



exchange2023
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Enhancing Oncology Model (EOM)

Center for Medicare and Medicaid Innovation's (CMMI) new national, 5-year voluntary Enhancing Oncology Model (EOM) was designed from the feedback of the oncology community combined with learned lessons from its predecessor program – Oncology Care Model (OCM) which ran from July 1, 2016 – June 30, 2022.

The EOM performance period began July 1, 2023 and will run through June 2028.

EOM aims to transform the affordability and accessibility of cancer care for both beneficiaries and Medicare.



Oncology Care Model (OCM) – participants



Source: Centers for Medicare & Medicaid Services

- After an open application and selection period, nearly 200 physician groups and 17 payers, in addition to CMS, are participating in OCM.

<https://www.cms.gov/priorities/innovation/innovation-models/oncology-care>

As of June 30, 2022 there were 122 practices and 5 commercial payers participating in the Oncology Care Model.

Enhancing Oncology Model (EOM) – design elements



Aligned multi-payer payment model

- Medicare fee-for-services (FFS)
- Partnerships with other payers who agree to participant with EOM
 - Private payers
 - Medicare advantage plans
 - Medicaid agencies



Updates been made in the development of the EOM program

- Health equity – collect and report, screen, develop care plan and health equity plan
- Electronic Patient Reported Outcomes (ePROs) – implantation
- MEOS payments – decreased reimbursement, additional dual eligible
- Cancer types - seven
 - Breast cancer, chronic leukemia, small intestine/colorectal cancer, lung cancer, lymphoma, multiple myeloma, and prostate cancer
- Immediate required downside risk

EOM – design elements – risk

EOM participants must select a two-sided risk arrangement and the selection can be changed on specific dates semi-annually

RA1 – risk arrangement 1, default

- Upside risk of 4% - payment
- Downside risk of 2% - recoupment
- MIPS APM, not enough risk for advanced status

RA 2 – risk arrangement 2, upon request

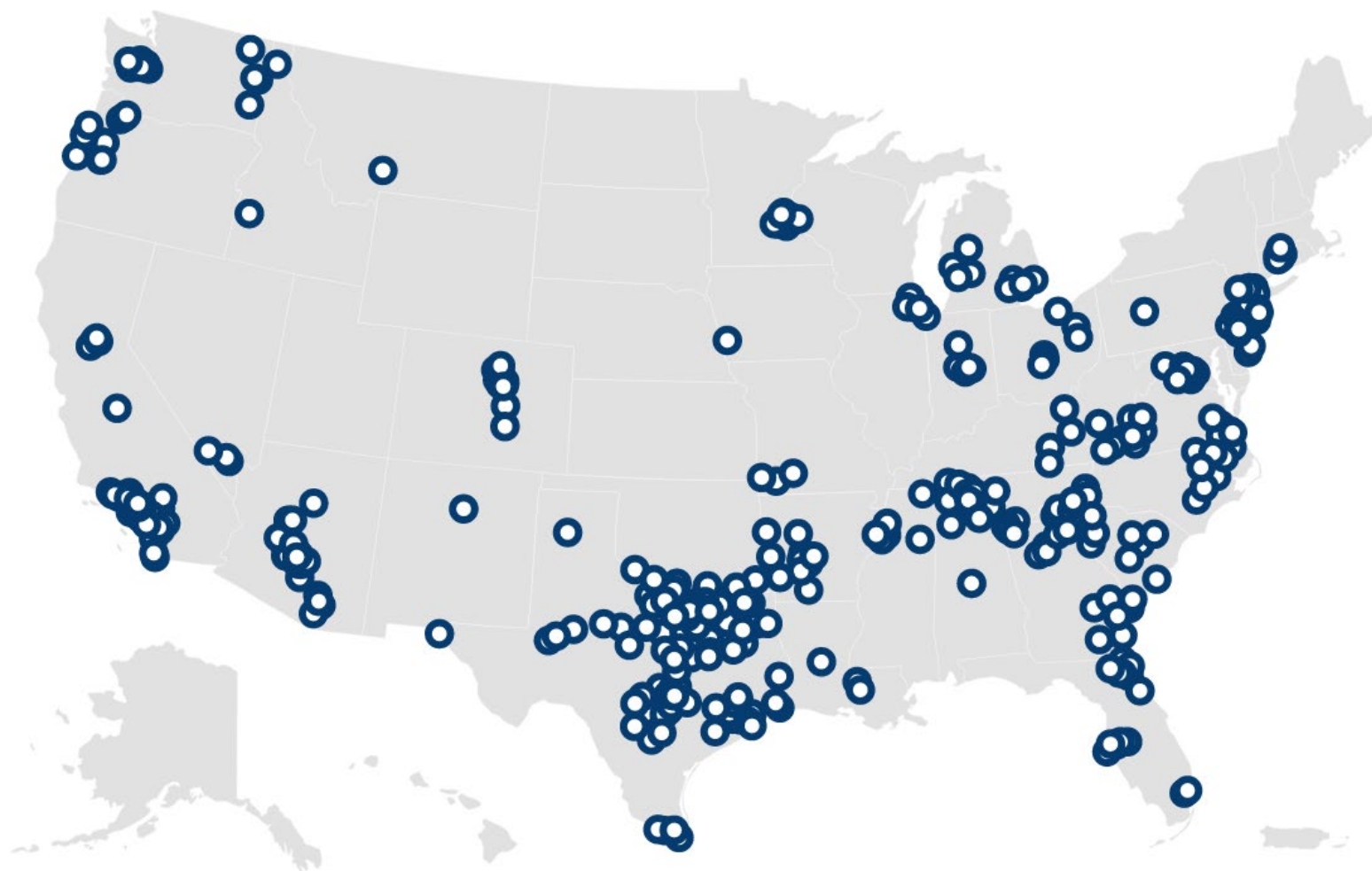
- Upside risk of 12% - payment
- Downside risk of 6% - recoupment
- Advanced APM, not required to report traditional MIPS
 - If you earn QP status – you will not be scored on MIPS
 - **Note:** since the program did not start until July 1 of this year – EOM participants should plan to report MIPS, because QP status will be difficult to achieve within a partial year



Keep in mind

MIPS reporting may be required even with EOM participation

Enhancing Oncology Model (EOM) – participants sites of care



- 44 practice participants
- 12 ION members
- 3 commercial payers

Source: Centers for Medicare & Medicaid Services

Overview of QPP

MIPS vs. Advanced APMs



QPP participation

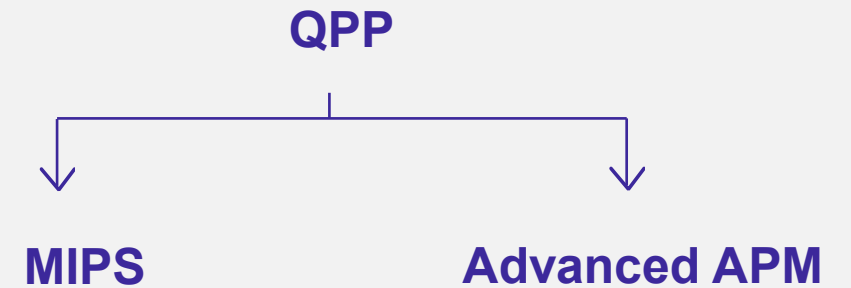
The quality payment program (QPP) is comprised of two paths:

MIPS

- Traditional MIPS
- MVPs
- MIPS APMs

Advanced APMs

- Potential to achieve QP status



Category weighting for 2023

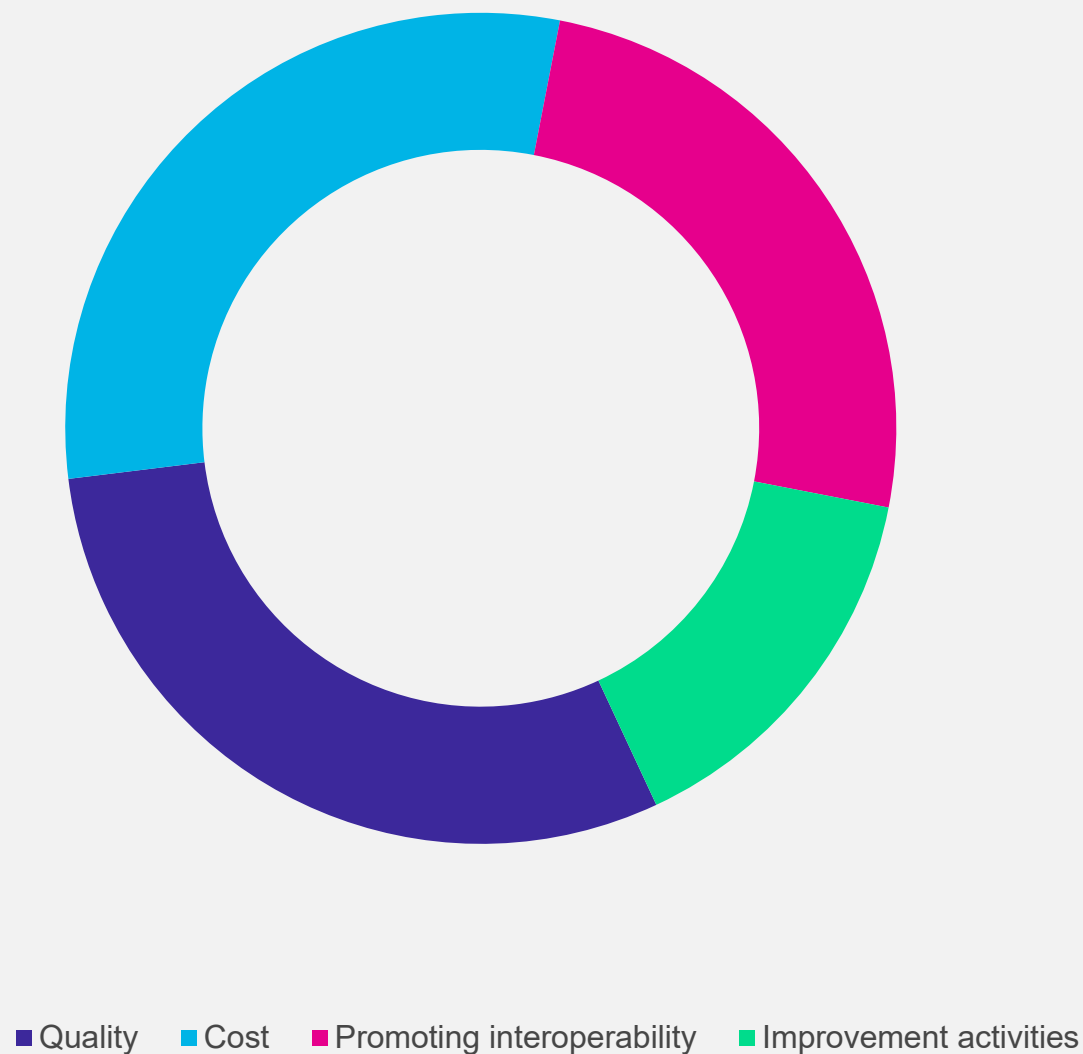
Traditional MIPS

30% quality

30% cost

25% promoting interoperability

15% improvement activities



APM participants eligible for MIPS

Any MIPS eligible (non-QP) clinicians can report MIPS.

Options:

- Individual
- Group
- Virtual group (controlling score)
- MVPs
- MIPS APM entity (cost weighted at 0%)
- APM performance pathway (APP)
- Combination



Reporting paths: scoring compared

Depending on your path and unique situation, category weights differ.

Category	Traditional MIPS	APM performance pathway	APM entity
Quality	30%	50%	55%
Promoting interoperability	25%	30%	30%
Cost	30%	0%	0%
Improvement activities	15%	20%	15%







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