MILLIMAN WHITE PAPER

Enhancing Oncology Model (EOM): OCM "2.0"

CMMI's latest oncology innovation

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The Center for Medicare and Medicaid Innovation (CMMI) recently announced[1] a new voluntary oncology model (scheduled to begin on July 1, 2023) for the Medicare fee-for-service (FFS) population that builds on the concepts introduced in the recently completed Oncology Care Model (OCM): the Enhancing Oncology Model (EOM).

EOM builds on the principles and methodology set forth in OCM, with notable updates to reflect learnings and feedback from OCM. EOM's stated purpose 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)."[2]

Under EOM, participating providers will take on financial accountability for episodes of care relating to chemotherapy administration to cancer patients covered by Medicare FFS. The Centers for Medicare and Medicaid Services (CMS) plans to operate EOM for the Medicare FFS population while EOM payers (including private payers, Medicare Advantage plans, and state Medicaid agencies) will operate the model for their enrollees. This article highlights key components and considerations for providers interested in EOM regardless of past participation in OCM.

Applications for EOM must be submitted using the EOM Request for Application (RFA) portal[3] by September 30, 2022.

Program overview

BACKGROUND

OCM was designed as a specialty model that sought to encourage higher-quality care for patients receiving chemotherapy for cancer treatment. One of the stated goals of the program was to promote effective care coordination in an effort to lower costs associated with cancer treatment while improving patient experience and/or health outcomes.[4]

At the end of OCM's first three years—performance periods (PPs) 1 to 6—there were 173 participating practices with nearly 780,000 episodes. Results suggest that, even though OCM resulted in net losses for Medicare, OCM led to care delivery improvements that benefited all cancer patients, not just those with Medicare coverage.[5]

EOM expects to continue improving health outcomes by placing an added emphasis on equitable health outcomes for all beneficiaries, focusing on a handful of cancer types with greater savings potential and using a more cancer type-specific measurement approach.

What's the same?

CMS has decided to retain many aspects of OCM in EOM:[6]

- **Total cost-of-care performance:** Participants will measure their performance period expenditures against a target amount to potentially receive a performance-based payment/recoupment (PBP/PBR).
- **Episode construction**: Six-month, total cost of care episodes.
- **Quality**: Must achieve a minimum aggregate quality score (AQS) to be eligible for performance-based payments (PBPs). Participants' AQS is used to determine the performance multiplier, which reduces potential PBPs if quality standards are not met.
- **Optional Monthly Enhanced Oncology Services (MEOS) payments:** Monthly payment to support the implementation of Enhanced Services (note that the specific payment amount has changed as discussed below).
- **Drug payment**: All drugs will be reimbursed at Medicare FFS rates.

What's new?

CMMI has made several notable modifications to build on the concepts introduced in OCM and revised them to align with current priorities.

In the section below (and shown in Figure 1), we outline key changes reflected in the EOM versus the methodology used in OCM and discuss the implications of the changes on existing oncology practices as well as prospective EOM participants. Many

of these changes are modifications to concepts seen in OCM but they have been updated and refined based on learnings from past performance years. The changes discussed below will impact who will participate in the model, how a PBP/PBR will be calculated, and organizational requirements for participants.

1. INCLUDED CANCER TYPES

CMS found that reduction in total episode payments under OCM was concentrated in a subset of higher-risk episodes, most of which are treated with systemic chemotherapy as opposed to exclusively hormonal chemotherapy.[7] Under EOM, the list of included cancer types has been reduced (breast cancer, lung cancer, lymphoma, multiple myeloma, prostate cancer, small intestine/colorectal cancer, and chronic leukemia) and systemic chemotherapy is required to trigger an episode. [8]

EOM focuses on seven cancer types: **breast cancer, lung cancer, lymphoma, multiple myeloma, prostate cancer, small intestine/colorectal cancer,** and **chronic leukemia**

Why this matters: This change will limit the types of oncology practices that can participate in EOM as well as the volume of episodes covered by the program, which limits the opportunity for savings.

2. CHANGE TO RISK ARRANGEMENTS

Participants in OCM had the option of remaining in a one-sided risk arrangement through PP7. Those that achieved a PBP by PP4 were permitted to remain in a one-sided risk arrangement for the remainder of the program; all other participants were required to shift to two-sided risk. Figure 1 summarizes the risk options available under OCM.[9]

FIGURE 1. OCM RISK ARRANGEMENTS

	One-sided and original two-sided	Alternative two-sided
Discount	4%	2.75%
Stop-Gain	20% of benchmark	16% of total Part B revenue
Stop-Loss	20% of benchmark	8% of total Part B revenue
Hurdle Rate	0%	0%

Under EOM, participants will be able to choose between two different risk arrangements (RAs), which both expose participants to downside risk. Additionally, both RA1 and RA2 of EOM include hurdle rates and neutral zones, which are percentages above the target amount that the participant must exceed in order to begin accruing a PBR. Figure 2 summarizes the RAs available in EOM.[10]

FIGURE 2. EOM RISK ARRANGEMENTS

	RA1	RA2
Discount	4%	3%
Stop-Gain	4% of benchmark	12% of benchmark
Stop-Loss	2% of benchmark	6% of benchmark
Hurdle Rate	2%	1%

Additionally, to incentivize maintaining high-quality care when participants owe a PBR to CMS, PBRs are reduced by 10% for those with an AQS of 75% or higher, and 5% for those with an AQS between 50% and 75%.[11]

Why this matters*: Unlike OCM, participants in EOM will be exposed to downside risk in all performance periods*. The new hurdle rates and neutral zones protect participants from first-dollar losses and imply that participants need to realize meaningful losses to owe a PBR. Additionally, the impact of quality on PBRs further safeguards participants who continue to provide high-quality care while in loss positions.

3. CHANGE TO NOVEL THERAPIES ADJUSTMENT

The novel therapies adjustment increases the benchmark price for episodes attributed to practices with a high share of costs for oncology therapies newly approved by the U.S. Food and Drug Administration.

This adjustment in OCM was calculated in aggregate across all cancer types, which may have dampened the effect of new-to-market, cancer-specific therapies. In EOM, the novel therapies adjustment will be calculated and applied for each cancer type separately.[12]

Why this matters: By applying the novel therapy adjustments at the cancer-type level, EOM will adjust the benchmark to more appropriately reflect true episode expenditures. Practices will be more incentivized to use the new treatments that may lead to improved patient outcomes without the negative impact on the potential to generate a PBP.

4. MONTHLY ENHANCED ONCOLOGY SERVICES PAYMENT AMOUNT

OCM resulted in net losses for Medicare, largely driven by the optional Monthly Enhanced Oncology Services (MEOS) payments, which were designed to provide financial support for providing enhanced care.[13] MEOS payments in EOM will be lower than those in OCM, but participants will receive an additional $30 per beneficiary per month (PBPM) payment for dual-eligible beneficiaries (duals). To acknowledge that duals may require more focused care, this additional payment for duals will not be included in total episode expenditures.[14]

FIGURE 3. MEOS PAYMENTS PBPM

	OCM	EOM
Dual-eligible beneficiaries	$160	$100; *includes $30 not counted toward total episode expenditures*
Other beneficiaries		$70

Why this matters: MEOS payments have been reduced in EOM, which decreases the overall financial support from CMS to participants but helps support practices that may serve a disproportionate number of dual-eligible patients.

5. EMPHASIS ON HEALTH EQUITY

A 2020 study from the American Association for Cancer Research found that there are notable disparities in cancer incidence and mortality rate for racial and ethnic minorities. Furthermore, socioeconomic status and geographic disparities may have confounding effects on observed disparities.[15] EOM places an emphasis on health equity by introducing the following policies, some of which are components of the participant redesign activities (PRAs) described in the next section:

- **Sociodemographic data**: Participants will be required to collect and report to CMS sociodemographic data on EOM beneficiaries. Factors include but are not limited to race, ethnicity, sexual orientation, and gender identity.
- **Health-related social needs (HRSN)**: Participants will be required to use screening tools to collect HRSN data such as the degree of food insecurity, limitations on housing, and access to transportation.
- **Patient navigation**: Participants need to facilitate follow-up care and advocate for the use of community resources.
- **Payment adjustments**: Modifications to the payment methodology that recognize differences in resource need for beneficiaries in underserved communities (see the "Other Notable Changes" section below for more detail).
- **Patient-centered care**: Participants will be required to provide 24/7 access to a clinician with access to the beneficiary's medical records.
- **Health equity plan**: Participants will be required to create a health equity plan, describing where health disparities may already exist along with proposed solutions to address them.

Why this matters: Examining and addressing health disparities is an important part of improving care delivery. However, some practices may need to invest additional resources in order to meet these requirements. EOM plans to adjust benchmarks to account for dual eligibility and low-income subsidy (LIS) status, which allow participants to direct extra resources toward patients with the greatest need.

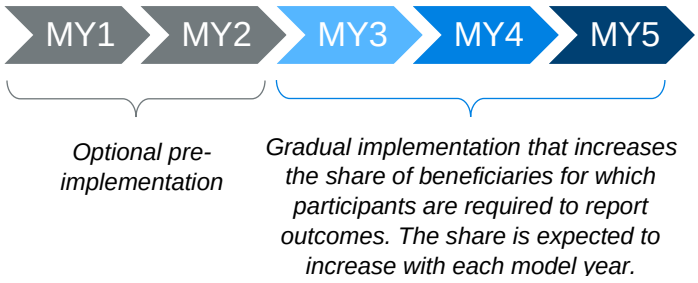
6. PARTICIPANT REDESIGN ACTIVITIES

Participant redesign activities (PRAs) are specific care management functions of the program that encourage participants to emphasize quality while also providing cost-effective care to beneficiaries. EOM participants will be required to implement eight PRAs, six of which were previously included in OCM. One of the new PRAs is the required use of a HRSN screening tool as described in the prior section. The other new PRA is the gradual implementation of electronic patient-reported outcomes (ePROs), which capture data directly from patient responses (outside of a healthcare setting). The ePROs can lead to improved care delivery due to better provider-patient communication, increased patient satisfaction, and fewer medical complications.[16]

While participants will not be required to use a specific ePRO tool, the ePRO tool used must measure outcomes for four domains: symptoms and/or toxicity, functioning, behavioral health, and HRSNs. The tool must also be integrated with the practice's electronic health records (EHRs).

Because participants may not have the infrastructure in place at the beginning of the program, the use of ePROs will be phased in over the duration of the model. Figure 3 demonstrates the implementation timeline throughout model years (MYs).

FIGURE 3. EPRO IMPLEMENTATION TIMELINE



Why this matters: While many of the PRAs required in EOM are consistent with those required in OCM, the two new PRAs may necessitate investment from participants in order to satisfy their requirements.

7. OTHER NOTABLE CHANGES

EOM introduced other notable changes from OCM:

EPISODE ATTRIBUTION

OCM's episode attribution methodology used a simplistic approach of attributing episodes based on the plurality of evaluation and management (E&M) services during the six-month episode. Under EOM, episodes are attributed to a practice if:

- The first qualifying E&M visit after initiating chemotherapy is with the practice
- At least 25% of cancer-related E&M services during the six-month episode are with the practice

If the initiation practice does not have at least 25% of the cancer-related E&M services, then the episode is attributed based on the plurality of E&M services.[17]

Why this matters: Participants will have a better idea of which episodes will ultimately be attributed to them in real time as they treat and see patients.

RISK ADJUSTMENT

EOM's risk adjustment models will be developed at the cancer type level, improving upon OCM's risk adjustment model that included separate coefficients for each cancer type but included a handful of variables that were developed in aggregate. EOM's models will generate separate coefficients for non-cancer type variables, which may result in increased predictive power.

In addition to the variables used in OCM, two new clinical variables will be introduced to the model:

- **Ever-metastatic status**: Applicable for breast cancer, lung cancer, and small intestine/colorectal cancer.
- **Human epidermal growth factor receptor 2 (HER2) status**: Applicable for breast cancer.

Why this matters: An increase to the predictive power of the risk adjustment model will lead to more accurate target prices in most cases and allow PBPs to more closely reflect true performance.

Closing thoughts

CMMI has decided to continue the concept introduced in the OCM model while introducing a number of enhancements, with the aim of generating savings for the Medicare program as well as enhancing the care provided to oncology patients. While there are some new concepts introduced in the EOM model, previous participants of OCM will recognize the general model structure. Those interested in participating (including those who participated in OCM, as well as those new to CMS oncology risk models) should perform additional analyses to assess whether the model may be a good fit for their practice.

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ENDNOTES

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