

Enhancing Oncology Model Summary

On Monday, June 27, 2022, the Centers for Medicare and Medicaid Services (CMS) issued a request for applications (RFA) associated with the introduction of the Enhancing Oncology Model (EOM). According to the RFA, the purpose of the EOM is to drive transformation in oncology care by preserving or enhancing the quality of care furnished to beneficiaries undergoing treatment for cancer while reducing program spending under Medicare Fee-for-Service (FFS). The EOM is a voluntary five-year model that begins on January 1, 2023, and ends June 2028. Applications are being accepted through September 30, 2022.

EOM is a total cost of care (TCOC) model that includes all Part A, Part B and certain Part D services. Similar to the Oncology Care Model (OCM), an episode is triggered with chemotherapy infusion through a six-month period, which could include radiation therapy services. As described in the summary below, the role of the radiation oncologist is limited to the optional “Care Partner” financial arrangement. Additionally, the use of radiation therapy is limited to its inclusion as a cost component associated with episode benchmark pricing.

ASTRO is disappointed that CMS has decided to move forward with a payment model in the oncology space that ignores the value of radiation oncology as a key component within the cancer continuum. One of the tenets of value-based care is the development of alternative payment models that allow physicians to manage the costs that they can control. Radiation therapy is an appropriate candidate for episode-based payment since it is a distinct component of care within the broader cancer care continuum. It involves a unique treatment, delivered over a specific period, that involves medical professionals with specific levels of expertise, such as the medical physicist, and expensive capital resources that are not found elsewhere in medicine.

EOM Participant

To be eligible to participate in EOM as an EOM Participant, a Physician Group Practice (PGP) must be composed of at least one “EOM practitioner,” which must be an “oncology practitioner” defined as a Medicare-enrolled physician by an individual National Provider Identifier (NPI) with a specialty code of Hematology/Oncology or Medical Oncology.

Participating physicians take on financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients via a lump-sum performance-based payment (PBP) or performance-based recoupment (PBR). Additionally, they will have the opportunity to submit claims for Monthly Enhanced Oncology Services (MEOS) payments for enhanced services furnished to Medicare FFS beneficiaries.

The EOM also establishes an **optional** “Care Partner” financial arrangement in which an EOM participant may enter into an agreement with Medicare-enrolled provider or supplier that contributes to episode performance under EOM. ASTRO understands Care Partner to include radiation oncologists who may be involved in the delivery of radiation therapy services as part of an EOM episode of care. Under this type of financial arrangement, EOM participants may share all or some of the PBP they receive from CMS or responsibility for repaying PBRs to CMS with the Care Partner.

According to the RFA, Care Partners must engage in one of the Participant Redesign Activities (PRAs) as described below. They must formally enter into a Care Partner arrangement with the EOM; be identified on the EOM's Care Partner List; and not be an EOM practitioner.

EOM Payers

The EOM is a multi-payer model operated via two tracks. One of the two tracks will be operated by CMS for Medicare FFS (EOM FFS) beneficiaries. Private payers, Medicare Advantage plans, and state Medicaid agencies are eligible to apply for the model and enter into a MOU with CMS to align their own oncology value-based payment models with EOM in key areas, such as health equity activities, accountability, quality measurement and data sharing with EOM participants and CMS. The second track is for EOM payers ("EOM Other Payer") that will apply to patients of an EOM participant who are insured by a participating payer and deemed "EOM Other Payer Beneficiaries." To be eligible to partner with CMS as an EOM other payer, a payer will be required to partner with at least one EOM participant throughout the entirety of the model demonstration period.

Episode Length and Cancer Types

The EOM is a total cost of care (TCOC) model that includes all Part A, Part B and certain Part D expenditures for a six-month episode of care. The EOM is limited to beneficiaries receiving systemic chemotherapy, not beneficiaries receiving hormonal therapy only, for the following seven cancer types:

- Breast Cancer (excluding low risk breast cancer)
- Chronic Leukemia
- Small Intestine/Colorectal Cancer
- Lung Cancer
- Lymphoma
- Multiple Myeloma
- Prostate Cancer (excluding low intensity* prostate cancer)

An episode begins with the beneficiary's receipt of the initiating therapy in combination with a qualifying Evaluation and Management (E&M) service. CMS will issue a list of initiating cancer therapies and update the list of therapies prior to each performance period.

*The RFA says "low intensity", but ASTRO believes the Agency intended to state "low risk."

Monthly Enhanced Oncology Services (MEOS)

The Monthly Enhanced Oncology Services (MEOS) payment to EOM participants will be set at \$70 per beneficiary to support enhanced services such as 24/7 clinician access, patient care navigation, etc. An additional \$30 per beneficiary will be applied to the MEOS payment associated with dual eligible beneficiaries. The \$70 MEOS payment will be applied to the overall TCOC, whereas the \$30 portion will not be included in TCOC calculations.

Baseline Period and Performance Period

CMS establishes eight (six month long) distinct baseline periods between July 1, 2016 - June 30, 2020, and nine (six month long) performance periods between July 1, 2023 - December 31, 2027. For both baseline and performance period episodes, CMS will exclude specific MS-DRGs and any Part D expenditures not included in EOM. Additionally, any MEOS payments associated with prior OCM participation, chimeric antigen receptor t-cell therapy (CAR T-cell therapy) expenditures, and episodes including a COVID-19 diagnosis will be removed from the baseline period.

Payment Methodology

EOM participants are responsible for the total cost of care, including all items and services provided during the episode to the EOM beneficiary by any Medicare providers or suppliers, including the EOM participant, its EOM practitioners and Care Partners, non-EOM oncology physician group practices, and non-oncology providers and suppliers. It should be noted that this includes radiation therapy services delivered by a radiation oncologist during the six-month episode of care. Radiation oncologists who find themselves affiliated with an EOM participant should take measures to ensure that patients with cancer continue to have access to the appropriate radiation therapy treatments necessary to secure optimal patient outcomes.

The EOM payment methodology includes the establishment of a benchmark price for every episode based on the model baseline period. Adjustments will be made to account for participation in other payment models, such as OCM; account for the historical impact of sequestration, changes in inflation and changes in the cost of cancer care; and account for outliers. Additionally, cost benchmarks will be adjusted by dual eligible and low-income subsidy (LIS) status as proxies for income and social risk. CMS will then use the baseline period episodes to create a separate price prediction model for each included cancer type. Specific beneficiary and episode characteristics will be taken into consideration such as age, sex, dual eligibility, non-cancer comorbidities, receipt of select cancer directed treatments, **including radiation therapy**, history of prior chemotherapy use, etc. Additionally, cost benchmarks will be adjusted by dual eligible and low-income subsidy (LIS) status as proxies for income and social risk. CMS will apply an experience adjuster, a clinical adjuster for certain cancer types, a retrospective trend factor and an adjustment for novel therapies to establish the final benchmark rate.

Target Rate and Risk Arrangements

The Model has two risk arrangements. The first, Risk Arrangement 1 or “RA1,” discounts the benchmark amount by 4% and has a stop-loss of 2% of the benchmark amount with an upside cap of 4% of the benchmark amount. The second, Risk Arrangement 2 or “RA2,” discounts the benchmark by 3% with a stop-loss of 6% of the benchmark and an upside cap set at 12% of the benchmark.

In both risk arrangements, the threshold for recoupment will be 98% of the benchmark amount. Those participants, in either risk arrangement, will owe a PBR if their expenditures are greater than 98% of the benchmark.

There will also be a neutral zone within the EOM. For RA1 EOM participants, the neutral zone for expenditures is set between 96% and 98% of the benchmark. For RA2 EOM participants, the neutral zone for expenditures is set at 97% and 98% of the benchmark.

Reconciliation

The reconciliation process will take place on a semi-annual basis, following the end of each performance period, allowing for a one-month claims run out period. A final “true-up” will take place one year after the initial reconciliation.

Health Equity Strategy

EOM participants will be required to collect beneficiary-level sociodemographic data (e.g., race, ethnicity, language preference, disability status, sexual orientation, gender identity) from EOM beneficiaries willing to share this information, and report data collected to CMS. CMS will use the data for monitoring and evaluation activities, as well as to inform feedback reports sent to EOM participants. EOM participants will also be required to use health-related social needs (HRSN) screening tools to collect HRSN data (e.g., food insecurity, housing instability and transportation concerns) from EOM beneficiaries to identify and address potential health disparities within their beneficiary populations. The Agency believes that the identification and addressing of social needs can be accomplished through a combination of patient navigation, which is a required component of the model, and care planning activities — both of which are required Participant Redesign Activities described in the next section. Finally, EOM participants will be required to establish a health equity plan as part of their continuous quality improvement (CQI) efforts. According to the Agency, this will allow EOM participants to identify and monitor where disparities exist in their EOM beneficiary population and use data to support evidence-based strategies to address health care disparities.

Participant Redesign Activities

EOM participants will be required to implement eight Participant Redesign Activities (PRAs), many of which were required under the Oncology Care Model:

- 1) Provide beneficiaries 24/7 access to an appropriate clinician with real-time access to the EOM participant’s medical records;
- 2) Provide patient navigation, as appropriate, to EOM beneficiaries;
- 3) Document a care plan for each EOM beneficiary that contains the 13 components of the Institute of Medicine (IOM) Care Management Plan, as applicable to the EOM beneficiary;
- 4) Treat beneficiaries with therapies in a manner consistent with nationally recognized clinical guidelines;
- 5) Identify EOM beneficiary health-related social needs (HRSN) using a health-related social needs screening tool;
- 6) Gradual implementation of electronic Patient Reported Outcomes (ePROs);
- 7) Utilize data for continuous quality improvement (CQI); and
- 8) Utilize Certified EHR Technology (CEHRT) as specified in 42 CFR § 414.1415(a).

Quality & Clinical Data Elements

An EOM participant's performance on quality measures will be used to determine their aggregate quality score (AQS) which will impact the participant's PBP earned or PBR owed. The measure set will focus on the following domains: patient experience, avoidable acute care utilization, management of symptoms toxicity, management of psychosocial health, and management of end-of-life care. Payment for all of the quality measures will be considered pay-for-performance. For an EOM participant that earns a high AQS, the EOM participant will either maximize their PBP or reduce the amount of PBR owed to CMS. Alternatively, if an EOM participant has a low AQS, their PBP will be reduced. If the EOM participant has a low AQS there will be no impact on the PBR owed to CMS if the performance period expenditures exceed the 98% threshold for recoupment.

EOM participants will also be required to collect and submit to CMS certain beneficiary-level, clinical data elements (CDE) not available in claims or captured in quality measures on a semi-annual basis. CMS will notify EOM participants of CDE reporting requirements prior to the Model's start date.

Advanced APM and MIPS-APM Status

According to the RFA, Risk Arrangement 2 of EOM will satisfy the criteria for both Advanced APM status and MIPS-APM status. Risk Arrangement 1 does not meet the nominal risk requirements associated with Advanced APM status, therefore EOM participants who choose this level of risk will be deemed MIPS-APMS.

Benefit Enhancements

Three optional benefit enhancements will be made available to EOM participants through a conditional waiver for telehealth, post discharge home visits, and care management home visits. EOM participants are required to describe the strategic use of these benefits and how they would be monitored to address potential misuse as part of the application process. CMS will make these available at the start of the model and will consider others as future additional benefit enhancements.

RO Model Overlap

CMS notes that should the **RO Model** ever be operationalized then it would count the RO Model payments for RT services in the EOM performance period expenditures. Any savings generated by the RO Model discount and withholds would be added to the total cost of the EOM performance period during reconciliation to ensure there is no double counting of savings. This would be done on a prorated basis for RT services that are not completed within the six-month episode.

More information about EOM can be found at the following links:

Fact Sheet: <https://www.cms.gov/newsroom/fact-sheets/enhancing-oncology-model>

FAQs: <https://innovation.cms.gov/media/document/eom-fags>

RFA: <https://innovation.cms.gov/media/document/eom-rfa>

CMS is hosting an EOM Overview Webinar on Thursday, June 30 at 3:00 p.m. ET. [Registration](#) is open.