1 will slides be shared after the event?

Yes. See https://www.communityoncology.org/blog/2017/12/14/webinar-evolving-the-ocm-ocm-2-0-beyond/

2 Will these slides be made available?

Yes. See https://www.communityoncology.org/blog/2017/12/14/webinar-evolving-the-ocm-ocm-2-0-beyond/

3 How does CMS propose to define ""primarily managed by medical oncologist"" as definition for episode/trigger definition when that certainly hasn't been done thus far?

Hmmm - you may be seeing the results of how CMMI is addressing plurality. See the OCM connect article OCM Episode Definitions and Triggers Volume 1_Podcast_Transcript_20170808. We also suggest you contact your OCM Project Officer or CMMIConnectHelpDesk@cms.hhs.gov or 888-734-6433, option 4, with specific examples.

4 Has it been considered utilizing the OCM 2.0 initiative as a possible EHR reset? What I mean by that is, OCM was implemented and focused on the individual participant organization to define and decipher the OCM requirement. The reset I recommend is that we take a unifying approach and include the participating EHRs to take the lead. This approach limits variability and bakes-in IT support and limited variability.

CMMI hosts monthly discussions or meetings with most oncology EHR companies. These discussions have led to enhancements in data submission processes, formats and due dates. The EHR companies will certainly be included in OCM 2.0. Suggestion - ask your own EHR company how the OCM process can be improved further. Have them share these ideas with the CMMI team.

5 What is an optimal staffing model for a practice to implement the OCM?

Difficult question to answer. It will depend on how many of the OCM requirements your team was doing prior to the implementation of the OCM. The data extraction piece requires a lot of effort but that too depends on how cooperative and helpful your EHR vendor is. Your question does point to the need to thoughtful and efficient in reviewing duties for the OCM and any other reform model. Your expense budget should be under any PMPM amount in the model you are considering.

6 What do you see in the future as the role of payer specific pathways program?

Payer specific pathways programs are likely to have a stronger role in the future, but its still too soon to tell.

7 It would be helpful to have the payer automatically pay PMPM for eligible patients to practices, rather than requiring practices to submit bills and anticipate recoupments

We have seen received this suggestion from several. Attribution is challenge in any payment reform model. It is almost impossible to design a reform model without it. It is also important for care teams to understand and be able to identify and manage their own attributable patients. An analogy to this question is to suggest that the government do your taxes for you. Attribution is a necessary evil, similar to filing taxes. The key is to make the process more transparent on both sides so that surprises can be minimized.

8 What is the process for OCM 2.0 being approved by Medicare as an APM? Has then been submitted MedPac yet? Also - would this replace, or augment the current OCM? Thank you!

Yes, OCM started with a Letter of Intent. We are now following their outline for an official application. We will be including recent white papers and studies on this topic and the results of numerous interviews with different stakeholders.

9   Can you clarify what you mean by """community-based medical oncology?"" Is this referring to including multiple clinicians or is it referring to focusing more on what patients want/need based on their feedback?

> Community-based medical oncology refers to multiple environments and includes many models of care, including but not limited to clinicians who practice in office-based settings.

10   Are there thoughts around the needed adjustment to the MEOS amount per beneficiary related to OCM 2.0?

> There are no discussions that we are aware of related to increasing the MEOS payments in any way.

11   In discussion of 2.0 could we consider MEOS being paid quarterly from the attribution report generated by CMS? This would prevent us from billing for patients that ultimately are not attributed. It seems it would save a lot of time for the practice as well as CMS...

> See the similar question above. Attribution will likely remain. Our goal is to simplify the PMPM so that it is more easily reconciled between the stakeholders. More frequent reporting will be key. This should help the PMPM concept as well as attribution. We will be including that and other ideas in OCM 2.0.

12   Thoughts on attribution issues the practices are now seeing? lack of final attribution for patients we are exclusively treating for cancer and recoupment of MEOS will impact funding of care teams to provide these services

> We have seen a wide list of attribution issues as well as a wide gap in counts between the two entities. We feel that a lot of these discrepancies and surprises could be avoided with some program modifications.

13   Will there be any recommendations for MEOS billing especially for oral drugs? This process now is quite tedious and double work after receiving the attribution list.

> Similar to some other issues, the management of oral drugs in a reform model can be challenging. We will be including oral drugs in OCM 2.0 but will be focus on timely information between stakeholders on utilization of oral therpay and to also minimize surprises during the reconciliation of PMPM.

14   Ideally the current OCM is to last 5 years. Are you anticipating that your OCM 2.0 model or Oncology Medical home will be the next step after the 5 years is up?

> Our goal is to launch OCM 2.0 in advance of the completion of the current OCM.

15   Interventions that may help reduce unnecessary ED visits (i.e. rehabilitation) increase cost...but prevent longer-term total costs

> Not sure of the question but we can say that sound, effective and proven care delivery policies and procedures will be fundamental to OCM 2.0.

16   Ideally the optimal model would be adopted universally however there is always a transition period with all payers. So, the challenge for practices to juggle the individual payer requirements to be seen as someone using best practices is to meet the OCM requirements

> Very good point. There was a previous question regarding the future of pathways. As you recall, many different pathway models and programs evolved other the last several years. This made care complicated and cumbersome for provider teams and patients. The goal of OCM 2.0 is to build a base framework that could be applicable to all while allowing for a degree of flexibility. This flexibility will be needed for stakeholders that are relatively new to payment reform.

17   Will OCM be Aligned with NCCN guidelines? At least for Medicare. as Commercial payers use their own (some)

OCM will be aligned with the authoritative library of evidence. NCCN is currently the library of choice for cancer care.

18 Has the OCM 2.0 Initiative considered making MEOS payments available for all practices who provide OCM enhanced services? I'm also curious: Is there precedence for a program where practices provide services that meet eligibility for a code, are provided payment for those services, and subsequently have those payments recuperated when it's been established that those enhanced services were provided.

Current reform initiatives are shaping new ideas for all, even when a group is not in a specific reform model. Today, reform initiatives come with an agreement between payer and care team. This is due to some of the complications that are inherent in any reform model. It may be that reform programs evolve to a new normal that includes a standard PMPM but also new standards in care delivery.

19 Retrospective 'attribution' makes sense because there is a lot of data we do not have access to: 1) # of visits the beneficiary has with other provides and 2) fill dates 3) exact trigger dates. Unfortunately, with our best efforts, we won't get 100% Of the dates or attribution estimates correct and unfortunately are penalized for it with recoupment

It does seem logical but the OCM 2.0 team feels that there is responsibility on both sides. See above. Timing, reporting and communications can be improved to ease the burden for both sides.

20 Sorry incomplete question sent in error.

Ok

21 Can attribution be done transparently with patient involvement? For example, the Chronic Care Management CMS model requires a patient to sign a participation agreement to have their services provided by one specific practice/TIN and if they want to switch, then they sign the consent for with another practice. Transparency would help financial planning as well as patient expectation.

This is a very interesting concept. There may be a way to increase patient involvement in the attribution process. This could also have positive implications to care coordiantion and cost reduction. Good idea.