4% → Target Price = $28,800
3) If **actual** OCM-FFS episode Medicare expenditures are **below target** price, the practice could receive a performance-based payment
    - Example: Actual = $25,000 → Performance-based payment up to $3,800
4) The amount of the performance-based payment is adjusted based on the participant's achievement on a range of **quality measures**

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# OCM-FFS Risk Adjustment

Benchmark prices are risk-adjusted for factors that affect episodic expenditures:

- Age
- Sex
- Dual eligibility for Medicaid and Medicare
- Selected non-cancer comorbidities
- Receipt of selected cancer-directed surgeries
- Receipt of bone marrow transplant
- Receipt of radiation therapy
- Type of chemotherapy drugs used during episode (only Part D-covered drugs versus some or all Part B-chemotherapy drugs; for breast cancer only)
- Institutional status
- Participation in a clinical trial
- History of prior chemotherapy use
- Episode length
- Hospital referral region

Over time, the risk adjustment methodology may incorporate additional factors not captured in claims data, such as cancer staging.

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# OCM-FFS Novel Therapies Adjustment

- Potential adjustment based on the proportion of each practice's average episode expenditures for novel therapies compared to the same proportion for episodes that are not part of OCM
  - Includes oncology drugs that received FDA approval after December 31, 2014
  - Use of the novel therapy must be consistent with the FDA-approved indications for inclusion in the adjustment
  - Oncology drugs are considered "new" for 2 years from FDA approval for that specific indication
- The novel therapies adjustment may lead to a higher benchmark only (i.e., it will never lower a benchmark)
- In the future, CMS may modify this adjustment to incorporate value of the novel therapies

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# OCM-FFS Risk Arrangement Options

## One-Sided

- OCM practices are NOT responsible for Medicare expenditures that exceed the target price
- Medicare discount = 4%
- *Must qualify for performance-based payment by mid-2019 to remain in one-sided risk*

## Two-Sided

- OCM practices are responsible for Medicare expenditures that exceed target price
- Option to take two-sided risk begins in 2018
- Medicare discount = 2.75%

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# OCM-FFS Quality Measures that Affect Performance-Based Payment

| OCM # | Measure Description | Source |
|---|---|---|
| OCM-1 | Risk-adjusted proportion of patients with all-cause hospital admissions within the 6-month episode | Claims |
| OCM-2 | Risk-adjusted proportion of patients with all-cause ED visits that did not result in a hospital admission within the 6-month episode | Claims |
| OCM-3 | Proportion of patients who died who were admitted to hospice for 3 days or more | Claims |
| OCM-4a | Oncology: Medical and Radiation – Pain Intensity Quantified (NQF 0384/PQRS 143) | Practice |
| OCM-4b | Oncology: Medical and Radiation – Plan of Care for Pain (NQF 0383/PQRS 144) | Practice |
| OCM-5 | Preventive Care and Screening: Screening for Depression and Follow-Up Plan (NQF 0418/ eCQM CMS2.6.3) | Practice |
| OCM-6 | Patient-Reported Experience | Survey |
| OCM-7 | Prostate Cancer: Adjuvant Hormonal Therapy for High or Very High Risk Prostate Cancer (NQF 0390/PQRS 104) | Practice |
| OCM-8 | Adjuvant chemotherapy is recommended or administered within 4 months (120 days) of diagnosis to patients under the age of 80 with AJCC III (lymph node positive) colon cancer | Practice |
| OCM-9 | Combination chemotherapy is recommended or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0M0, or Stage IB - III hormone receptor negative breast cancer (NQF 0559) | Practice |
| OCM-10 | Trastuzumab administered to patients with AJCC stage 1 (T1c) – III and human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy (NQF 1858) | Practice |
| OCM-11 | Breast Cancer: Hormonal Therapy for Stage I (T1b)-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer (NQF 0387/eCQM CMS140v5.0) | Practice |
| OCM-12 | Documentation of Current Medications in the Medical Record (NQF 0419/eCQM CMS68v6.1) | Practice |

# OCM FFS Program and Payment Overlap

**Program Overlap:**

- Overlap with OCM is allowable for the following programs:
  - Shared savings programs (e.g., Pioneer Accountable Care Organizations [ACOs], Medicare Shared Savings Program [MSSP])
  - Comprehensive Primary Care Initiative (CPC)
  - Bundled Payments for Care Improvement Initiative (BPCI)
  - Comprehensive Care for Joint Replacement Model (CJR)
  - Medicare Care Choices Model (MCCM)
- OCM practitioners may not participate concurrently in OCM and the Transforming Clinical Practice Initiative (TCPI)

**Care Management Services**

- Chronic Care Management (CCM), Transitional Care Management (TCM), Home Health Care Supervision, Hospice Care Supervision, and End Stage Renal Disease management services: Practices that bill the MEOS payment cannot also bill for these services in the same month for the same beneficiary.

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# OCM-FFS Monitoring and Evaluation

**Monitoring** aims to assess participants' compliance, understand use of model funding, and promote the safety of the beneficiaries and the integrity of model. Monitoring data sources may include:

- Claims data;
- Practice-reported quality measure and clinical data;
- Medical records;
- Patient surveys and patient feedback;
- Interviews with OCM Beneficiaries and their caregivers;
- Site visits;
- Documentation requests, including responses to surveys and questionnaires.

**Evaluation:** CMS's independent evaluation contractor is employing a non-randomized research design using matched comparison groups to detect changes in utilization, costs, and quality that can be attributed to the model

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# OCM Learning Community

**The OCM Learning Community includes:**

- Topic-specific webinars that allow OCM participants to learn from each other
- An online collaboration platform to support learning through shared resources, tools, ideas, discussions, and data-driven approaches to care
- Action groups in which practices work together virtually to explore critical topic areas and build capability to deliver comprehensive oncology care
- Site visits to better understand how practices manage services, use evidence-based care, and practice patient-centered care
- Technical support to help practices overcome barriers to improvement

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# Oncology Care Model Overview

*For More Information*

Oncology Care Model
CMMI Patient Care Models Group
OCMSupport@cms.hhs.gov
http://innovation.cms.gov/initiatives/Oncology-Care/

# Questions?

# Thank you!

The next vendor call will be held on **Thursday, October 20 from 12:00 – 1:30 p.m. ET**. CMS will share more information as it becomes available.