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Enhancing Oncology Model (EOM) Health Equity Strategy

Health Equity Strategy

- 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 use of data for Continuous Quality Improvement (CQI)

The following sections describe EOM's health equity strategy in more detail.

Incentivize care for underserved communities

EOM includes a differential MEOS payment for **dually eligible**[1] beneficiaries to support the implementation of Enhanced Services, such as patient navigation and HRSN screening.

INCLUDED in TCOC responsibility
$110 PBPM[2] BASE MEOS PAYMENT[3]

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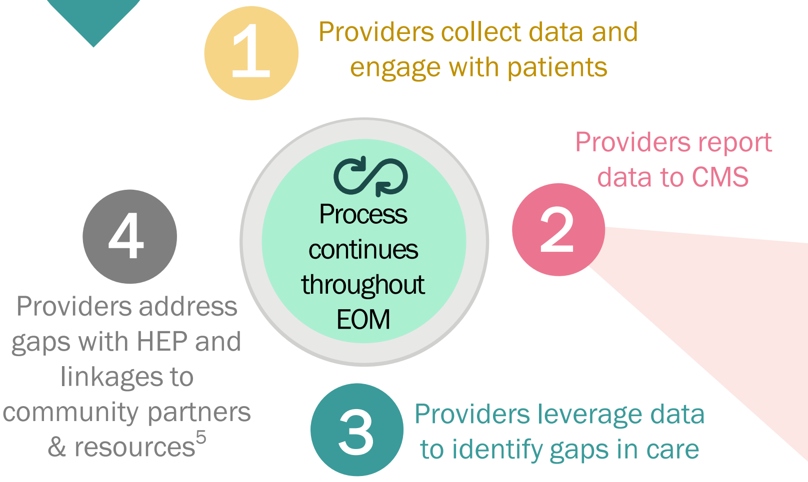
EXCLUDED from TCOC responsibility
$30 DUALLY ELIGIBLE PBPM MEOS PAYMENT

This adjustment is meant to help mitigate any potential disincentive in a total cost of care model (TCOC) to serve dually eligible patients who historically account for a disproportionate share of Medicare expenditures and are associated with higher episode expenditures.

EOM allows limited flexibility for billing overlap to ensure providers can serve patients across different sites of care, for example, in rural and underserved communities.

Collect and report beneficiary-level sociodemographic data



EOM participants collect and report the *following*[4] sociodemographic data elements to CMS **no more than once** per performance period (PP):

- Race
- Ethnicity
- Preferred Language
- Disability Status
- Sex
- Gender Identity
- Sexual Orientation

CMS uses the data to:

- Evaluate model impact
- Monitor to ensure equitable access and treatment
- Inform participant-specific feedback reports so EOM participants can identify and address disparities

EOM participants are **NOT** be required to report sociodemographic data to CMS for **any beneficiary who CHOOSES NOT to provide** such data

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[1] Dually eligible refers to beneficiaries who are eligible for both Medicare and Medicaid. Dual eligibility serves as a proxy for income and social risk. U.S. Department of Health and Human Services. (2020) Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. Retrieved from https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//171041/ASPESESRTCfull.pdf

[2] PBPM stands for per-beneficiary-per-month, meaning that EOM participants can bill CMS for each month Enhanced Services are furnished to EOM beneficiaries.

[3] The increase in base MEOS payment amount to $110 per beneficiary per month is effective January 1, 2025. Prior to that date, base MEOS payment amount is $70 per beneficiary per month

[4] List subject to change.

[5] Facilitating linkages to follow-up services and community resources is a core function of patient navigation as described in Appendix C of the EOM RFA.

Participants will identify and are encouraged to address health-related social needs (HRSNs)

EOM participants are required to **identify EOM beneficiaries' HRSNs**, using HRSN screening tools to screen for the following at a minimum:

REQUIRED HRSNs

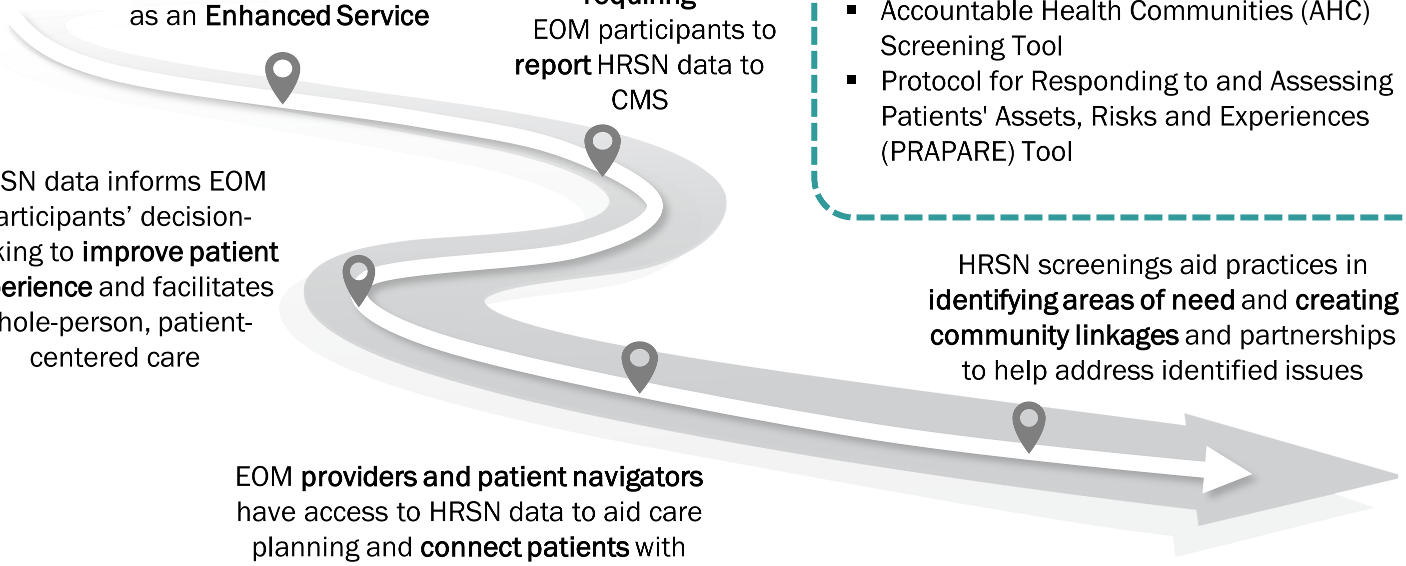
- Transportation
- Food Insecurity
- Housing Instability

OPTIONAL HRSNs

While not required, other HRSNs may be helpful to screen for, based on beneficiary needs, including, but not limited to:

- Social isolation
- Emotional distress
- Interpersonal safety
- Financial toxicity

EOM participants have the flexibility to select their HRSN screening tool



EOM Start Date

EOM participants **collect** HRSN data as an **Enhanced Service**

CMS is currently **not requiring** EOM participants to **report** HRSN data to CMS

HRSN data informs EOM participants' decision-making to **improve patient experience** and facilitates whole-person, patient-centered care

EOM **providers and patient navigators** have access to HRSN data to aid care planning and **connect patients** with referrals to community resources

HRSN screenings aid practices in **identifying areas of need** and **creating community linkages** and partnerships to help address identified issues

What are social determinants of health (SDOH) and health-related social needs (HRSN)?

SDOH:

The conditions in which people are born, grow, work, live and age as well as the wider set of forces and systems shaping the conditions of daily life[8, 9]

- SDOH encompass the **structural, systemic, and contextual factors** that shape a person's life
- Evidence shows that identifying and addressing SDOH is essential to reducing health disparities and promoting health equity[10]

HRSNs:

Adverse social conditions that negatively impact a person's health or health care[7]

- HRSN screening tools can help capture **individual level factors**, such as lack of access to transportation for an upcoming appointment or financial toxicity from chemotherapy costs.

Example Screening Tools[11]

- The National Comprehensive Cancer Network® (NCCN®) Distress Thermometer and Problem List
- Accountable Health Communities (AHC) Screening Tool
- Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) Tool

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[7] A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights. (2021). Retrieved from: https://innovation.cms.gov/media/document/ahcm-screeningtool-companion

[8] World Health Organization. "Social Determinants of Health." Retrieved from: https://www.who.int/health-topics/social-determinants-of-health

[9] Green, K. & Zook, M. (2019). When Talking about Social Determinants, Precision Matters. Health Affairs Blog.

[10] Artiga, S. & Hilton, E. (2018). Beyond Health Care: The role of social determinants in promoting health and health equity. Kaiser Family Foundation.

[11] These are examples and do not constitute an endorsement by CMS or CMS affiliates.

Improve access to treatment and care planning

Participants are required to develop a **comprehensive care plan**[12] with their EOM beneficiaries which includes two elements related to achieving health equity

- Addressing a patient's psychosocial health needs
- Estimating total and out-of-pocket costs (financial toxicity)

EOM participants are encouraged to share a physical and/or electronic copy of the care plan with the beneficiary

Develop Health Equity Plans (HEP), as part of use of data for Continuous Quality Improvement (CQI)

EOM participants use evidence-based strategies detailing how they will achieve health equity within EOM and update these goals throughout the model performance period

Robust HEPs require a range of resources, such as:

- Internal data sources (e.g., Medicare claims, feedback reports, HRSN data (participant collected), sociodemographic data)
- External data sources (e.g., CDC's Behavior Risk Factor Surveillance System (BRFSS), HHS Office of Minority Health Mapping Medicare Disparities Tool, USDA Food Environment Atlas & Food Access Research Atlas, FCC's Fixed Broadband Deployment)

HEPs are intended to be used as a tool that can support EOM participants as they ***identify disparities in care*** *within their patient populations and* ***work to address*** *them over the course of the model*

EOM participants develop and submit health equity plans to CMS annually

The HEP should be a living document that evolves over time

HEP Resources in EOM

- **EOM HEP Guide** - Provides a framework, additional details, and resources for developing your HEP
- **HEP Starter Tips** – examples and tips to consider when PGPs begin their HEPs
- **HEP Example** - a sample response for each HEP question
- **HEP User Guide** – provides technical direction for filling in the HEP form online
- **HEP Completion Checklist** – a checklist to help ensure all tasks are completed before submission
- **Building Your EOM Health Equity Plan** - tips gathered from PGPs while developing their HEPS
- **Publicly Available Data Sources** – A list of publicly available sociodemographic and SDOH data to inform the HEP

For more detailed information on EOM HEP resources, refer to the EOM website.

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[12] More information on the 13 Institute of Medicine components required in a care plan can be found in Appendix D of the EOM RFA.

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Data Collection and Sharing Within EOM

The sections below describes data collection and reporting requirements under EOM.

Clinical & Staging Data

EOM clinical data elements include: ICD-10 diagnosis code and initial diagnosis data; current clinical status and date; primary tumor, nodal disease, metastasis (TNM staging); estrogen receptor; progesterone receptor; HER2 amplification; and histology [14, 15]

EOM participants **COLLECT AND REPORT** data to CMS, no more than once per performance period. For more information, please reference the Clinical & Staging Data section in the Clinical Data Elements Guide.

Quality Measure Data

EOM participants **COLLECT AND REPORT** data to CMS, no more than once annually to align with MIPS calendar year submission.

For more information on the quality measure dataset required under EOM please visit the Quality Measures Guide.

Socio-demographic Data

Sociodemographic data required includes race, ethnicity, preferred language, sex (assigned at birth), gender identity, sexual orientation, and disability status [16]

EOM participants **COLLECT AND REPORT** data to CMS, no more than once per performance period. For more information, please reference the Sociodemographic Data section in the Sociodemographic Data Elements Guide.

HRSN Data

At a minimum, EOM participants collect data on transportation, food insecurity, and housing instability. While not required, screening for other HRSN domains may help EOM participants meet additional patient needs

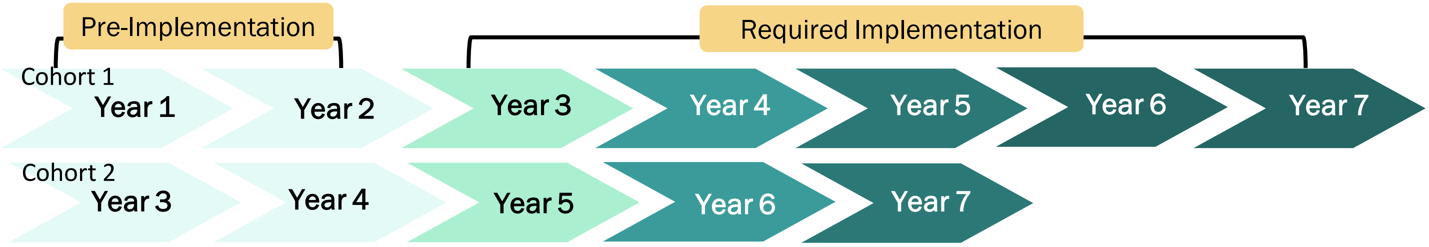
EOM participants **COLLECT** data, but are not required to report to CMS at this time. For more information, please reference the HRSN Data section in the HRSN Guide.

ePROs Data

EOM participants will be required (for the third EOM year) to use ePROs tools that capture outcomes for each of the following domains: symptoms or symptomatic toxicities, functioning, behavioral health, and health-related social needs.

EOM participants will **COLLECT** data, but are not required to report to CMS at this time. For more information please reference the ePROs Data section in the ePROs Guide.

Example ePROs Implementation Timeline



EOM participant identifies ePROs data collection tool, develops capabilities to successfully implement ePROs (e.g., pilot/test the approach in practice)

EOM participant collects ePROs data for **35%*** of EOM attributed patient population

EOM participant collects ePROs data for **50%*** of EOM attributed patient population

EOM participant collects ePROs data for **75%*** of EOM attributed patient population

*Note: This timeline includes *example* percentages of ePROs data collection.

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[14] Subject to change; this list represents the minimum data elements that CMS may collect. CMS continues to explore ways to align with other reporting standards (e.g., mCODE, USCDI) and is open to feedback on the list of required clinical and staging data elements.
[15] More information on data that EOM participants will be required to submit to CMS is on EOM's website at EOM Clinical Data Elements Guide V2.0 (cms.gov).
[16] Subject to change; EOM participants will NOT be required to report sociodemographic data to CMS for any beneficiary who chooses not to provide such data.