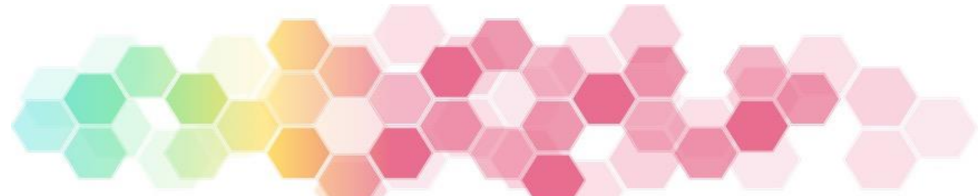
ENHANCING ONCOLOGY MODEL

EOM OVERVIEW WEBINAR

June 30, 2022

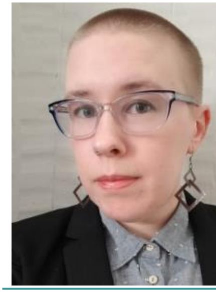


TODAY'S PRESENTERS

Lara Strawbridge
Division Director, Division of Ambulatory Payment Models
CMS Innovation Center

Hillary Cavanagh
Deputy Division Director, Division of Ambulatory Payment Models
CMS Innovation Center

Alexandra Chong
EOM Team Lead
CMS Innovation Center



Elizabeth Ela
EOM Payment Lead
CMS Innovation Center

AGENDA

This webinar will provide an introduction of the Enhancing Oncology Model (EOM). The following topics will be discussed:

1. The CMS Innovation Center Introduction
2. Enhancing Oncology Model (EOM) Background
3. Model Goals and Design
4. Timeline and Next Steps
5. Q&A

WELCOME REMARKS

THE CMS INNOVATION CENTER INTRODUCTION

STATUTORY AUTHORITY FOR CMMI

The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles.

The CMS Innovation Center was established by section 1115A of the Social Security Act (the "Act") (as added by section 3021 of the Affordable Care Act).

CMMI BACKGROUND

Created for the purpose of developing and testing **innovative health care payment** and **service delivery models** within Medicare, Medicaid, and CHIP programs nationwide.

Innovation Center Priorities and Strategic Refresh

Strategic Refresh White Paper is available at https://innovation.cms.gov/strategic-direction-whitepaper

CMS defines health equity as: The attainment of the highest level of health **for all people**, where everyone has a **fair and just opportunity** to **attain their optimal health** regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

EOM BACKGROUND & GOALS

ENHANCING ONCOLOGY MODEL (EOM) BACKGROUND

Cancer is one of the **most common and devastating diseases** in the United States (US):

Over 1.9 million people are estimated to be diagnosed with cancer in the US in 2022.[1]

609,360 deaths estimated in 2022. Cancer was the second leading cause of death in the US but was the leading cause of death for males and females aged 60-79 years old, the majority of whom are Medicare patients.[2]

Examples of disparities in cancer care include, but are not limited to, delays in initiation of chemotherapy, **more advanced stage** of diagnosis, **underrepresentation and access** to clinical trials, decreased medication adherence, **more frequent hospitalizations** and ICU admissions near the end of life, and **lower enrollment in hospice.**[3, 4]

EOM Purpose:

To **drive transformation in oncology care** by preserving or enhancing the quality of care furnished to beneficiaries undergoing treatment for certain cancer types, and with the expectation that such transformations will **reduce Medicare expenditures.**

1. National Cancer Institute, Cancer Stat Facts: Cancer of Any Site. Available at: https://seer.cancer.gov/statfacts/html/all.html
2. Siegel RL, Miller KD, Fuchs, H.E. Cancer statistics, 2022. CA Cancer J Clin. 2022 Jan;72(1):7-33.
3. AACR Cancer Disparities Progress Report. (2020). American Association for Cancer Research. Retrieved from: https://cancerprogressreport.aacr.org/wp-content/uploads/sites/2/2020/09/AACR_CDPR_2020.pdf
4. NIH (2021). Cancer Disparities. Retrieved from: https://www.cancer.gov/about-cancer/understanding/disparities

EOM ALIGNMENT WITH CANCER MOONSHOT

Main Pillars of Cancer Moonshot

- Prevention
- Target the Right Treatment for the Right Patients
- Progress on Deadliest and Rare Cancers
- Support Patients and Caregivers ★
- Learn More from Patients
- Cancer Screening and Early Detection
- Address Inequities

EOM TRANSFORMATION OF FEE-FOR-SERVICE

Traditional Fee-for-Service (FFS)

Oncology providers and suppliers generally **receive separate payments for each item or service** furnished to a beneficiary during the course of their cancer treatment.

Focus on **treating the disease and not the person**, resulting in fragmented care

EOM Alternative Payment Model (APM)

Participants will **be incentivized to consider the whole patient** and engage with them proactively, during and between appointments.

Physician group practices (PGPs):

1. Take on **financial and performance accountability** for episodes of care surrounding chemotherapy administration
2. Have the opportunity to submit payment for **provision of Enhanced Services** furnished to beneficiaries
3. Are encouraged to **promote health equity**, to improve beneficiaries' health outcomes and reduce costs

EOM DESIGN

OVERVIEW OF ONCOLOGY CARE MODEL (OCM)

OCM provides a strong foundation for EOM design.

FOCUS

Six-year, **voluntary payment and delivery model** running from July 1, 2016-June 30, 2022, that focuses on innovative payment strategies that promote high-quality and high-value cancer care in Medicare FFS beneficiaries with a cancer diagnosis who are undergoing **chemotherapy treatment**

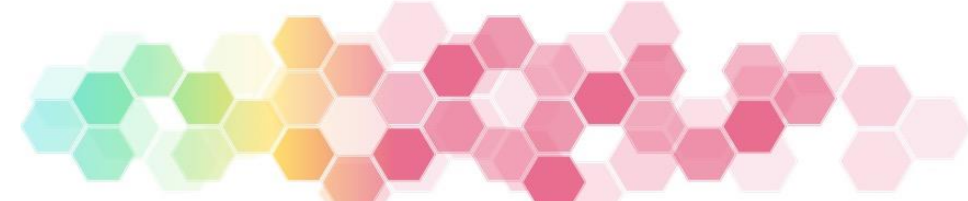
SCOPE

126 oncology practices and 5 payers that account for about **25% of the chemotherapy-related care** for Medicare FFS beneficiaries in the US

QUALITY & PAYMENT*

Model participants are paid FFS with the addition of **two** financial incentives to **improve quality** and **reduce cost**:

- Additional $160 per-beneficiary-per-month **Monthly Enhanced Oncology Services (MEOS)** payment to support care transformation; OCM practices furnished **Enhanced Services** (e.g., patient navigation, documenting a care plan) to OCM beneficiaries
- Potential **performance-based payment (PBP)** based on the total cost of care (including drugs) and quality performance during 6-month episodes that begin with the receipt of chemotherapy



OCM TRANSFORMATION TO EOM

EOM is a **voluntary** five-year, total-cost-of-care model designed to test **innovative payment strategies** and promote equitable, high-quality, evidence-based cancer care.

BUILDS ON OCM LESSONS LEARNED

INCREASED ENGAGEMENT OF PATIENTS, PAYERS, AND ONCOLOGISTS

IMPROVED CARE QUALITY, HEALTH EQUITY, AND HEALTH OUTCOMES

OVERVIEW OF ENHANCING ONCOLOGY MODEL (EOM)

EOM will continue to drive care transformation and reduce Medicare costs

FOCUS

Five-year, **voluntary payment and delivery model** scheduled to begin July 2023 and conclude June 2028, that focuses on innovative payment strategies that promote high-quality, person-centered, equitable care to Medicare FFS beneficiaries with certain cancer diagnoses who are undergoing **chemotherapy treatment**

PARTICIPANTS

Oncology Physician Group Practices (PGPs) and **other payers** (e.g., commercial payers, state Medicaid agencies) through multi-payer alignment

QUALITY & PAYMENT

EOM participant are paid FFS with the addition of **two** financial incentives to **improve quality** and **reduce cost**:

- Additional payment to support care transformation in the form of a **$70** per-beneficiary-per-month **Monthly Enhanced Oncology Services (MEOS)** to support care transformation. Participants can bill an additional **$30** per-beneficiary-per-month MEOS for EOM beneficiaries that are dually eligible, this additional payment will be excluded from EOM participants' total cost of care (TCOC) responsibility. EOM participants would be eligible to receive MEOS for furnishing Enhanced Services
- Potential **performance-based payment (PBP)** or **performance-based recoupment (PBR)** based on the total cost of care (including drugs) and quality measures during 6-month episodes that begin with the receipt of chemotherapy

ELIGIBILITY: DEFINING EOM PARTICIPANTS AND PRACTITIONERS

EOM Participant

Must be a **Medicare-enrolled oncology PGP** identifiable by a unique federal taxpayer identification number (TIN).

- EOM Practitioner List: Must identify **one or more EOM practitioner(s)**, including at least one EOM practitioner must be an oncology practitioner with a specialty code of Hematology/Oncology or Medical Oncology.
- Excluded: Oncology PGPs that routinely refer beneficiaries to Prospective Payment System (PPS)-Exempt Cancer Hospitals (PCH) for chemotherapy services are not eligible to participate
- For EOM, unlike OCM, we plan to have participation requirements that allow a limited degree of flexibility for EOM practitioners simultaneously billing under the TIN of the EOM participant and the TIN of another PGP, while still preserving program integrity.

EOM Practitioner

Must be a **Medicare-enrolled physician or non-physician practitioner** (e.g., Nurse Practitioner) identified by an individual National Provider Identifier (NPI) who:

1. Furnishes E&M services to Medicare beneficiaries receiving chemotherapy for a cancer diagnosis
2. Bills under the TIN of the PGP for such services
3. Reassigned his or her right to receive Medicare payments to the PGP
4. Appears on the participant's EOM Practitioner List (to be updated semiannually)

EOM EPISODES

INCLUDED CANCER TYPES

Subject to certain exceptions, **seven cancer types** will be included in EOM. These include breast cancer, chronic leukemia, small intestine/colorectal cancer, lung cancer, lymphoma, multiple myeloma, and prostate cancer.

INITIATING CANCER THERAPIES

Each episode will begin with a **beneficiary's receipt of an initiating cancer therapy** and **must include a qualifying Evaluation & Management (E&M) service** during the 6-month period that follows. CMS will maintain a list of initiating cancer therapies.

ATTRIBUTION

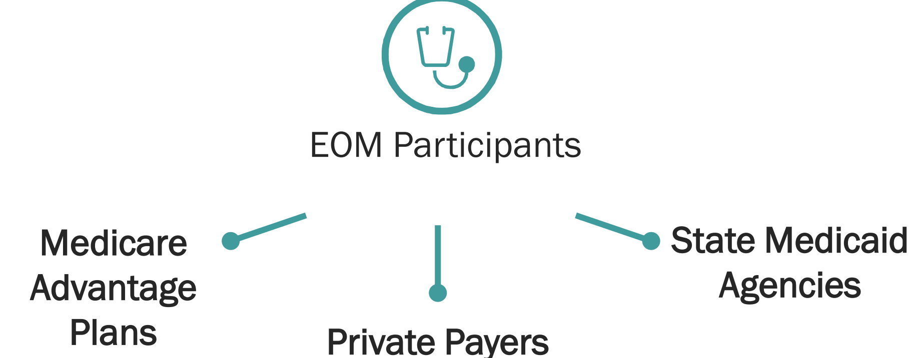
Attribute to the eligible oncology PGP that provides the first qualifying E&M service after the initiating chemotherapy, provided that the PGP has at least 25% of the cancer-related E&M services during the episode; if the initiating oncology PGP does not did not bill at least 25% of cancer-related E&M services during the episode, then attribute based on plurality of cancer-related E&M services at an oncology PGP.

PAYER ALIGNMENT

EOM is a **multi-payer model.**

Goal: Payers align their oncology value-based payment models with EOM in key areas (e.g., commitment to health equity, alignment on payment approach, and data sharing with EOM participants and CMS) to promote a consistent approach across payers and patient populations.

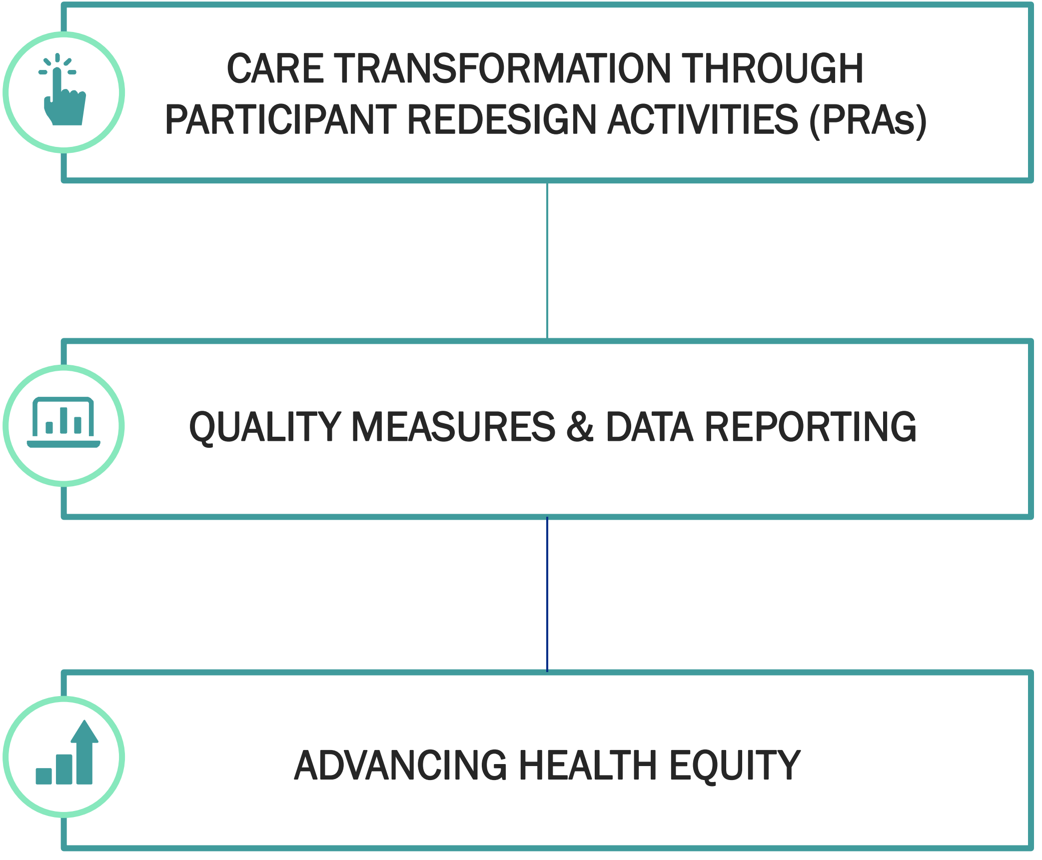
The following payers are eligible to apply:



Payers must partner with at least one EOM participant **throughout the entirety of the model** to continue participating in EOM.

To the extent permitted by law, CMS will provide **payers with data and resources** including opportunities to collaborate and engage with other payers and learning activities.

QUALITY STRATEGY



CARE TRANSFORMATION THROUGH PARTICIPANT REDESIGN ACTIVITIES (PRAS)

Provide beneficiaries **24/7 access** to an appropriate clinician with real-time access to the EOM participant's medical records

Provide **patient navigation**, as appropriate, to EOM beneficiaries

Document a **care plan** for each EOM beneficiary that contains the 13 components of the Institute of Medicine (IOM) Care Management Plan

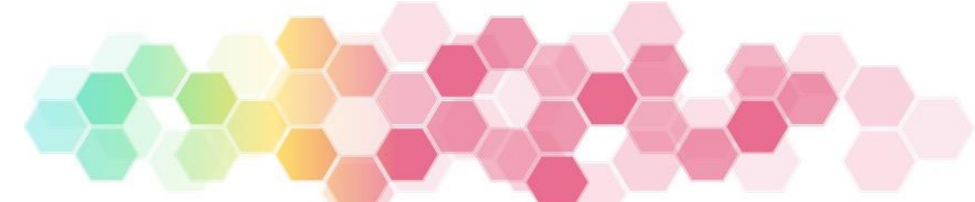
Treat beneficiaries with therapies in a manner consistent with nationally recognized **clinical guidelines**

Identify EOM beneficiary **health-related social needs** using a health-related social needs screening tool

Gradual implementation of **electronic Patient Reported Outcomes (ePROs)**

Utilize data for continuous quality improvement (CQI), including the development of a health equity plan

Use **certified Electronic Health Records (EHR) Technology** (CEHRT)



QUALITY MEASURES & DATA REPORTING

EOM will include valid, reliable, and meaningful claims-based, participant-reported and survey measures. Performance on these measures will be tied to payment:

Quality Measures will focus on the following domains:

- Patient experience
- Avoidable acute care utilization
- Management of symptoms toxicity
- Management of psychosocial health
- Management of end-of-life care

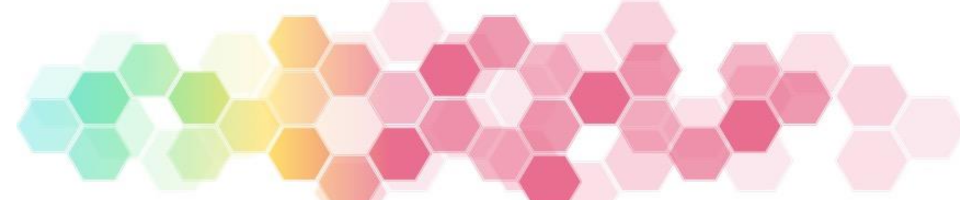
Clinical Data Elements – collection and reporting of clinical data elements not available in claims or captured in the quality measures (e.g., ever-metastatic status, HER2 status) for purposes of monitoring, evaluation, and payment

Sociodemographic Data Elements – collection and reporting of beneficiary-level sociodemographic data to be used for monitoring and evaluation. Feedback reports will stratify aggregate de-identified data by sociodemographic variables in order for EOM participants to identify and address disparities within their beneficiary populations

HEALTH EQUITY

EOM seeks to improve quality of care and equitable health outcomes for all EOM beneficiaries, including but not limited to:

	EOM Requirement	Description
1	Incentivize care for underserved communities	**Differential MEOS payment** to support Enhanced Services (base: $70 PBPM; $30 PBPM, outside of TCOC accountability, for dual eligible beneficiaries) TCOC benchmark will be **risk adjusted for multiple factors**, including, but not limited to, dual status and low-income subsidy (LIS) status
2	Collect beneficiary-level sociodemographic data	EOM participants will collect and report **beneficiary-level sociodemographic data** to report to CMS for purposes of monitoring and evaluation
3	Identify and address health-related social needs (HRSN)	EOM participants will be required to use **screening tools** to screen for, at a minimum, three **HRSN domains**: transportation, food insecurity, and housing instability Example HRSN screening tools: • NCCN Distress Thermometer and Problem List • Accountable Health Communities (AHC) Screening Tool • Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences (PRAPARE) Tool **Collect ePROs** from patients, including a HRSN domain*
4	Improved shared decision-making and care planning	EOM participants will be required to **develop a care plan** with the patient, including discussion of prognosis and treatment goals, a plan for addressing psychosocial health needs, and estimated out-of-pocket costs
5	Continuous Quality Improvement (CQI)	EOM participants will be required to develop a **health equity plan** as part of using data for CQI



DATA SHARING AND HEALTH IT

EOM PARTICIPANT DATA SHARING

DATA COLLECTION STRATEGY

Electronically enabled mechanism to report model-related data abstracted from the EOM participant's own health IT

TYPES OF DATA

1. Quality measure data
2. Clinical and staging data
3. Beneficiary-level sociodemographic data

TIMING

EOM participants will be required to report data at a time and manner specified by CMS, but no more than **once per performance period**

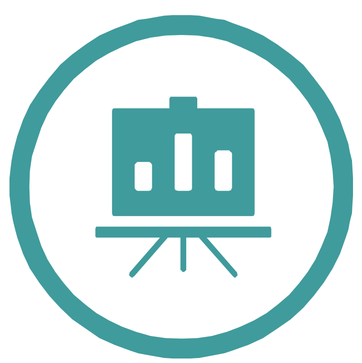
CMS DATA SHARING WITH PGPs

QUARTERLY FEEDBACK REPORTS

SEMIANNUAL RECONCILIATION REPORTS, ATTRIBUTION LISTS, AND EPISODE-LEVEL FILES

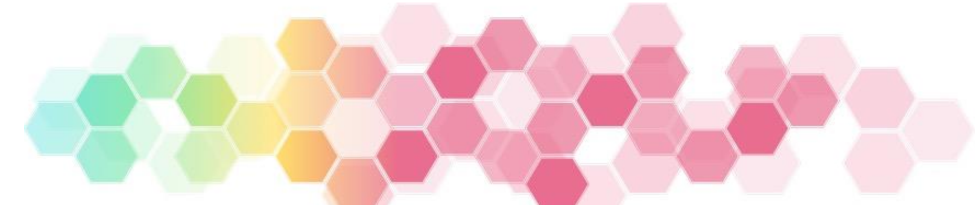
MONTHLY CLAIMS DATA

AUDIENCE POLL



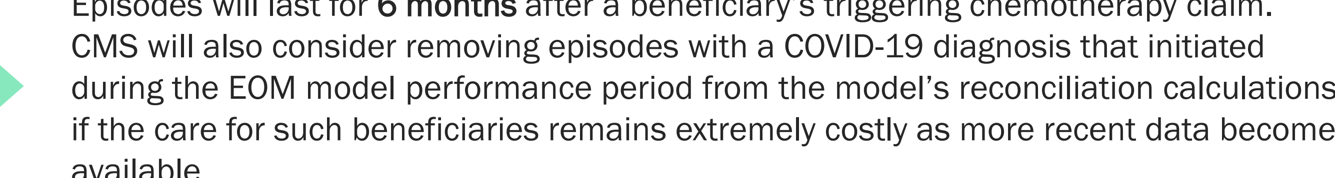
For PGPs on the call, what sociodemographic data elements does your practice collect at this time?

a) Race/ethnicity
b) Gender and sexual identity (SOGI)
c) Preferred Language
d) Other sociodemographic data not listed here
e) I/we don't collect sociodemographic data elements yet
f) Not applicable to me / I'm not a PGP



TWO-PART PAYMENT APPROACH

EPISODE DURATION AND SCOPE



Episodes will last for **6 months** after a beneficiary's triggering chemotherapy claim. CMS will also consider removing episodes with a COVID-19 diagnosis that initiated during the EOM model performance period from the model's reconciliation calculations if the care for such beneficiaries remains extremely costly as more recent data become available.

Monthly Enhanced Oncology Services (MEOS) Payment

The base MEOS payment amount will be **$70** per EOM beneficiary per month.

Beneficiaries dually eligible for Medicare and Medicaid: CMS will pay an additional **$30** per dually eligible beneficiary per month, for a total MEOS payment of **$100** per beneficiary per month. The additional $30 will not count toward the EOM participant's total cost of care responsibility.

Performance-Based Payment (PBP) or Recoupment (PBR)*

EOM participants will be responsible for **the total cost of care (TCOC)** (including drugs) during each attributed episode. Based on total expenditures and quality performance, participants may:

- **Earn a PBP**
- **Owe a PBR**
- **Fall into the neutral zone (neither earn a PBP nor owe a PBR)**

PBP, PBR, AND NEUTRAL ZONE

PERFORMANCE BASED PAYMENT

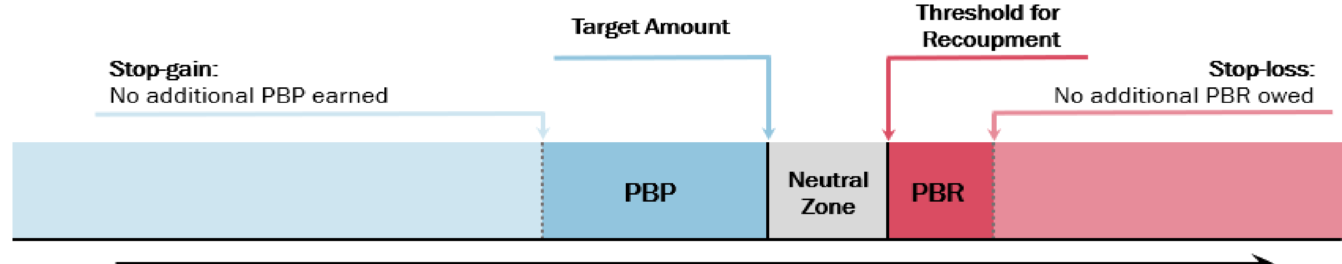
Total Expenditures < Target Amount
EOM participants or pools may earn a PBP if total expenditures for attributed episodes are below a risk-adjusted target amount.

PERFORMANCE BASED RECOUPMENT

Total Expenditures > Threshold for Recoupment
EOM participants or pools will owe a PBR if total expenditures for attributed episodes exceed the threshold for recoupment.

NEUTRAL ZONE

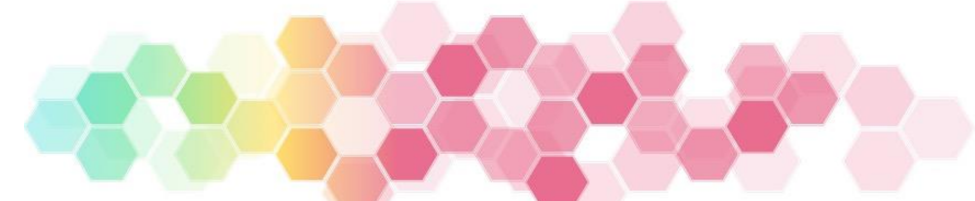
Target Amount < Total Expenditures ≤ Threshold for Recoupment
EOM participants or pools will fall into the neutral zone (neither earning a PBP nor owing a PBR) if total expenditures for attributed episodes are above the target amount and below or equal to the threshold for recoupment.



RISK ARRANGEMENT OPTIONS

Amounts of PBP earned or PBR owed by the EOM participant or pool **will be calculated as a percentage of the benchmark** amount. The benchmark amount represents the total projected cost of attributed episodes in the absence of EOM.

	Risk Arrangement 1 (RA1)		Risk Arrangement 2 (RA2)	
EOM Discount	4%	of the benchmark amount	3%	of the benchmark amount
Target Amount	96%	of the benchmark amount	97%	of the benchmark amount
Threshold for Recoupment	98%	of the benchmark amount	98%	of the benchmark amount
Stop-loss / Stop-gain	2% 4%	Stop-Loss Stop-Gain	6% 12%	Stop-Loss Stop-Gain



QUALITY PAYMENT PROGRAM

Advanced Alternative Payment Model (Advanced APM)

Beginning in Performance Period 1 (July 1, 2023), we expect **Risk Arrangement 2 of EOM** will meet the criteria under 42 CFR § 414.1415 to be an **Advanced Alternative Payment Model (Advanced APM).** See the Advanced APM section in EOM's RFA for additional information.

Merit-based Incentive Payment System (MIPS)

We expect **both Risk Arrangement 1 and Risk Arrangement 2** of EOM will meet the criteria to be a **Merit-based Incentive Payment System (MIPS) APM.** See the MIPS section in EOM's RFA for additional information.

CARE PARTNERS AND MODEL OVERLAP

Care Partner

EOM participants may elect to enter into financial arrangements with certain individuals or entities called "Care Partners." For purposes of EOM, the term "Care Partner" means **any Medicare-enrolled provider or supplier that:**

1. Engages in at least one of the PRAs during a performance period;
2. Has entered into a Care Partner arrangement with an EOM participant;
3. Is identified on the EOM participant's Care Partner list; and
4. Is not an EOM practitioner

Model Overlap

Oncology PGPs participating in **other CMS models and programs** that provide health care entities with opportunities to improve care and reduce spending during the model performance period (July 2023-June 2028) will **also be eligible to participate.**

- More information on model overlap is currently available in the EOM RFA
- Model overlap will be discussed in more detail in future webinars

WAIVERS

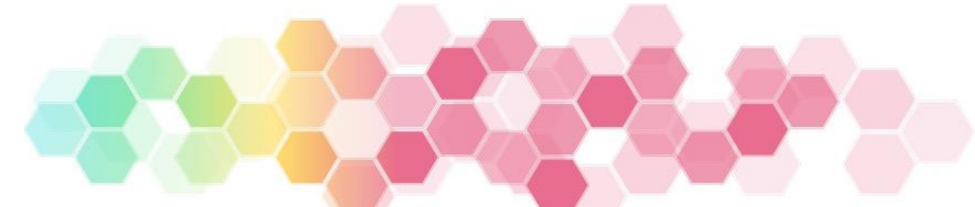
Any payment and programmatic waivers will be issued separately.

Benefit enhancements: In order to emphasize high-value services and support the ability of EOM participants to manage the care of beneficiaries, we believe it is necessary to utilize the authority under section 1115A(d)(1) of the Act to conditionally waive certain Medicare payment requirements as part of testing certain benefit enhancements under EOM.

Telehealth Benefit Enhancement

Post-Discharge Benefit Enhancement

Care Management Home Visits Benefit Enhancement



EOM LEARNING COMMUNITY

EOM Learning System will support the achievement of the EOM's Strategic goals through:

1. **Leveraging CMS and EOM participant and payer data** to identify **new knowledge and best practices**
2. **Sharing and spreading new knowledge** and best practices through **learning communities and networks**
3. Information and work will be shared through three communication channels:*
    1. From participant to participant
    2. From CMS to participants
    3. From participants to CMS

The EOM Learning System will be **based on novel aspects of EOM** and will also **build upon pertinent learnings from OCM.** It will include resources such as:

ONLINE COLLABORATION PLATFORM

CASE STUDIES & INNOVATION SPOTLIGHTS

AFFINITY AND ACTION GROUPS

WEBINARS

*The same communication channels will be used for payer communications.

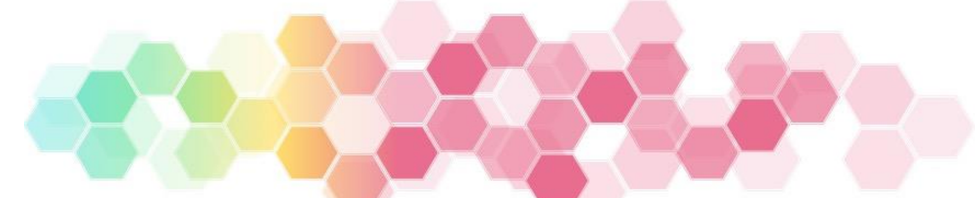
MONITORING AND EVALUATION

MONITORING

- CMS will conduct **monitoring activities** to evaluate compliance by the EOM participant, its EOM practitioners, and its Care Partners with the terms of the EOM Participation Agreement
- Monitoring is **designed to protect beneficiaries** and **potential program integrity risk**
- Monitoring data sources may include:
  - Claims analyses to identify fraudulent behavior or program integrity risks
  - Interviews with any individual participating in PRAs
  - Interviews with EOM beneficiaries, eligible beneficiaries, and their caregivers
  - Audits of charts, medical records, implementation plans, and other data from EOM participants
  - Site visits to EOM participants
  - Documentation requests to EOM participants

EVALUATION

- CMS's independent evaluation contractor will employ a mixed-methods approach to assess the model's impacts on utilization, costs, quality, equity and the experiences of participants and patients.



TIMELINE AND NEXT STEPS

MODEL TIMELINE

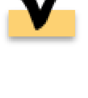
Milestone	Planned Timing[1]
RFA released / Application portal opens	June 27, 2022
Application deadline	September 30, 2022
Participant selection & Participant Agreement (PA) signing	Late Winter 2022 or Early Spring 2023
Pre-implementation period	January 1, 2023 – June 30, 2023
Performance periods	Start July 1, 2023

[1] Dates are subject to change

HOW TO APPLY

Application period for EOM is currently open
All EOM applications must be submitted by 11:59 pm Eastern Daylight Time on September 30, 2022. CMS may not review applications submitted after the deadline.

Submit application to https://app.innovation.cms.gov/EOM.
Submission of the PDF version of this application will not be accepted.



Refer to https://innovation.cms.gov/innovation-models/enhancing-oncology-model for directions on how to access the EOM RFA Application Portal
Once logged into the portal, there are further instructions on how to navigate the application included on the right-hand side of the home page by selecting the "User Manual" link.

Refer to the RFA on EOM website for further details
Further details regarding participation requirements and application submission criteria are available in the RFA on the https://innovation.cms.gov/innovation-models/enhancing-oncology-model. Applications will be reviewed for completion of all required fields and a signed and dated application certification.

Sign up for the EOM listserv
EOM will host additional recruitment events and release more resources during Summer/Fall 2022 to help potential participants understand the model before the application deadline. Sign up for the EOM listserv to learn about these materials as they are announced.

Q&A SESSION

EOM MODEL OPEN Q&A

Open Q&A

Please **submit questions via the Q&A pod** to the right of your screen.
Specific questions about your organization can be submitted to EOM@cms.hhs.gov.

ADDITIONAL RESOURCES

RESOURCES AND CONTACT INFO

For more information about the EOM and to stay up to date on upcoming model events:

Visit

innovation.cms.gov/innovation-models/enhancing-oncology-model

Help Desk

EOM@cms.hhs.gov

1-888-734-6433 Option 3

Follow

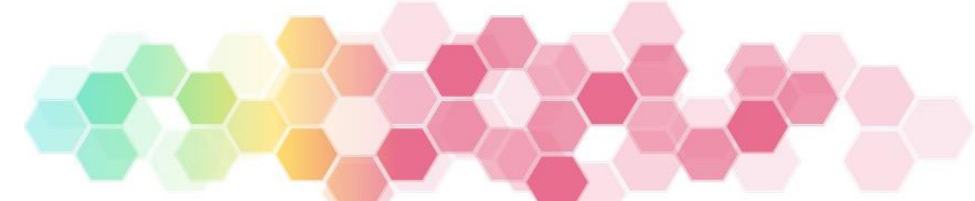
Listserv

Sign up for the EOM listserv at this listserv registration link

UPCOMING EVENTS

EOM Event	Planned Date[1]
EOM Payment Methodology Webinar	July 26, 2022
EOM Application Support Office Hour	August 16, 2022
Quality Strategy Webinar	August 2022

[1] Dates are subject to change



APPENDIX

OCM TO EOM HIGH LEVEL COMPARISON

	OCM	EOM
Health equity	No explicit focus	Key element of design and implementation
Beneficiary population	Beneficiaries with all cancer types who receive chemotherapy or hormonal therapy	High-risk beneficiaries with certain cancer types receiving systemic chemotherapy only
Use of ePROs	No requirement	Required gradual implementation
MEOS payment	$160 PBPM for each OCM beneficiary	$70 PBPM for beneficiaries not dually eligible for Medicaid and Medicare $100 PBPM for beneficiaries dually eligible for Medicaid and Medicare
Attribution	Based on plurality of E&M claims	Based on initial care plus at least minimum care over time
Benchmark and novel therapy calculations	At the practice level; limited use of clinical data to inform risk adjustment	At the cancer type level; more robust use of clinical data to inform risk adjustment
Risk arrangements for performance-based payment	One-sided risk in performance period 1, followed by the option for one- or two-sided risk in performance periods 2-7 Participants earning a performance-based payment by the initial reconciliation of PP4 have the option to stay in one-sided risk in PP8—PP11; other participants must either accept two-sided risk in PP8—PP11 or be terminated from the model	Two downside risk arrangement options

*Please note this list is not exhaustive. For additional information on how EOM differs from OCM, refer to Appendix A of the EOM RFA

PATIENT NAVIGATION

EOM participants will be required to provide the core functions of patient navigation, as appropriate, to all EOM beneficiaries who request and/or need these services.

Core functions of patient navigation

1. Coordinating appointments with health care providers to ensure timely delivery of diagnostic and treatment services;
2. Maintaining communication with EOM beneficiaries, families, and the health care providers to monitor EOM beneficiary satisfaction with the cancer care experience and provide health education;
3. Ensuring that appropriate medical records are available at scheduled appointments;
4. Providing language translation or interpretation services in accordance with federal law and policy;
5. Facilitating linkages to follow-up services and community resources (e.g., make referrals to cancer survivor support groups and community organizations or other third parties that provide child/elder care, transportation, or financial support); and
6. Providing access to clinical trials as medically appropriate.

INSTITUTE OF MEDICINE (IOM) CARE PLAN ELEMENTS

Each EOM participant will be required to document a comprehensive cancer care plan for the EOM beneficiary, and the EOM participant will be required to engage the EOM beneficiary in the development of the care plan.

1. **Patient information** (e.g., name, date of birth, medication list, and allergies)
2. **Diagnosis,** including specific tissue information, relevant biomarkers, and stage
3. **Prognosis**
4. **Treatment goals** (curative, life-prolonging, symptom control, palliative care)
5. **Initial plan for treatment and proposed duration**, including specific chemotherapy drug names, doses, and schedule as well as surgery and radiation therapy (if applicable)
6. Expected **response** to treatment
7. **Treatment benefits and harms**, including common and rare toxicities and how to manage these toxicities, as well as short-term and late effects of treatment
8. Information on **quality of life** and a patient's likely experience with treatment
9. Who would take **responsibility** for specific aspects of a patient's care (e.g., the cancer care team, the primary care/geriatrics care team, or other care teams)
10. **Advance care plans,** including advanced directives and other legal documents
11. Estimated **total and out-of-pocket costs** of cancer treatment
12. A plan for addressing a patient's **psychosocial health needs**, including psychological, vocational, disability, legal, or financial concerns and their management
13. **Survivorship plan**, including a summary of treatment and information on recommended follow-up activities and surveillance, as well as risk reduction and health promotion activities

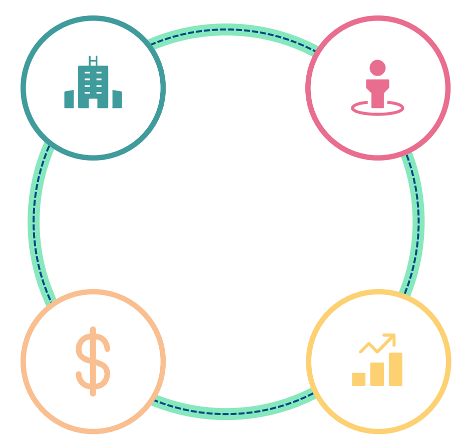
OCM LESSONS LEARNED: PRACTICE PERSPECTIVES[1]

Standardizing Efficient Care Delivery

- ✓ Standardizing information technology
- ✓ Standardizing care across sites/clinics
- ✓ Benefits of standardization for non-Medicare patients (spillover from OCM)

Person-centered Care Improvements

- ✓ Better and faster patient access
- ✓ Reorganized teams, workflows and communication
- ✓ Patient navigation
- ✓ More complete information to support shared decision making



Moving Toward Value-based Care

- ✓ Weighing costs of cancer treatments
- ✓ Favoring lower-cost supportive care therapies
- ✓ Reducing drug wastage
- ✓ Value of reduced ED visits or hospitalizations

Using Data for Quality Improvement

- ✓ Using Feedback Report metrics and benchmarks for continuous quality improvement (CQI)
- ✓ Using Medicare claims for CQI
- ✓ Using other data for CQI

1 Evaluation of the Oncology Care Model: Participants' Perspectives (December 2021). Available fromhttps://innovation.cms.gov/data-and-reports/2021/ocm-ar4-eval-part-persp-report