ENHANCING ONCOLOGY MODEL

2024 EOM QUALITY, HEALTH EQUITY, AND CLINICAL DATA STRATEGY

August 15, 2024

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
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Slide 1

Hello! Welcome to the EOM Quality, Health Equity, and Clinical Data Strategy Webinar. We are incredibly grateful and humbled by all of you taking the time to join us today. I am now going to turn the call over to my Enhancing Oncology Model colleague, Becky Metzger. Becky, the virtual floor is now yours.

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Thank you so much, Lisa. Hello and welcome again to the Enhancing Oncology Model Quality, Health Equity, and Clinical Data Strategy webinar. I'm Becky Metzger and I wanted to start out by introducing our presenters for today's event. I'm pleased to introduce Priya Chatterjee, our EOM Quality and Health Equity Lead. In addition, we also have Kirsten Lawrence, our EOM Care Transformation and Clinical Lead as well as Mike Berkery, our EOM Data and Payer Lead. We appreciate you all joining us today and our presenters today.

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So next, we're going to just go over the agenda and here's our agenda for today we'll start out with an overview of EOM, and next we'll go through what participant responsibilities are, including participant redesign activities, quality measures, data sharing and reporting, and then activities for advancing health equity. We'll then go over details of how to apply for the Cohort 2 of EOM, and then have time for questions and answers from all of the participants today. Finally, we're going to provide some hopefully helpful resources for folks who might be considering applying. And now, with that, I'm going to hand the call to our first presenter, Priya Chatterjee. Priya, please go ahead.

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Thank you, Becky. My name is Priya Chatterjee, and I am the Quality and Health Equity Lead for EOM. I am so happy to welcome you all today. I will provide a quick overview of EOM before we dive deeper into the Quality Strategy.

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So as a refresher, EOM is a voluntary payment and delivery model designed to test innovative payment strategies and promote equitable, high-quality, evidence-based cancer care to Medicare Fee-For-Service beneficiaries with specific cancer diagnoses undergoing cancer treatment. The model test began July 1st, 2023, with the Cohort 1 and we are excited to offer a second application period that is currently open. The new cohort will begin July 1, 2025, to both payers and practices. The model will now extend through June of 2030 for both cohorts. The model is being extended so that both cohorts will have at least five years to participate in the model test. A seven-year model test will allow EOM participants to have sufficient time to engage in investments, resources, and learnings to not only implement model requirements but to plan strategically for potential long-term transformation. The target participants for EOM are oncology Physician Group Practices that function under a TIN or Tax Identification Number as well as other payers. This is a multi-payer

model, and we look forward to partnering with both physician group practices and payers to advance value-based care. For the quality and payment components of EOM, participants are paid their typical fee for service reimbursements, along with two financial incentives to improve quality and reduce cost. The first payment incentive, the Monthly Enhanced Oncology Services (or MEOS), supports care transformation, specifically our enhanced services, which we will dive into further in a few slides. Starting on January 1, 2025, the base MEOS payment amount will be now $110 dollars per beneficiary per month. Participants can also bill for an additional $30 for each dually eligible Medicare and Medicaid beneficiary. We use dual status as a proxy for social risk. EOM's total cost of care benchmark will be risk adjusted for multiple factors, including but not limited to dual status and low-income subsidy status. The higher MEOS amount for dually eligible beneficiaries reflects the more complex needs of this patient population. Providing additional resources to EOM participants caring for dually eligible beneficiaries is one element of the model's health equity strategy. Finally, the 30 additional MEOS dollars do not count towards the EOM participants total cost of care responsibility. The second payment incentive is the potential to earn a performance-based payment (or PBP), or you may be subject to pay a performance-based recoupment (or PBR). Strong performance on your quality measures can also decrease the amount owed for a PBR. In EOM, we have two different, two-sided risk arrangements. There is more information about the risk arrangements, MEOS payments, and how PBPs and PBRs are calculated in our Payment Methodology and from our payment webinar we gave a few weeks ago, both you can find on our website. I would encourage you to review those materials to find more details about the technical components of our financial incentives.

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I'll be walking us through our EOM's Quality Strategy, which is composed of three key elements. That is the aim to transform care through participant redesign activities, inclusion of quality measures tied to payment to assess participant performance, and last but not least, advancing health equity. In the next several slides we'll go into more detail on each of these three pillars of the strategy. As a reminder, I would encourage you to send in your questions that you have for the EOM team through the Q&A pod at the bottom of your screen. We've saved some time at the end to try to respond to all of your questions by the end of the webinar. If we don't get time to answer your question, we do encourage you to contact us through the EOM helpdesk.

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The first pillar of the quality strategy are Participant Redesign Activities (or PRAs). In this section, we will walk through each of the PRAs and how they contribute to ensuring high quality, equitable, and person-centered care for our EOM beneficiaries.

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So, on this slide, you will see the eight PRAs that are included in EOM. EOM participants will implement all eight PRAs collectively to drive higher quality care. The first six PRAs are considered our enhanced services that I mentioned earlier. EOM participants have the option to bill CMS for MEOS payments, for furnishing these services to their EOM beneficiaries. The last two PRAs, utilizing data for continuous quality improvement, which includes the development of a health equity

plan (or HEP), and the use of Certified Electronic Health Record Technology or CEHRT are also required elements of the model. We will cover each PRA in detail in the next several slides. And with that, I will hand things over to my colleague Kiersten Lawrence. Kiersten.

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Thank you, Priya. Thank you for that overview. Let's dive a little deeper into each of the care transformation requirements. The first requirement is 24/7 access to a clinician. Beneficiaries need to have 24/7 access to an appropriate clinician with real-time accessibility to the beneficiary's medical record. As many cancer patients have complex medical needs that evolve over the course of treatment, continuous availability of real time patient provider communication, as well as access to the most up to date medical record is fundamental. This helps promote safety, improve quality of care, and reduces fragmentation that could possibly lead to an avoidable ED visit or inpatient stay. In OCM, practices addressed this enhanced service by implementing strategies such as phone triage, same day urgent care, and other care coordination efforts in order to support patients' needs. We believe access to care extends beyond access to insurance. For example, there are inequities in access to timely receipt of care that when mitigated, can improve the care experience, and reduce avoidable acute care utilization. We encourage EOM participants to assess their protocols to promote equity, including but not limited to, identifying health equity goals, and identifying potential barriers in access to care.

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The next PRA requirement is patient navigation. EOM participants will be required to provide the core functions of patient navigation as appropriate to all EOM beneficiaries who request or need these services. And while not every EOM beneficiary may require patient navigation, these services should be made available to all EOM beneficiaries. Patient navigation is a key element in addressing health disparities, which is a large focus of EOM. We see patient navigation as a way to offer support and guidance to EOM beneficiaries with the goal of overcoming barriers to timely, quality care. Included here are the core functions of patient navigation, for example, maintaining communication with EOM beneficiaries, families, and the health care team to monitor EOM beneficiary satisfaction with the cancer care experience, provide health education, facilitate linkages to follow-up services, and community resources. A few examples would be making referrals to cancer survivor support groups and community organizations or other third parties that provide child or elder care, transportation, or financial support. While the patient navigation services listed here are not an exhaustive list of all possible options, we believe offering at a minimum, each activity listed here, will allow EOM participants to provide high-quality care and facilitate care coordination and practice transformation for all EOM beneficiaries. Examples of additional patient navigation activities conducted by OCM Practices included assessing and facilitating referrals to address whole person health needs and establishing interdisciplinary care teams composed of clinical and/or lay navigators to provide support for services.

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The next PRA is documenting a care plan for each EOM beneficiary that contains the 13 components of the Institute of Medicine's Care Plan. Care plans help to facilitate communication

between health care providers and their patients, while simultaneously allowing for shared decision-making and assistance in navigating cancer care. Actively engaging beneficiaries and gathering beneficiary-level data has been shown to lead to better health outcomes, and in combination with patient navigation, as mentioned previously, is a key element of EOM's health equity strategy. We recognize and want to highlight the importance of beneficiary involvement and engagement during the care planning process. The EOM participant will be required to document the comprehensive cancer care plan in collaboration the beneficiary. We encourage EOM participants to share a physical and or electronic copy of the care plan with their beneficiary for discussion and review of prognosis and treatment goals on an ongoing basis as cancer care evolves over time.

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We see here the thirteen elements of the IOM Care Plan. The IOM Care Plan serves as a roadmap for delivering high-quality, patient-centered care, which are goals of the model. I'd like to call out two elements in particular, that are tied to health equity. The first is Number 11, which is estimating the total and out of pocket costs of cancer treatment for the period of each EOM episode for every EOM beneficiary. Many individuals diagnosed with cancer in the United States experience significant financial burden associated with their treatment. Economic stability, inclusive of expenses and debt, has been identified as a key social determinant of health. Financial distress, also known as financial toxicity, can impact the mental, physical, and emotional health of cancer patients, and is important in considering whole-person care. The second element I would like to highlight is number 12, addressing a patient's psychosocial health needs, for example, stress, untreated mental illness, and social factors, such as social isolation, can contribute to emotional distress and affect the patient's adherence to treatment and quality of life. Social risk factors and their accompanying health related social needs can contribute to health disparities. Having a thorough care plan documented in the EMR will complement patient navigation services to address these needs.

Slide 13

Clinical guidelines is the next PRA. Clinical guidelines are evidence-based recommendations for clinical practice that are used to determine appropriate treatments and care, including genomic testing when appropriate. We believe that treating EOM beneficiaries with therapies consistent with nationally recognized clinical guidelines, will improve the quality of care furnished to EOM beneficiaries by decreasing unnecessary practice variation and increasing the use of proven, beneficial research into clinical practice. We require EOM participants to treat EOM beneficiaries with therapies consistent with CMS approved clinical guidelines, except as contraindicated by clinical decision making for a given EOM beneficiary. For purposes of this requirement, CMS will approve only those clinical guidelines that are nationally recognized, developed by clinicians with relevant disease experience, evidenced based with links to supporting literature, and patient focused with alternative treatment options included and considered. Examples of clinical guidelines that satisfy these criteria include, but are not limited to, those published by ASCO and NCCN. EOM participants may utilize a pathways program to satisfy this requirement, as long as the pathways are based on clinical guidelines approved by CMS.

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The next PRA is the gradual implementation of electronic patient-reported outcomes, also known as ePROs. ePROs are the electronic capture of measurements based on a report that comes directly from the patient, without amendment or interpretation of the patient's response. The use of ePROs has been shown to lead to better identification of health needs, improved patient-provider communication, care management, patient satisfaction, and advances in cancer outcomes such as decreased ED visits and increased survival from certain cancers. Not only do ePROs improve clinician awareness of concerning changes in the patient's clinical status on a timely basis, but ePROs can also aid in your practices' process and quality improvement efforts. The ultimate goal of ePROs is to identify and address potential issues upstream, as well as maintain the continuity of care between visits. EOM participants will be required to use ePROs that capture outcomes and identify domains which we'll explore in the next slide. EOM participants will set up capabilities for the required gradual implementation of ePROs beginning in model year three, and I will also speak more to that in the coming slides. Additionally, I would like to note that ePROs will need to be integrated into the EHR. This will allow for ePROs to be integrated into the various office workflows so that data is more readily available and actionable. For more information on ePROs, please refer to the ePROs Guide.

Slide 15

We have identified domains and standards for the use of ePROs under the model. The domains include symptoms, toxicity, functioning, behavioral health, and health-related social needs. A few examples of each have been included next to each domain. These domains also represent areas for potential quality improvement in EOM and oncology service delivery. There are several ePROs tools available that practice can choose to use to collect this information. At this time, we are not requiring the use of a specific ePROs tool and allow for flexibility as this is a newly emerging field. That said, this flexibility will also allow for practices to continue the use of existing tools that may already be utilized in a practice prior to the start of EOM. In line with CMS' focus on achieving health equity, we encourage EOM participants to consider ePROs tools and communication methods that are valid and reliable for a diverse population. As you may have noticed, we have health-related social needs listed twice. Should participants choose not to implement ePROs at the very start of the model, they will still need to screen for health-related social needs. We encourage screening through ePROs, and there is additional flexibility given the gradual implementation timeline.

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I would like to emphasize that ePROs is a gradual implementation, in that the first two years or model Years 3 and 4 for Cohort 2, will be optional pre-implementation years with the third year, or model Year 5, for Cohort 2 will be the first required year for ePROs. The example timeline above shows both the pre-implementation and implementation periods for both Cohort 1 and 2. Beginning in the required implementation period, EOM participants are to capture ePROs data from EOM beneficiaries, a minimum of once before each visit, where one or more qualifying E&M Services are furnished to the EOM Beneficiary with the exception of the first visit. Gradual implementation will provide flexibility for EOM participants with and without experience with ePROs and allow the necessary time to adjust workloads and technology in order to integrate ePROs into clinical care

delivery. External expert feedback showed strong support for incorporating ePROs, highlighting the value and the need for specific real-time beneficiary-informed data to improve the quality of cancer care for Medicare beneficiaries. We believe that ePROs will improve each of the EOM participant's ability to engage with EOM beneficiaries and incorporate patient-reported outcomes data in order to deliver patient-centered care throughout the course of treatment. EOM participants can choose to implement ePROs in Years 1 and 2, however, as I said before, waiting is fine too, they would still need to implement and build the capabilities to be ready starting model Year 3. So, the first two years are the development period, and beginning Year 3, begins the gradual implementation. Please note here that the percentages listed are just an example to show the gradual increase in patient engagement over time. There is currently no set minimum collection requirement. At this time, EOM participants are not required to report ePROs data to CMS. However, as the ePROs field progresses, and CMS assesses implementation of ePROs under EOM, we may require that participants report ePROs data to CMS beginning in later performance periods. And at this time, I will pass it back to Priya.

Slide 17

EOM participants will be required to identify beneficiaries' health related social needs using an HRSN screening tool. We encourage participants to address disparities they identify over the course of the model. I want to take a few minutes to define some terms since there are many used to discuss these concepts but often not a uniform understanding. There is a difference between social determinants of health and health related social needs – two terms that are often used interchangeably. Social determinants of health are the structural and contextual factors that shape a person's life. These are the conditions in which people are born, grow, live, and age, and the wider set of forces and systems that shape the conditions of daily life.

Health-related social needs are the individual-level, adverse social conditions that negatively impact a person's health or health care. Examples of HRSNs include challenges in obtaining proper nutrition during chemotherapy treatment, accessing transportation for infusion appointments, or experiencing financial difficulties due to treatment costs. HRSNs impact the overall health and well-being of many Medicare beneficiaries with cancer. There is a risk of exacerbating health disparities, if HRSNs are not identified and mitigated properly through referrals and other patient navigation efforts. Actively identifying and addressing social determinants of health is essential to reducing health disparities and promoting health and health equity. In the box on the right, we included a few examples of free and proprietary screening tools that practices could implement. The HRSN screening tools included here are only examples, and EOM participants have the flexibility to use other screening tools that meet the unique needs of their beneficiary population. EOM participants will be required to screen for a minimum of three HRSN domains. Those domains are food and transportation insecurity, and housing instability. We encourage EOM participants to screen for additional HRSNs as each patient population has unique needs across the country. And these are included, but not limited to, social isolation, emotional distress, interpersonal safety, and financial toxicity. I wanted to highlight a point that Kiersten made earlier, at this time, CMS is not requiring EOM participants to report the beneficiary-level HRSN or ePROs data. However, standardization and building out workflows in EHRs and amongst staff is very important. She mentioned before ePROs collection starts in Model Year 3 for Cohort 1 and Model Year 5 for Cohort 2, but HRSN screening is required as one of the ePROs domains. Please note, that while ePROs implementation is gradual, participants are required to screen and collect HRSN data from EOM beneficiaries

beginning the first performance period of model participation. As additional standards are developed, CMS may require that EOM participants report HRSN data to CMS beginning in later performance periods. But as of right now, there is no requirement to report to CMS at this time.

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This slide provides a little “road map” of how we envision HRSN screening will be used throughout the model. First, EOM participants will collect HRSN data as an Enhanced Service. Then, this HRSN data helps EOM participants make informed decisions that will ultimately improve the patient’s experience and encourages whole-person, patient centered care. From the 2024 Health Equity Plan submissions we were encouraged to see that many practices use their HRSN data to inform how they will tackle health disparities in their communities. Together, EOM providers and patient navigators can leverage screening results to create tailored care plans and connect their patients with referrals in their community to address their specific needs. Finally, we hope the screening results will help inform practices broadly identify areas of need and help foster strong community partnerships to address those identified issues.

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The next PRA is utilizing data for continuous quality improvement, which includes the development of a Health Equity Plan. I want to emphasize the importance of leveraging data to drive quality improvement. Another example of use of data for CQI beyond the HEP includes the electronic data feedback report or eDFR which is chock full of data to help practices make more informed decisions. We are continuously making updates to our data feedback tool and always welcome your feedback here. EOM participants will have ninety days from their start date to begin use of data for CQI. EOM participants are asked to develop and submit an annual health equity plan. We believe it's important for EOM participants to use data to develop strategies to achieve health equity and to update these goals throughout the model performance period. Health equity plans should be used as a tool to assist EOM participants as they work to implement initiatives that meet the needs of their underserved communities and improve care for all of their beneficiaries. As use of data for CQI is an iterative process, the health equity plan, too, should be a living document that evolves over time. We hope to provide strong support through our learning system by highlighting and connecting practices through affinity and huddle groups, where participants can speak to one another, share their best practices, webinars, and helpful resources.

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The final PRA is the use of certified Electronic Health Record technology (or CEHRT). CEHRT is important to facilitating delivery of Enhanced Services in EOM as well as storing data in a structured format. This is a model-specific requirement, and EOM participants will follow the standards and other criteria set by CMS. Participants are required to attest annually to the use of CEHRT. With that I will turn things over to my colleague Mike Berkery to walk through our data reporting requirements, Mike, over to you.

Slide 21

Thanks, Priya. So, we'll now go over the data sharing and reporting components of the model as well as the quality measures meant to promote better care and treatment.

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So, EOM requires participants to collect and report quality, clinical, and sociodemographic data to CMS. We'll provide more details on this process in the following slides, but first we'll discuss ways that CMS will share data with participants. EOM data-sharing options allow participants to request claims data monthly, so they can promote quality improvement and data-informed decision making. The claims data will help identify areas for improvement in care coordination and quality assessment activities. Participants also have access to feedback reports and dashboards, which are updated on a quarterly basis. This includes de-identified, beneficiary-level utilization and expenditure data patterns. Participants can also compare their utilization and expenditure data with other EOM participants, as well as non-EOM comparison oncology practices. To identify and address disparities, participant-facing dashboards may also contain stratified, aggregate, de-identified data by sociodemographic elements. EOM participants can also request reconciliation reports, attribution lists, and episode-level files on a semi-annual basis.

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EOM participants are also required to collect and report participant-reported quality measures to CMS once annually. EOM will include valid, reliable, and meaningful measures from claims-based, participant-reported, and survey information. Performance on these measures are tied to payment Quality measures, which will focus on the following domains: patient experience, avoidable acute care utilization, management of systems toxicity, and management of psychosocial health, and management of end of life. For more detailed information on EOM Quality Measure Data, please refer to EOM Quality Measures Guide. EOM participants are also required to collect and report clinical and sociodemographic data semiannually. More information on these data elements will be discussed on the coming slides and can be found in the SDE and CDE Guides on the EOM website.

Slide 24

Thank you, Mike. I am going to briefly walk through our current 6 EOM quality measures. Quality measures were chosen from the domains listed here, and these are areas identified as important to advancing and providing the best oncology care for beneficiaries. Areas such as end of life care, management of psychosocial health and symptoms toxicity, have shown room for growth and improvement. Each of these types of measures are key for CMS to verify clinical improvements, assess patient health outcomes, and EOM patient care coordination activities, and ensure continued quality of care for beneficiaries. EOM quality measures include three claims-based measures, two participant reported measures, and a patient-reported experience of care measure. We have explored ways to include health equity within our quality measure set, except for the patient experience survey measures. Generally, quality measures will not be risk adjusted for socio-demographic factors to avoid masking meaningful differences in the quality of care. To promote high quality equitable care for all, we would consider risk adjustment for social risks, if and when

appropriate. In terms of our claims-based measures, we include the admissions and emergency department visits for patients receiving outpatient chemotherapy (or EOM-1); the proportion of patients who died who were admitted to hospice for three days or more (or EOM-2); and percentage of patients who died from cancer, receiving chemotherapy in the last fourteen days of life (or EOM-3). These measures do not require any reporting from practices. Our participant-reported measures, EOM-4a, EOM 4b, and EOM-5 will be reported annually to CMS, and that's really to align with MIPS annual reporting. As a side note, EOM-4a and 4b are a composite measure and count as a single measure. We're continuously looking for ways to align with programs such as MIPS when there is an opportunity to reduce participant reporting burdens. The patient-reported experience of cancer care survey (or EOM-6), will be collected directly from patients by a CMS contractor. This measure also does not require any reporting from practices. All measures are pay-per-performance and together form an Aggregate Quality Score (or AQS), which we'll describe more in the next slide.

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Quality performance will be linked to payment in one of two ways for an EOM participant or pool that earns a high AQS. They will either maximize their PBP if they earned, and are eligible to receive a PBP, or reduce the amount of PBR owed to CMS if the performance period expenditures exceed the threshold for recoupment. If an EOM participant or pool earns a low AQS, they will either reduce their PBP if they earned and is eligible to receive a PBP or have no impact on the amount of PBR owed to CMS if their performance period expenditures exceed the threshold for recoupment. To calculate quality performance, we will compare an EOM participant or pool's performance for each measure to the measure's benchmarks. Then we will calculate the AQS, and we will have a few examples of this coming up. Lastly, we will crosswalk the AQS to either the green table for the PBP performance multiplier if they earned a PBP or the pink table for the PBR performance multiplier if they owe a PBR. For purposes of calculating the AQS as described in the second step, each measure will be weighted equally. Additionally, CMS will apply a minimum episode threshold when scoring each quality measure to ensure the score is meaningful and not based on a small number of encounters. For example, if an EOM participant has less than 20 episodes for a given quality measure, CMS will not include the measure as part of the AQS calculations. The minimum episode thresholds will also be applied to the total number of attributed episodes for practices who are in pools.

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Let's walk through an example of how the AQS translates to the performance multiplier. Before we begin, I want to note that EOM-4 and EOM-5 will not be scored in performance period 1 (PP1) for Cohort 1, and performance period 5 (PP5) for Cohort 2 but will be included as part of the AQS beginning in performance period (PP2) and performance period (PP6) respectively. More details on reporting timing can be found in the Payment Methodology that's on our website. So, let's imagine we are reporting in Payment Methodology (PP1). Remember, participants are not required to report EOM-4 and 5, since those measures are reported annually and thus will not be included in the AQS calculation for this example. Assume that a participant earns 11 points for EOM-1, 10 points for EOM-2, 8 points for EOM-3, and 9 points for EOM-6, and for a total of 38 quality points (11+10+8+9 = 38 points). I would then divide 38 by 48, which is the total number of points that can be earned in PP1, for an AQS of 79.2%. When I check the performance multiplier tables, the participant would either earn 100% of their potential PBP amount, if their actual expenditures are lower than the target

amount or they would qualify for a 10% reduction of their PBR amount if their actual expenditures are higher than the threshold for recoupment.

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This example will take place in PP2 as I mentioned before, that would be for Cohort 1 and PP6 for Cohort 2. Now the maximum available points will be 72 because we have a full calendar year to score EOM-4 and EOM-5 so they will be included as part of the AQS. So, let's assume that a participant earns 10 points for EOM-1, 8 points for EOM-2, 7 for EOM-3, 9 for EOM-4, 8 points for EOM-5, and 9 points for EOM-6 for a total of 51 quality points (10+8+7+9+8+9 = 51 points). I would then divide 51 by 72, for an AQS of 70.8%. Next, I'm going to check my performance multiplier tables. This participant would earn 75% of their potential PBP amount if their actual expenditures are lower than the target amount or they would qualify for a 5% reduction of their PBR amount if their actual expenditures are higher than the threshold for recoupment. As discussed during the payment webinar a few weeks ago, the performance multiplier is just one factor that contributes to a PGP's PBP or PBR. Now I will hand the call back to Kiersten to talk more about our EOM Clinical Data Elements. Kiersten.

Slide 28

EOM participants will be required to report the clinical data elements to CMS on at least a minimum of 90% of attributed episodes for the beneficiaries attributed to the PGP for each performance period. EOM participants are required to report CDEs for EOM-attributed beneficiaries on a semi-annual basis, within 30 days of attribution data being made available in the EOM HDR application for each performance period. The receipt of a qualifying initiating cancer therapy by an eligible beneficiary for an included cancer type will trigger the start of an episode, as long as the beneficiary receives a qualifying E&M service during the episode. This list represents the current minimum data elements that CMS may collect; CMS reserves the right to modify data elements throughout the duration of the model. CMS continues to explore ways to further align with other reporting standards such as mCODE and USCDI. One EOM data submission option for CDEs includes the use of HL7-FHIR-based API which is in alignment with mCODE and USCDI and Cancer IG.

For those participants planning to use high-tech options for CDE data submission, the EOM Implementation Guide (or IG) uses US Core Data for Interoperability (or USCDI) + Cancer standards, which are a set of cancer data classes and elements. This also ensures that EOM data can be integrated across healthcare systems. Engaging with the EOM IG ensures that EOM participants and their vendors can share and receive the core USCDI and Cancer data elements. This allows a robust exchange of cancer data via FHIR. It also provides the ability to work with the critical core set of cancer data that are foundational for future USCDI and Cancer initiative use cases, such as clinical trial matching, tracking adverse events, and improving clinical data registry reporting. For additional information on the clinical data elements, please see the EOM Clinical Data Elements Guide. Additional information on clinical adjusters for episodes involving certain cancer types, can be found in the "Clinical Adjusters" section of the EOM Payment Methodology document.

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EOM participants will also be required to collect and submit a number of sociodemographic data elements (or SDEs) to CMS no more than once per performance period. SDEs have a large influence in health outcomes for patients. Current SDEs include race, ethnicity, preferred language, sex, gender identity, sexual orientation, and disability status. Collection of SDEs aids in providing whole-person care to EOM beneficiaries to improve health outcomes and health equity. Additionally, SDEs will be used for monitoring and evaluation. Feedback reports may stratify aggregate de-identified data by sociodemographic variables for EOM participants to identify and address disparities within their beneficiary populations. EOM participants can select from two submission options: the manual submission via an Excel template or submission through the EHR via a FHIR API. More information can be found in the EOM SDE Guide on the model website.

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EOM episodes, performance periods, and reporting timelines for SDEs and CDEs, each performance period consists of the episode initiation date and end date as shown here. EOM Cohort 2 participants begin with performance period 5. EOM participants are required to report SDEs for EOM-attributed beneficiaries on a semi-annual basis, within 30 days of attribution data being made available in the EOM HDR application for each performance period. This is at the same time as reporting the CDE data. The receipt of a qualifying initiating cancer therapy by an eligible beneficiary for an included cancer type will trigger the start of an episode, as long as the beneficiary receives a qualifying E&M service during the episode. Episodes will last for 6 months. If a beneficiary continues to receive a qualifying initiating cancer therapy after completing the 6-month episode, a new episode of care will begin. If the beneficiary entered hospice or has passed during the 6-month episode, the episode will still continue for the full 6 months, and it will include hospice costs or claims of care that occurred during and around the time of death but were not processed until after the beneficiary's passing. The episode start date refers to the receipt of a qualifying initiating cancer therapy identified by the date of service listed on the claim with a cancer diagnosis that triggers the beginning of an episode. The episode end date refers to the six months after the date on which an episode is initiated. The episode start and end date will be pre-populated in the SDE Data Submission Template for EOM participants. So as a reporting reminder for performance period 5 reporting will be in the Fall 2026, performance period 6 reporting will be Spring 2027 And this time, I will pass it back to Priya, thank you.

Slide 31

Thank you, Kiersten. I will briefly walk through our Health Equity Requirements.

Slide 32

So, we have touched on the importance of addressing health equity (or HE) throughout this presentation. But I want to cover our HE requirements holistically. EOM seeks to improve quality of care and equitable health outcomes for all EOM beneficiaries, that are including, but not limited to, five main strategies. Number one, incentivizing care for underserved communities. As discussed earlier, EOM participants are eligible to bill for the MEOS payment for furnishing enhanced services

such as patient navigation or HRSN screenings for our EOM beneficiaries. Our second strategy is to collect beneficiary level SDE, or sociodemographic data, as Kiersten discussed earlier in our presentation. EOM participants are required to collect and report beneficiary level socio-demographic data to CMS for purposes of monitoring and evaluation semi-annually. Our SDE Guide is available on the EOM website for more information. This version aligns with the USCDI v3 updates. Current sociodemographic data elements include race, ethnicity, preferred language, gender identity, sexual orientation, and disability status. Our third strategy is to identify and address health related social needs. During our PRA discussion we covered that EOM participants are also required to use screening tools for at a minimum, for three HRSN domains: transportation, food insecurity, and housing instability. This is also shown in the gradual implementation and collection of ePROs where HRSN is a domain. Our fourth strategy is to improve shared decision making and care planning. EOM participants are required to develop a care plan with patients, including discussions of prognosis and treatment goals, a plan for addressing psychosocial health needs, and estimating out of pocket costs. And finally, participants are required to develop an annual health equity plan as part of the PRA that uses data for continuous quality improvement. Mike is going to address the rest of the slides up to our Q&A portion of this presentation. Mike, please take us home!

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So, I'm now going to discuss the model, application timeline and process for applying, and again, the RFA is currently live and closes on September 16th.

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So, here's a timeline of the EOM application and other milestones such as the application deadline, review and selection process, data disclosure and attestation or DRA submission, and when we'll provide historical data for accepted applicants who've signed the applicant DRA. Feedback from EOM Cohort 1 applicants informed this new data sharing process. They noted it would have been helpful to have more time to review their historical data before deciding whether to join the model. At the bottom of this timeline, you'll see that the Cohort 2 begins, as we've said before, on July 1st, 2025.

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So, this slide provides information on how to apply to the RFA. This list also directs applicants to the EOM website, where you can access the PDF version of the RFA and the new EOM Application Portal Guide, which provides step by step instructions for completing the application in the portal. We also encourage you to sign up for the CMS listserv to receive updates on future events, as well as Cohort 2 information and guidance. A quick note about the RFA application portal: please make sure to select the correct RFA application since there's one for PGPs and one for payers. We'll now open it up for the Q&A portion of the webinar.

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Batsheva Honig: This is a friendly reminder to please continue to submit your questions. We'll get through as many as we can today. And if we don't get to your questions after the webinar or you

have additional questions, please remember to submit them to the EOM help desk. So, with that, we'll get started with some of our pre-submitted questions.

So, Priya, this first question is for you. Would EOM consider allowing practices to ask for updated sociodemographic data elements information via the patient portal alongside the beneficiary notification letter?

Priya Chatterjee: Thanks, Batsheva, good question. So, EOM participants do have the flexibility in how they collect SDE data and where this information is displayed as long as EOM participants just comply with CDE submission requirements which can all be found in our SDE guide. The two methods of submission are first, to the HDR via the standardized Excel template, which is pre-populated with the attributed beneficiaries or the high tech FHIR based API version, which enables electronic sharing of healthcare data across systems. As a reminder, the beneficiary notification letter (or BNL) is set language that EOM participants are required to share with EOM beneficiaries and cannot be altered. Should an EOM participant choose to share this letter via a physical paper letter or via the portal, they must confirm that the beneficiary has received the BNL and is able to access it.

Batsheva Honig: Great, thank you, Priya. All right. This next question I'm going to turn to you, Kiersten. What option should be selected for current clinical status trend and current or history of metastatic disease if the patient was not metastatic at the time of diagnosis but develops metastasis after diagnosis or was metastatic at the time of diagnosis? So, either of those scenarios.

Kiersten Lawrence: OK, great. Thank you. That's a that's a great question. In reporting clinical data elements in EOM, it's important when determining payment adjustment for ever metastatic to capture if a beneficiary was metastatic at diagnosis. It should be reported in the M value as EOM instructs to report the T&M at initial diagnosis. Also important to capture if a patient is metastatic during the episode or if the beneficiary has any history of metastatic disease for the attributed cancer type. The three data elements may look at metastatic status at a point from diagnosis to during the episode to general historical status, so all three are used to determine if the beneficiary will be eligible for the clinical adjuster ever metastatic.

Batsheva Honig: Great, thank you so much, Kirsten. I'm going to turn it back to you, Priya. We had a question related to Health Equity specifically. Can you describe a little bit more and maybe a recap some of those HealthEquity metrics that were included earlier in the presentation?

Priya Chatterjee: Yes, no problem. So, in alignment with our CMS Health Equity strategy, EOM also embeds health equity throughout EOM design. So that includes incentivizing care for underserved communities, collecting and reporting beneficiary level sociodemographic data, identifying and addressing health related social needs, improving access to treatment and care planning, and also developing Health Equity Plans as part of the use for data for continuous quality improvement.

Batsheva Honig: Thank you so much, Priya. This next question that we received is can this individual reach out directly to EOM for feedback guidance in their application process. I will respond to this one. So please, please do feel free to reach out to us via the EOM helped us. That's EOM@cms.hhs.gov or also via phone at where our number is 1-888-734-6433 Option 3, and all this information, it will be available and is part of the slide deck here, so, if you need to capture that, we will have it written down for you, and we can work to address your questions. We will also be having a final Office Hours in two weeks. So please do bring any and all application questions to there as

well. This next question that came in is related to Health Equity Plan, so I'm going to turn to you Priya.

This question specifically is asking if there is supposed to be a new Health Equity Plans submitted each year or if you can provide an update on the one from the previous year?

Priya Chatterjee: Yes, that's a good question. So, the HEP, as I mentioned during the presentation, is an iterative process. So, while we have our EOM participants required to submit a HEP annually to CMS, for some PGPs that might mean updating information from their prior years. And as more information comes in, you may want to be adding that to future years of your Health Equity Plan. So that might mean you're including new interventions and new data sources. Any updates that you would want us to know about would be helpful in health equity plan.

Batsheva Honig: Great. Thank you so much, Priya. I'm going to turn to some of the questions that we, additional questions we received. So, the first one here, I'm looking at our list, is related to ePROs, so I'm going to turn this one to you Kiersten. To meet the ePROs requirement, does an EOM participant need to offer a tool that allows two-way communication? Will messaging to a patient to encourage completion of a screening for example, meet the requirement?

Kiersten Lawrence: Thank you. That's a really good question, so I'm glad somebody asked it. EOM participants are encouraged to meet the needs of their unique beneficiary populations. These efforts may include finding alternative ways to collect and monitor beneficiary ePROs data. Some examples could be automated phone calls, doing something in the clinic, such as staff administered surveys and if each of the EOM participants should plan to train staff on how and when to follow up with eligible beneficiaries who do not engage with ePROs, or whose ePROs engagement is delayed. Staff are expected to reach out to beneficiaries to inquire into the reason for not responding, as a non-response could indicate other potential concerns. There's more details in the EOM ePROs guide if you're looking for more details or feel free to reach out to us. Thank you.

Batsheva Honig: Thanks, Kiersten. This next question you received is related to some data efforts. I'm going to turn to you, Mike. How can we use the eDFR reports to strategize? We don't always know what the data means, and we'd like to know what we're working with and what is and isn't there. If you could provide some more information, that would be great.

Mike Berkery: Yes, thank you. And this is a good data question. I think it's a common data question for eDFR. So, data from the eDFR, which includes dashboards, measures and associated claims data can really be used to identify potential areas for improvement in care. So, for example, if a participant's ER hospital admission rate due to treatment symptoms is higher than others, they could leverage this data to help identify interventions to improve care and reduce costs. So generally, participants can use these measures and claims to identify potential opportunities really for clinical quality improvement and implementing these intervention process changes using this data can have an impact in their processes.

Batsheva Honig: Great, thank you so much, Mike. All right, for our next question, this is related to some of our quality measures as well as other data collection, so this question is kind of a two part one. So, Priya, I'm going to turn it to you for EOM-5, will a depression or HRSN assessment completed once annually be accepted for the metric?

Priya Chatterjee: Yes, also a very good question. So, if a validated reliable tool for screening for depression is used in the administration of HRSNs or ePROs screening, which also qualifies for the EOM-5 criteria, and all of the criteria are met. So that's administered within the kind of appropriate time frame of the encounter. They may count for EOM-5 as well. But I just want to note here that the HRSN screening requirement is separate from the quality measure requirement. So HRSN screening is required but not reported to CMS at this time. And the EOM participant reported quality measures are separate and reported directly to CMS through an EOM specific reporting process and that's on an annual basis in alignment with the MIPS CQM specifications.

Batsheva Honig: Great, thank you so much, Priya. And we actually did get another measures question. So, I'm going to just tag this one along to that one. So, are there individual PDF measures specification documents for EOM-4ab and 5? Will these measures need to be reported as numerator denominator only like OCM? Or will an Excel file template be needed?

Priya Chatterjee: Yep, good question. So, EOM participants are required to report participant reported measures at the aggregate level only. So, numerator denominator exclusions and exceptions. EOM uses the MIPS QPP CQM specifications. So, the details specifications are located in the QPP Resource Library at cms.gov for each of the measures and the data elements and corresponding codes are located in the MIPS CQM single source for each measure. And I think there is a link that just popped up if you want to look at that. And so, these documents are updated annually and released at the end of the year prior to the performance year.

Batsheva Honig: Great, thank you so much, Priya. Next question you received is related to what triggers an episode and total cost of care, so, I'm actually going to call on you Liz to help with this one. So, in the event of an episode for an EOM beneficiary that goes beyond six months, can the EOM practitioner trigger another chemotherapy episode and how will the total cost of care be calculated for that six-month episode?

Liz Ela: Yes, great question. So, an episode actually it will always last six months, but it is possible for a beneficiary to have multiple episodes if their treatment extends beyond a six-month period. So, a beneficiary can have consecutive episodes or multiple episodes at different times. A beneficiary can only ever be in one episode at a time though. So, after the conclusion of an episode, if the beneficiary has an initiating cancer therapy and continues to meet the other EOM criteria to have an episode, they can then start a second episode, potentially a third episode, depending on how long they continue to meet the criteria and how long they're continuing to receive treatment. I do want to note that in the event that a beneficiary has a consecutive episode, that each episode is going to get its own benchmark and it's going to have its own expenditure calculation. And, part of this question was about how that total cost of care is calculated for an episode, and I'm going to give you a high-level answer now, and then I'm also going to refer you to some other payment resources that will have some more detailed information because this can get as weedy as we want it to be. So, in broad strokes, the total cost of care for an episode includes nearly all spending on services rendered to the beneficiary during their episode. These could be services rendered by any Medicare provider or supplier, it's not limited to oncology care only. The expenditures include most Part A expenditures, most Part B expenditures, certain claims-based and beneficiary specific Part D expenditures. And there are some additional adjustments that CMS makes when calculating the episode expenditures. There are some excluded expenditures, and I want to refer you to a few resources that cover all of these topics in greater detail. So first off, a good place to start would be some of the documents from

the payment webinar that we put on last month. These are available on the EOM website, and they include both the slides from that presentation, which include a lot more detail and an example. There's also a recording of that webinar on the website if you'd prefer to listen along. Also on the EOM website is the EOM payment methodology document, which includes a lot more technical information about how the expenditures are calculated. And I also want to refer you to a document on the website called the EOM Technical Payment Resources. And that document has several different tabs that all have different useful information about payment methodology, and one of those tabs has a list of excluded MS-DRGs, so that would provide some more information about specific carve outs that are not included in episode expenditures. So just to sort of tie all that in a bow, in broad strokes, the total cost of care includes essentially all of the care expenditures for the beneficiary during their episode unless specifically excluded and we encourage you to take a look at those other resources to learn more of the technical details. And as always, if you have questions after you've looked into that further or specific questions about what counts and what doesn't, you're always welcome to contact the EOM help desk and we'll get you an answer that way.

Batsheva Honig: Great. Thank you so much for that comprehensive answer and for those additional links and resources. I'll now answer the next question. Is a practice required to participate in the first performance period once submitting assigned participation agreement or can the practice withdraw prior to July 1, 2025? I will reiterate this is a voluntary payment model, participants may withdraw from participation prior to the start of the model given advance notice is provided in alignment with the participation agreement. Additional information will be provided in the participation agreement for your review prior to signing the agreement with additional information. So more coming on that soon.

So, I will now turn it to a question that we have received before but continue to get and it's always good I think to do a quick reminder here and we are happy to share. And so, I'm going to turn this one to you, Liz. This is actually about historical data and when that will be available and what time period that covers and if that includes actual cost and predicted cost. So, if you could give us a review of that answer, again that would be most appreciated.

Liz Ela: Sure, no problem. So, to start, I want to make a distinction between baseline data and historical data. So, the EOM baseline data are already available on the EOM website and these baseline data are de-identified public use files that include all of the baseline period episodes nationally. So those are episodes that initiated 2016 through 2020 and these are the episodes that inform many parts of the payment methodology such as price prediction models, trend factors, other parts of the benchmarking methodology. I already mentioned that EOM technical payment resources document that's also on the EOM website that has a lot of useful documentation related to these data files, including things like the list of the initiating cancer therapies that applied to the model baseline period, so a lot of good information there and that is already available on the website right now. Now let's talk about historical data. So later this fall, CMS will be offering an applicant HIPAA covered Data Disclosure Request Form or a DRA to provisionally accepted applicants in the EOM Cohort 2. So, by signing this applicant DRA late in 2024, the Cohort 2 of applicants will have the opportunity to receive participant specific and beneficiary identifiable historical data prior to signing and executing their participation agreement, which is slated for the spring of 2025. CMS tentatively plans to share participant specific and beneficiary identifiable historical data with these provisionally accepted Cohort 2 applicants towards the end of this year, so late 2024. These historical data are going to include episode level data as well as claims data for attributed historical episodes that initiated

January 2020 through December 2022. As for the cost information that's included in those data, the baseline period data, and the historical period data both include actual expenditures. Additionally, they include the price prediction model covariates, so it's possible to use these data to collect to calculate the predicted expenditures for each episode. So, to do this, you would need to refer to the price prediction model coefficients and these are available in that EOM technical payment resources file that I mentioned that are on the website. Now, because we're talking about predicted expenditures, I just want to stress there's more information about what those predicted expenditures are and what they have to do with benchmarking in some of those financial like this payment methodology resources that I mentioned a little earlier. So again, I'm going to refer you to those payment webinar slides and the recording as well as the Payment Methodology document.

Batsheva Honig: Great. Thank you so much, Liz. I really appreciate going over that again and always really helpful. So, for our next question, I'm going to turn this one to you, Priya, if you could just give a high-level overview again and remind us what are the EOM participant reported quality measure reporting requirements, that would be stellar.

Priya Chatterjee: Yes, happy to. So annual reporting for participant repeated reported measures will begin in January of 2025 and reporting should be completed by mid-February of each year and annually thereafter. We also have an EOM measure abstraction tool, which is optional but is available on connect to all participants, and we aggregate measure results and that's required for reporting for our participant reported measures so, EOM-4a or b and EOM-5. So, for those measures, the aggregate numerator and denominator counts must be manually entered in the Innovation Support Platform (or ISP) and that's in their Health Data Reporting application (or HDR) for each performance year by the reporting deadline. So, participants are also required to report denominator exceptions. So, the eligible population exception counts, but that's just for EOM-5. And prior to entering the denominator or the eligible population count in the HDR application, the denominator exclusion count should also be removed. And that's just for EOM-5. So, CMS may require patient level data on quality measures as part of an auditing and monitoring process, such as list of patients included in the calculation of a quality measure and more detailed data elements for each measure. But if that were to happen, each participant will be provided with further information if they're subject to that audit and monitoring activity.

Batsheva Honig: Great, thank you so much Priya. So, this next question is another data question. And Mike, I know you answered the eDFR lens, but can you give us a little more information about what data will be available for through EOM for the participant once they start the model?

Mike Berkery: Sure. Thanks, Batsheva. So, EOM participants will be provided monthly claims data via their data custodians as designated by the participants DRA agreement. This includes beneficiary level claims data. In addition, claims data associated with the feedback reports and dashboards will also be available as well as associated claims with those feedback reports and dashboards. These reports dashboard and associated data could include items like beneficiary characteristics, expenditures, utilization, and end of life measures. Following the conclusion of each performance period EOM participants will receive reconciliation reports along with the corresponding underlying raw Medicare claims data in episode files for their attributed episodes.

Batsheva Honig: Great, thank you so much, Mike. We're now going to turn to some questions on the clinical data elements. So, Kirsten, if you could take this first one, can you give us an overview of what the EOM clinical data elements reporting requirements are?

Kiersten Lawrence: Sure, absolutely. So, the EOM participants are required to report CDEs for all EOM attributed beneficiaries on a semiannual basis within 30 days of attribution data being made available in the EOM HDR application for each performance period. And I know I just said all, excuse me, that was a slight slip up. EOM participants are required to report complete and valid clinical data for at least 90% of their attributed beneficiaries in the performance period to be able to qualify for clinical adjusters for the episodes involving certain cancer types. So, in preparation for reporting clinical data, the PGPs should ensure that their systems have capabilities to ensure all required CDEs for reporting are able to be captured. Thank you.

Batsheva Honig: Thank you, Kiersten. Kind of going to continue on the CDE train here. Mike, can you answer this next question? Are all EOM clinical data elements required to be reported for a given beneficiary?

Mike Berkery: Sure, good question. So, all EOM CDEs applicable to the cancer type for the attributed beneficiary identified during the episode are required to be reported to the EOM Health Data Reporting or HDR application. All required CDEs must be answered for the record to be marked complete. If the CDEs are not complete, the EOM HDR application will reject the file as incomplete until the missing or invalid data is reported or corrected. So, when all required CDEs are reported accurately to the EOM HDR application, the attributed beneficiary will be considered complete.

Batsheva Honig: Amazing, thank you so much, Mike. I'm now going to turn it back to you, Priya. Can you go over a little bit more in terms of what the purpose is for the HealthEquity plan?

Priya Chatterjee: Yes, happy to. So, we believe it is important for EOM participants to develop evidence-based strategies for how they aspire to achieve health equity within EOM. And then we ask them to update these goals throughout the model performance and that's in line with our PRA of using data for continuous quality improvement objectives. So HEP should really be seen as a tool to assist participants as they work to implement those initiatives and that meets the needs of their underserved communities and improved care for all of their beneficiaries.

Batsheva Honig: Amazing. Thank you so much, Priya. I'm going to now turn to some of the questions we got on the IOM Care plan and submission there. So, the first question is if one of the 13 elements in the Institute of Medicine, or the IOM Care Plan is not applicable for a beneficiary, how should the participant note this in their electronic health record? So, I'm going to turn that to Kirsten for this question.

Kiersten Lawrence: Good question, thank you. If a certain element of the IOM care plan is not applicable for a certain patient, the participant should note N/A are not applicable in the EHR. There is more details in Appendix B of the participation agreement. I'll just point it out here. Some of the 13 elements will not be relevant to all patients. So, the EOM participant may note when particular elements of the care plan are irrelevant. Thank you.

Batsheva Honig: Thank you, Kirsten. I'm going to continue on the IOM questions. Can you tell us a little bit of how do participants document the 13 elements of the IOM care plan? And isn't acceptable for all items to be included in the patient record but not in necessarily in the same location?

Kiersten Lawrence: Another really good question. So, EOM participants, you must document all 13 elements of the IOM care plan in the EHR, but they do not have to be in a single location within the EHR. The care plan elements should be accessible to the care team and the patients and families should be involved in the care planning process. Additionally, just to point out that the practice will need to attest annually to the completion of the IOM care plan for every eligible EOM beneficiary and that during the monitoring and site visit, the practice must also be able to locate this easily within the EMR to the site surveyor.

Batsheva Honig: Great, thank you so much, Kirsten. I am hopping around a little bit, but I want to cover a question we have on SDE. So, the sociodemographic data elements. And the question is, is there a reporting threshold for EOM participants to complete the socio demographic data for EOM attributed beneficiaries to CMS when reporting? So, I'm going to turn this one to you, Priya.

Priya Chatterjee: Thanks, Batsheva. So, while EOM participants are expected to ask every EOM beneficiary for this information, and we do encourage completeness and accuracy of that data, there is no penalty should a beneficiary feel uncomfortable or choose not to disclose, including some, but not all of the information. So, CMS believes collecting standardized patient demographic and language data across care settings is a really important first step towards improving population health. But you know, however, to avoid discouraging beneficiaries from accessing care at an EOM practice, beneficiaries are allowed to not share sociodemographic data with their providers or with CMS. The EOM practices are not required to report this data to CMS for any beneficiary who does not wish to disclose that. And additional information can be found on our SDE guide that's on the EOM website. EOM participants are expected to collect and report the associated demographic data from eligible beneficiaries that have not opted out of sharing such data.

Batsheva Honig: Great. Thank you so much, Priya. All right, these next two questions are related to ePROs. So, I'm going to ask you, Kirsten, if you can go over which electronic patient reported outcomes or ePROs tools should EOM participants use?

Kiersten Lawrence: Sure. CMS does not require the use of a specific ePROs tool. EOM participants must use surveys that capture, where applicable, outcomes for each of the domains we covered in the webinar. So, I'll go over those again: symptoms, toxicities, functioning, health related social needs and behavioral health. And in line with CMS focus on achieving health equity. EOM participants should consider ePROs surveys that have been previously tested and shown to be valid and reliable, including in diverse populations. We encourage the use of free and non-proprietary ePROs surveys. Examples of non-proprietary and established ePROs surveys and other resources available to EOM participants, along with additional information about the gradual implementation of ePROs can be found in the ePROs Guide, which is on the EOM website.

Batsheva Honig: Great, thank you so much, Kiersten. As I promised, there was a second ePROs question. So, if you could explain to us what are some of the expected benefits of collecting ePROs from EOM beneficiaries?

Kiersten Lawrence: Sure, great, thank you. Potential benefits of ePROs include but are not limited to of course prompting discussions with a clinician, streamlining consultations, increasing awareness, triaging of symptoms, facilitating interprofessional communication, and that ePROs has also been shown to lead to improved survival, sometimes exceeding the benefits of oncology drugs. So, using

ePROs tool in an oncology setting can lead to better identification of patient's health needs. Again improving that patient provider communication, improving care management, patient satisfaction and advancing cancer outcomes such as decreased emergency room visits and increased survivals like I mentioned earlier from certain cancers. ePROs can also be used in processing quality improvement efforts within the clinic, including clinician awareness around concerning changes in a patient's clinical status and a timely basis.

Batsheva Honig: OK, thank you so much, Kirsten. And I'm just looking at the time now. I think we have probably time for two more questions. So, I'm just going to go down the list here. OK. So, I'm going to turn this next question to you, Priya. It's about HRSN or the health-related social needs. Can you explain to us what are the health-related social needs that you and participants are required to collect versus those that domains that are required or suggested?

Priya Chatterjee: Yes, good question. So, the required HRSN domains are food insecurity, housing instability and transportation needs. However, we do kind of encourage or suggest EOM participants to screen for additional HRSNs and as applicable really to meet the unique needs of each patient population. So other domains can include social isolation, emotional distress, interpersonal safety, financial toxicity, and there are others as well that I haven't mentioned. We have a few free examples and non-proprietary screening tools that you know such as the National Comprehensive Cancer Network Distress Thermometer and Problem with the Accountable Health Community's screening tool, AHC and the protocol for responding to assessing patients' assets risks and experiences or the PREPARE tool. And again, more information can be found on the EOM HRSN screening guide on our website.

Batsheva Honig: Great, thank you so much, Priya. And I think we're going to end with this last question. I'm going to turn it to you, Mike, take us home. How do EOM participants report their clinical data to CMS?

Mike Berkery: Thanks, Batsheva. I know it's such a seemingly simple question, but really an important one. And just wanted to note that the model team and our contractors were working closely with vendors and the participants to really explain this process and try to make it as seamless as possible in the future. So, for EOM participants and their EHR vendors must report all CDEs applicable to the ICD-10 diagnosis code for cancer type using one of the two reporting options. So, one as we mentioned before is the low-tech option using the template available within the EOM HDR application, while the other is that long winded one, the high-tech option which is the fast healthcare interoperability resources (or FHIR) based API. And the API is an Application Programming Interface. So, reporting via FHIR based API enables the electronic sharing of the healthcare data across systems. It also allows different healthcare systems such as hospitals and specialty clinics to share patient data seamlessly and securely. So, with FHIR based API, participants can use different healthcare applications to talk to each other more easily, which our hope is will improve interoperability and coordination of oncology care. And also want to note that SDE data can also be submitted via these two options with the Excel templates for FHIR based API.

Batsheva Honig: Great, thank you so much, Mike. A lot there and I know we got in a short amount of time. So, more information can be found in our clinical data elements and sociodemographic data elements guides. We have quite a few resources on the website. And as I mentioned, if you continue to have questions, please do reach out to us. And with that, I will turn it to Becky to close us out.

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Thank you so much, Batsheva. So, appreciate everybody's great questions today. Thank you so much to the CMS model team for sharing all this information and providing answers. If we can go to the next slide.

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As Batsheva mentioned, we do have numerous resources available to folks interested in applying for the model. So, there's some material specific to the Cohort 2, and those can be found in the links here. And again, we have shared the link to the presentation which is also on the EOM website and all these links can be found in the presentation or on the EOM website. We also have the EOM fact sheets which provide overviews of some of the concepts we discussed today as well as overall participation. We have additional resources that we've listed here, we mentioned earlier the EOM payment methodology, Clinical Data Element Guide and many more guides, associate demographic data, HSRN ePROs and health related social needs guide as well as health equity. So, we also have the drug lists available on the EOM website and again all these links will be available in the slides if you would like to download them.

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We did also want to provide reference to where your folks can find the specifications for the participant reported quality measures as those were touched on today. Again, those quality measures are aligned to the MIPS CQMS and so forth performance year 2024, we've provided a link to the QPP Resource Library where you're able to find those specifications.

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We do just want to encourage folks, if you do have follow up questions, any information that you may need in order to complete your application, or any support you need as you go through the application process, we really encourage you to reach out to us at EOM@cms.hhs.gov or you can call the number listed on this slide. We also encourage folks to visit the EOM website where all this great information is available. You're also able to subscribe to the EOM listserv. Doing so ensures that you are on distribution of any important communication related to EOM. And then you can follow CMS on CMS Innovates. And we'll have Lisa close us out then. Thank you so much.

Thank you for joining! That concludes today’s webinar. Enjoy your day.