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ALERT ▪ Health Care

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Enhancing Cancer Care: New CMMI Model Invites Physician Practices, Payers to Reconsider Traditional Reimbursement for Oncology Services

Attorneys
Devin Cohen
David O. Ault
Ryan B. Marcus

On June 27, 2022, the Center for Medicare and Medicaid Innovation ("CMMI") at the Centers for Medicare & Medicaid Services ("CMS") announced the Enhancing Oncology Model ("EOM"), a new, voluntary advanced payment model aimed at improving cancer care for Medicare patients and lowering health care costs. EOM is the successor to the Oncology Care Model ("OCM") and seeks to build upon the lessons learned and feedback received during its six-year run that concluded on June 30, 2022. EOM will commence on July 1, 2023 and continue until June 30, 2028. Applications to participate in EOM are open until 11:59 pm Eastern Daylight Time on September 30, 2022.

Unlike many of the CMMI specialty care payment models, EOM contemplates direct participation by physician practices without the use of an intermediary entity, but still offers unique opportunities to management services companies and commercial payors. This Alert outlines the key features of EOM and opportunities across potential stakeholders in the EOM program.

Key Features of EOM

1. *Eligible Participants*. EOM applications for participation are only open to physician practice groups ("PGP") enrolled in Medicare and that provide oncology services. The PGP must treat Medicare beneficiaries for at least one of seven cancer types: breast cancer, chronic leukemia, small intestine/colorectal cancer, lung cancer, lymphoma, multiple myeloma, and prostate cancer. CMMI has significantly narrowed the number of eligible cancer treatment types under OEM, as providers had qualified for OCM if they treated *any* cancer patient receiving chemotherapy.

   The PGP must also include at least one physician or mid-level practitioner enrolled in Medicare that furnishes Evaluation and Management services to Medicare beneficiaries receiving chemotherapy for a cancer diagnosis, bills under the federal taxpayer identification number of the PGP for the services, has reassigned his or her right to receive Medicare payments to the PGP, and appears on the PGP's "EOM Practitioner List," the list of "EOM Practitioners" approved by CMS for participation in EOM. Additionally, at least one EOM Practitioner must be a Medicare-enrolled physician with an individual NPI designating a specialty code of Hematology/Oncology or Medical Oncology.

2. *Participant Redesign Activities ("PRA")*. EOM requires participating PGPs (such participating PGPs, "EOM Participants") to complete a total of eight PRAs, or enhanced services that each EOM Participant must provide to beneficiaries, which are compensated with a separate per beneficiary per month payment. The PRAs include providing 24/7 access to a clinician with real-time access to a practice's medical records, patient navigation services, the design of an extensive care plan for patients, use of a health-related social needs screening tool (a new health equity PRA), and implementation of electronic Patient Reported Outcomes (a report that serves as another health-equity focused requirement from CMS and comes directly from the patient without amendment or interpretation).

3. *Shared Savings/Losses*. Unlike OCM, EOM Participants' payments will be eligible for both shared savings and shared losses. There are two risk tracks, one with limited upside and downside (up to 4% of the benchmark in shared savings with a cap on shared losses at 2% of the benchmark), and one with significant upside and

moderate downside risk (up to 12% of the benchmark in shared savings and a cap on shared losses at 6% of the benchmark). Similar to OCM, EOM Participants can bill CMS for a Monthly Enhanced Oncology Services ("MEOS") fee. The MEOS fee funds the PRAs provided by PGPs and is priced at $70 per beneficiary per month (a reduction from $160 in the OCM) where the beneficiary is not a Medicare dual-eligible beneficiary, and $100 per beneficiary per month where the beneficiary is a Medicare dual-eligible beneficiary.

4. *Pooling of Participants.* As with OCM, EOM allows for the pooling of two or more EOM Participants. Pooling of EOM Participants mean that the episode of care expenditures for two or more EOM Participants are considered together for payment calculations, both to set cost of care benchmarks and to determine shared savings or shared losses amounts. Pooling offers the opportunity for EOM Participants to further pool resources and collaborate to achieve the PRAs.

5. *Care Partners.* For health care providers that do not wish to participate directly in EOM, EOM offers "Care Partner" participation. A Care Partner includes any Medicare-enrolled provider or supplier that engages in at least one of the PRAs during a performance period and (i) has entered into a Care Partner arrangement with an EOM Participant, (ii) is identified on EOM Participant's Care Partner list, (iii) and is not an EOM Practitioner. EOM Participants must submit a proposed Care Partner list with their application to participate in EOM and resubmit the list at least semi-annually, but solely to the extent the Care Partner arrangement contemplates financial remuneration. Notably, the EOM Request for Applications expressly states that fraud and abuse waivers are not being published for EOM at this time, meaning any Care Partner relationship will need to be closely scrutinized to ensure compliance with the federal Anti-Kickback Statute ("AKS") and Stark Laws. Participants should be mindful of the new safe harbors to the AKS and exceptions to the Stark Law for value-based care arrangements and CMS-sponsored models when entering into these arrangements.

6. *Role of Commercial Payers and Medicare Advantage Plans.* Like OCM, EOM is a multi-payer model that will encourage "other payers" (e.g., commercial payers, Medicare Advantage plans, and state Medicaid agencies) to align with the model's structure and requirements. Practically speaking, this means that commercial payers are able to, and are encouraged to, implement a private version of the EOM. To participate, the payer must collaborate with at least one EOM Participant and enter into a memorandum of understanding with CMS. CMS has offered to provide "other payers" with aggregated model-level de-identified participant data, among other benefits. In carrying out their collaborations with PGPs, payers should closely analyze the applicability of fraud, waste, and abuse considerations given the lack of waivers contemplated for the EOM, with a mind towards the AKS and the recent implementation of value-based care safe harbors and CMS-sponsored model exemption.

Opportunities for Oncology Practices and Payers

1. Oncology Practices. As discussed above, PGPs can participate directly in the EOM program, rather than through an intermediary entity—as is this case, for example, with the Medicare Shared Savings Program and other Accountable Care Organization initiatives. However, EOM still provides an opportunity for third-party service providers (and in particular, privately backed administrative services providers or data analytics support organizations) to support interested managed practices achieve the PRAs. PRAs will likely require significant financial and administrative investment on the part of the EOM Participant. Administrative services providers that support a network of oncology practices could also position those practices for success under EOM's pooling requirements, as intraoperative and overlapping data systems improve their ability to achieve shared savings.

2. Payers. The partnership model contemplated by EOM offers a unique opportunity to vertically integrated payers to work with their affiliated oncology practice groups to achieve meaningful shared savings that reward both parties. These payers likely already have pre-existing care coordination resources that can be deployed for EOM

Participants to achieve the PRAs. Further, payers may also see this as an opportunity to enhance their partnerships with individual in-network oncology practices in the transition to value-based care. Because EOM lacks centralized contracting entities, payers can directly interface with participants and develop better care coordination for their covered members. In doing so, however, payers should be mindful of program waivers, if and when released, and relevant fraud, waste, and abuse laws, given the direct interface with provider groups and two-sided risk structure of the EOM program.

If you have any questions, or are considering applying to EOM, please do not hesitate to contact the authors or your usual Ropes & Gray advisor.