ENHANCING ONCOLOGY MODEL

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PERSPECTIVES FROM ONCOLOGY PRACTICES & THE PATH FORWARD IN VALUE-BASED CARE

Understanding the Enhancing Oncology Model (EOM)

What is the EOM?

On June 27, 2023, the Centers for Medicare & Medicaid Services (CMS) introduced its new value-based care initiative and reimbursement model for oncology care, the Enhancing Oncology Model (EOM). The EOM is a 5-year voluntary program beginning on July 1, 2023, where oncology group practices participate in a risk-based payment arrangement with CMS in exchange for implementing redesign activities and reporting on cost and quality-related data for Medicare patients with certain cancers. By providing payment incentives and the opportunity for enhanced reimbursement to healthcare providers, the model aims to improve the quality of care and support for cancer patients, focus on health equity, and reduce costs of care.

The EOM builds on the framework, methodology, program goals, and industry learnings from the Oncology Care Model (OCM), a 5-year voluntary value-based payment model led by CMS' Innovation Center that ended in 2022. Under the OCM, participating practices entered performance- and value-based payment arrangements with CMS to improve the episodic quality of care for oncology patients and decrease costs.

EOM vs OCM At-A-Glance

EOM	OCM
Voluntary **5-year** program Beginning July 1, 2023, and ending on June 30, 2028	Voluntary **6-year** program Beginning July 1, 2016, and ended on June 30, 2022
44 participating practices and **3** commercial payers (as of July 25, 2023)	**122** participated practices and **5** commercial payers (as of June 30, 2022)
• Limited to **7** common cancer types: breast cancer, chronic leukemia, small intestine/colorectal cancer, lung cancer, lymphoma, multiple myeloma, prostate cancer • Excludes patients receiving hormone-only therapy	• Includes all **21** cancer types • Includes patients receiving any form of systemic anticancer therapy • Includes hormone-only therapy
Option between 2 **double-sided risk** models, both requiring downside risk from the start	One-sided **upside-only risk** model, with optional downside risk (not mandated)
Two-part payment system based on 6-month episodes of care: 1) Monthly Enhanced Oncology Services (MEOS) Payment: **$70** per Medicare beneficiary per month 2) Performance-based payment or recoupment is calculated retrospectively based on quality of care and cost savings	Two-part payment system based on 6-month episodes of care: 1) MEOS Payment: **$160** per beneficiary per month 2) PBP if total expenditures do not exceed target benchmarks (only for higher-volume cancer types); no PBR calculated under upside-only risk model if total costs exceeds targets
Required to use health-related social needs (HRSN) screening tool and implement electronic patient-reported outcomes (ePROs)	Use of HRSN screening tool or implementation of ePROs not considered required participant redesign activities

Provider Billing and Reimbursement Under EOM

In addition to fee-for-service payments, participating providers and practices can receive enhanced reimbursement under the EOM while simultaneously taking on financial risk based on performance. Unlike its predecessor with the OCM, the EOM implements a two-sided risk approach to payment from the start of the model.

MONTHLY ENHANCED ONCOLOGY SERVICES (MEOS) PAYMENT

- Participants bill for a MEOS payment for Enhanced Services provided to eligible beneficiaries
  - EOM participants may bill Medicare for up to six MEOS charges for episodes of care, equal to **$70 per beneficiary per month**
  - MEOS payments are higher for beneficiaries dually eligible for Medicare and Medicaid – an additional **$30 per month**, totaling $100 per beneficiary per month
  - Dates of service begin 30 days prior to the episode start to 30 days after the episode ends
  - MEOS payments may be billed in real time or within 12 months following the date of service
  - For participants' delivery of Enhanced Services, patients are not responsible for cost sharing for any portion of the new EOM payment

LOWER MEOS PAYMENTS. *The EOM payment amounts for providing "enhanced services" are notably less than the amounts under OCM ($70/$100 per beneficiary/dually eligible beneficiary per month versus $160 per beneficiary per month), while requiring greater data collection and reporting requirements.*

RETROSPECTIVE PERFORMANCE-BASED PAYMENT

- Participants elect one of two risk arrangement options, which have differing levels of downside risk:

	Stop-Gain	Payment (+)	Recoupment (-)	Stop-Loss
Risk Adjustment Option #1	4%	96%	98%	2%
Risk Adjustment Option #2	12%	97%	98%	6%

- CMS uses 8, 6-month episodes from July 1, 2016 – June 30, 2020, as a baseline for targets, along with applying a risk-based adjustment based on cancer-type and "experience" adjustments to account for geographic and practice-specific factors.
- For each 6-month episode of care, participants assume all costs of proving care; quality metrics, cost savings, and target benchmarks are used to determine participants' performance and corresponding payment (or recoupment) amount following the care episode.
  - **Performance-Based Payment (PBP):** Participants earn a PBP if total expenditures for episodes of care are less than a risk-adjusted target amount
  - **Neutral Zone**: If episodic care expenditures fall between the target amount and threshold for recoupment, no payment is earned nor owed
  - **Performance-Based Recoupment (PBR):** Participants owe a PBR if total expenditures for episodes of care are greater than the threshold for recoupment

DOUBLE-SIDED RISK. *The two-sided risk approach of the EOM deviates from OCM, which did not include the PBR to penalize poor performance. Oncology practices – particularly smaller offices – are finding the PBR to be a deterrent for participation; while larger systems may have the pooling power to keep expenditures low, many smaller practices may see potential recoupments as too big a barrier to successfully participate.*

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Key EOM Redesign Elements

To improve the delivery of oncology care and reduce program healthcare costs, EOM establishes several "participant redesign activities" that focus on delivering high-quality and patient-centered care.

Physician group practice participants under EOM are required to focus on 8 patient-focused practice redesign activities, which include 6 requirements from the OCM with heightened expectations, as well as two new required activities that will be gradually phased in over the model's 5-year performance period.

EOM PARTICIPANT REDESIGN ACTIVITIES

- Screen for **health-related social needs** (HRSN) using a HRSN screening tool
- Gradually begin collecting **electronic patient reported outcomes** (ePROs)
- Use **certified electronic health record technology** (CEHRT)
- Provide care consistent with nationally recognized **evidence-based guidelines**
- Provide **patient navigation** services to EOM beneficiaries, as appropriate
- Provide **24/7 access** to a clinician with real-time access to medical records
- Document detailed **care plans** for each EOM beneficiary, containing the 13 components in the Institute of Medicine (IOM) Care Management Plan
- Collect and report on **clinical data** elements, **quality measure data**, and patient-level **sociodemographic data** to continuously improve quality of care

New Focus on Health Equity

The EOM incorporates several program elements and participant requirements to work toward achieving CMS' goals of advancing health equity and addressing health disparities:

- Incentivize care for underserved communities
- Collect and report beneficiary-level sociodemographic data
- Identify and address health-related social needs (HRSN)
- Improve access to treatment and care planning
- Develop health equity plans (HEP), as part of the use of data for continuous quality improvement (CQI)

HEALTH EQUITY REQUIREMENT. *The EOM requires participants to use a health-related social needs (HRSN) screening tool to identify and incorporate social conditions and environmental factors in patients' care planning and connect patients to available resources in their communities to promote health equity. Participants are required to screen for at least three HRSN categories: food insecurity, transportation, and housing instability.*

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Perspectives from Oncology Practices

EOM ADVISORY PANEL DISCUSSION WITH ONCOLOGY PRACTICE LEADERS

To gather early perceptions of the EOM and understand how practices evaluated participation decisions in the new model, Magnolia Innovation facilitated an advisory panel discussion with key opinion leaders (KOLs) in May. The collective expertise of the advisory panel comprised of pharmacy directors, pharmacists, value-based care professionals, quality directors, medical directors, physicians, chief medical officers, and chief executive officers. These KOLs represented health systems, cancer centers, and oncology practice groups who had previously participated in the OCM. During the panel discussion, KOLs shared their knowledge, experiences, and learnings from their organization's journey with value-based care and success under the OCM and provided insights into their decision-making when considering EOM participation beginning in 2023.

Emerging Themes From Oncology Leaders Participating in Value-Based Care

KEY LEARNINGS FROM PARTICIPATING IN OCM

- **Controlling Costs of Care –** Under the OCM payment model, practices were in a more competitive reimbursement environment than their historic fee-for-service contracts created, which led to more appropriate and efficient management of patients through incentivizing care coordination, encouraging improved communication, and utilizing personnel and patient time more efficiently.
- **Improvements to Patient Care –** OCM participation requirements allowed participating practices the opportunity to build the necessary infrastructure, implement process improvements, and establish new workflows needed to improve patient care. By offering 24/7 access to care, extending practice hours, allowing same-day appointments, adding new service lines, building intermediate care centers, and implementing triage processes, patients were receiving care in more appropriate and cost-effective settings than the emergency department.
- **Provider and Staff Buy-In –** When undergoing a significant practice transformation like OCM, buy-in from all levels of staff, providers, administrators, and executive leadership is a key determinant of outcomes from participating in alternative payment and delivery models. OCM participation and program success relied on an organization-wide culture shift, engagement from all practice stakeholders, adaptability from healthcare providers, and robust education and training.

TRANSFERRING OCM LEARNINGS TO OPPORTUNITIES IN EOM

By building on the framework of OCM, the EOM provides oncology practices the continued opportunity to gain experience in value-based care, improve their delivery of care, benefit from cost-savings/reducing total costs of care, and receive enhanced reimbursement – all through utilizing the existing infrastructure and experience gained from previous participation in the OCM.

KOL panelists agreed participating in alternate payment models and value-based care programs like OCM and EOM establishes practices and health systems as leaders in healthcare delivery reform and innovation.

> "People want to be involved in innovation and value-based care – participating in OCM was a stamp of that, and EOM is as well."
>
> *- Chief Medical Officer, Community-Based Oncology Practice Group*

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Emerging Themes From Oncology Leaders Participating in Value-Based Care (cont.)

KEY FACTORS CONSIDERED IN DECISION-MAKING FOR EOM PARTICIPATION

Downside Financial Risk

Unlike in the OCM, EOM participants face downside financial risk from the start of the model, and may potentially owe recoupment payments based on under-performance/high costs of care; concern for taking on double-sided risk is greater where practices have not participated in similar models previously

Lower MEOS Payments

MEOS payment under the EOM framework is $70 per beneficiary per month – an over 50% reduction in payment per beneficiary received under the OCM, raising concerns of the financial benefit of participation without sufficient payment to offset increased operational costs of participation

Performance Targets and Benchmarks

Performance improvement (and subsequently payment or recoupment calculation) is measured against the practice's own historical performance – disadvantaging participants' that have historically performed well under the OCM, have already implemented cost-control practices in delivery of care, and/or have mitigated

Data Reporting Requirements

While the OCM was criticized to have burdensome reporting requirements and in-actionable data (resulting in minimal benefits to the practice or patient care), the EOM includes heightened data requirements, potentially increasing the administrative time spent collecting, analyzing, and reporting large volumes of data

Staffing and Personnel

Smaller practices may feel disadvantaged under the EOM by placing more pressure on staffing and personnel shortcomings in data reporting requirements; EOM participation impacted by existing staff education level, technical proficiency, and/or bandwidth, or practice may be limited by lack of budget to increase staffing needs

Fewer Cancer Types

Number of included cancer types decreased from 21 under the OCM, to 7 in the EOM - resulting in a smaller pool of eligible patients per practice and a smaller patient pool to spread risk across; Smaller allowed diagnoses under the EOM also creates a smaller, more homogenous, patient population, which inherently creates selection bias

> "The financial environment right now for health systems and practices is getting tighter and tighter. We're used to upside risk, [and] we're good with that – but [mandatory downside risk] is pushing us into an area that we haven't been yet, and I think that is our biggest concern."
>
> - Director of Pharmacy Services, Academic Medical Institution

To learn more about the implications of the Enhancing Oncology Model and how federal policy affects your organization's strategy, contact us at info@magnoliamarketaccess.com.

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Key Takeaways for Biopharmaceutical Manufacturers

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When asked about biopharmaceutical manufacturers and their role as the industry looks toward the path forward with value-based care in oncology:

- KOLs emphasized the continued need from biopharmaceutical manufacturers in supporting practices through the transition away from fee-for-service, and toward alternative payment models,
- encourage biopharmaceutical manufacturers to bolster their role and impact in the delivery of high-quality, cost-efficient care through innovative strategies,
- **and identified avenues for engagement and opportunities for biopharmaceutical manufacturers to assist practices and providers in navigating the ever-changing and dynamic healthcare ecosystem:**

AVAILABILITY OF CLINICAL STUDIES AND DATA

- Conduct clinical and outcomes studies and make that information available to practices and other decision-makers
- Share data, learnings from studies, and tools regarding social determinants of health
- Ensure the availability and accuracy of data through health information technology

DISTRIBUTION NETWORK STRATEGIES

- Consider distribution network strategy for oral medications and the role of pharmacy benefit managers (PBMs)
- Balance between strategies focusing on the front end (prescribers making treatment decisions) versus back end (negotiations with payers)

VALUE PROPOSITION AND PRICING

- Shift the value proposition and messaging away from focusing on higher margins due to high prices and toward reducing total cost of care while keeping quality of treatment equal
- Leverage contracting and pricing frameworks to increase value to practices and patients

EDUCATIONAL MATERIALS AND RESOURCES

- Provide practices with unbranded educational resources for patients and training materials for office staff
- Sponsor local educational events
- Participate in state society meetings
- Facilitate knowledge transfer and learnings between practices and health systems

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