



Health Equity/SDOH embedded in Payment Systems

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CMS is promoting health equity through various payment models

Enhancing Oncology Model

- Successor to Oncology Care Model (OCM)
- Oncology focused, voluntary payment model that pays for specific cancer types under a bundled payment for 6-month episodes
- Providers at risk for costs that exceed bundle
- Special focus on social determinants of health (SDOH) and health-related social needs (HRSN)

ACO REACH

- Primary care/special-populations focused, voluntary payment model that provides capitated, prospective payment to the accountable care organization based on a population of patients
- 130+ accountable care organizations are participating, with an estimated 2.1 million covered lives
- Heavy focus on health equity

The Enhancing Oncology Model will require participants to collect SDOH and HRSN data, as well as ePROs

- With this requirement, providers will gain insight on HRSN across their patient populations **which will inform plans to implement efforts to mitigate those that impact patient access to care and outcomes**
- Practices will have to determine how they collect HRSN data

Enhancing Oncology Model (EOM) Health Equity Strategy
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 date; current clinical status and date; primary tumor, nodal disease, metastasis (TNM staging); estrogen receptor; progesterone receptor; HER2 amplification; and histology ^{13, 14} EOM participants will COLLECT AND REPORT data to CMS, no more than once per performance period
Quality Measure Data	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-cfes-sd-data EOM participants will COLLECT AND REPORT data to CMS, no more than once annually to align with MIPS calendar year submission
Socio-demographic Data	Sociodemographic data required includes race, ethnicity, preferred language, sex (assigned at birth), gender identity, and sexual orientation ¹⁵ EOM participants will COLLECT AND REPORT data to CMS, no more than once per performance period
HRSN Data	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 EOM participants will COLLECT data, but are not required to report to CMS at this time
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 and/or toxicity, functioning, behavioral health, and health-related social needs EOM participants will COLLECT data, but are not required to report to CMS at this time

Example ePROs Implementation Timeline

Year	Implementation Status
Year 1	Pre-Implementation
Year 2	Pre-Implementation
Year 3	Required Implementation (35% of EOM attributed patient population)
Year 4	Required Implementation (50% of EOM attributed patient population)
Year 5	Required Implementation (75% of EOM attributed patient population)

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

Enhancing Oncology Model (EOM) Health Equity Strategy

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

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

- OPTIONAL HRSNs: Social isolation, Emotional distress, Interpersonal safety, Financial toxicity

EOM participants will have the flexibility to select their HRSN screening tool

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 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

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

For Pharma → address health equity in value demonstration for new drug products



- Address equity in registrational trial design and implementation
 - Use RWE on health equity to support clinical trial site recruitment and patient enrollment
- Incorporate equity objectives in evidence generation to support reimbursement decisions
 - Subgroup analyses in registrational trials?
 - Distributional cost-effectiveness
 - RWE in underrepresented groups in registrational trials?