

Enhancing Oncology Model (EOM) Benefit Enhancements

EOM is a national voluntary model designed to test care transformation, quality improvement, and financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients.

EOM Goals

- Put the patient at the center of a care team that provides equitable, high value, evidencebased care
- Build on Oncology Care Model (OCM) lessons learned and continue the value-based journey in oncology, which is a high-cost area of Medicare spending
- Observe improved care quality, healthy equity, and health outcomes as well as achieve savings over the course of the model test

Available Benefit Enhancements



Telehealth1

Example: Practice A utilizes the telehealth benefit to provide E&M services to the eligible beneficiary in their home.



Post-Discharge Home Visits

Example: Practice A sends a nurse practitioner to complete post-discharge home visit for an eligible beneficiary.



Care Management Home Visits

Example: An eligible beneficiary calls into Practice A's 24/7 hotline;
Practice A sends a nurse practitioner to the home of a beneficiary at risk of hospitalization to provide care management services.

Benefit Enhancements Process



- EOM participants can select the optional benefit enhancement(s) they wish to offer and submit an implementation plan for each benefit enhancement.
- EOM participants can select to **offer benefit enhancements on a semiannual basis** before each performance period.



- CMS must approve the EOM participant's selection to participate in a given benefit enhancement before the EOM participant may implement the benefit enhancement.
- After CMS approval, the EOM participant, its EOM practitioners, and its Care Partners may furnish services pursuant to the benefit enhancement, subject to the terms of the participation agreement.



CMS incorporates a variety of program integrity safeguards in the participation agreement to
ensure that these benefit enhancements do not result in program integrity issues or patient
abuse.



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Telehealth Benefit Enhancement

The telehealth benefit
enhancement¹ will allow EOM
participants, their EOM
practitioners, and their Care
Partners to provide telehealth
services to eligible beneficiaries
to improve access and efficiency
of care for all eligible
beneficiaries, including those
with limited mobility or
transportation barriers, by
allowing eligible beneficiaries to
receive care wherever they are
located, including at their home
or place of residence.

CMS finds it necessary solely for the purpose of testing EOM to waive the requirements of:

The originating site requirements with respect to telehealth services furnished to eligible beneficiaries

Section 1834(m)(4)(C) of the Social Security Act and 42 CFR § 410.78(b)(3)–(4)

The originating site requirement in the eligible telehealth individual provision with respect to telehealth services being "furnished at an originating site"

Section 1834(m)(4)(B) of the Social Security Act

The originating site facility fee provision with respect to telehealth services furnished to an eligible beneficiary at his/her home or place of residence

Section 1834(m)(2)(B) of the Social Security Act and 42 CFR § 414.65(b)

Post-Discharge Home Visits Benefit Enhancement

The post-discharge home visits benefit enhancement conditional waiver allows **payment for certain home visits** furnished to eligible beneficiaries by auxiliary personnel **under general supervision**, rather than direct supervision of the physician or other practitioner. This benefit enhancement allows an eligible beneficiary to receive **up to nine post-discharge home visits within 90 days** following discharge.

42 CFR § 410.26(b)(5)

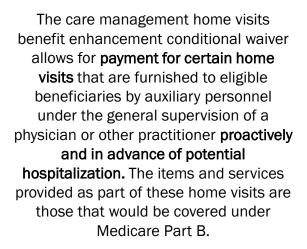
The physician or other practitioner must be an EOM practitioner or Care Partner and permitted under Medicare rules to submit claims for "incident to" services.

Claims Eligibility Medicare payments are made for these home visits only when they are furnished following an eligible beneficiary's discharge from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility.



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Care Management Home Visits Benefit Enhancement



42 CFR § 410.26(b)(5)

Beneficiary Eligibility

- An eligible beneficiary is permitted to receive up to 10 care management home visits within a performance period.
- The eligible beneficiary must be determined to be at risk of hospitalization.
- The eligible beneficiary must not qualify for Medicare coverage of home health services (unless the sole basis for qualification is living in a medically underserved area).
- The services must be furnished in the eligible beneficiary's home by auxiliary personnel under the general supervision of an EOM practitioner or Care Partner.

Claims Eligibility

The physician or other practitioner must be an EOM practitioner or Care Partner and permitted under Medicare rules to submit claims for "incident to" services as defined in Chapter 15, Section 60 of the Medicare Benefit Policy Manual.

Additional Information

EOM Website:

https://innovation.cms.gov/innovation-models/enhancing-oncology-model Request for Applications:

https://www.cms.gov/priorities/innovation/media/document/eom-rfa-2024

All EOM applications must be submitted by 11:59 PM EDT on September 16, 2024

EOM Helpdesk

EOM@cms.hhs.gov Phone: 1-888-734-6433 option 3

