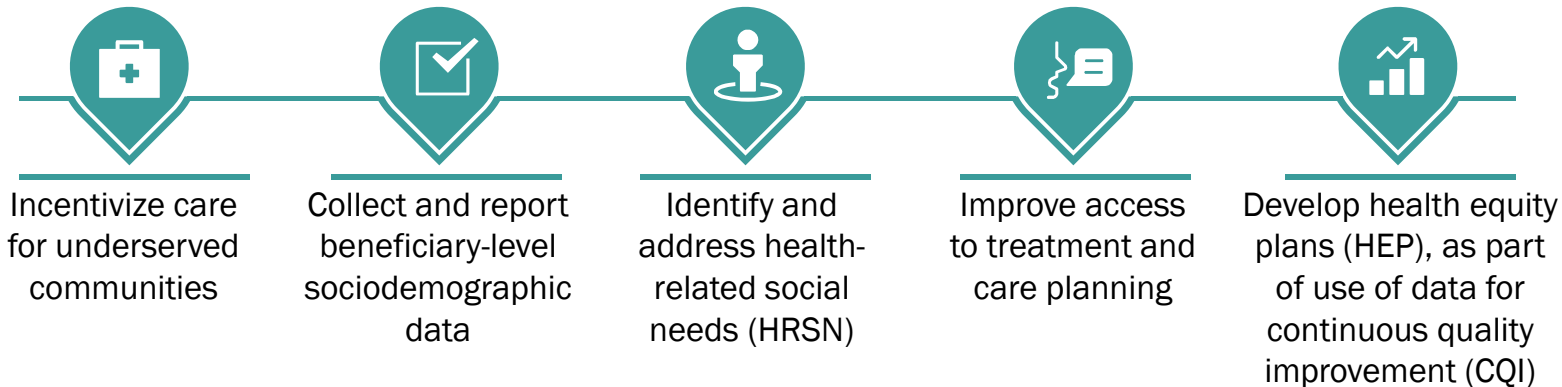


Health Equity Strategy



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.

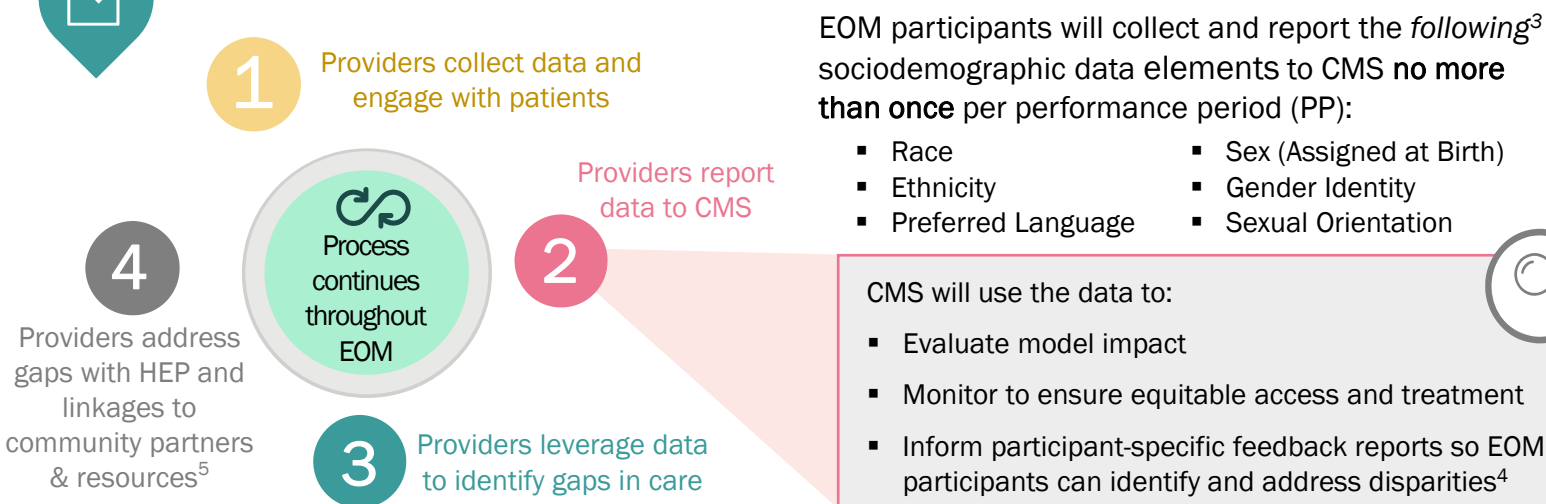


This adjustment is meant to help mitigate any potential disincentive in a total cost of care model (TCOC) to serve dually eligible patients who historically account for a disproportionate share of Medicare expenditures and are associated with higher episode expenditures.

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

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/ASPESERTCfull.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 List subject to change.

⁴ There also may be aggregated use of the data in EOM's feedback report dashboards.

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' health-related social needs, 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 will have the flexibility to select their HRSN screening tool

EOM Start Date

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

CMS is **not requiring** EOM participants to report HRSN data to CMS at this time

HRSN data can inform EOM participants' decision-making to **improve patient experience** and facilitate whole-person, patient-centered care

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



What are Health-Related Social Needs (HRSN) and Social Determinants of Health (SDOH)?

HRSNs:

Adverse social conditions that negatively impact a person's health or health care⁶

- 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.

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^{7, 8}

- 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 equity⁹

Example Screening Tools ¹⁰

- 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
- North Carolina Department of Health and Human Services SDOH Screening Questions

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

⁶ 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>

⁷ World Health Organization. "Social Determinants of Health." Retrieved from: <https://www.who.int/health-topics/social-determinants-of-health>

⁸ Green, K. & Zook, M. (2019). When Talking about Social Determinants, Precision Matters. Health Affairs Blog.

⁹ Artiga, S. & Hilton, E. (2018). Beyond Health Care: The role of social determinants in promoting health and health equity. Kaiser Family Foundation.

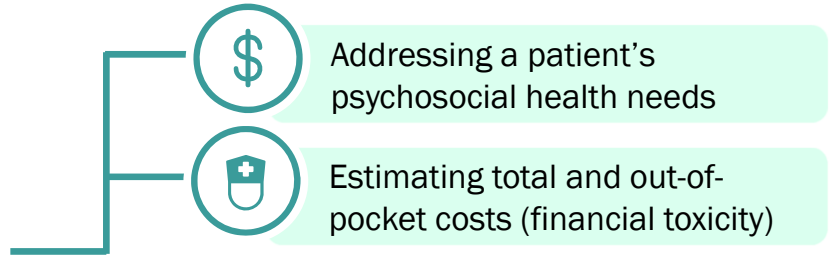
¹⁰ These are examples and do not constitute an endorsement by CMS or CMS affiliates.



Improve access to treatment and care planning



Participants are required to engage EOM beneficiaries in the **development of a comprehensive care plan**¹¹ which includes two elements that relate to health equity



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



Develop health equity plans (HEP), as part of use of data for continuous quality improvement (CQI)

EOM participants will develop HEPs that describe evidence-based strategies for how they will achieve health equity within EOM and update these goals throughout the model performance period

HEPs should consider a range of resources,¹² 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 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 will develop and submit health equity plans to CMS, in a form, manner, and by the date specified by CMS

The HEP should be a living document that evolves over time

HEP Resources in EOM

- Prior to the HEP submission deadline, CMS will publish an EOM specific HEP template and guide that will work to aid participants in their HEP submission
- CMS will also support EOM participants through robust learning system activities and resources

¹¹ More information on the 13 Institute of Medicine components that are required in a care plan is in Appendix D of the [EOM RFA](#).

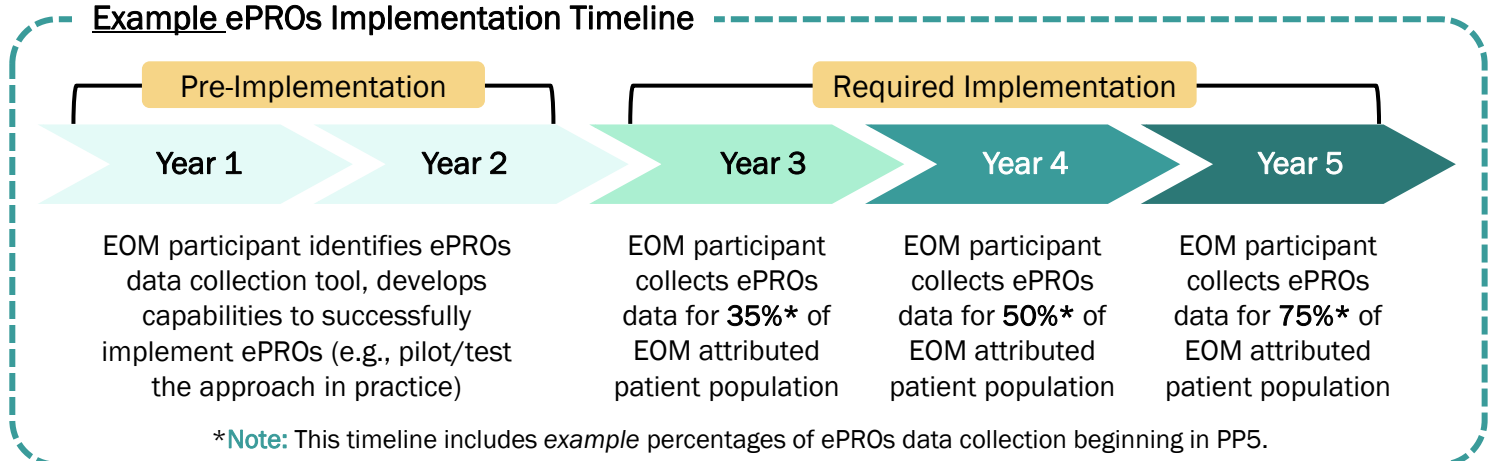
¹² The EOM Learning System will support participants in identifying additional external data sources and can facilitate sharing of data sources between model participants, as part of use of data for continuous quality improvement.

Data Collection and Sharing Within EOM

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

Clinical & Staging Data	<p>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 ^{13, 14}</p> <p>EOM participants will COLLECT AND REPORT data to CMS, no more than once per performance period</p>
Quality Measure Data	<p>More information on the quality measure dataset required under EOM are provided on the EOM website at https://innovation.cms.gov/media/document/eom-qms-cdes-sd-data</p> <p>EOM participants will COLLECT AND REPORT data to CMS, no more than once annually to align with MIPS calendar year submission</p>
Socio-demographic Data	<p>Sociodemographic data required includes race, ethnicity, preferred language, sex (assigned at birth), gender identity, and sexual orientation ¹⁵</p> <p>EOM participants will COLLECT AND REPORT data to CMS, no more than once per performance period</p>
HRSN Data	<p>At a minimum, EOM participants will 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</p> <p>EOM participants will COLLECT data, but <u>are not required to report</u> to CMS at this time</p>
ePROs Data	<p>EOM participants will be required (for the third EOM year) to use ePROs tools that capture outcomes for each of the following domains: symptoms and/or toxicity, functioning, behavioral health, and health-related social needs</p> <p>EOM participants will COLLECT data, but <u>are not required to report</u> to CMS at this time</p>

Example ePROs Implementation Timeline



¹³ 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.

¹⁴ More information on data that EOM participants will be required to submit to CMS is on EOM's website at <https://innovation.cms.gov/media/document/eom-qms-cdes-sd-data>.

¹⁵ 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.