Enhancing Oncology Model Overview for ACOs

Background

The CMS Innovation Center (CMMI) has created a new alternative payment model (APM) focused on improving cancer care in Medicare. The Enhancing Oncology Model (EOM) builds upon and replaces the Oncology Care Model (OCM), which ended on June 30, 2022. Under the new model, participating oncology practices will take accountability for patients' total cost of care and quality in six-month episodes triggered by chemotherapy administration in patients with one of seven common cancer types. EOM places an emphasis on health equity and introduces new elements such as the use of electronic Patient Reported Outcomes (ePROs). Providers will be paid standard fee-for-service rates with two additional financial incentives: a Monthly Enhanced Oncology Services (MEOS) payment and a performance-based payment (PBP) or recoupment (PBR). Like OCM, the EOM is voluntary and designed to be multi-payer. The new model also supports President Biden's Unity Agenda and Cancer Moonshot initiative to improve the experience of people and their families living with and surviving cancer.

EOM is scheduled to start on July 1, 2023, and last for five years. More detail can be found in the request for applications (RFA) and these frequently asked questions.

Overlap with ACO Models and Other Payers

CMS will allow oncology practices to dually participate in EOM and the Medicare Shared Savings Program, ACO REACH, Comprehensive Kidney Care Contracting, Bundled Payments for Care Improvement Advanced, Comprehensive Care for Joint Replacement, Primary Care First, and other CMS and CMMI models.

EOM participants may enter into financial arrangements with entities that CMMI calls "Care Partners" to help with episode performance. These may include ACOs. Care Partners may share all or some of the PBPs that EOM participants receive. Conversely, Care Partners may share responsibility for repaying PBRs to CMS. EOM participants must submit a proposed Care Partner list with their applications. More information is expected in the forthcoming participation agreement.

Private payers, Medicare Advantage plans, and state Medicaid agencies are eligible to apply to partner with CMS in the model with their payments to EOM participants providers serving patients covered by those other payers. CMS says it will encourage payers to enter into Memoranda of Understanding with CMS to participate in EOM with their patients.

Eligibility

EOM is limited to physician group practices (PGP) with at least one Medicare-enrolled physician or non-physician practitioner who furnishes evaluation and management (E&M) services to Medicare beneficiaries receiving chemotherapy for a cancer diagnosis, bills under the TIN of the PGP for such services, has reassigned his or her right to receive Medicare payments to the PGP, and appears on the PGP's EOM Practitioner List. PGPs that

routinely refer beneficiaries to Prospective Payment System-Exempt Cancer Hospitals for chemotherapy services are not eligible to participate in EOM. Unlike OCM, CMS plans to allow a limited degree of flexibility for EOM practitioners simultaneously billing under the TIN of an EOM participant and the TIN of another PGP not in EOM.

Like OCM, EOM will allow two or more EOM participants to "pool" for purposes of the semi-annual reconciliation calculations, including to set benchmark prices and to determine PBP or PBR amounts. EOM participants will be allowed to voluntarily form a pool, but CMS says it will mandate pooling in cases of significant billing overlap between different EOM participants.

Episodes

The EOM will include seven cancer types: breast cancer, chronic leukemia, small intestine/colorectal cancer, lung cancer, lymphoma, multiple myeloma, and prostate cancer. These cancers represent all prevalent types in the United States, have sufficient Medicare claims data to calculate benchmark prices, and are commonly treated with systemic chemotherapy, which triggers an episode in the model. However, low-risk breast cancer and low-intensity prostate cancer will be excluded from EOM because episodes for these cancer types did not achieve savings in OCM. EOM will have a much narrower allowance of cancer types in the model compared to OCM, which was largely open to all cancer types treated with chemotherapy.

A six-month episode is triggered with the administration of certain chemotherapies as long as the beneficiary receives a qualifying E&M service during the episode. CMS lists the chemotherapies and qualifying E&M services in the RFA and plans to update the list annually.

Attribution

An episode will be attributed to the EOM participant who delivers the first qualifying E&M service after the beneficiary receives the initiating cancer therapy. However, that EOM participant must also provide at least 25 percent of qualifying E&M services during the episode. This is different from OCM, which attributed patients based on the plurality of care. If the initiating PGP did not bill at least 25 percent of cancer-related E&M services during the episode, then the episode will be attributed to the PGP that billed the plurality of cancer-related E&M services.

Financial Details

EOM participants are responsible for patients' total cost of care during a 6-month episode. Performance on both cost and quality will result in either a PBP paid to participants or a PBR owed to CMS. EOM offers two risk arrangements that offer different discounts, target prices, and stop-loss and -gain. Both risk arrangements are two-sided, so unlike OCM, there is no one-sided risk option. 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. CMMI plans to release more information in forthcoming financial papers.

Risk Arrangement Options in EOM

Risk Arrangement	Downside Risk (Stop-Loss)	Upside Risk (Stop-Gain)	EOM Discount	MIPS APM	Advanced APM
RA1	2% of benchmark	4% of benchmark	4% of benchmark	Yes	No
RA2	6% of benchmark	12% of benchmark	3% of benchmark	Yes	Yes

Monthly Enhanced Oncology Services
EOM will continue to offer the option to bill for MEOS payments, up to six for each six-month episode. These MEOS payments aim to support what CMMI calls "Enhanced Services," which include providing patients 24/7 access to care, navigation tools, identifying and addressing social needs, implementing ePROs, among others. CMMI will pay $70 per beneficiary per month, which is far lower than the $160 OCM paid. However, dual eligible patients will receive an additional $30 per patient per month, making MEOS $100 per patient per month. The base $70 MEOS payment will be counted as EOM participants' total cost of care responsibilities, but not the $30 payment for dual eligibles. Because OCM has failed to prove it lowered total Medicare spending or improved quality, CMMI felt the need to lower these MEOS payments to meet its goals of lowering spending.

Benchmark Prices
CMMI will create separate benchmarks that predict the cost of a six-month episode for each of the seven cancer types. Benchmarks will be based on historical claims between July 1, 2016, and June 30, 2020. Specifically, EOM will create a price prediction model to predict expenditures for each baseline period and corresponding performance period episode. CMS will adjust for regional, national, and EOM participant-specific episode. Prices will be further adjusted for certain clinical, trend factors, and novel therapies to ensure EOM participants are not financially responsible for changes in spending out of their control.

Overlap Adjustments in Baseline Periods
CMS says it will make certain adjustments to performance period episode expenditures to account for overlaps in beneficiaries and participants between EOM and these other CMS models. For example, if a patient were aligned to ACOs participating in the Next Generation ACO Model or the Vermont Medicare ACO initiative receiving an All-Inclusive Population Based Payment or Population-Based Payment, then CMS will adjust the paid amount on claims to reflect the amount that would have been paid in the absence of fee reductions to avoid any artificial reduction in spending due to the reduction in Next Gen or the Vermont model. CMS will also not count monthly AIPBP or PBP payments made to Next Generation ACOs or Vermont ACOs to aligned beneficiaries in the baseline period episode expenditures under EOM. For beneficiaries also attributed to Comprehensive Primary Care Plus during baseline years, CMS prorated care management fees in baseline spending but will exclude performance-based incentive payments because those weren't beneficiary specific. Conversely, pro-rated BPCI/BPCI Advanced or CJR episode payments will be included in the baseline for EOM payments.

Quality Payment Program
CMMI expects EOM's Risk Arrangement 1 will be an Advanced APM when the model starts on July 1, 2023. They also expect Risk Arrangement 2 will be a MIPS APM when it starts.

Health Equity
In keeping with a CMMI-wide goal of addressing health disparities through its payment models, EOM includes several adjustments to encourage cancer care providers to work to improve health equity. These include requirements for:

- Collecting beneficiary-level sociodemographic data from EOM beneficiaries willing to share this information and reporting data collected to CMS for purposes of monitoring and evaluation. These include data on race, ethnicity, language preference, disability status, sexual orientation, gender identity, etc.

- Using health-related social needs screening tools to collect data such as food insecurity, housing instability, and transportation concerns from EOM beneficiaries to identify and address potential health disparities. CMS may require EOM participants to report health-related social needs data to CMS in later years of the model.
- Providing patient navigation, as appropriate, to EOM beneficiaries, including but not limited to facilitating linkages to follow-up services and community resources. CMS will encourage EOM participants to develop relationships with community partners to accomplish this goal.
- Providing EOM beneficiaries with 24/7 access to a clinician with real-time access to the practice's medical record.
- Establishing a health equity plan as part of the use of data for continuous quality improvement efforts.

CMMI also plans to make multiple adjustments to payment methodologies to better recognize caring for patients with complex needs and in underserved communities. The MEOS will be $30 higher for dual eligible beneficiaries, making total payments $100 a month for those patients. Benchmarks will be adjusted for dually eligible and low-income subsidy beneficiaries, which serve as a proxy for income and social risk. CMMI plans to release more information on these adjustments in forthcoming financial papers.

Quality

EOM will measure quality in three ways: participant-reported, claims-based, and patient experience survey quality measures. While specific measures were not named in the RFA, CMMI says the measures will be similar to those used in OCM as CMMI explores updates to the quality measure set over time. EOM will focus on five domains: patient experience, avoidable acute care utilization, management of symptoms toxicity, management of psychosocial health, and management of end-of-life care.

EOM participants' performance-based payments or recoupments will be tied to each participant's or pool's performance on these quality measures. For example, participants or pools that earn high quality scores will either receive their maximum performance-based payment or reduce the amount of recoupment owed to CMS. Conversely, participants or pools that earn low quality scores will either receive or reduce their performance-based payment or have no impact on the amount of recoupment owed to CMS.

All measures will be pay-for-performance from the start of the model. Benchmarks for claims-based measures will be based on national claims data from the model baseline period. Benchmarks for participant-reported measures will be based on MIPS data, where such benchmarks are available. Benchmarks for the patient experience survey measure will be based on data collected during OCM.

Participant Redesign Activities

EOM participants will be required to implement eight participant redesign activities (PRAs), which are similar to the PRAs part of OCM. Two new requirements are identifying beneficiary social needs using a health-related social needs screening tool and gradually implementing ePROs. The rest include:

- Providing beneficiaries 24/7 access to an appropriate clinician with real-time access to the EOM participant's medical records;
- Providing patient navigation, as appropriate, to EOM beneficiaries;
- Documenting a care plan for each EOM beneficiary that contains the 13 components of the Institute of Medicine (IOM) Care Management Plan;

- Treating beneficiaries with therapies in a manner consistent with nationally recognized clinical guidelines;
- Utilizing data for continuous quality improvement; and
- Using certified electronic health record technology.

Benefit Enhancements

CMMI plans to offer three waivers and benefit enhancements and says more may be allowed later. All are optional, and EOM participants must submit implementation plans for CMS to approve for each to be used. The three benefit enhancements are:

- **Telehealth** – CMS will waive geographic restrictions on the delivery of telehealth and allow patients to receive services in their homes.
- **Post-discharge home visits** – CMS will allow up to nine post-discharge home visits within 90 days of an inpatient stay.
- **Care management home visits** – CMS will pay for certain home visits by non-physician providers billed "incident to" physician supervision. These visits would supplement traditional physician home visits.

Application Information

Applications are due on September 30, 2022. Submitting an application does not commit an organization to participate in the model when it starts on July 1, 2023. CMMI staff said on a June 29 webinar that they expect just a single application period. Decisions are expected later this year with an implementation period to start in early 2023.

To file an application, applicants may access an electronic portal at https://app.innovation.cms.gov/EOM. Questions about the application should be directed to EOM@cms.hhs.gov.