External FAQs
Enhancing Oncology Model

General

Q. What are the goals of the Enhancing Oncology Model (EOM)?

A. The purpose of the new EOM is to drive transformation in oncology care by preserving or enhancing the quality of care furnished to beneficiaries undergoing treatment for cancer while reducing program spending under Medicare fee-for-service (FFS). EOM aims to put the patient at the center of a care team that provides equitable, high-value, evidence-based care; build on the lessons learned from the Oncology Care Model while continuing the value-based journey in oncology, which is a historically high-cost area of Medicare spending; increase engagement of patients, oncologists, and other payers in value-based care and quality improvement; and observe improved care quality, equity, and health outcomes as well as achieve savings over the course of the model test.

Q. Why is it necessary to transform cancer care?

A. Cancer is one of the most common and devastating diseases in the United States. Over 1.9 million people are estimated to be diagnosed with cancer in the United States in 2022.[1] With an estimated 609,360 deaths in 2022, cancer will be the second leading cause of death in the United States,[2] and the leading cause of death for males and females aged 60 – 79 years old, the majority of whom are Medicare patients.[3]

Under traditional Medicare fee-for-service (FFS), oncology providers and suppliers generally receive separate payments for each item or service furnished to a beneficiary during the course of their cancer treatment. Thus, traditionally, cancer care has focused on treating the disease and not the person, which can result in fragmented care (e.g., the oncologist's focus on the patient is typically limited to the time when they are in an exam room with limited coordination with other providers involved in a patient's care). Under EOM, participants will be incentivized to consider the whole patient and engage with them proactively, during and between appointments. Through EOM, CMS is testing whether an alternative payment model in which physician group practices (PGPs):

- Take on financial and performance accountability for episodes of care surrounding chemotherapy administration;
- Have the opportunity to bill for provision of Enhanced Services furnished to beneficiaries, and;

[1] National Cancer Institute, Cancer Stat Facts: Cancer of Any Site. Available at: https://seer.cancer.gov/statfacts/html/all.html

[2] Siegel RL, Miller KD, FuchsFuchs, H.E. Cancer statistics, 20222022. CA Cancer J Clin. 20222022 Jan;7272(1):7-3333.

[3] Siegel RL, Miller KD, FuchsFuchs, H.E. Cancer statistics, 20222022. CA Cancer J Clin. 2022 Jan;7272(1):7-33.

- Are encouraged to promote health equity, improve beneficiaries' health outcomes and reduce costs.

Q. What is the model performance period for EOM?
A. EOM is a five-year model test. The EOM performance period will start on July 1, 2023, which is the first date EOM episodes may initiate, and end on June 30, 2028.

Q. How is EOM different from the Oncology Care Model (OCM)?
A. While EOM builds on previous OCM experiences and feedback from the oncology community, including OCM participants, patient advocacy groups, oncology professional associations, and others, EOM differs from OCM in several ways. These differences include the addition of an explicit focus on health equity (such as a requirement that participants screen for health-related social needs), required downside risk for all EOM participants at the start of the model, a differential Monthly Enhanced Oncology Services (MEOS) payment based on the beneficiary's dual eligibility status, a cancer-type specific approach to calculating benchmarks, and the gradual requirement to use electronic patient reported outcomes (ePROs).

Further, EOM includes Medicare fee-for-service (FFS) beneficiaries receiving Part B or Part D chemotherapy for a cancer diagnosis of one or more of the following cancer types: breast cancer, chronic leukemia, small intestine/colorectal cancer, lung cancer, lymphoma, multiple myeloma, and prostate cancer. Unlike OCM, EOM focuses on beneficiaries receiving systemic chemotherapy, and will not include beneficiaries who receive hormonal therapy only.

More information about the differences between EOM and OCM can be found in Appendix A of EOM's Request for Applications.

Q. What participant redesign activities (PRAs) are EOM participants required to implement in EOM?
A. EOM participants will be required to implement eight participant redesign activities (PRAs), the first six of which are Enhanced Services (EOM participants can receive MEOS payments from CMS for the provision of Enhanced Services). When compared to OCM, EOM includes two new and additional PRAs (there are italicized below). The eight EOM PRAs are:

1. Provide beneficiaries 24/7 access to an appropriate clinician with real-time access to the EOM participant's medical records;
2. Provide patient navigation, as appropriate, to EOM beneficiaries;
3. Document a care plan for each EOM beneficiary that contains the 13 components of the Institute of Medicine (IOM) Care Management Plan, as applicable to the EOM beneficiary;
4. Treat beneficiaries with therapies in a manner consistent with nationally recognized clinical guidelines;
5. *Identify EOM beneficiary health-related social needs using a health-related social needs screening (HRSN) tool;*
6. *Gradual implementation of electronic Patient Reported Outcomes (ePROs);*
7. Utilize data for continuous quality improvement (CQI); and
8. Use Certified EHR Technology (CEHRT) as specified in 42 CFR § 414.1415(a).

Q: What is the EOM Quality Strategy and when will CMS release the specific measures?
A. The EOM quality strategy will focus on measures from the following domains: patient experience, avoidable acute care utilization, management of symptoms and toxicity, management of psychosocial health, and management of end of life care. In selecting specific measures, we will prioritize measures that reflect national priorities for quality improvement and patient-centered care consistent with Section 1890(b)(7)(B) of the Act, as well as outcomes-based measures. Outcomes-based measures, including those collected from patients, minimize EOM participant burden where possible, and align with CMS and Innovation Center quality strategy. The measures set will be similar to measures included in OCM and we will continue to explore opportunities to update the quality measure set over time in alignment with the principles and domains outlined above as new measures emerge, including those that promote equity. CMS anticipates releasing the specific measures list in the Summer/Fall 2022.

Q. What cancer types will be included in EOM?
A. Subject to certain exceptions, EOM will include the following seven cancer types for beneficiaries undergoing systemic chemotherapy: breast cancer, chronic leukemia, small intestine/colorectal cancer, lung cancer, lymphoma, multiple myeloma, and prostate cancer.

Q: What data will EOM participants report to CMS, and how often? What data will EOM participants be able to request from CMS and how often?
A. EOM participants will report participant-level quality measure data, beneficiary-level clinical and staging data, and beneficiary-level sociodemographic data to CMS no more than once a performance period. EOM participants will be able to request beneficiary-level claims data as well as episode- and participant-level data from CMS. Upon request, CMS intends to provide these data on a more frequent basis compared to OCM. CMS will also provide feedback reports that include aggregated and de-identified utilization data stratified by sociodemographic metrics for EOM participants to better understand utilization and expenditure patterns.

Q: How does EOM interact with the Quality Payment Program (QPP)?
A. EOM includes two risk arrangements with differing levels of downside risk. Both EOM risk arrangements are expected to qualify as a Merit-based Incentive Payment System (MIPS) Alternative Payment Model (APM) under QPP beginning in July 2023. The risk arrangement with increased downside risk (EOM's Risk Arrangement 2) is expected to meet the criteria under 42 CFR § 414.1415 to be an Advanced APM under QPP beginning in July 2023. Advanced APM participation allows a clinician the opportunity to achieve Qualifying APM Participant (QP) status and be excluded from the MIPS reporting requirements and payment adjustments. Eligible clinicians in an Advanced APM that do not achieve QP status will be subject to the MIPS reporting requirements and payment adjustments unless an exception applies.

EOM Participant and Care Partner Eligibility

Q. Which types of health care providers are eligible to apply to participate in EOM?
A. EOM applications for participation are open to Physician Group Practices (PGPs) only. A PGP must apply to the model and execute a participation agreement in order to be an EOM participant. An EOM participant must be a Medicare-enrolled oncology PGP identifiable by a single federal taxpayer identification number (TIN)) and must be composed of at least one EOM

practitioner that is an oncology practitioner. An EOM practitioner is defined as a Medicare-enrolled physician or non-physician practitioner (e.g., nurse practitioner or physician assistant) identified by an individual National Provider Identifier (NPI),), who furnishes Evaluation and Management (E&M) services to Medicare beneficiaries receiving chemotherapy for a cancer diagnosis, bills under the TIN of the PGP for such services, has reassigned his or her right to receive Medicare payments to the PGP, and appears on the PGP's EOM practitioner list. An oncology practitioner is defined as a Medicare-enrolled physician identified by an individual NPI with a specialty code of Hematology/Oncology or Medical Oncology.

Applicant PGPs that are selected to participate in EOM will become EOM participants upon signing the participation agreement with CMS.

Q. What is a Care Partner in EOM? What is the difference between an EOM Participant and a Care Partner?
A. For purposes of EOM, the term "Care Partner" means a Medicare-enrolled provider or supplier that engages in at least one of EOM's PRAs during a performance period; has entered into a Care Partner arrangement with an EOM participant; is identified on the EOM participant's Care Partner list; and is not an EOM practitioner.

If a PGP applicant intends to enter into aa Care Partner arrangement, it must submit a proposed Care Partner list with its application. If selected to participate in EOM, the PGP applicant will become an EOM participant and will be required to submit a proposed updated Care Partner List on at least a semiannual basis during the model performance period.

Each EOM participant will be required to ensure that its Care Partners comply with all applicable laws and regulations, as well as all applicable EOM participation agreement requirements.

Each EOM participant is required to comply with all terms of the model's participation agreement, including but not limited to, implementation of all PRAs, collecting and reporting data, and accountability for attributed episodes' total cost of care in a two-sided risk arrangement, etc.). A PGP applicant's proposed Care Partners are required to engage in at least one of EOM's PRAs during the model performance period.

Q. Can an entity apply to become an EOM participant if it is currently participating in another Innovation Center model or CMS Program? Similarly, can an EOM participant also participate in other Innovation Center models or CMS Program?
A. Yes, PGPs participating in certain other Innovation Center models and CMS Programs that provide health care entities with opportunities to improve care and reduce spending during EOM's model performance period of July 2023 to June 2028 (e.g., Medicare Shared Savings Program, Bundled Payments for Care Improvement Advanced Model, Maryland Total Cost of Care Model) are eligible to participate in EOM. Similarly, an EOM participant can participate in certain other Innovation Center models and CMS Programs. Details on specific model overlap policies are provided in section V.E. of the EOM Request for Applications, and will be further described in the EOM participation agreement.

Q. Who is ineligible to participate in EOM?

A. Medicare-enrolled oncology PGPs that routinely refer beneficiaries to PPS-Exempt Cancer Hospitals (PCHs) for chemotherapy services are not eligible to participate in EOM. Entities other than PGPs are also ineligible to participate in EOM.

Q. What is pooling under EOM? What are the differences between voluntary and mandatory pooling?
A. Pooling in EOM is an arrangement between two or more EOM participants whose episode expenditures are aggregated for the purposes of reconciliation. Participants in a pool will be jointly responsible for the total cost of care for all EOM episodes attributed to participants in their pool. For each pool, CMS will calculate a single benchmark amount, calculate total expenditures as the sum of expenditures for all episodes attributed to participants in the pool, and determine whether the pool earned a performance-based payment (PBP) or owes CMS a performance-based recoupment (PBR). As part of the pooling arrangement (described in greater detail in section VII.B of the RFA), pools will designate one participant to receive PBPs and pay PBRs on behalf of the pool.

Pools may be voluntary or mandatory. Pooling will be mandatory when CMS determines that an EOM participant has billing overlap with another oncology PGP in excess of a mandatory pooling threshold. Reconciliation is conducted in the same manner for voluntary and mandatory pools. If a pool is voluntary, an EOM participant in that pool may terminate a pooling arrangement or terminate an EOM participation agreement without jeopardizing participation in EOM by other participants in that pool. If an EOM participant in a mandatory pool terminates its EOM participation agreement, the other participant(s) in the mandatory pool will need to reduce their billing overlap with that EOM participant below the mandatory pooling threshold in order to continue participating in EOM, and may be required to maintain the mandatory pooling relationship amongst the remaining participants.

Applications

Q. Where can entities interested in participating in EOM access the Request for Applications (RFA) for EOM?
A. The RFA and PDF versions of the PGP and Payer applications for EOM can be found on the EOM website at https://innovation.cms.gov/innovation-models/enhancing-oncology-model.

Q. How can entities interested in participating in EOM apply to the model?
A. To apply to participate in EOM, applicants must submit their applications using the EOM RFA Application Portal at https://app.innovation.cms.gov/EOM. Submission of the PDF version of this application will not be accepted. Instructions on how to log onto the EOM RFA Application Portal can be found on the EOM website at https://innovation.cms.gov/innovation-models/enhancing-oncology-model.

The EOM RFA Application Portal is available now. All EOM applications must be submitted by 11:59 PM ET on September 30, 2022. CMS may not review applications submitted after the deadline.

Q: If a current or former OCM participant would like to join EOM, do they need to apply to EOM?
A. Yes, all PGPs that wish to participate in EOM will need to apply through the EOM RFA Application Portal at https://app.innovation.cms.gov/EOM.

Q: If a PGP applies for EOM, is the application binding on the PGP?
A. Submitting an application does not obligate aa PGP to participate in EOM. If an application is approved by CMS, the approved applicant will be offered a participation agreement (PA) to sign prior to the model start date. An approved applicant will only be bound to the terms of the PA upon signing the PA. PGPs can apply and subsequently withdraw their applications. Instructions for withdrawing an application can be found in section III.C of the RFA.

Q. How will CMS select PGP applicants to participate in EOM?
A. An internal committee will review completed applications. CMS will review applications for completeness and conduct a program integrity (PI) screening of all applicants. Applications to participate in EOM will be accepted on the basis of completeness, quality of narratives, and the result of a PI screening. The PI screening may include, but is not limited to, the following:

- Confirmation of current Medicare enrollment status and history of adverse enrollment actions;
- Identification of delinquent Medicare and Medicaid debt;
- Review of performance in, and compliance with the terms of, other CMS models, demonstration programs, and initiatives;
- Review of compliance with Medicare and Medicaid program requirements;
- Review of billing history and any administrative audits, investigations, or other activities conducted regarding suspicious billing or other potential program fraud and abuse; and
- Review of any administrative, civil, or criminal actions related to program integrity or other factors relevant to participation in an initiative involving Federal funds.

Q. Is there a cap on the number of PGP applicants that CMS will accept?
A. Currently, there is no cap on the number of applications for EOM participation. CMS notes that sufficient participation in the model by EOM participants will be necessary in order for CMS to be able to detect a meaningful change in Medicare's expenditures as a result of the model test.

Q. When will PGPs be notified of their selection to participate in EOM?
A. CMS intends to notify PGPs of their selection in late 2022 or early 2023.

Q: How may I receive more information?
A. For more information regarding EOM, visit the EOM website at https://innovation.cms.gov/innovation-models/enhancing-oncology-model, read the EOM Request for Applications (which is posted on the EOM website), and submit any questions to the EOM Help Desk at EOM@cms.hhs.gov or call 1-888-734-6433 option 3.

Q. What documentation should be submitted in the Incorporation and Licensure section of the EOM Application?
A. For question 1 ("Please attach a copy of a certificate of incorporation or other documentation demonstrating that the PGP applicant is recognized as a legal entity by the state in which it is

located or under federal or tribal law"), any documentation that shows how the PGP is structured would be acceptable (i.e., PGPs might not have a "certification of incorporation" as they may instead be organized as a partnership, limited liability partnership, or another arrangement.)

For question 2 ("Please attach documentation demonstrating that the PGP applicant has been licensed as a risk-bearing entity under applicable state, federal, or tribal law, or that it is exempt from such licensure and/or other such requirements"), EOM applicants should consult with their general counsel on whether they are a risk bearing entity or not, whether they are required to be a risk bearing entity by their state/federal/tribal laws, and what documentation is needed, as this documentation will vary by regulator and by state.

Then, there are three choices to answer this question in the EOM RFA Application portal:

1. If the PGP applicant is required to obtain licensure as a risk-bearing entity under applicable state, federal, or tribal law, and the PGP applicant has been licensed as a risk-bearing entity, upload a copy of the appropriate certification or documentation.

2. If the PGP applicant is required to obtain licensure as a risk-bearing entity under applicable state, federal, or tribal law, but the PGP is not yet currently licensed as a risk-bearing entity under one or more such laws, please describe the progress the PGP applicant has made toward obtaining such licensure (e.g., uploading a documenting that describes the progress the PGP has made).

3. If the applicable state, federal, or tribal laws do not have a licensure requirement for risk-bearing entities, or if the PGP applicant does not meet the applicable definitions established by such laws, please upload an attestation made by an individual authorized to act on behalf of the PGP applicant indicating that this is so. Said another way, if your state/federal/tribal laws do not require licensure as a risk-bearing entity, then simply submit a document stating that in the EOM RFA Application portal.

*Note that applicants can upload any documentation that they wish in the EOM RFA Application portal.

Payment Methodology

Q. How is an EOM episode defined?
A. An EOM episode will begin with a beneficiary's receipt of an initiating cancer therapy (as identified by either the date of service listed on a Part B chemotherapy claim with a cancer diagnosis, or the fill date of a Part D chemotherapy claim with a corresponding Part B claim with a diagnosis code for cancer on the day of, or the 59 days preceding, the fill date on the Part D drug claim) and must include a qualifying Evaluation & Management (E&M) service during the six-month period that follows the receipt of the initiating cancer therapy.

For the purposes of EOM, a qualifying (E&M) service would mean the evaluation and management of a new or established patient, furnished to an eligible beneficiary with an included cancer type and with a CPT® code[4] in the ranges 99201-99205 or 99211-99215.

Q: How does CMS attribute episodes to EOM participants?
A. CMS will attribute an episode to an eligible EOM participant if the EOM participant provided the first qualifying E&M service after the beneficiary received the initiating cancer therapy, as long as that participant provided at least 25% of all qualifying E&M services during the episode. Otherwise, CMS will attribute the episode to the oncology PGP that billed the plurality of qualifying E&M services furnished to the beneficiary during the episode.

Q: What are the risk arrangement options offered under EOM?
A. Participants and pools will select between two risk arrangements:

Risk Arrangement 1 (RA1):
- EOM discount: 4% of the benchmark amount
- Target amount: 96% of the benchmark amount
- Downside risk (stop-loss): 2% of the benchmark amount
- Upside risk (stop-gain): 4% of the benchmark amount

Risk Arrangement 2 (RA2):
- EOM discount: 3% of the benchmark amount
- Target amount: 97% of the benchmark amount
- Downside risk (stop-loss): 6% of the benchmark amount
- Upside risk (stop-gain): 12% of the benchmark amount

In both risk arrangements, the threshold for recoupment is 98% of the benchmark amount, meaning that expenditures above this amount would be repaid by the EOM participant to CMS, up to the stop-loss limit. Practices or pools whose total expenditures are greater than their target amount and less than or equal to the threshold for recoupment will fall into the neutral zone and will neither earn a performance-based payment (PBP) nor owe a performance-based recoupment (PBR).

Q: Can an EOM participant or pool move between risk arrangements during the model?

[4] Current Procedural Terminology (CPT®) is a registered trademark of the American Medical Association.

A. Participants and pools will have the opportunity to move from one risk arrangement to the other risk arrangement on a semi-annual basis prior to the start of the subsequent performance period.

Q: How does the EOM MEOS payment differ from the OCM MEOS payment?
A. In OCM, the MEOS payment amount was $160 per beneficiary per month. In EOM, the base MEOS payment amount will be $70 per EOM beneficiary per month. In EOM, like OCM, the base MEOS payment will be included in the participants' total cost of care responsibility.

For episodes involving a beneficiary who is dually eligible for Medicare and Medicaid, CMS will pay an additional $30 per dually eligible beneficiary per month, for a total MEOS payment of $100 per beneficiary per month. The additional $30 per dually eligible beneficiary per month will be excluded from EOM participants' total cost of care responsibility.

Q. Why does EOM offer a higher payment amount for dually eligible beneficiaries?
A. CMS is providing additional payment for dually eligible beneficiaries to encourage participation from PGPs who engage with underserved communities and to provide additional resources for the more resource intensive care management of complex patients. This adjustment will help mitigate any potential disincentive in a total cost of care model to serve dually eligible beneficiaries who historically account for a disproportionate share of Medicare expenditures and are associated with higher episode expenditures.

Q. How will benchmark amounts be calculated in EOM?
A. CMS will create a separate price prediction model for each included cancer type. After using these models to establish predicted expenditures for each EOM episode, CMS will apply a series of adjustments (described in more detail in section VI.C.iii.3 of the RFA) to obtain the benchmark price for each episode:

- An experience adjuster accounting for regional and participant-specific variation in the cost of oncology care not otherwise accounted for in the price prediction models;
- Clinical adjusters based on clinical and staging data (certain cancer types only);
- Cancer type-specific trend factors adjusting for inflation and other cancer type-specific changes in spending patterns occurring across the oncology field as a whole; and
- Cancer type-specific novel therapy adjustments to increase the benchmark price for episodes of a given cancer type if an EOM participant has a high share of expenditures within that cancer type for newly FDA-approved oncology drugs.

The benchmark amount for an EOM participant that is not in a pool will be the sum of the benchmark prices for all episodes attributed to that participant for a given performance period. The benchmark amount for a pool will be the sum of the benchmark prices for all episodes attributed to EOM participants in the pool for a given performance period.

Beneficiaries

Q. How can beneficiaries enroll in EOM?

A. Beneficiaries do not enroll in EOM. Eligible beneficiaries who receive chemotherapy at participating practices will have their episodes attributed to participants in the model. Eligible beneficiaries retain their freedom to choose any provider or supplier, and may also choose for their data not to be shared with EOM participants. If an eligible beneficiary or their caregiver feels care has been compromised, or has concerns about EOM, the Innovation Center has a model liaison that is a part of the Medicare Beneficiary Ombudsman team in the Office of Hearings and Inquiries. The model liaison can be reached through 1-800-MEDICARE or they may contact their Quality Improvement Organization (QIO).

Q. How does the model impact Medicare beneficiaries?
A. The central goal of EOM is to better support patients and improve their care experience. Beneficiaries with traditional Medicare retain all of their rights, coverage, and benefits, including the freedom to see any Medicare provider. EOM does not limit beneficiaries' choice of provider or dictate from whom they seek cancer treatment; patients retain the ability to seek care wherever they choose. Further, EOM does not dictate which drugs or services practitioners must provide. Participating practices are expected to use shared decision-making techniques to work with beneficiaries in the model to develop the most appropriate course of treatment for each patient. Importantly, patients will not be responsible for paying for any portion of the new EOM payment for participants' delivery of enhanced, patient-focused services. Medicare will cover the full amount of this payment.

Beneficiaries in EOM may have better communications with their oncologist and care team in between appointments and be able to more easily reach them with questions. An eligible EOM beneficiary may expect to receive patient-focused services like:

- 24/7 access to an appropriate clinician with real-time access to the beneficiary's medical records
- Patient navigation services
- A detailed care plan that involves beneficiary engagement and preferences on discussions surrounding prognosis, treatment options, symptom management, quality of life, and psychosocial needs, among other topics
- Screening for health-related social needs (HRSNs; such as needs related to food, transportation, housing)
- Questions regarding your overall cancer care experience and health outcomes, such as symptoms, physical functioning, behavioral health, and HRSNs

If beneficiaries have complaints about their providers, they should call 1-800-MEDICARE or contact their Quality Improvement Organization (QIO), at https://www.qioprogram.org/locate-your-qio.

Q: Can beneficiaries opt-out of CMS data sharing with EOM participants?
A. Yes. EOM beneficiaries can opt out of having CMS share their claims data with an EOM participant for care coordination and quality improvement purposes at any time by contacting 1-800-MEDICARE. CMS will provide EOM beneficiaries who inquire about or wish to modify their preferences regarding claims data sharing with information about how to modify their data

sharing preferences via 1-800-MEDICARE. EOM participants will be required to allow EOM beneficiaries to reverse a claims data sharing preference at any time via 1-800-MEDICARE.

Benefit Enhancements and Patient Incentives

Q: What are some examples of benefit enhancements that will be offered in EOM?
A. To emphasize high-value services and support the ability of EOM participants to manage the care of beneficiaries, CMS is exercising its authority under section 1115A(d)(1) of the Act to conditionally waive certain Medicare payment requirements as part of testing certain benefit enhancements under EOM. The three benefit enhancements include a telehealth benefit enhancement, a post-discharge home visits benefit enhancement, and a care management home visits benefit enhancement. More information regarding these benefit enhancements can be found in section VII.A. of the RFA. CMS will incorporate 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.

Q: What are some examples of patient incentives that will be offered in EOM?
A. Beneficiary engagement and coordination of care could be enhanced by providing certain in-kind patient incentives to beneficiaries that would potentially advance one or more clinical goals for the beneficiaries by encouraging beneficiaries to become actively involved in their health care. Specifically, EOM participants, EOM practitioners, and Care Partners would be permitted to provide certain in-kind items or services to EOM beneficiaries, subject to compliance with all applicable laws and regulations and the terms of the participation agreement. See section VII.C. of the RFA for more information.

Q: Are EOM participants required to offer these benefit enhancements and/or patient incentives?
A. Benefit enhancements and patient incentives are optional for EOM participants. Acceptance into EOM is not contingent upon an EOM participant offering any particular benefit enhancement to beneficiaries. An EOM participant may choose to implement some or all benefit enhancements and patient incentives available under EOM. EOM participants will be required to provide information, via an Implementation Plan, regarding their proposed execution of any benefit enhancements they select to offer. In a form and manner, and by a date or dates specified by CMS, an EOM participant may change its benefit enhancement selections times during the model performance period.

Health Equity

Q. How will EOM contribute to CMS's health equity strategy?
A. The CMS Innovation Center announced in 2021 a strategic refresh that prioritized embedding health equity throughout the model's life cycle, from design to implementation to evaluation.[5] This goal is integral to the CMS Innovation Center's mission to improve health care quality for all beneficiaries.

[5] "Innovation Center Strategy Refresh": https://innovation.cms.gov/strategic-direction-whitepaper

Acknowledging that the first step of advancing health equity is identifying health disparities, EOM includes requirements on participants to collect and report beneficiary sociodemographic data to CMS. EOM participants will have access to feedback reports and dashboards, where key metrics will be stratified by sociodemographic data so that EOM participants can identify and address health disparities. EOM participants will also be required to submit health equity plans to CMS, detailing their evidence-based strategies to mitigate health disparities identified within their patient populations. CMS plans to review EOM participant's health equity plans. Health equity plans would be used as a tool for EOM participants to develop evidence-based strategies to advance health equity within their EOM beneficiary population for purposes of continuous quality improvement (CQI).

CMS will provide an additional payment, as part of EOM's MEOS payment, for beneficiaries who are dually eligible for Medicare and Medicaid. These payments acknowledge that additional resources may be needed to care for complex and underserved communities to promote better access to care and improve shared decision-making and care planning for all beneficiaries. EOM's risk adjustment will also include dual eligibility status and Low-Income Subsidy (LIS) eligibility as proxies for income and social risk, to ensure appropriate cost benchmarks.

EOM aims to put the beneficiary at the center of a care team through improved shared-decision making and advocating for the beneficiary's voice. Advancing health equity is a key pillar of the EOM quality strategy.

Q: What is the purpose of the Health Equity Plan?
A. We believe it is important for EOM participants to develop strategies for how they aspire to achieve health equity within EOM and to update these goals throughout the model performance period, in line with use of data for continuous quality improvement (CQI) objectives. 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.

Q: When would EOM participants submit the Health Equity Plan?
A. EOM participants will be required to develop and submit health equity plans as part of the using data for CQI requirement. As use of data for CQI is an iterative process, the health equity plan should be a living document that evolves over time.

EOM Other Payers

Q. May payers align with CMS in EOM?
A. Yes, EOM is a multi-payer model. As such, private payers, Medicare Advantage plans, and state Medicaid agencies are eligible to apply to align with CMS in the model as EOM "other payers." To be eligible to align with CMS in EOM as an EOM other payer, an applicant payer will be required to partner with at least one EOM applicant PGP. Payer applicants that are selected to align their payment methodology with CMS under EOM will become an EOM other payer upon signing an EOM Other Payer Memorandum of Understanding (MOU) with CMS.

Q. How will other payers be selected toto align with CMS in EOM?
A. Other payers who wish to participate in EOM must submit an EOM payer application as detailed in section III of the RFA. An internal committee will review completed applications. Payer applicants will be accepted to align with CMS in EOM on the basis of application completeness, quality of narratives, and the result of a program integrity screening as detailed in section III.B of the RFA.

Applicants approved to align with CMS in EOM will become "EOM Other Payers" upon signing a Memorandum of Understanding (MOU) with CMS.

Q. Is there a cap on the number of payers that CMS will accept?
A. Currently, there is no cap on the number of other payers that may align with CMS.

Q. With which components of EOM are EOM other payers required to align?
A. EOM other payers will provide financial incentives that are aligned with the Medicare payments in EOM, for example, payments that provide funding during the oncology episode for Enhanced Services (could be an advance payment or PBPM) and for actual performance with an adjustment for quality performance (for example, retrospective lump sum or increased monthly payments).

While EOM payers will commit to paying their aligned participants for Enhanced Services furnished to EOM Other Payer Beneficiaries, CMS will not dictate the frequency, amount, method, or basis for this payment.