ENHANCING ONCOLOGY MODEL

EOM Quality, Health Equity, and Clinical Data Strategy

August 15, 2024

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

TODAY'S PRESENTERS

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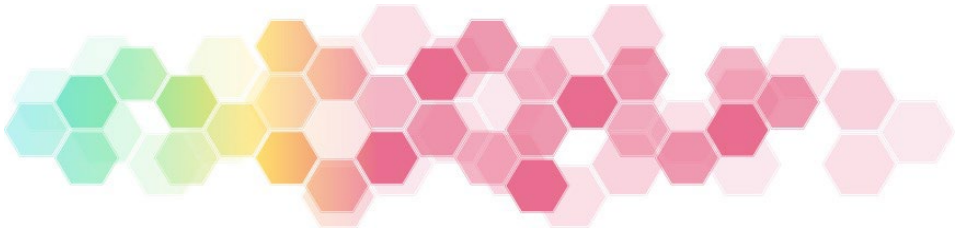
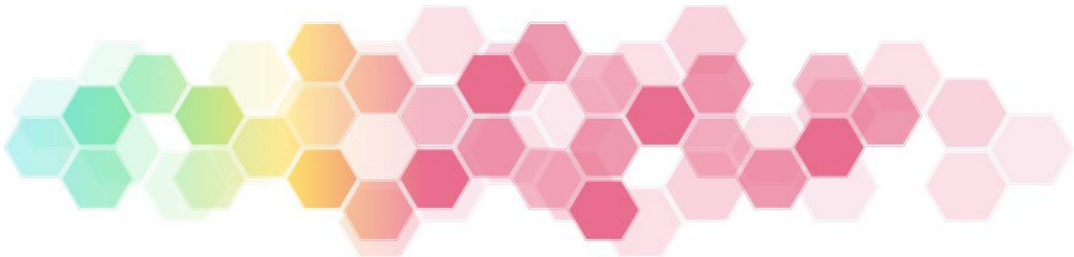
AGENDA

This webinar will provide an introduction of the EOM Quality Strategy. The following topics will be discussed:

1) **EOM Overview**
2) **Participant Responsibilities**
   - Participant Redesign Activities (PRAs)
   - Quality Measures, Data Sharing, & Reporting
   - Advancing Health Equity
3) **How to Apply**
4) **Q&A Session**
5) **Resources**



EOM OVERVIEW

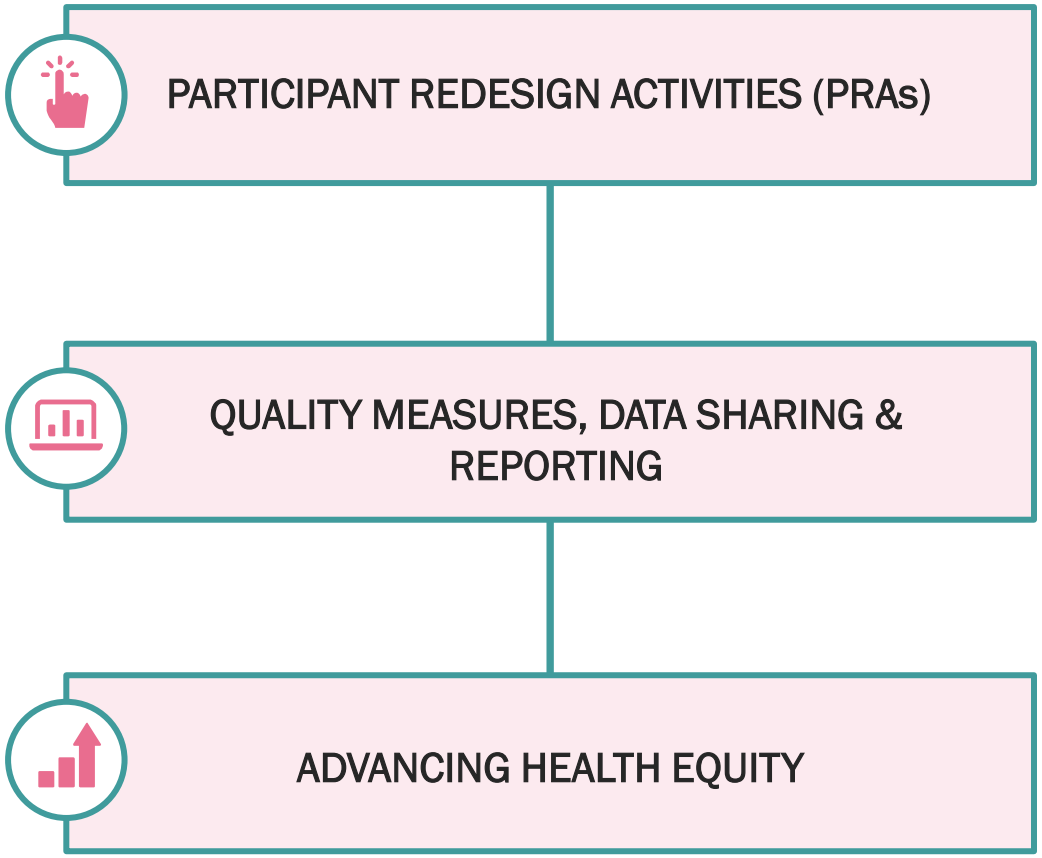


EOM OVERVIEW

EOM aims to drive care transformation and reduce Medicare costs

EOM Focus & Performance Period	**Voluntary payment and delivery model** focused on innovative payment strategies that promote **high-quality, person-centered, equitable care** to Medicare Fee-For-Service (FFS) beneficiaries with certain cancer diagnoses who are undergoing **cancer treatment.** The model began on July 1, 2023. A second cohort of participants will begin **July 1, 2025**. For both cohorts, the model end date is **June 30, 2030**
Participants	**Oncology Physician Group Practices (PGPs)** and **other payers** (e.g., commercial payers, state Medicaid agencies) through multi-payer alignment
Quality & Payment	EOM participants are paid FFS with the addition of **two** financial incentives to **improve quality** and **reduce cost**: ▪ The **Monthly Enhanced Oncology Services (MEOS) payment** supports the provision of Enhanced Services. Starting in 2025, the base MEOS amount is **$110** per-beneficiary-per-month (PBPM). Participants can bill an additional **$30 PBPM** for EOM beneficiaries who are dually eligible. The additional $30 PBPM for duals is excluded from EOM participants' total cost of care (TCOC) responsibility ▪ Potential **performance-based payment (PBP)** or **performance-based recoupment (PBR)** based on the total cost of care (including drugs) and quality performance during 6-month episodes that begin with the receipt of an initiating cancer therapy

QUALITY STRATEGY



PARTICIPANT REDESIGN ACTIVITIES (PRAS)

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**
- Collect and monitor **electronic Patient Reported Outcomes (ePROs)**
- Identify EOM beneficiary **health-related social needs** using a health-related social needs screening tool
- **Utilize data** for continuous quality improvement (CQI), including the development of a health equity plan
- Use **Certified Electronic Health Records (EHR) Technology** (CEHRT)

ACCESS TO A CLINICIAN

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

Purpose:

- Promote patient safety
- Improve the quality of care furnished to the EOM beneficiary
- Reduce care fragmentation that can result in avoidable hospitalizations and ED visits

EOM participants:

- Provide continuous availability of patient-provider communication in real-time, as well as access to the most up-to-date record of care for the cancer treatment regimen
- Assess protocols to promote equity, including identifying health equity goals and identifying potential barriers to access to care (e.g., transportation, health literacy)

Participant Perspective

*Practices **identified patients in need of additional support**, leveraging the **MEOS payments** to support interventions such as increased phone triage, same-day urgent care, and robust care coordination* *

*Abt Associates (2021). Evaluation of the Oncology Care Model: Participants' Perspectives, pg 64. Available from https://innovation.cms.gov/data-and-reports/2021/ocm-ar4-eval-part-persp-report

PATIENT NAVIGATION

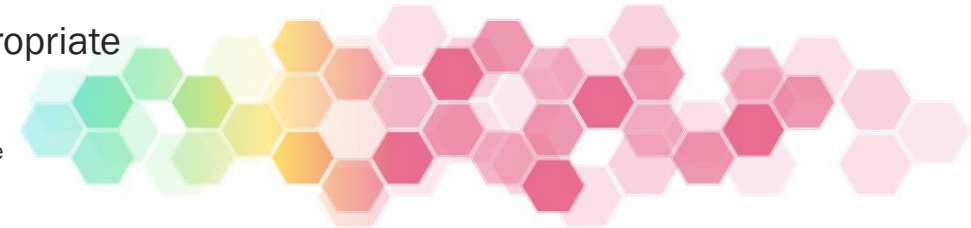
Provide **patient navigation**, as appropriate, to EOM beneficiaries

Purpose:

- Key element of identifying and addressing health disparities
- Facilitate care coordination for EOM beneficiaries
- Support and guide EOM beneficiaries with the goal of overcoming barriers to timely, quality care

Core Functions of Patient Navigation:*

- Coordinate appointments with health care providers to ensure timely delivery of diagnostic and treatment services
- Maintain communication with EOM beneficiaries, families, and the health care providers to monitor EOM beneficiary satisfaction with the cancer care experience and provide health education
- Ensure that appropriate medical records are available at scheduled appointments
- Provide language translation or interpretation services in accordance with federal law and policy
- Facilitate 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)
- Provide access to clinical trials as medically appropriate



* While not every eligible beneficiary may need patient navigation services, these services should be available to all eligible beneficiaries. Patient navigation must be provided in a manner that is compliant with all applicable laws and regulations

IOM CARE PLAN

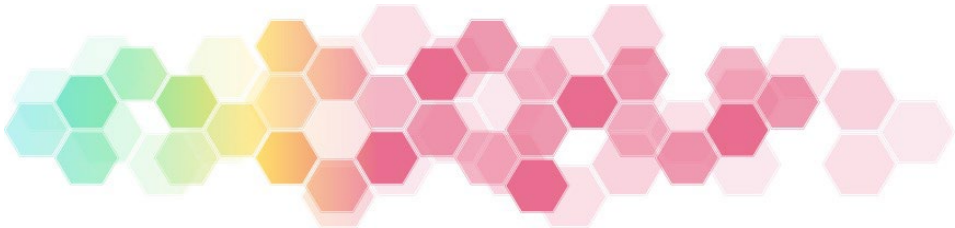
Document a care plan for each EOM beneficiary that contains the 13 components of the Institute of Medicine (IOM) Care Management Plan

Purpose:

- Facilitate communication and shared decision making between health care providers and their patients

EOM participants:

- Document a comprehensive cancer care plan, including information from the 13 elements in IOM Report
- Engage EOM beneficiary in the development of the care plan
- Share a physical or electronic copy of the care plan with EOM beneficiary for discussion and review of treatment goals on ongoing basis



IOM CARE PLAN (CONTINUED)

Components of the Institute of Medicine (IOM) Care Management Plan
1. Patient information (e.g., name, date of birth, medication list, 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 team, other care team)
10. Advance care plans, including advanced directives and other legal documents
11. Estimated total 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

CLINICAL GUIDELINES

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

Purpose:

- Promote standardization of care delivery
- Increase the use of evidenced-based research into clinical practice

EOM participants:

- Utilize nationally recognized clinical guidelines that have been approved by CMS, except as contraindicated by clinical decision-making for a given EOM beneficiary
- Encouraged to use health equity lens when utilizing clinical guidelines

Clinical Guidelines Must Be:

- Nationally recognized
- Developed by clinicians with relevant disease expertise
- Evidence-based with links to supporting literature
- Patient-focused, with alternative treatment options that account for patient variability, preferences, and comorbidities

Example clinical guidelines include the American Society of Clinical Oncology (ASCO) and National Comprehensive Cancer Network (NCCN)

ELECTRONIC PATIENT-REPORTED OUTCOMES (SLIDE 1 OF 3)

Collect and monitor electronic Patient-Reported Outcomes (ePROs)

Purpose:

- Improved identification of patient's needs, patient-provider communication, care management, patient satisfaction, and cancer outcomes
- Can aid process and quality improvement, including clinician awareness of concerning changes in a patient's clinical status on a timely basis

ePROs Definition

Electronic capture of measurements based on a report that comes directly from the patient, without amendment or interpretation of the patient's response.

More information can be found in the EOM ePROs Guide

EOM participants:

- Use ePROs tools that capture outcomes in identified domains
- Integrate ePROs with electronic health records (EHR)
- Capture ePROs data from EOM beneficiary a minimum of once before each visit where one or more qualifying E&M services are furnished to the EOM beneficiary

ELECTRONIC PATIENT-REPORTED OUTCOMES (SLIDE 2 OF 3)

Required Domains:

Domain:	Examples:
Symptoms and/or toxicity	Frequency, severity, activity interference, presence/absence
Functioning	Physical functioning, role functioning
Behavioral health	Psychosocial functioning, anxiety, depression, and other behavioral conditions
Health-related social needs*	Housing instability, transportation, food insecurity

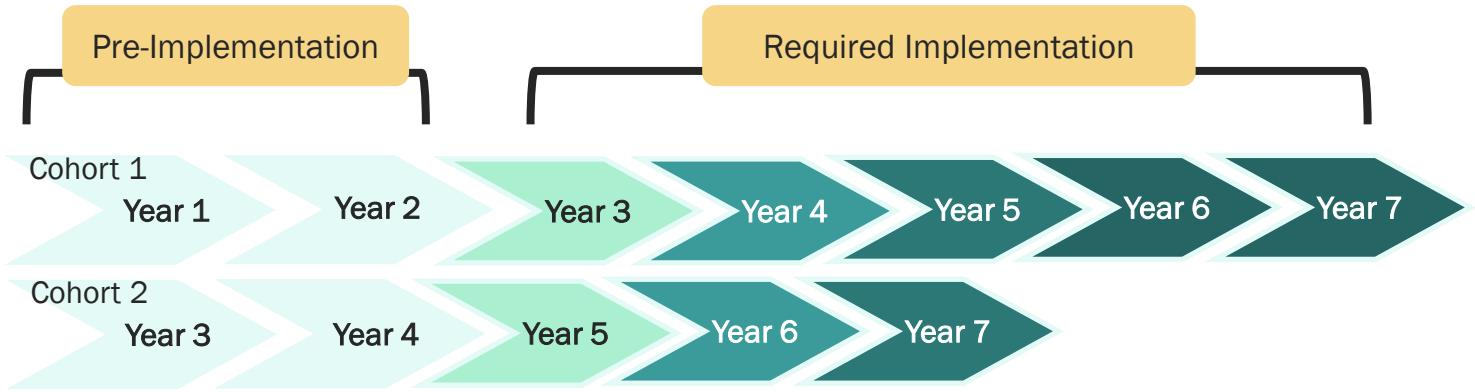
Learning Support for ePROs Implementation

The EOM Learning System will provide learning resources and facilitate learning communities for EOM participants to share best practices on collecting and using ePROs data to measure and improve the experience of care for beneficiaries

* CMS encourages EOM participants to screen EOM beneficiaries through ePROs; however, we will allow for additional flexibility. Should participants choose not to implement ePROs at the model start, they will still need to screen for health-related social needs (HRSNs) from the model start, per EOM's PRA requirements

ELECTRONIC PATIENT REPORTED OUTCOMES (SLIDE 3 OF 3)

Example ePROs Implementation Timeline



EOM participant identifies ePROs data collection tool, develops capabilities to successfully implement ePROs (e.g., pilot/test the approach in practice)

EOM participant collects ePROs data for **35%*** of EOM attributed patient population

EOM participant collects ePROs data for **50%*** of EOM attributed patient population

EOM participant collects ePROs data for **75%*** of EOM attributed patient population

*Note: This timeline includes *example* percentages of ePROs data collection

HEALTH-RELATED SOCIAL NEEDS (HRSN)

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

Purpose:

- Identify and address disparities in care
- Facilitate communication between health care providers and patients

EOM participants:

- Screen EOM beneficiaries for HRSNs in the following domains at a minimum:
  - Food insecurity
  - Transportation
  - Housing
- Encouraged to screen for additional HRSNs to meet the needs of their unique patient population, including but not limited to social isolation, emotional distress, interpersonal safety, and financial toxicity

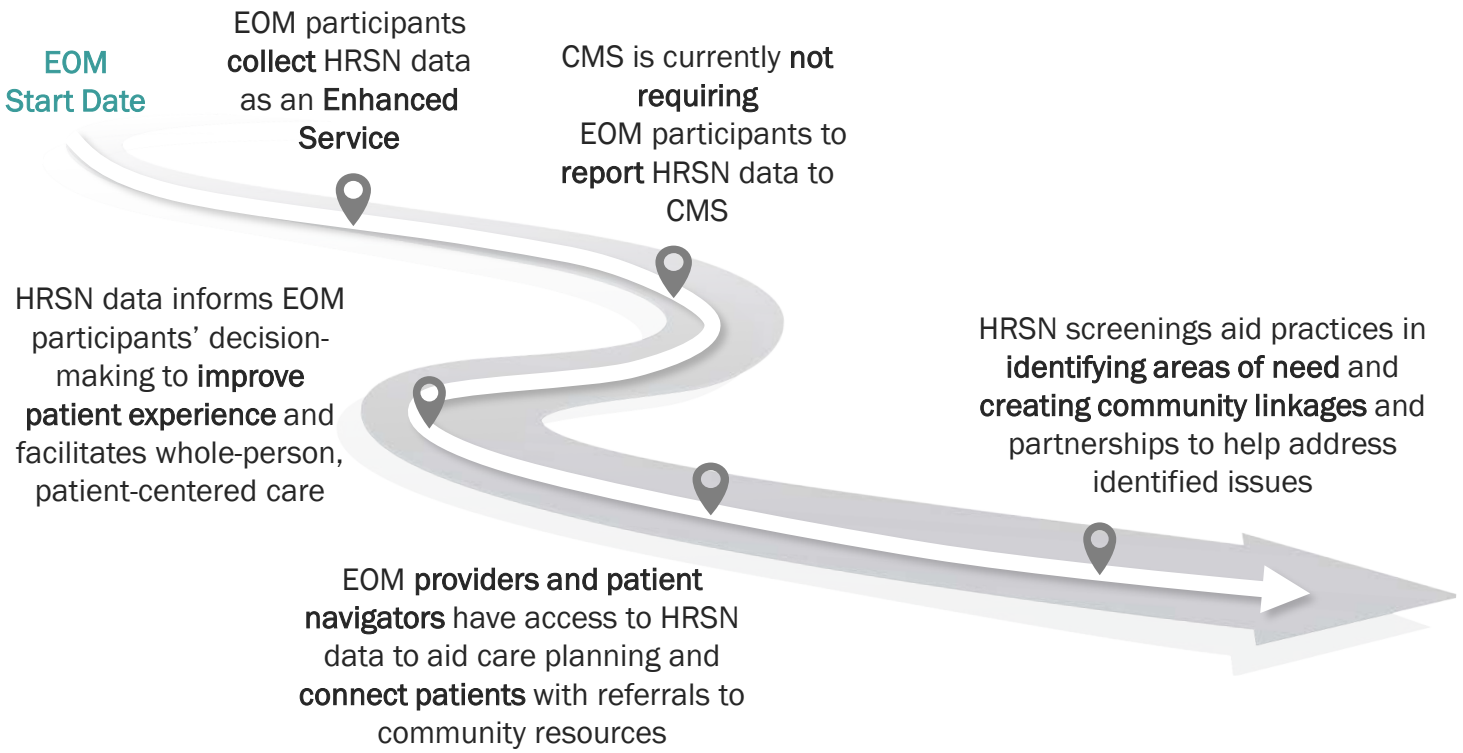
Tools*

Examples of free and non-proprietary HRSN screening tools include, but are not limited to, the NCCN Distress Thermometer and Problem List, Accountable Health Communities (ACH) Screening Tool, and Protocol for Responding to Assessing Patient's Assets, Risks and Experiences (PRAPARE) Tool

More information can be found in the EOM HRSN Guide

* The HRSN screening tools included here are examples only and do not constitute an endorsement by CMS or CMS affiliates, and EOM participants will have flexibility to use other HRSN tools.

HEALTH-RELATED SOCIAL NEEDS (HRSN) CONTINUED



CONTINUOUS QUALITY IMPROVEMENT

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

Purpose:

- Use data to improve performance, patient outcomes, and achieve model goals

EOM participants:

- As appropriate, leverage data to drive quality improvement (e.g., feedback and reconciliation reports, etc.)
- Develop and submit a health equity plan (HEP) that:
  - Uses data to identify where health disparities may currently exist in their care or patient population
  - Describes evidence-based strategies the EOM participant will explore to address identified disparities
  - Is regularly updated to include refreshed goals and strategies throughout the model performance period
- EOM participants will have a 90-day period from EOM participant's start date to begin to use data for CQI

CERTIFIED ELECTRONIC HEALTH RECORDS TECHNOLOGY

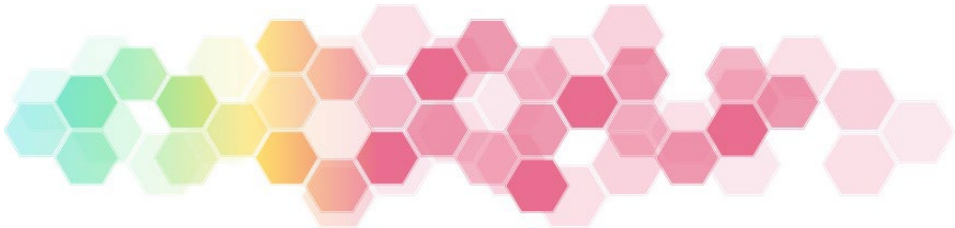
Use of **certified Electronic Health Records (EHR) Technology** (CEHRT)

Purpose:

- Facilitate delivery of Enhanced Services in EOM
- Store data in a structured and secure format

EOM participants:

- Follow the standards and other criteria as set by CMS and the Office of the National Coordinator for Health Information Technology (ONC)
- Annually attest their use of CEHRT* as specified at 42 CFR § 414.1415(a) and in a form and manner specified by CMS



* More information on CEHRT use requirements is available in Section V.C.iii of the EOM RFA
https://innovation.cms.gov/media/document/eom-rfa

QUALITY MEASURES, DATA SHARING, AND REPORTING

CARE TRANSFORMATION THROUGH PARTICIPANT REDESIGN ACTIVITIES (PRAs)

DATA SHARING AND HEALTH IT

EOM PARTICIPANT DATA SHARING

DATA COLLECTION STRATEGY

Electronically enabled mechanism to report model-related data obtained 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

CMS makes various data available, upon request, to EOM participants, such as:

Quarterly updates to feedback reports and dashboards

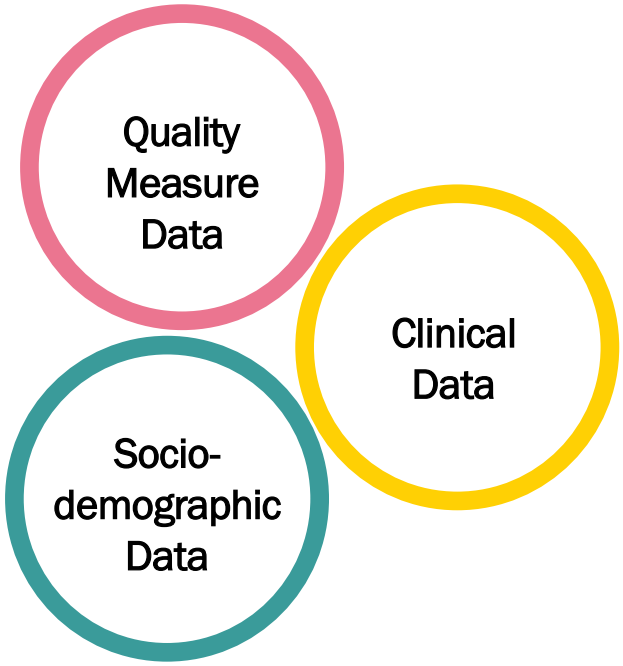
Semiannual reconciliation reports, attribution lists, and episode-level files

As often as **Monthly** claims Data

DATA SHARING REQUIREMENTS

Data Collection

EOM participants will be required to collect and submit data to CMS while in the model. These data may be used by CMS for purposes of monitoring, evaluation, and payment.



Quality Measure Data

Includes quality domains such as management of symptoms toxicity and management of psychosocial health. For more information on EOM Quality Measure Data, refer to EOM Quality Measures Guide

Clinical Data

Collect and report clinical data elements that are not captured in claims or in the quality measures. For more information on EOM CDEs, refer to the EOM CDE Guide.

Sociodemographic Data

Feedback reports will stratify aggregate, de-identified data by sociodemographic variables. CMS requires EOM participants to collect and report specific sociodemographic data elements. For more information on EOM SDEs, refer to the EOM SDE Guide

EOM QUALITY MEASURES

Quality Measure Data

Measure Title	EOM Measure Number	Domain	Measure Source	Type of Reporting by EOM Participant
Claims-based Measures				
Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy (OP-35 Respecified)	EOM-1	Avoidable acute care utilization	Claims-based	None. Calculated by CMS using Administrative Data
Proportion of Patients who Died who Were Admitted to Hospice for 3 Days or More	EOM-2	Management of end-of-life care	Claims-based	None. Calculated by CMS using Administrative Data
Percentage of Patients who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life	EOM-3	Management of end-of-life care	Claims-based	None. Calculated by CMS using Administrative Data
Participant-Reported Measures				
Pain Assessment and Management Set: a) Oncology: Medical and Radiation - Pain Intensity Quantified (NQF 0384; CMS Quality ID # 143) b) Oncology: Medical and Radiation - Plan of Care for Pain (NQF 0383; CMS Quality ID #144)	EOM-4 (composed of EOM-4a and EOM-4b)	Management of symptoms toxicity	EOM Participant Reported	Reported in aggregate across all patients
Preventive Care and Screening: Screening for Depression and a Follow-Up Plan (NQF 0418; CMS Quality ID #134)	EOM-5	Management of psychosocial health	EOM Participant Reported	Reported in aggregate across all patients
Patient-Reported Measure				
Patient-Reported Experience of Care Survey	EOM-6	Patient Experience	Patient Reported	None. Patient-reported; CMS fields survey

For more detailed information on EOM Quality Measure Data, refer to EOM Quality Measures Guide

QUALITY MEASURES CONT'D

EOM's quality strategy includes an **enhanced quality measures set** that aims to **promote better care across the spectrum of treatment**, including end-of-life care, where there continues to be opportunities for improvement. Excellent performance in quality measures can either **maximize performance-based payments (PBP)** or **reduce potential performance-based recoupments (PBR)** amounts

Example PBP Performance Multiplier

AQS (% of maximum points)	PBP Performance Multiplier
≥75% to 100%	100%
≥50% and <75%	75%
≥30% and <50%	50%
Less than 30%	0%

Example PBR Performance Multiplier

AQS Range (% of maximum points)	PBR Performance Multiplier
≥75% to 100%	90%
≥50% and <75%	95%
≥30% and <50%	100%
Less than 30%	100%

To calculate quality performance, CMS will:

1. Compare an EOM participant's or pool's performance on each measure to the measure's benchmarks
2. Calculate the EOM participant's or pool's aggregate quality score (AQS)
3. Cross-walk the EOM participant's or pool's AQS to the PBP performance multiplier or PBR performance multiplier, as appropriate

For more information, please see the EOM Payment Methodology

TRANSLATING AQS TO PERFORMANCE MULTIPLIER EXAMPLE*

Example Measure Scores for PP1 (Cohort 1) and PP5 (Cohort 2)

Measure	Score
EOM-1	11/12
EOM-2	10/12
EOM-3	8/12
EOM-4	N/A
EOM-5	N/A
EOM-6	9/12
Total	38/48

38/48 = 79.2%

AQS (% of maximum points)	PBP Performance Multiplier
≥75% to 100%	100%
≥50% and <75%	75%
≥30% and <50%	50%
Less than 30%	0%

OR

AQS Range (% of maximum points)	PBR Performance Multiplier
≥75% to 100%	90%
≥50% and <75%	95%
≥30% and <50%	100%
Less than 30%	100%

*Example is provided for illustrative purposes only and does not depict any real practice or patient

TRANSLATING AQS TO PERFORMANCE MULTIPLIER EXAMPLE CONTINUED*

Example Measure Scores for PP2 (Cohort 1) and PP6 (Cohort 2)

Measure	Score
EOM-1	10/12
EOM-2	8/12
EOM-3	7/12
EOM-4	9/12
EOM-5	8/12
EOM-6	9/12
Total	51/72

51/72 = 70.8%

AQS (% of maximum points)	PBP Performance Multiplier
≥75% to 100%	100%
≥50% and <75%	75%
≥30% and <50%	50%
Less than 30%	0%

OR

AQS Range (% of maximum points)	PBR Performance Multiplier
≥75% to 100%	90%
≥50% and <75%	95%
≥30% and <50%	100%
Less than 30%	100%

*Example is provided for illustrative purposes only and does not depict any real practice or patient

EOM CLINICAL DATA ELEMENTS (CDE) REPORTING

EOM participants will be required to collect and submit to CMS certain **beneficiary-level, clinical data elements**, not available in claims data or captured in the quality measures, on a **semiannual** basis

EOM participants will be required to report all required clinical data elements for the attributed cancer type to CMS on at least a **minimum of 90%** of attributed episodes in each performance period

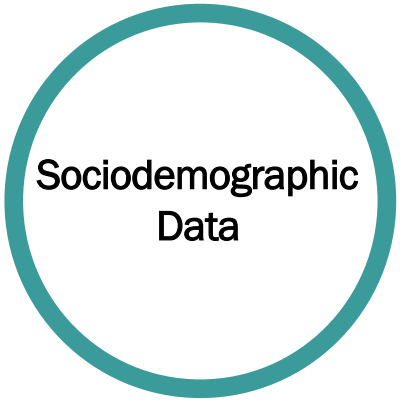
Clinical Data Elements*

- Attributed Cancer Diagnosis: ICD-10 Diagnosis Code and Initial Date of Diagnosis
- Current Clinical Status Data and Current Clinical Status Date
- TNM Staging: Primary Tumor, Nodal Disease, Metastasis
- Tumor Markers: Estrogen Receptor, Progesterone Receptor, HER2 Amplification (Results, Test Specified and Test Quantity)
- Histology
- The EOM Clinical Data Elements Guide is available on EOM Connect and the model website

** **Note:** For additional information and criteria regarding clinical adjusters for episodes involving certain cancer types, refer to Section 4.1.3, "Clinical Adjusters", in the EOM Payment Methodology document on the **EOM website***

SOCIODEMOGRAPHIC DATA ELEMENTS (SDE)

EOM participants will be required to collect and submit sociodemographic data on EOM beneficiaries* to CMS:



- Race
- Ethnicity
- Preferred Language
- Sex
- Gender Identity
- Sexual Orientation
- Disability Status

Please the EOM SDE Guide for additional information and resources to guide EOM participants with sociodemographic data collection

* List subject to change. While CMS believes in the importance of collecting complete and accurate data, to avoid discouraging beneficiaries from accessing care from EOM participants, EOM participants will not be required to report to CMS sociodemographic data for any EOM beneficiary who chooses not to provide such data

EOM EPISODES, PERFORMANCE PERIODS (PP), AND REPORTING TIMELINE FOR SDES AND CDES

Performance Period	Episode Initiation Dates	Episode End Dates	Reporting Timeline
1	7/1/2023–12/31/2023	12/31/2023–6/29/2024	Fall 2024
2	1/1/2024–6/30/2024	6/30/2024–12/29/2024	Spring 2025
3	7/1/2024–12/31/2024	12/31/2024–6/29/2025	Fall 2025
4	1/1/2025–6/30/2025	6/30/2025–12/29/2025	Spring 2026
5	7/1/2025–12/31/2025	12/31/2025–6/29/2026	Fall 2026
6	1/1/2026–6/30/2026	6/30/2026–12/29/2026	Spring 2027
7	7/1/2026–12/31/2026	12/31/2026–6/29/2027	Fall 2027
8	1/1/2027–6/30/2027	6/30/2027–12/29/2027	Spring 2028
9	7/1/2027–12/31/2027	12/31/2027–6/29/2028	Fall 2028
10	1/1/2028–6/30/2028	6/30/2028–12/29/2028	Spring 2029
11	7/1/2028-12/1/2028	12/31/2028-6/29/2028	Fall 2029
12	1/1/2029–6/30/2029	6/30/2029–12/29/2029	Spring 2030
13	7/1/2029-12/1/2029	12/31/2029-6/29/2030	Fall 2030

Cohort 2 Start

ADVANCING HEALTH EQUITY

ADVANCING HEALTH EQUITY

HEALTH EQUITY REQUIREMENTS

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

- Incentivize care for underserved communities
- Collect beneficiary-level sociodemographic data
- Identify and address health-related social needs (HRSN)
- Improved shared decision-making and care planning
- Develop health equity plans as part of continuous quality improvement (CQI)

APPLYING TO EOM - TIMELINE AND NEXT STEPS

APPLY TO EOM

COHORT 2 MODEL TIMELINE

Milestone	Planned Timing[1]
RFA released / Application portal opens	July 1, 2024
Application Deadline	September 16, 2024
Participant Selection	Mid to Late Winter 2024
Selected Participants Sign HIPAA-Covered Data Disclosure and Attestation (DRA) to receive Historical Data	Mid to Late Winter
Participant Agreement (PA) Signing	Early Spring 2025
Pre-implementation Period (Data will be made available to accepted applicants who sign the DRA for analysis during this period)	January 1, 2025 – June 30, 2025
Cohort 2 Model Start	Start July 1, 2025

[1] Dates are subject to change

HOW TO APPLY

Application period for EOM will be open July 1st, 2024
All EOM applications must be submitted by 11:59 pm Eastern Daylight Time on September 16, 2024. CMS may not review applications submitted after the deadline

Submit applications 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 Request for Application (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 2024 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

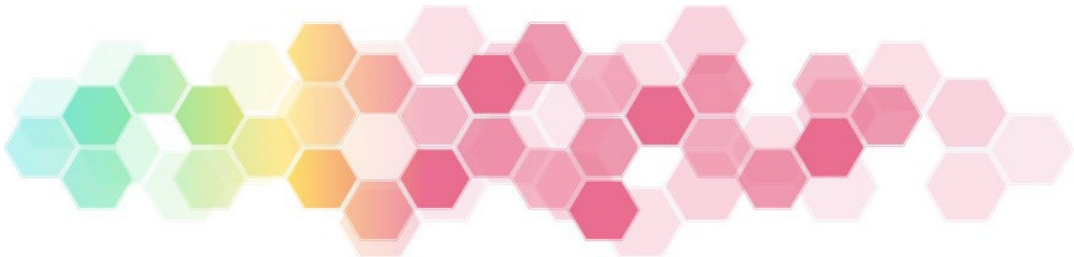
Refer to the EOM Application Portal Guide
This EOM Application Portal User Guide will assist applicants in accessing the application portal and providing direction on all information which must be provided in the RFA as well as tips to assist with completion of the application

EOM 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

RESOURCES



EOM RESOURCES

The following documents are available on the EOM model website:

EOM Cohort 2 Materials

- EOM Cohort 2 Request for Application
- EOM Cohort Fact Sheet
- EOM Cohort 2 Announcement FAQs
- EOM Application Portal Guide

EOM Factsheets

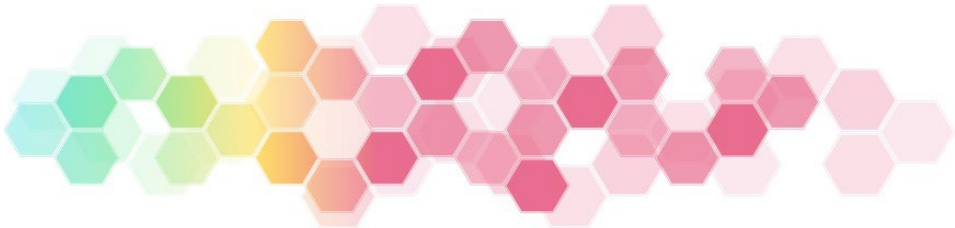
- EOM PGP Factsheet
- EOM Payer Factsheet
- EOM Benchmarking Factsheet
- Benefit Enhancements Factsheet
- EOM Health Equity Strategy Factsheet
- EOM ePROs Factsheet

Additional Resources

- EOM Payment Methodology
- EOM Clinical Data Elements Guide
- EOM Quality Measures Guide
- EOM Sociodemographic Data Element Guide
- EOM Health Related Social Needs Guide
- EOM Electronic Patient Reported Outcomes Guide
- EOM 2023 Health Equity Plan Guide (PDF)

Drug lists

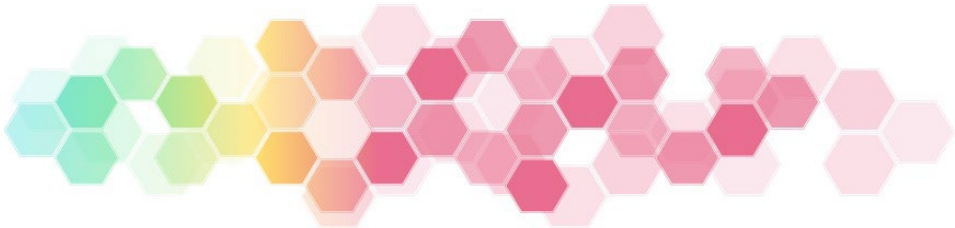
- EOM Initiating Therapies Effective July 2024
- EOM Novel Drug Therapies List (May 2024)



EOM PARTICIPANT-REPORTED QUALITY MEASURES - ADDITIONAL RESOURCES

The following documents are available on the QPP Resource Library, after selecting the applicable performance year:

- MIPS CQM specifications
  - 2024_Measure_143_MIPSCQM (EOM-4a)
  - 2024_Measure_144_MIPSCQM (EOM-4b)
  - 2024_Measure_134_MIPSCQM (EOM-5)
- MIPS CQM Single Source



CONTACT INFO

Stay up to date on upcoming model events and get the latest EOM information:

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