

Enhancing Oncology Care Model (EOM) 2024 Update

ASCO Fact Sheet

The Centers for Medicare and Medicaid Services announced the opening of a second round of Enhanced Oncology Model [applications](#) in July 2024. The new cohort's EOM term will begin in July of 2025 and end in June 2030.

Additionally, CMS will also implement several changes to the Model which includes:

- An increase in the Monthly Enhanced Oncology Services (MEOS) payment from **\$70** per beneficiary per month to **\$110** per beneficiary per month (\$140 for dual-eligible [Medicare/Medicaid] beneficiaries).
- A raise in the threshold for the point in which participants are required to pay back CMS for costs related to their patient's care.
- Extension of the model for the first cohort to **June 2030** (originally **June 2028**).

Key Points

- The Center for Medicare and Medicaid Innovation's (CMMI) Enhancing Oncology Model (EOM) aims to ensure quality care is provided to fee-for-service beneficiaries who are undergoing treatment for cancer, while also reducing spending.
- Eligible model participants include Physician Group Practices (PGPs) with at least one Hematologist/Oncologist or Medical Oncologist, excluding PGPs affiliated with a PPS-exempt Cancer Hospital. Participation in the model is voluntary.
- The program may be administered by either the Centers for Medicare and Medicaid Services (traditional Medicare) and "other" payers, such as private payers, Medicare Advantage plans, and state Medicaid agencies.
- EOM participants may also participate in certain other programs and models such as the Medicare Shared Savings Program (Shared Savings Program) or the Radiation Oncology Model.
- The Model's performance period for the second cohort begins in July 2025 and ends in June 2030 (5 years).

- EOM participants must implement “Participant Redesign Activities” (PRA) in the practice to comply with the program and provide quality care.
- In addition to fee-for-service (FFS) payments, participants may also receive financial incentives: a) \$110 per patient, per month Monthly Enhanced Oncology Services (MEOS) payment, b) additional \$30 per patient, per month MEOS for dual-eligible (i.e., Medicare and Medicaid) patients, and c) Potential Performance-Based Payment (PBP) or Performance-Based Recoupment (PBR).
- Each EOM participant or pool is in a two-sided risk arrangement. Participants have a choice between one of two, two-sided risk options.
- Applications for the performance period beginning in July 2024 must be submitted to CMS using the [EOM RFA Application Portal](#) by **11:59 pm EDT September 16, 2024**.
- The full model test will span both the first and second cohorts from July 1, 2023, to June 30, 2030.

Eligibility

Who is eligible to participate in the EOM?

- Physician Group Practice (PGP):
 - A Medicare enrolled PGP with a unique federal taxpayer identification number (TIN).
 - Includes one or more EOM Practitioners:
 - ✓ Medicare-enrolled physician or non-physician practitioner (e.g., nurse practitioner or physician assistant).
 - ✓ Provides Evaluation and Management Services.
 - ✓ Bills under the TIN of the PGP.
 - ✓ Has reassigned rights to receive Medicare payments to the PGP.
 - At least one EOM Practitioner must be a physician with a Hematology/Oncology or Medical Oncology specialty code.
 - PGP is not affiliated with PPS-exempt Cancer Hospital.
- Other Payers
 - Medicare Advantage and other payers may participate in the model, partnering with PGPs of their choosing and with the same or differing performance and payment methodologies.¹

Which beneficiaries are eligible?

¹ Center for Medicare and Medicaid Innovation: “The Enhancing Oncology Model (EOM) Request for Applications”, p. 8. Centers for Medicare and Medicaid Services. July 2022.
<https://innovation.cms.gov/media/document/eom-rfa>.

To qualify for the EOM program, beneficiaries must meet the following requirements:

- Receives a diagnosis for an included cancer type: breast cancer, chronic leukemia, small intestine/colorectal cancer, lung cancer, lymphoma, multiple myeloma, and prostate cancer.
- Receives an initiating cancer systemic therapy (chemotherapy or immunotherapy; excludes hormonal therapy) triggering an episode. CMS will maintain a list of initiating cancer therapies.
- Receives a qualifying E/M service from an oncology PGP during the episode (within 6 months of receipt of the initiating cancer therapy).
- Eligible for Medicare Part A and enrolled in Medicare Part B for the entirety of the episode.
- Not enrolled in any Medicare managed care organization, such as Medicare Advantage, at any point during the episode.
- Not eligible for Medicare due to an End Stage Renal Disease (ESRD) diagnosis at any point during the episode.
- Medicare is the primary payer for the entirety of the episode.²
- Beneficiaries participating in a clinical trial for which Medicare pays routine costs may be considered eligible if all the eligibility criteria are met.

Model Design

When does an episode begin and end?

An episode begins upon receipt of an initiating cancer therapy for any included cancer type. The start date is the date of service listed on a Part B chemotherapy claim with a cancer diagnosis, or the fill date of a Part D chemotherapy claims with a diagnosis code for cancer on the day of or in the 59 days preceding the fill date on the Part D drug claim. The episode ends after a 6-month period. During the 6-month episode, the beneficiary must be provided a qualifying E/M service.³

How are the models created?

CMS will develop models which predict the cost of a 6-month episode of care based on beneficiary characteristics and clinical variables.

What information or data is used to create baseline period episodes?

Episodes starting from July 1, 2016, through June 30, 2020 (divided into 8, 6-month periods) are used as a foundation to establish the predicted expenditures for performance period episodes. A set of adjustments are applied to the predicted expenditures for each performance period episode to obtain a benchmark price for each performance period episode.

² Ibid., p. 20.

³ Ibid, p. 5.

What is the EOM performance period?

The EOM performance period is between July 1, 2023, through June 30, 2030 (7 years). That period is divided into 13, 6-month performance periods.

Does the EOM overlap with other programs and models?

EOM participants in the first or second cohort may also participate in certain other programs or models such as:

- **Medicare Accountable Care Organization (ACO) Initiatives:**
 - ACO Realizing Equity, Access and Community Health (REACH) Model (formerly known as the Global and Professional Direct Contracting Model)
 - Medicare Shared Savings Program
 - Comprehensive Kidney Care Contracting Options in the Kidney Care Choices Model
- **Other Innovation Center Models:**
 - Bundled Payments for Care Improvement (BPCI) Advanced Model
 - Comprehensive Care for Joint Replacement (CJR) Model
 - Primary Care First (PCF) Model
 - Maryland Total Cost of Care (TCOC) Model
 - Pennsylvania Rural Health Model (PARHM)
 - Making Care Primary (MCP) Model (expected start date July 1, 2024)
 - Guiding an Improved Dementia Experience (GUIDE) Model (expected start date July 1, 2024)

Care Delivery and Transformation

What does an EOM participant need to put in place to provide beneficiaries with quality care?

EOM participants are required to implement Participant Redesign Activities (PRAs):

1. Provide eligible beneficiaries 24/7 access to an appropriate clinician who has real-time access to the EOM participant's medical records for the eligible beneficiaries;
2. Providing patient navigation, as appropriate, to EOM beneficiaries.
3. Documentation of a care plan for each EOM beneficiary that contains the 13 components of the Institute of Medicine (IOM) Care Management Plan, as applicable to the EOM beneficiary.
4. Treating beneficiaries with therapies in a manner consistent with nationally recognized clinical guidelines.
5. Identifying EOM beneficiary health-related social needs (HRSN) using a health-related social needs screening tool. ([EOM Health-Related Social Needs Guide](#))

6. Collect electronic Patient Reported Outcomes (ePROs) from eligible beneficiaries and monitor eligible beneficiaries as described in the [EOM Electronic Patient-Reported Outcomes Guide](#);
7. Utilize data for continuous quality improvement (CQI).
8. Using Certified EHR Technology (CEHRT) as specified in 42 CFR § 414.1415(a).⁴

The first six items are considered “Enhanced Services” when provided to a beneficiary between 30 days *prior* to the start of an episode and 30 days *after* the last day of the episode.

Can an EOM participant partner with another provider or supplier for Participant Redesign Activities (PRAs)?

Yes, EOM participant can utilize any Medicare-enrolled provider or supplier (Care Partner) who:

- Engages in at least one of the PRAs during a performance period.
- Enters a Care Partner arrangement with an EOM participant.
- Is identified on the EOM participant’s Care Partner list.
- Not an EOM practitioner.

An EOM participant may share Performance Based Payments (PBP) they receive from CMS with their Care Partners. EOM Participants and Care Partners can also share the responsibility for repaying any Performance Based Recoupments (PBR) to CMS.

How can the EOM program be used to address health equity and reduce disparities?

Advancing health equity and reducing disparities is a significant part of care transformation activities. EOM participants will be required to:

- Develop and establish a health equity plan.
- Collect beneficiary-level sociodemographic data and report data to CMS.
- Use health-related social needs (HRSN) screening tools to correct HRSN data.
- Provide patient navigation to EOM beneficiaries such as connecting them to services and community resources.
- Provided EOM beneficiaries with 24/7 access to a clinician that has real-time access to the patient’s medical record.⁵

⁴ Ibid., p. 23.

⁵ Ibid., Appendix B.

Data Sharing

How do EOM participants share their data with CMS?

EOM participants will be able to electronically report to CMS various model-related data from their own health IT.

What are the types of data that will be reported to CMS?

The three types of data that will be reported to CMS are:

1. Quality Measures: Patient experience, avoidable acute care utilization, management of symptoms of toxicity, management of psychosocial health, and management of end-of-life care.
2. Clinical Data Elements: Collection and reporting of clinical data elements not available in claims or captured in the quality measures for the purposes of monitoring, evaluation, and payment.
3. Sociodemographic Data Elements: Collection and reporting of sociodemographic data used for monitoring and evaluation.
4. Reporting of HRSN data may be added in future performance periods.⁶

How often does data need to be reported to CMS?

CMS will only require data to be reported once per performance period. A time and method of submitting the data is to be determined by CMS.

Will CMS share any data with EOM participants?

CMS will provide data to PGPs via:

- Quarterly feedback reports
- Semiannual reconciliation reports
- Attribution lists
- Episode level files
- Monthly claims data⁷

Participants may request certain types of data needed to perform certain health care operations activities as part of the EOM.

Will there be a data sharing agreement (DSA) for the EOM?

Like other models, CMS will use a Data Sharing Agreement (DSA) for EOM.

⁶ Ibid., p. 65-66.

⁷ Ibid., p. 66-68.

Payment Methodology

What are the financial incentives for participating in the EOM?

In addition to FFS payments, participants may also receive two financial incentives:

1. **Month Enhanced Oncology Services (MEOS)** - The purpose of a MEOS payment is to support the provision of “Enhanced Services.”

EOM participants may bill Medicare for up to six MEOS charges for episode attributed to them, equal to \$110 per beneficiary per month. If the beneficiary is a dual eligible (Medicare and Medicaid), an additional \$30 may be paid per month.

The dates of service can begin 30 days prior to the start of the episode to 30 days after the end of the episode. The MEOS payment may be billed in real time or within 12 months following the date of service.

2. **Potential Performance-Based Payment (PBP) or Performance-Based Recoupment (PBR)**- Participants may either earn a PBP, owe CMS a PBR, or fall into a neutral zone. The PBP or PBR is based on the total cost of care (which includes drugs) and quality measures during the 6-month episodes beginning with the receipt of chemotherapy.

- **Performance Based Payment (+):** Total expenditures for attributed episodes are below a target amount.
- **Performance Based Recoupment (-):** Total expenditures for attributed episodes exceed the threshold for recoupment.
- **Neutral Zone (=):** Total expenditures for attributed episodes are above or equal to the target amount and below or equal to the threshold for recoupment.⁸

Pooling

The EOM allows for both mandatory and voluntary pooling of EOM participants. One EOM participant is designated as the pool payee. The payee is responsible for receipt of PBPs or be accountable for the PBR on behalf of the pool. Pooling allows for each EOM participant party to the pooling arrangement to distribute PBPs to, or collect the PBRs from, other EOM participants in the pooling arrangement.⁹

⁸ Ibid., p. 34.

⁹ Ibid., p. 64.

Performance Methodology

How is an EOM participant or pool's payment or recoupment assessed?

The Performance Based Payment or Performance Based Recoupment is calculated as a percentage of the benchmark amount for an attributed episode.¹⁰

How is the benchmark amount devised?

The benchmark amount is the total projected costs of attributed episodes. CMS anticipates eight baseline periods from July 1, 2016-June 30, 2020 (8, 6-month episodes) will be used for the values. These baseline periods will be attributed to the eligible oncology PGP that provides the first qualifying E/M service after the initiation of chemotherapy.

Risk & Experience Adjusters

CMS will also apply a risk-adjusted benchmark price based on cancer-type specific models to predict expenditures for each episode. The expenditures are then subject to an “experience adjuster” which is specific to the EOM participant. It accounts for regional and participant variation in cost of care and is a weighted average of national, regional, and EOM specific adjusters. For certain cancer types, such as ever metastatic status and HER 2 statuses, the predicted expenditures are multiplied by clinical risk adjusters.¹¹

Trend Factors

In addition, predicted expenditures for each episode are multiplied by cancer-specific trend factors. These factors account for systematic changes in the cost of oncology care between the final baseline period and a specific performance period.¹¹

Novel Therapies

If an EOM participant and pool's expenditures are above-average due to the use of newly FDA-approved oncology drugs, a novel therapy adjustment will be applied.¹¹

How are episodes attributed to EOM participants or pools?

Episodes are attributed 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.¹²

¹⁰ Ibid., p. 36.

¹¹ Ibid., p. 38.

¹² Ibid., p. 22.

What are the risk arrangement options for EOM participants and pools?

Each EOM participant and pool is in a two-sided risk arrangement. Participants have a choice between one of two options: Risk Arrangement 1, which is the default, and Risk Arrangement 2. Both risk arrangements meet the criteria to be a Merit-based incentive payment system (MIPS) APM under the Quality Payment Program (QPP). RA 2 also qualifies as an Advanced APM.

The target amount for an EOM participant or pool is their benchmark amount less the EOM discount (either 4% for RA1 or 3% for RA2) in the selected risk arrangement.¹³

Risk Arrangement Options		
	RA1 (Default)	RA2
EOM Discount	4% of benchmark amount	3% of benchmark amount
Target amount	96% of benchmark amount	97% of benchmark amount
Downside risk (stop-loss)	2% of benchmark amount	6% of benchmark amount
Upside risk (stop-gain)	4% of benchmark amount	12% of benchmark amount
Threshold for recoupment	100% of benchmark amount	100% of benchmark amount

Example

The EOM participant's benchmark amount is **\$1,000,000**. Therefore, the target amount for RA1 **\$960,000** (96% of the benchmark) while the target amount for RA2 **\$970,000** (97% of the benchmark). From there, the stop-gain and stop-loss amounts can be calculated accordingly.¹⁴

Risk Arrangement 1 (Default)		Risk Arrangement 2 (Optional)	
Stop Gain 4% of Benchmark Amt	\$40,000	Stop Gain 12% of Benchmark Amt	\$120,000
Target Amount 96% of Benchmark Amt	\$960,000	Target Amount 97% 96% of Benchmark Amt	\$970,000
Neutral Zone Will not earn a PBP or owe a PBR.	Between \$960,000 and \$1,000,000	Neutral Zone Will not earn a PBP or owe a PBR.	Between \$970,000 and \$1,000,000
Threshold for Recoupment 100% of Benchmark Amt	\$1,000,000	Threshold for Recoupment 98% of Benchmark Amt	\$1,000,000
Stop Loss 2% of Benchmark Amt	\$20,000	Stop Loss 6% of Benchmark Amt	\$60,000

¹³ Ibid., p. 43.

¹⁴ Center for Medicare and Medicaid Innovation, "Payment Methodology Webinar". 2022. Centers for Medicare and Medicaid Services. <https://innovation.cms.gov/media/document/eom-pay-meth-webinar-slides>.

Once expenditures are assessed for the performance period, the amount will be compared to the target to determine whether the participant earns a PBR or owes a PBR and the amount.

Benefit Enhancements and Incentives for Beneficiaries

Do beneficiaries receive any benefit enhancements or other incentives as part of being in the EOM?

Medicare will waive certain payment requirements for two benefit enhancements provided under the EOM: post-discharge home visits and care management home visits. Current telehealth flexibilities are scheduled to expire on December 31, 2024. If CMS does not extend the telehealth benefits, a telehealth benefit enhancement may be offered under the ROM.

The benefit enhancements are an optional feature of the EOM and are not a requirement to participate. EOM participants may select which enhancements they want to provide. To include the benefit enhancements, an implementation plan must be submitted to CMS for review and approval.¹⁵

Benefit enhancements and patient incentives are optional for EOM participants. Offering benefit enhancements or incentives to beneficiaries is not a requirement to be accepted into the program.

Telehealth

Currently, to provide beneficiaries with more access to care, CMS is allowing for the originating site rules to be waived. Outside of the Public Health Emergency (PHE), telehealth services are limited to areas designated as a rural health professional shortage area, a county that is not included in a Metropolitan Statistical Area, and from an entity that participates in a federal telemedicine demonstration project. The benefit enhancement allows telehealth services to be provided wherever the beneficiary is located (including their homes), not just those in rural areas.

For beneficiaries who receive telehealth services from their residence, CMS is waiving the facility fee. The facility fee is a payment for the facility's administrative duties related to telehealth services. As there are no administrative duties when a beneficiary is receiving telehealth from their residence, the facility fee does not apply.¹⁶

¹⁵ CMMI: EOM RFA, p. 59.

¹⁶ SSA, ORDP. n.d. "Special Payment Rules for Particular Items and Services."
https://www.ssa.gov/OP_Home/ssact/title18/1834.htm.

As noted above, telehealth benefits are scheduled to expire at the end of 2024, but may be extended under the EOM.

Post Discharge Home Visits

Another benefit enhancement is certain home visits provided by non-physician practitioners (ex. nurse practitioners, physician assistants, and clinical nurse specialists). Under this benefit, beneficiaries can receive up to nine post-discharge home visits within 90 days following discharge.

Typically, CMS requires direct supervision (presence of a physician) for these services. The EOM enhanced benefit will allow for the services to be provided under general supervision, which does not require the physician's presence at the time of the service.

Care Management Home Visits

Participants may also provide care management home visits if the patient is at risk of hospitalization. Like the "Post Discharge Home Visits", CMS will allow payment for certain home visits provided by auxiliary personnel under general supervision. Beneficiaries may receive up to ten home visits within a performance period.

Care Management Home Visits are supplement supplemental and are not a substitute for physician or practitioner visits in an outpatient health care setting.

In addition, EOM participants, practitioners, and Care partners are permitted to provide in-kind items or services to EOM beneficiaries (patient incentives), subject to compliance with all applicable laws, regulations, and the terms of the participation agreement AND subject to certain conditions.¹⁷

Application and Screening

What is the application and screening process for the EOM?

- Interested PGPS and payers may submit an application using the [EOM RFA Application Portal](#) by 11:59 EDT pm **September 16th, 2024**.¹⁸
- Applications will also be screened to determine eligibility for further review based on criteria detail in the RFA, applicable laws/regulations, and a program integrity (PI) screening.

Can applications to the EOM program be withdrawn?

Applicants may withdraw an application by submitting a request to CMS via email (EOM@cms.hhs.gov) prior to signing the participation agreement.

Participation in the second cohort of the EOM will not begin until on July 1, 2025. The EOM application is not binding. Thus, entities may apply to EOM, but they will not be

¹⁷ CMMI: EOM RFA, p. 64.

¹⁸ Ibid., p. 11-12.

considered participants in the model until the Participation Agreement is executed and EOM launches on July 1, 2025.

An EOM participant may terminate its participation agreement at any point during the model performance period provided that the EOM participant provides advanced written notice to CMS in a form and manner specified by CMS. At CMS' request, the EOM participant will be required to provide feedback regarding its decision to terminate the participation agreement and its experience as it relates to the implementation of Participant Redesign Activities (PRAs) and other model requirements.

Inquiries

Inquiries regarding the EOM program can be sent to CMS via email at EOM@cms.hhs.gov or by calling 1-800-Medicare.

References and Resources

Centers for Medicare and Medicaid Services

[Enhancing Oncology Model](#)

Information for Cohort 2 Applicants

- [EOM Cohort 2 Request for Applications \(PDF\)](#)
- [EOM Fact Sheet](#)
- [EOM Cohort 2 Fact Sheet](#)
- [EOM Cohort 2 Announcement FAQs](#)
- [EOM PGP Fact Sheet \(PDF\)](#)
- [EOM Payer Fact Sheet \(PDF\)](#)