An EOM and OCM Comparison

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On June 27, the Centers for Medicare & Medicaid Services (CMS) announced the long-awaited successor to the Oncology Care Model (OCM). The new Enhancing Oncology Model (EOM) is in many ways a very similar model to its predecessor, whose final participation period ended on June 30. Like OCM, EOM is a voluntary, multi-payer model, meaning that commercial payers, Medicare Advantage plans, and state Medicaid agencies are also eligible to apply to align their payment methodologies with EOM. Also like OCM, EOM participants will be responsible for the total cost of care during a six-month episode triggered by the receipt of an initiating cancer therapy for an included cancer type.

Many other OCM elements will remain the same in the EOM, including drug payments counting toward the total cost of care responsibility and all of the OCM's participant redesign activities—with the addition of two new requirements to implement a social needs screening tool and electronic patient-reported outcomes. However, interested applicants should consider several key differences between the OCM and the EOM before agreeing to participate in the new program.

Required Downside Risk from the Start

The OCM was largely a upside-only risk model, where participants were able to earn performance-based payments if they generated savings when compared to the model's risk-adjusted historical benchmarks. In the OCM, only participants that had not earned a performance-based payment by the initial reconciliation of performance period 4 were required to accept downside risk beginning in the eighth performance period or be terminated from the model. Any participants that had generated sufficient savings by that point in the model had the option to remain in the one-sided risk track for the remainder of the OCM.

In the EOM, on the other hand, all participating practices will be required to select one of two risk arrangements, including downside risk from the model's start. In the less aggressive risk arrangement, the upside risk will be 4 percent of the benchmark amount and downside risk will be 2 percent of the benchmark amount. In the more aggressive risk arrangement, the upside risk will be 12 percent of the benchmark amount and the downside risk will be 6 percent of the benchmark amount. In both risk arrangements, if a participant's performance period episode expenditures are greater than 98 percent of the benchmark, the participant will owe a performance-based recoupment. If their expenditures are less than the target amount, participants may still earn a performance-based payment.

Ultimately, this requirement to take downside risk from the start of the model may prove to be a significant disincentive for many practices interested in participating, particularly if they do not have prior experience in the OCM or another two-sided risk model. Even those with prior experience will be paying close attention to the specifics of the pricing methodology and price prediction models in analyzing whether it will be possible to achieve savings and avoid owing a performance-based recoupment under this new model.

Reduced Payments for Enhanced Oncology Services

One important financial element of the OCM was the ability for participants to submit claims for a per beneficiary per month payment amount for "enhanced services" called the Monthly Enhanced Oncology Services (MEOS) payment. These enhanced services included 24/7 access to a clinician, patient navigation services, the documentation of a care plan, and treatment consistent with nationally recognized clinical guidelines. In the OCM, the MEOS payment amount was $160 per beneficiary per month, all of which was included in the participant's total cost of care responsibility. Under the EOM, CMS reduced the MEOS payment by more than half to $70 per beneficiary per month. However, for dual-eligible beneficiaries, participants can bill for an additional payment of $30 (for a total of $100 per beneficiary per month), and the additional $30 will not be included in the total cost of care responsibility.

The significant reduction in MEOS payments is another point of concern for cancer programs and practices considering participation in the EOM, given that those payments were necessary to subsidize required practice transformation activities in the OCM. Though the additional MEOS payment for dual-eligible beneficiaries is a nice incentive to encourage participation from practices who treat underserved communities, it is yet to be seen whether that incentive will outweigh concerns around the potential for losses due to required downside risk.

Fewer Included Cancer Types

Nearly all cancer types were included in the OCM, including beneficiaries receiving hormone-only therapies for lower-complexity cancers. In designing the EOM, CMS made the decision to remove beneficiaries receiving exclusively hormonal therapies and limit the scope of the model to systemic chemotherapy treatment for just seven cancer types: breast cancer, chronic leukemia, small intestine/colorectal cancer, lung cancer, lymphoma, multiple myeloma, and prostate cancer. As CMS indicated in the EOM Request