ASCO Practice Leadership Series

Updates from the Enhancing Oncology Model

Thursday, March 23, 2023
Welcome!

- Please mute your phones
- Q&A session at the end
  - Use the Q&A button in the bar at the bottom of your Zoom window
  - Type in your question
  - We will address questions in the order they are received
TODAY’S SPEAKER

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EOM Policy Lead
Division of Ambulatory Payment Models
Patient Care Models Group
Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
AGENDA

1. Enhancing Oncology Model (EOM) Background
2. Updated clarifications and additional information
3. Why Join EOM?
4. Timeline and Next Steps
5. Q&A
OVERVIEW OF ENHANCING ONCOLOGY MODEL (EOM)

FOCUS

Five-year, voluntary payment and delivery model scheduled to begin July 2023 and conclude 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

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 will 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 will continue to drive care transformation and reduce Medicare costs.
UPDATED CLARIFICATIONS AND ADDITIONAL INFORMATION
EOM HEALTH EQUITY STRATEGY

Incentivize care for underserved communities
EOM includes a differential MEOS payment for dually eligible 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 episode 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

1. Providers collect data and engage with patients

2. Providers report data to CMS

3. Providers leverage data to identify gaps in care

4. Process continues throughout EOM

EOM participants will collect and report the following 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

EOM participants will NOT be required to report sociodemographic data to CMS for any beneficiary who CHOOSES NOT to provide such data.
Participants will identify and are encouraged to address health-related social needs (HRSNs)

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

- **REQUIRED HRSNs**
  - Transportation
  - Food Insecurity
  - Housing Instability

- **OPTIONAL HRSNs**
  - Social isolation
  - Interpersonal safety
  - Emotional distress
  - Financial toxicity

- EOM participants will have the flexibility to select their HRSN screening tool
- CMS is **NOT requiring** EOM participants to report HRSN data to CMS at this time.
Improve access to treatment and care planning

Participants are required to engage EOM beneficiaries in the development of a comprehensive care plan, which includes two elements that relate to health equity:

1. Addressing a patient’s psychosocial health needs
2. Estimating total and out-of-pocket costs (financial toxicity)

EOM participants are encouraged to share a physical and/or electronic copy of care plan with the beneficiary.
Develop health equity plans (HEP), as part of use of data for continuous quality improvement (CQI)

EOM participants will develop HEPs that describe evidence-based strategies for how they will achieve health equity within EOM and update these goals throughout the model performance period.

HEPs should consider a range of resources, such as:

- Internal data sources (e.g., Medicare claims, feedback reports, HRSN data (participant collected), sociodemographic data)
- External data sources (e.g., CDC’s Behavior Risk Factor Surveillance System (BRFSS), HHS Office of Minority Health, Health Mapping Medicare Disparities Tool, USDA Food Environment Atlas & Food Access Research Atlas, FCC’s Fixed Broadband Deployment)

HEPs are intended to be used as a tool that can support EOM participants as they identify disparities in care within their patient populations and work to address them over the course of the model.

EOM participants will develop and submit health equity plans to CMS, in a form, manner, and by the date specified by CMS.

The HEP should be a living document that evolves over time.
EOM BENCHMARKING

What are the benchmark price, benchmark amount, and target amount?

**Benchmark price**

Represents projected Medicare expenditures for one episode (in the absence of EOM)

**Benchmark amount**

For a non-pooled participant:

- Sum of benchmark prices for all episodes attributed to the participant during a performance period

For a pool:

- Sum of benchmark prices for all episodes attributed to all members of the pool during a performance period

\[
\text{Target Amount} = \left( \frac{\text{Benchmark Amount}}{- \text{EOM Discount (3% or 4%, depending on the selected risk arrangement)}} \right)
\]
How do Benchmarks Respond to Developments in Oncology Care?

**Trend Factor**
Adjusts for changes in average cost in oncology care outside of the model

**Novel Therapy Adjuster (NTA)**
Raises benchmark prices when an EOM participant or pool uses novel therapies above the level already reflected in the trend factor
EOM BENCHMARKING CONT.

Trend Factor

Modifies the predicted expenditures to account for inflation, updates to treatment standards, and other changes in expenditure patterns across the oncology field as a whole

- Cancer-type specific
- Recalculated every performance period
- Based on expenditures for episodes attributed to non-EOM PGPs

Achieving savings in early performance periods will NOT result in a lower trend factor for later performance periods. The trend factor is based solely on changing costs among non-EOM oncology PGPs.
The novel therapy adjustment increases a participant’s or pool’s benchmark prices for all attributed episodes of a specific included cancer type in a given performance period, if:

1. The participant or pool uses newly FDA-approved oncology drugs\(^3\) to a greater extent than non-EOM oncology PGPs
2. The use of these novel therapies is consistent with the FDA-approved indications

\[
\text{Participant/pool eligible for Novel Therapy Adjustment (NTA) if } \left( \frac{\text{Proportion of expenditures from novel therapies among attributed episodes of specified cancer type}}{\text{Proportion of expenditures from novel therapies among episodes of specified cancer type attributed to non-EOM oncology PGPs}} \right) > 0
\]

*NTAs may only result in a **higher** benchmark price; they will **never lower** a benchmark price*
Why are ePROs important to EOM?

Immediate benefits of ePROs include, but are not limited to:

- Prompting discussions with a clinician
- Streamlining consultations
- Increasing awareness and triaging of symptoms
- Facilitating interprofessional communication

Clinicians in community settings report that utilization of ePROs has been shown to be helpful for clinical documentation. Studies also show high levels of patient engagement, for patients who are 65 years and older. Patients report that utilization of ePROs improved discussions with providers and made them feel more in control of their care.
**EOM EPROS CONT.**

### ePROs Domains

<table>
<thead>
<tr>
<th>Symptoms and/or Toxicity</th>
<th>Functioning</th>
<th>Health-Related Social Needs (HRSN)</th>
<th>Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples: frequency, severity, activity interference, presence/absence of symptoms</td>
<td>Examples: physical functioning, role functioning*</td>
<td>Examples: financial toxicity, transportation, food insecurity</td>
<td>Examples: psychosocial functioning, anxiety, depression, other behavioral health conditions</td>
</tr>
<tr>
<td>*refers to an individual’s ability to work or pursue social and/or personal functions</td>
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</table>

Model participants must integrate ePROs data into electronic health records (EHRs). However, EOM participants **do not need** to report the data to CMS at this time.

### ePROs Collection Methods

CMS requires that ePROs be administered in an electronic format, including but not limited to the following:

- **Screen-Based Reporting Devices** *(e.g., via the patient portal on a smart phone or computer)*
- **Interactive Voice Response Systems** *(e.g., calls to a patient who responds to phone prompts)*
- **SMS Text Systems** *(e.g., patient provides information via text on mobile device)*
- **ePRO Collection In the Waiting Room** *(e.g., patient provides data via a tablet while waiting for office visit)*
**Example ePROs Gradual Implementation Timeline**

- **Year 1**: Pre-Implementation
  - EOM participant identifies ePROs data collection tool, develops capabilities to successfully implement ePROs (e.g., pilot/test the approach in practice).

- **Year 2**: Pre-Implementation

- **Year 3**: Required Implementation
  - EOM participant collects ePROs data for **35%** of EOM attributed patient population.

- **Year 4**: Required Implementation
  - EOM participant collects ePROs data for **50%** of EOM attributed patient population.

- **Year 5**: Required Implementation
  - EOM participant collects ePROs data for **75%** of EOM attributed patient population.

*Note*: This timeline includes example percentages of ePROs data collection beginning in PP5.
WHY JOIN EOM?
WHY JOIN EOM?

• Help drive the desired future state of oncology
• Evolving from a FFS system
• Missed opportunities from lack of participation in the Oncology Care Model (OCM)
• Opportunity to engage in value-based care through a supported environment
• Align with the White House Cancer Moonshot
TIMELINE AND NEXT STEPS
<table>
<thead>
<tr>
<th>Milestone</th>
<th>Planned Timing¹</th>
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<tbody>
<tr>
<td>RFA released / Application portal opened</td>
<td>June 27, 2022</td>
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<tr>
<td>Application deadline</td>
<td>October 10, 2022</td>
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<td>Provisional Participant selection</td>
<td>January 2022</td>
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<tr>
<td>Offering of Participant Agreement (PA) and Data Request and Attestation (DRA) to provisionally selected participants</td>
<td>Late Spring 2023</td>
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<tr>
<td>Distribution of participant-specific beneficiary level historical data</td>
<td>Late Spring 2023 upon PA and DRA execution</td>
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<tr>
<td>EOM Launches</td>
<td>July 1, 2023</td>
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¹ Dates are subject to change
Questions?

Use the Q&A button in the bar at the bottom of your Zoom window
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  ▪ Oncology Care Model

• Must have at least 1 ASCO member at your practice
• Contact us at practicenet@asco.org
Next Call

• Thursday, April 20
  ▪ Developing Strategies for Health Equity, Access, and Distress Screening
  ▪ 3rd Thursday of each month, 4:00pm Eastern Time

https://practice.asco.org/calendar