# Enhancing Oncology Model

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# Disclaimer

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# What do I need to know about EOM?

- Began on July 1st, 2023
- Voluntary 5-year model
- Replaced Oncology Care Model (OCM)
- Aims to improve quality and reduce costs through payment incentives and required participant redesign activities

- Lower Monthly Enhanced Oncology Services (MEOS) payments at $70 per Medicare beneficiary
- Two immediate downside risk options for EOM participants
- More precise cancer-type specific payment considerations

- Some customers (e.g., payers, provider group practices) may use their OCM performance to determine EOM participation
- Expect significant decrease in patient representation given the limited diagnoses included in EOM

## Key points for discussion

Briefly explain what EOM is for attendees

Explain the key components of the policy that are most relevant to all attendees

Explain which patients and customers are impacted directly by EOM and how it will affect them as changes go into effect

Source: https://innovation.cms.gov/innovation-models/enhancing-oncology-model

# Background on CMMI

# Centers for Medicare & Medicaid Innovation (CMMI): Overview

**Created within Centers for Medicare and Medicaid Services (CMS)**

- Explores new healthcare strategies to:
  - Improve the quality of patient care
  - Lower overall costs
  - Align with a value-based system
- **NOT new healthcare programs or insurance plans**
- Possesses broad authority to waive provisions of Medicare and Medicaid
  - For sole purposes of testing payment and service delivery models
- Goal: To enhance the standards of care for patients under the Medicare, Medicaid, and Children's Health Insurance Program (CHIP)

About the CMS Innovation Center. CMS.gov. https://innovation.cms.gov/about. Published August 4, 2022. Accessed October 17, 2022.

# Purview of CMMI

*CMMI was created within CMS to explore and test new healthcare strategies that improve the quality of patient care, lower overall costs, and align with a value-based system.*

**Established and funded with $10 billion per decade by Congress under the Affordable Care Act (ACA) in 2010, CMMI possesses a broad waiver authority that grants them the ability to:**

- Explore a variety of payment and delivery models with considerable flexibility
- Make changes to policies and plans with broad testing authority
- Not follow a formal rulemaking process or seek public feedback in their model development
- Make model implementation **voluntary or mandatory** based on their discretion
- Expand or alter models during its testing years

Longo N. Medicare Monday: Have you heard of CMMI? PhRMA. https://catalyst.phrma.org/medicare-monday-have-you-heard-of-cmmi. Published February 20, 2017. Accessed October 17, 2022.

# Types of CMMI Models

**More than 50 innovative models have launched since CMMI's inception that focus on:**

- Medicare, Medicaid, and CHIP coverage types - *Medicare Advantage or Part D*
- Alternative payment models (APMs) – *Accountable Care Organizations (ACOs)*
- Specific health conditions – *End-stage renal disease*
- Specific care episodes – *Hip or knee replacement surgery*
- Provider types – *Primary care or oncologist*
- Communities – *Rural or suburban*

***select examples of these focus areas are in italics***

About the CMS Innovation Center. CMS.gov. https://innovation.cms.gov/about. Published August 4, 2022. Accessed October 17, 2022.

# CMMI Waiver Authority: Description & Limitations

## Key Takeaways

- Waiver authority is for sole purpose of testing payment and delivery service models
- New payment models can not reduce benefits for Medicare and Medicaid program enrollees or lower the quality of services provided

| Waiver Authority | Description | Limitations |
|---|---|---|
| Section 1115A of Social Security Act | • Provision of the ACA that created the Center for Medicare and Medicaid Innovation<br>• Broad authority to test new payment methods to cut federal costs without harming quality | • Law explicitly mentions allowing all-payer plans, although such plans would be hard to enact on a budget-neutral basis<br>• Nothing in the authority allows for block granting Medicaid or revoking choices available to Medicare beneficiaries |
| Section 402(a) of the Social Security Amendments of 1967 | • Provision allows for testing of new methods for paying providers in Medicare | • The authority does not allow states to assume control over Medicare program spending |
| Section 1115 of the Social Security Act | • States can request waivers of various provisions of Medicaid law to allow for testing of new models of coverage and payment | • Section 1115 does not allow for waiving of the federal matching rate structure for financing Medicaid, which precludes lump sum payments and necessitates maintenance of separate Medicaid accounting |

Chen LJ, Capretta JC. Current Federal Health Care Waiver Authorities Will not Pave the Way For the New York Health Act. NYSPHA.

# Moving Forward

# OCM to EOM

# Oncology Care Model (OCM)

*The OCM aimed to provide higher quality, more coordinated oncology care for Medicare beneficiaries at the same or lower cost compared to Medicare.*

- Completed: July 1, 2016 – June 30, 2022
- 6-year **voluntary** model that tested payment strategies to promote quality and value of cancer care
- Objective: Utilize appropriately aligned financial incentives to enable improved care coordination, appropriateness of care, and access to care for beneficiaries undergoing chemotherapy
- Design
  - Episode-based: Targets chemotherapy and cancer-related care during 6-month period
  - Emphasizes practice transformation with performance-based quality measures
  - Two-fold financial approach to incentivizing: a per-beneficiary $160 Monthly Enhanced Oncology Services (MEOS) payment; the potential to earn PBPs for meeting quality and cost goals
- Included 126 practices and 5 participating payers
- Outcomes: Higher-value (more cost-conscious) use of supportive care drugs; OCM patients rated care experience very highly; no impact on patient-reported symptom management or ED visits/hospitalizations due to chemotherapy side effects

Source: https://innovation.cms.gov/innovation-models/oncology-care

# Transition from Oncology Care Model to Enhancing Oncology Model

## White House Relaunched Cancer Moonshot in 2022, with two primary goals

**Cut Cancer Death Rate** - Cancer Moonshot aims to cut today's age-adjusted death rate from cancer by at least 50 percent over the next 25 years

**Living with Cancer** - The Initiative aims to improve the experience of people living with and surviving cancer as well as their families

To accomplish the above goals, the Cancer Moonshot will seek to diagnose cancer sooner, prevent cancer before it appears, address inequities, and promote data sharing to facilitate learning from all patient experiences

https://innovation.cms.gov/media/document/eom-model-overview-slides
https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/02/fact-sheet-president-biden-reignites-cancer-moonshot-to-end-cancer-as-we-know-it/

# Enhancing Oncology Model (EOM)

*EOM focuses on value-based, patient-centered care for cancer patients undergoing chemotherapy based on 6-month care episodes, with a specific focus on health equity.*

- Beginning on July 1, 2023
- 5-year **voluntary** model intended to transform treatment for cancer patients
  - Improve care coordination, quality, and health outcomes while holding oncology practices accountable for total costs of care under Medicare fee-for-service
- Objectives:
  - Increase engagement of patients, oncologists, and other payers in value-based care and quality improvement
  - Observe improved care quality, health equity, and health outcomes, as well as achieve savings over model performance years
- Payment Design:
  - Payment incentives including a Monthly Enhanced Oncology Services (MEOS) payment, a performance-based payment (PBP), or a performance-based recoupment (PBR)

Source: https://innovation.cms.gov/innovation-models/enhancing-oncology-model

# Oncology Care Model (OCM) vs. Enhance Oncology Model (EOM)

| | OCM | EOM |
|---|---|---|
| **Participation** | Voluntary | Voluntary |
| **Trigger** | Receipt of an anti-cancer therapy | Receipt of an anti-cancer therapy |
| **Patient Population** | 21 cancer types | 7 most common cancer types |
| **Episode Length** | 6 months | 6 months |
| **Attributed Costs** | Total cost of care | Total cost of care |
| **Drug Payments** | ASP +6%, includes Parts B and D | ASP +6%, includes Parts B and D |
| **Risk** | Could opt into one-sided (upside only) or two-sided. Practice remained one-sided if qualified for performance-based payments. | Two-sided required |
| **Benchmarking** | At the practice level; limited use of clinical data to inform risk adjustment | At the cancer type level; more robust use of clinical data to inform risk adjustment |
| **Novel Therapies Adjustment** | Calculated in aggregate for the model | Calculated separately for each cancer type |
| **MEOS Payments** | $160 PBPM | Non-Dual $70/Dual $100 PBPM |
| **Health Equity Component** | No | Yes |
| **Number of Participant Redesign Activities** | 6 | 8 (same as OCM + social needs screening tool and electronic PROs) |



Source: https://innovation.cms.gov/innovation-models/enhancing-oncology-model

# 101 Enhancing Oncology Model

# EOM Program Details

- **Included Cancers:** breast cancer, chronic leukemia, lung cancer, lymphoma, multiple myeloma, prostate cancer, colorectal cancer
- **EOM Episodes:** Episodes are triggered by Part B or D oncolytics, but episodes with CAR T cell therapy claims will be excluded; incentivizes biosimilars
- **Participants**: Oncology Physician Group Practices (PGPs) and other payers (e.g., commercial payers, state Medicaid agencies) through multi-payer alignment
- **Quality Measures and Data Reporting**: EOM will include valid, reliable, and meaningful claims-based, participant-reported and survey measures. Performance on these measures will be tied to payment

Source: https://innovation.cms.gov/innovation-models/enhancing-oncology-model

# EOM payment framework

Fee-for-Service payments for items and services with two additional financial incentives:

- Per-beneficiary Monthly Enhanced Oncology Services (MEOS) payments
- Performance-based payment or performance-based recoupment

All participating providers **must take downside risk** and the performance-based financial framework also ties to quality measures

## EOM Alternative Payment Model (APM)

Participants will **be incentivized to consider the whole patient** and engage with them proactively, during and between appointments.

Physician Group Practices (PGPs):

1. Take on **financial and performance accountability** for episodes of care surrounding chemotherapy administration
2. Have the opportunity to submit payment for **provision of Enhanced Services** furnished to beneficiaries
3. Are encouraged to **promote health equity,** to improve beneficiaries' health outcomes and reduce costs

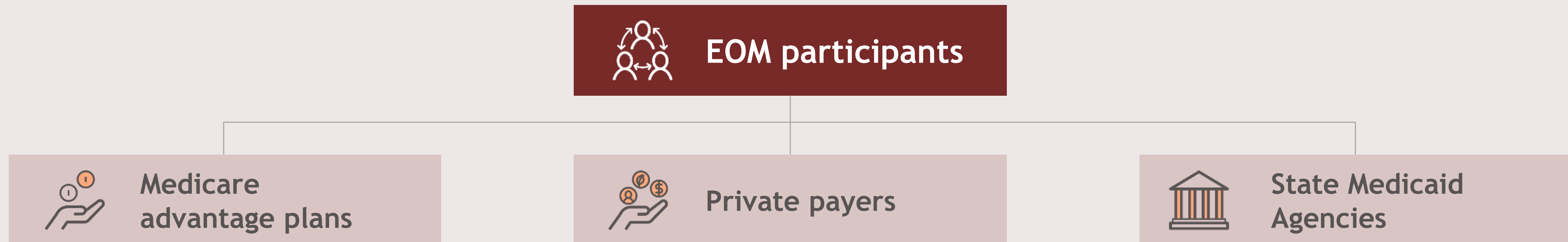
Source: https://innovation.cms.gov/innovation-models/enhancing-oncology-model

# Payer alignment

## EOM is a multi-payer model

**Goal:** Payers align their oncology value-based payment models with EOM in key areas (e.g., commitment to health equity, alignment on payment approach, and data sharing with EOM participants and CMS) to promote a consistent approach across payers and patient populations.

**The following payers are eligible to apply:**




Payers must partner with at least one EOM participant **throughout the entirety of the model** to continue participating in EOM.

To the extent permitted by law, CMS will provide **payers with data and resources** including opportunities to collaborate and engage with other payers and learning activities.

Source: https://innovation.cms.gov/innovation-models/enhancing-oncology-model

# Risk arrangement options

**Amounts of PBP earned or PBR owed** by the EOM participant or pool **will be calculated as a percentage of the benchmark** amount. The benchmark amount represents the total projected cost of attributed episodes in the absence of EOM.

| | Risk Arrangement 1 (RA1) | Risk Arrangement 2 (RA2) |
|---|---|---|
| **EOM discount** | **4%** of the benchmark amount | **3%** of the benchmark amount |
| **Target amount** | **96%** of the benchmark amount | **97%** of the benchmark amount |
| **Threshold for recoupment** | **98%** of the benchmark amount | **98%** of the benchmark amount |
| **Stop-loss/Stop-gain** | **2%** Stop-Loss<br>**4%** Stop-Gain | **6%** Stop-Loss<br>**12%** Stop-Gain |

Source: https://innovation.cms.gov/innovation-models/enhancing-oncology-model

# Care transformation through Participant Redesign Activities (PRAS)

Provide beneficiaries **24/7 access** to an appropriate clinician with real-time access to the EOM participant's medical records

Provide **patient navigation**, as appropriate, to EOM beneficiaries

Document a **care plan** for each EOM beneficiary that contains the 13 components of the Institute of Medicine (IOM) Care Management Plan

Treat beneficiaries with therapies in a manner consistent with nationally recognized **clinical guidelines**

Identify EOM beneficiary **health-related social needs** using a health-related social needs screening tool

Gradual implementation of **electronic Patient Reported Outcomes (ePROs)**

**Utilize data** for continuous quality improvement (CQI), including the development of a health equity plan

Use **Certified Electronic Health Records (EHR) Technology** (CEHRT)

Source: https://innovation.cms.gov/innovation-models/enhancing-oncology-model

# EOM health equity strategy

Incentivize care for underserved communities

Collect beneficiary-level sociodemographic data

Identify and address health-related social needs (HRSN)

Improved shared decision-making and care planning

Develop health equity plans as part of continuous quality improvement (CQI)

https://innovation.cms.gov/media/document/eom-model-overview-slides

# Health equity details

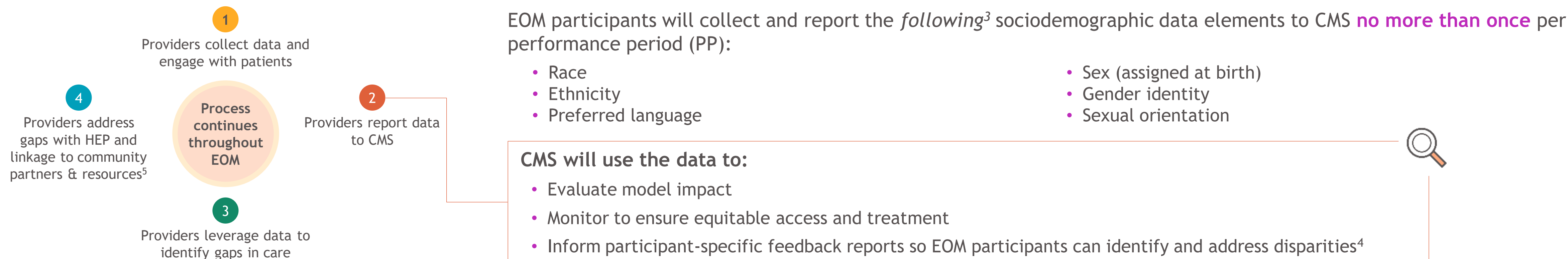
## Incentive care for undeserved communities

EOM includes a differential MEOS payment for **dually eligible**[1] beneficiaries to support the implementation of enhanced services, such as patient navigation and HRSN screening

*This adjustment is meant to help mitigate any potential disincentive in a total cost of care model (TCOC) to serve dually eligible patients who historically account for a disproportionate share of Medicare expenditures and are associated with higher episodes expenditures*

**EOM allows limited flexibility for billing overlap to ensure providers can serve patients across different sites of care, for example, in rural and underserved communities**

## Collect and report beneficiary-level sociodemographic data




EOM participants will collect and report the *following*[3] sociodemographic data elements to CMS **no more than once** per performance period (PP):

- Race
- Ethnicity
- Preferred language
- Sex (assigned at birth)
- Gender identity
- Sexual orientation

**CMS will use the data to:**

- Evaluate model impact
- Monitor to ensure equitable access and treatment
- Inform participant-specific feedback reports so EOM participants can identify and address disparities[4]

**EOM participants will NOT be required to report sociodemographic data to CMS for any beneficiary who CHOOSES NOT to provide such data**

[1] Dually eligible refers to beneficiaires who are eligible for both Medicare and Medicaid. Dual eligibility serves as a proxy for income and social risk. U.S. Department of Health and Human Services, (2020) Report to Congress: Social risk factors and performance under Medicare's value-based purchasing programs.
Source: https://innovation.cms.gov/ innovation-models/enhancing-oncology-modelMS Innovation Center

# Participation

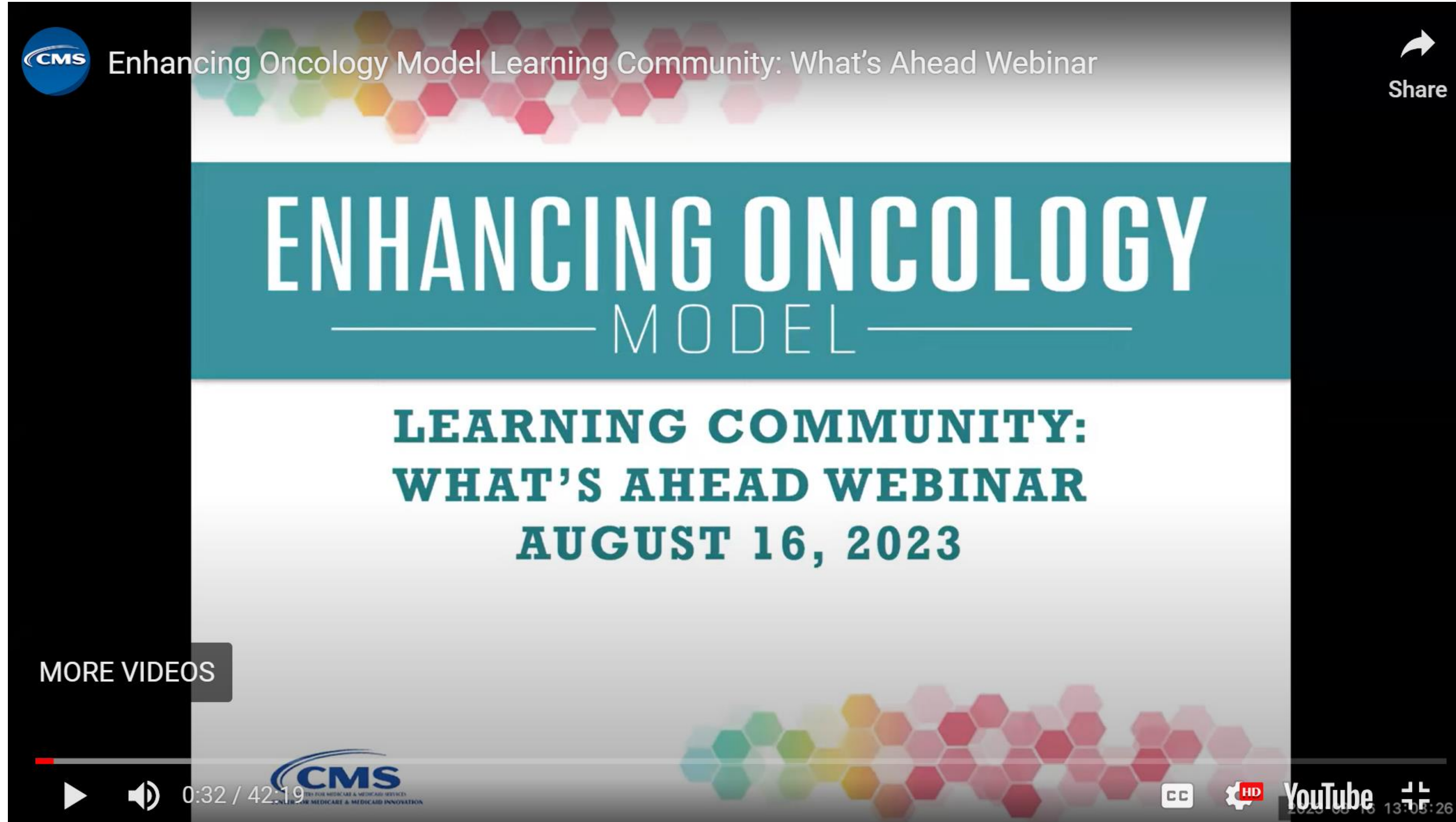
As of June 27th, 2023, 67 oncology physician group practices (PGPs) are participating in EOM. Across the 67 PGP participants, there are over 600 sites of care representing approximately 37 states nationally and over 3,000 unique practitioners.

Approximately 15% of EOM participants' sites of care are located in a rural/small town/micropolitan area, with a little over half of EOM participants having previously participated in the Oncology Care Model (OCM).

- The 3 participating payers are:
  - BlueCross BlueShield of South Carolina
  - BlueCross BlueShield of Tennessee
  - CVS Health/Aetna

Source: https://innovation.cms.gov/innovation-models/enhancing-oncology-model

# Resources




- CMS, Innovation Center
  - Enhancing Oncology Model | CMS Innovation Center
    - https://innovation.cms.gov/innovation-models/enhancing-oncology-model

# Thank you

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