# ENHANCING ONCOLOGY MODEL

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

# CMS INNOVATION CENTER STRATEGY

Created for the purpose of developing and testing **innovative health care payment** and **service delivery models** within Medicare, Medicaid, and CHIP programs nationwide.

## Innovation Center Priorities and Strategic Refresh

# OVERVIEW OF ENHANCING ONCOLOGY MODEL (EOM)

**EOM will continue to drive care transformation and reduce Medicare costs**

**FOCUS**

Five-year, **voluntary payment and delivery model,** began July 2023 and concludes June 2028, that focuses on innovative payment strategies that promote high-quality, person-centered, equitable care to Medicare FFS beneficiaries with certain cancer diagnoses who are undergoing **chemotherapy treatment**

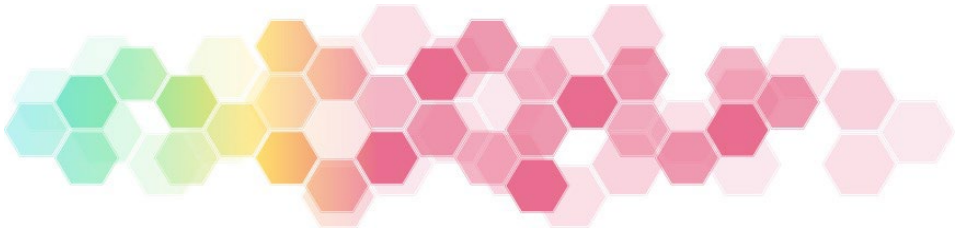
**PARTICIPANTS**

**Oncology Physician Group Practices (PGPs)** and **other payers** (e.g., commercial payers, state Medicaid agencies) through multi-payer alignment

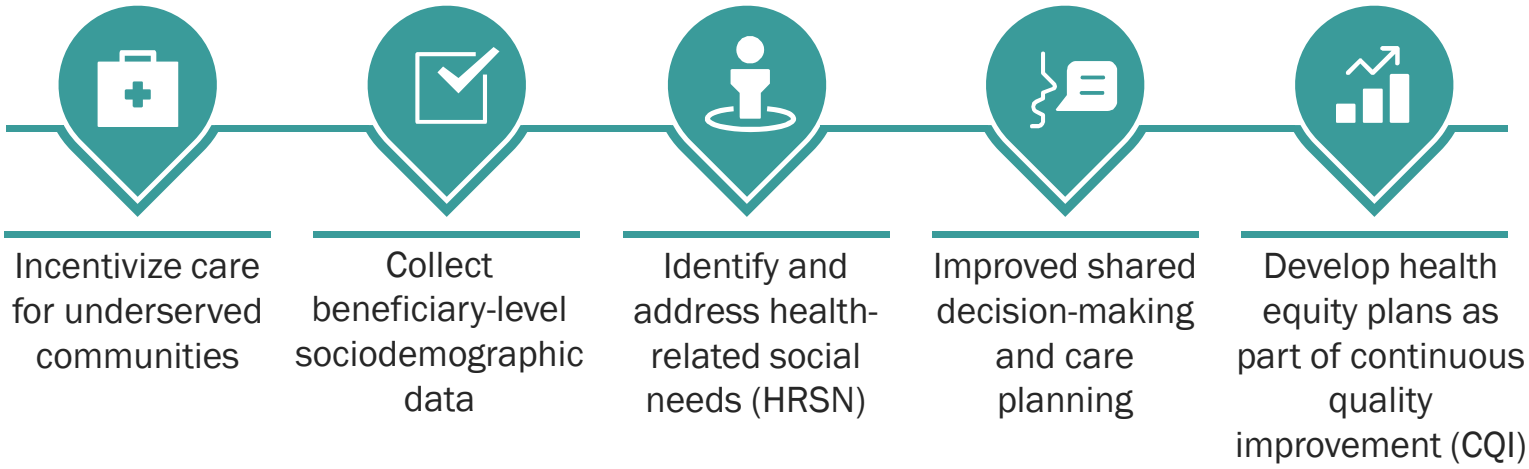
**QUALITY & PAYMENT**

EOM participant are paid FFS with the addition of **two** financial incentives to **improve quality** and **reduce cost**:

- Additional payment to support care transformation in the form of a **$70** per-beneficiary-per-month **Monthly Enhanced Oncology Services (MEOS)** to support care transformation. Participants can bill an additional **$30** per-beneficiary-per-month MEOS for EOM beneficiaries that are dually eligible, this additional payment will be excluded from EOM participants' total cost of care (TCOC) responsibility. EOM participants would be eligible to receive MEOS for furnishing Enhanced Services
- Potential **performance-based payment (PBP)** or **performance-based recoupment (PBR)** based on the total cost of care (including drugs) and quality measures during 6-month episodes that begin with the receipt of chemotherapy



# EOM HEALTH EQUITY STRATEGY




**CMS defines health equity as:** The attainment of the highest level of health **for all people**, where everyone has a **fair and just opportunity** to **attain their optimal health** regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

# IDENTIFYING HRSNS

Health-related social needs (HRSNs) are the adverse social conditions that negatively impact a person's health or health care. To access the EOM HRSN Guide, click here.

EOM participants are required to identify EOM beneficiaries' health-related social needs, using HRSN screening tools to screen for the following at a minimum:

- Transportation
- Food Insecurity
- Housing Instability

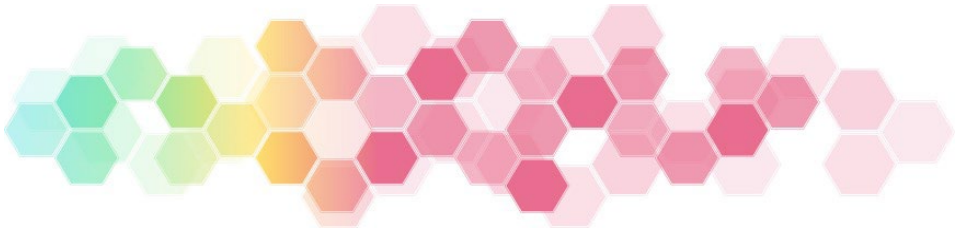
While not required, other HRSNs may be helpful to screen for, based on beneficiary needs, including, but not limited to:

- Social Isolation
- Emotional Distress
- Interpersonal Safety
- Financial Toxicity

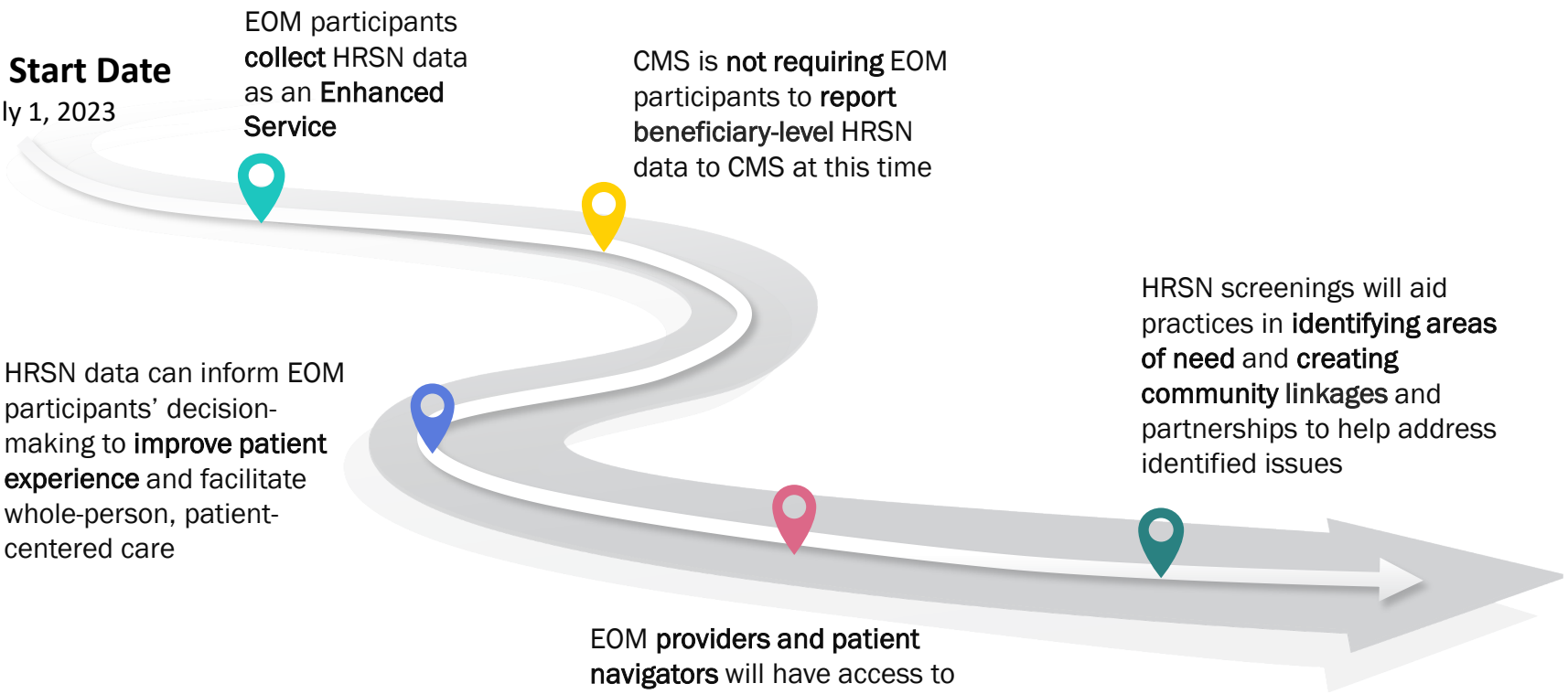
EOM participants have the flexibility to select their HRSN screening tool. Example screening tools include, but are not limited to:

- The National Comprehensive Cancer Network (NCCN) Distress Thermometer Problem List
- Accountable Health Communities (AHC) Screening Tool
- Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) Tool

**HRSN screening tools can help capture individual level factors**, such as lack of access to transportation for an upcoming appointment or financial toxicity from chemotherapy costs.



# HRSNS SCREENING AND REPORTING



# APPENDIX

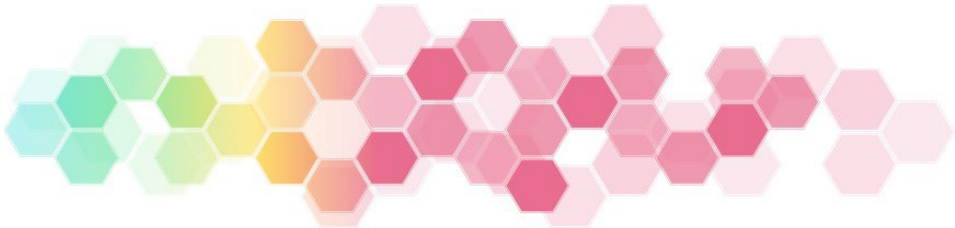
# OCM TO EOM HIGH LEVEL COMPARISON

| | OCM | EOM |
|---|---|---|
| **Health equity** | No explicit focus | Key element of design and implementation |
| **Beneficiary population** | Beneficiaries with all cancer types who receive chemotherapy or hormonal therapy | High-risk beneficiaries with certain cancer types receiving systemic chemotherapy only |
| **Use of ePROs** | No requirement | Required gradual implementation |
| **MEOS payment** | $160 PBPM for each OCM beneficiary | $70 PBPM for beneficiaries not dually eligible for Medicaid and Medicare<br>$100 PBPM for beneficiaries dually eligible for Medicaid and Medicare |
| **Attribution** | Based on plurality of E&M claims | Based on initial care plus at least minimum care over time |
| **Benchmark and novel therapy calculations** | 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 |
| **Risk arrangements for performance-based payment** | One-sided risk in performance period 1, followed by the option for one- or two-sided risk in performance periods 2-7<br>Participants earning a performance-based payment by the initial reconciliation of PP4 have the option to stay in one-sided risk in PP8—PP11; other participants must either accept two-sided risk in PP8—PP11 or be terminated from the model | Two downside risk arrangement options |

*Please note this list is not exhaustive. For additional information on how EOM differs from OCM, refer to Appendix A of the EOM RFA

# 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)

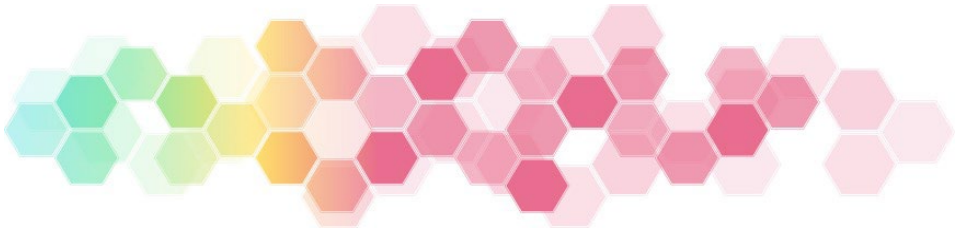


# PATIENT NAVIGATION

EOM participants are required to provide the core functions of patient navigation, as appropriate, to all EOM beneficiaries who request and/or need these services.

## Core functions of patient navigation

1. Coordinating appointments with health care providers to ensure timely delivery of diagnostic and treatment services;
2. Maintaining communication with EOM beneficiaries, families, and the health care providers to monitor EOM beneficiary satisfaction with the cancer care experience and provide health education;
3. Ensuring that appropriate medical records are available at scheduled appointments;
4. Providing language translation or interpretation services in accordance with federal law and policy;
5. Facilitating linkages to follow-up services and community resources (e.g., make referrals to cancer survivor support groups and community organizations or other third parties that provide child/elder care, transportation, or financial support); and
6. Providing access to clinical trials as medically appropriate.



# INSTITUTE OF MEDICINE (IOM) CARE PLAN ELEMENTS

Each EOM participant is required to document a comprehensive cancer care plan for the EOM beneficiary, and the EOM participant is required to engage the EOM beneficiary in the development of the care plan.

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 t**o 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 would 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