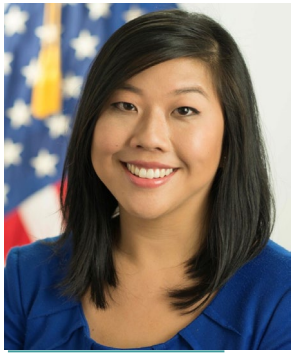
ENHANCING ONCOLOGY MODEL

EOM General Office Hour

September 13, 2022

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

TODAY'S PRESENTERS



Alexandra Chong
EOM Team Lead

CMS Innovation Center

Claire Kihn
EOM Team Member

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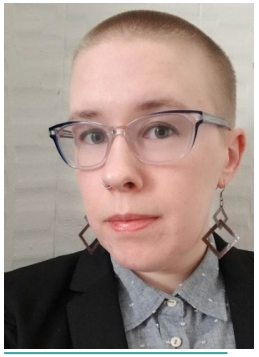
Batsheva Honig
EOM Quality and Health Equity Lead

CMS Innovation Center



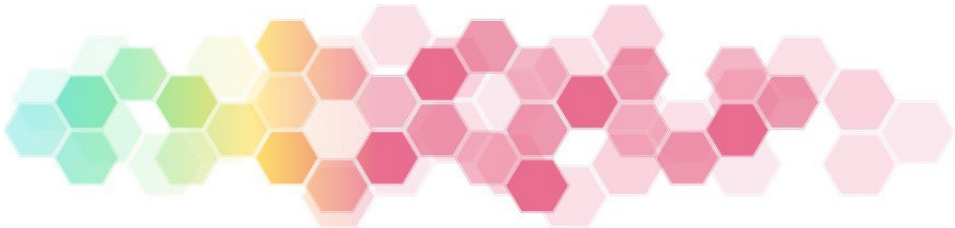
Elizabeth Ela
EOM Payment Lead

CMS Innovation Center

AGENDA

This webinar will provide an introduction of the Enhancing Oncology Model (EOM). The following topics will be discussed:

1. EOM Overview
2. Application Process and Timelines
3. Q&A Session
4. Additional Resources



EOM OVERVIEW

OVERVIEW OF ENHANCING ONCOLOGY MODEL (EOM)

EOM will continue to drive care transformation and reduce Medicare costs

FOCUS

Five-year, **voluntary payment and delivery model** scheduled to begin July 2023 and conclude June 2028, that focuses on innovative payment strategies that promote high-quality, person-centered, equitable care to Medicare FFS beneficiaries with certain cancer diagnoses who are undergoing **chemotherapy treatment**

PARTICIPANTS

Physician Group Practices (PGPs) and **other payers** (e.g., commercial payers, state Medicaid agencies) through multi-payer alignment

EPISODES

- **Seven included cancer types** (breast cancer, chronic leukemia, small intestine/colorectal cancer, lung cancer, lymphoma, multiple myeloma, and prostate cancer)
- Episodes begin with **beneficiary's receipt of an initiating cancer therapy** and **must include a qualifying Evaluation & Management (E&M) service** during the 6-month period that follows.
- Episode **attribution awarded** to the eligible oncology PGP that provides the **first qualifying E&M service** after the initiating chemotherapy; **PGP must have at least 25% of cancer-related E&M services** during the episode, otherwise, attribution will be based on plurality of cancer-related E&M services at an oncology PGP.

QUALITY & PAYMENT

EOM participants will be paid Fee-for-Service (FFS) with the addition of **two** financial incentives to **improve quality** and **reduce cost**:

- EOM participants are eligible to receive **Monthly Enhanced Oncology Services (MEOS)** payments for furnishing Enhanced Services in order to support care transformation.
- Potential **performance-based payment (PBP)** or **performance-based recoupment (PBR)** based on the total cost of care (including drugs) and quality measures.

OVERVIEW OF PAYMENT STRATEGY

Two Part Payment Approach*

Monthly Enhanced Oncology Services (MEOS) Payment

EOM participants will have the option to bill **MEOS payments** for **Enhanced Services** furnished to EOM beneficiaries.

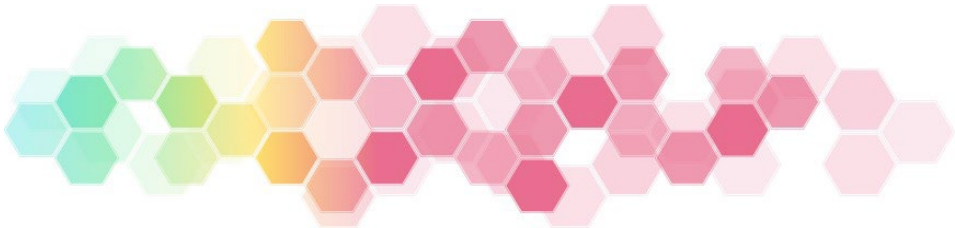
The base MEOS payment amount will be **$70 per beneficiary per month**. CMS will pay an additional **$30 per dually eligible beneficiary** per month that is **excluded from the total cost of care.**

+ Retrospective Performance-Based Payment (PBP) or Recoupment (PBR)*

EOM participants and pools will be responsible for **the total cost of care (TCOC)** (including drugs) for each attributed episode. Based on total expenditures and quality performance, participants or pools may:

- + Earn a PBP
- − Owe a PBR
- = Fall into the Neutral Zone

*FFS billing will continue during the model.



PARTICIPANT REDESIGN ACTIVITIES (PRAS)

- Provide beneficiaries **24/7 access** to an appropriate clinician with real-time access to the EOM participant's medical records
- Provide **patient navigation**, as appropriate, to EOM beneficiaries
- Document a **care plan** for each EOM beneficiary that contains the 13 components of the Institute of Medicine (IOM) Care Management Plan
- Treat beneficiaries with therapies in a manner consistent with nationally recognized **clinical guidelines**
- Identify EOM beneficiary **health-related social needs** using a health-related social needs screening tool
- Gradual implementation of **electronic Patient Reported Outcomes (ePROs)**
- **Utilize data** for continuous quality improvement (CQI), including the development of a health equity plan
- Use **certified Electronic Health Records (EHR) Technology** (CEHRT)

QUALITY MEASURES

Measure Title[1]	Measure Number	Domain	Data Source	Data Reporting Type
Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy (NQF 3490 / OP-35)	EOM-1	Avoidable acute care utilization	Claims-based	None. Calculated by CMS using Administrative Data
Proportion of Patients who Died who Were Admitted to Hospice for 3 Days or More (Combination of NQF 0215 and NQF 0216)	EOM-2	Management of end-of-life care	Claims-based	None. Calculated by CMS using Administrative Data
Percentage of Patients who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (NQF 0210; CMS Quality ID 453)	EOM-3	Management of end-of-life care	Claims-based	None. Calculated by CMS using Administrative Data
Pain Assessment and Management Set: a) Oncology: Medical and Radiation - Pain Intensity Quantified (NQF 0384; CMS Quality ID 143) b) Oncology: Medical and Radiation - Plan of Care for Pain (NQF 0383; CMS Quality ID 144)	EOM-4 (composed of EOM-4a and EOM-4b)	Management of symptoms toxicity	EOM Participant Reported	Reported in aggregate across all patients
Preventative Care and Screening: Screening for Depression and a Follow-Up Plan (NQF 0418; CMS Quality ID 134)	EOM-5	Management of psychosocial health	EOM Participant Reported	Reported in aggregate across all patients
Patient-Reported Experience of Care Survey	EOM-6	Patient experience	EOM Patient Reported	None. Patient-reported; CMS fields survey

[1] List subject to change

QUALITY MEASURES

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

Quality Measure Data

To calculate quality performance, CMS will:

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

Example PBP Performance Multiplier

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

Example PBR Performance Multiplier

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

HEALTH EQUITY REQUIREMENTS

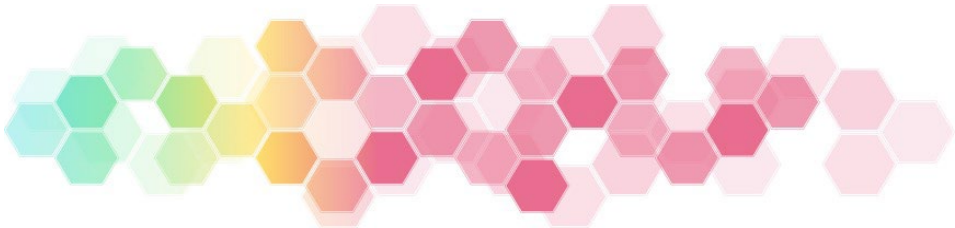
EOM seeks to improve quality of care and equitable health outcomes for all EOM beneficiaries, including but not limited to:

	EOM Requirement	Description
1	Incentivize care for underserved communities	**Differential MEOS payment** to support Enhanced Services (base: $70 PBPM; $30 PBPM, outside of TCOC accountability, for dual eligible beneficiaries) TCOC benchmark will be **risk adjusted for multiple factors**, including, but not limited to, dual status and low-income subsidy (LIS) status
2	Collect beneficiary-level sociodemographic data	EOM participants will collect and report **beneficiary-level sociodemographic data** to report to CMS for purposes of monitoring and evaluation
3	Identify and address health-related social needs (HRSN)	EOM participants will be required to use **screening tools** to screen for, at a minimum, three **HRSN domains:** transportation, food insecurity, and housing instability Example HRSN screening tools: • NCCN Distress Thermometer and Problem List • Accountable Health Communities (AHC) Screening Tool • Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences (PRAPARE) Tool **Collect ePROs** from patients, including a HRSN domain*
4	Improved shared decision-making and care planning	EOM participants will be required to **develop a care plan** with the patient, including discussion of prognosis and treatment goals, a plan for addressing psychosocial health needs, and estimated out-of-pocket costs
5	Continuous Quality Improvement (CQI)	EOM participants will be required to develop a **health equity plan** as part of using data for CQI

APPLICATION PROCESS AND TIMELINES

MODEL TIMELINE

Milestone	Planned Timing[1]
RFA released / Application portal opens	June 27, 2022
Application deadline	September 30, 2022
Participant selection & Participant Agreement (PA) signing	Spring 2023
Model Performance Period	Start July 1, 2023

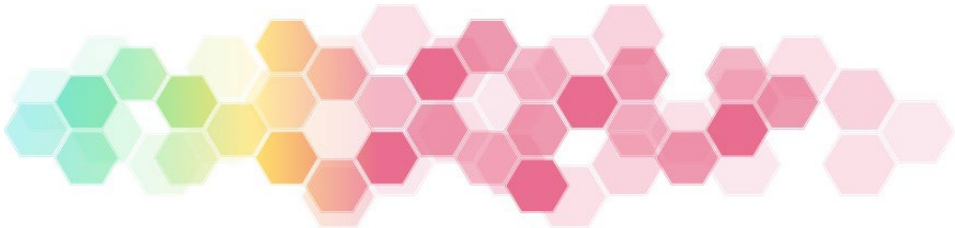


[1] Dates are subject to change

PGP APPLICATION REQUIREMENTS OVERVIEW

The Enhancing Oncology Model application contains the following sections:

Application Section	Description
Applicant PGP Information	Focuses on the legal name, location, and identification of the practice.
Contact Information	Focuses on primary, secondary, and tertiary point of contact for the practice.
PGP Profile Information	Focuses on PGP's organizational structure and area of medical specialty.
PGP Information	Focuses on geographic service area and practitioner listing.
Pooling with EOM Participants	Establishes intent to participate in a voluntary pooling arrangement under EOM, and if so whom the EOM PGP applicants are.
Care Partner Information	Establishes intent to participate with Care Partners and each individual and entity you propose to serve as a Care Partner.
Incorporation and Licensure	Requires documentation demonstrating legal entity and license.
Disclosure	Requires disclosure of any sanctions, corrective action, fraud investigations, and outstanding debts of each individual and entity proposed in the PGP applications.
Narratives	Requires submission of Implementation Plan and Financial Plan.



PGP APPLICATION PROCESS

Complete Profile

- Applicant PGP Information
- Contact Information

Complete Application

- PGP Profile Information
- PGP Information
- Pooling with EOM Participants
- Care Partner Information
- Incorporation and Licensure
- Disclosure
- Narratives
- Financial Plan

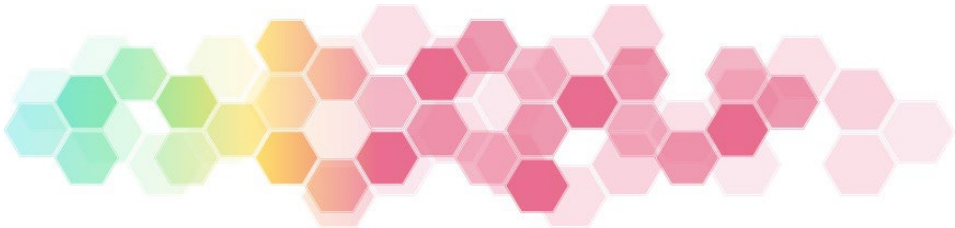
Certify and Submit

- Application
- Certification

PAYER APPLICATION REQUIREMENTS OVERVIEW

The Enhancing Oncology Model application contains the following sections:

Application Section	Description
Applicant Payer Information	Focuses on the legal name, location, and identification of the payer.
Contact Information	Focuses on legal name, primary address and primary, secondary and tertiary points of contact.
Payer Information	Focuses on line(s) of business, license number, and PGP's intended for an EOM-aligned payment and service delivery model.
Model Alignment	Outlines interest and commitment to partnering with CMS and how your payment and service delivery model align with EOM.
EOM Participants	Outlines plan to enter arrangements with EOM participants.
Quality Strategy	Outlines proposed EOM-aligned quality strategy including quality metrics and assessment of quality performance.
Data Sharing	Outlines plan for providing data feedback to partner EOM participants during the model.
Monitoring and Evaluation	Outlines plan to monitor and evaluate partner EOM participants' compliance and performance with the participation requirements, quality metrics, and outcomes under your EOM-aligned payment and service delivery model.



PAYER APPLICATION PROCESS

Complete Profile

- Applicant Payer Information
- Contact Information

Complete Application

- Payer Profile Information
- Payer Information
- Model Alignment
- Data Sharing
- Monitoring and Evaluation

Certify and Submit

- Application
- Certification

HOW TO APPLY

Application period for EOM is currently open
All EOM applications must be submitted by 11:59 pm Eastern Daylight Time on September 30, 2022. Applications submitted during the application window are non-binding. CMS may not review applications submitted after the deadline.

Submit application to https://app.innovation.cms.gov/EOM.
Submission of the PDF version of this application will not be accepted.

Refer to https://innovation.cms.gov/innovation-models/enhancing-oncology-model for directions on how to access the EOM RFA Application Portal
Once logged into the portal, there are further instructions on how to navigate the application included on the right-hand side of the home page by selecting the "User Manual" link.

Refer to the RFA on EOM website for further details
Further details regarding participation requirements and application submission criteria are available in the RFA on the https://innovation.cms.gov/innovation-models/enhancing-oncology-model. Applications will be reviewed for completion of all required fields and a signed and dated application certification.

Sign up for the EOM listserv
EOM will host additional recruitment events and release more resources during Summer/Fall 2022 to help potential participants understand the model before the application deadline. Sign up for the EOM listserv to learn about these materials as they are announced.

Q&A SESSION

ENHANCING ONCOLOGY MODEL

EOM OPEN Q&A

Open Q&A

Please **submit questions via the Q&A pod** to the right of your screen.
Specific questions about your organization can be submitted to EOM@cms.hhs.gov.

ADDITIONAL RESOURCES

RESOURCES AND CONTACT INFO

For more information about the EOM and to stay up to date on upcoming model events:

EOM RFA Application Portal User Manual

https://innovation.cms.gov/media/document/eom-app-portal-user-manual

EOM Payment Methodology

https://innovation.cms.gov/media/document/eom-payment-methodology

Visit

innovation.cms.gov/innovation-models/enhancing-oncology-model

Help Desk

EOM@cms.hhs.gov

1-888-734-6433 Option 3

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Listserv

Sign up for the EOM listserv at this listserv registration link

THANK YOU

For Attending Today's
EOM General Office Hour

ENHANCING ONCOLOGY MODEL

APPENDIX

OCM TO EOM HIGH LEVEL COMPARISON

	OCM	EOM
Health equity	No explicit focus	Key element of design and implementation
Beneficiary population	Beneficiaries with all cancer types who receive chemotherapy or hormonal therapy	High-risk beneficiaries with certain cancer types receiving systemic chemotherapy only
Use of ePROs	No requirement	Required gradual implementation
MEOS payment	$160 PBPM for each OCM beneficiary	$70 PBPM for beneficiaries not dually eligible for Medicaid and Medicare $100 PBPM for beneficiaries dually eligible for Medicaid and Medicare
Attribution	Based on plurality of E&M claims	Based on initial care plus at least minimum care over time
Benchmark and novel therapy calculations	At the practice level; limited use of clinical data to inform risk adjustment	At the cancer type level; more robust use of clinical data to inform risk adjustment
Risk arrangements for performance-based payment	One-sided risk in performance period 1, followed by the option for one- or two-sided risk in performance periods 2-7 Participants earning a performance-based payment by the initial reconciliation of PP4 have the option to stay in one-sided risk in PP8—PP11; other participants must either accept two-sided risk in PP8—PP11 or be terminated from the model	Two downside risk arrangement options

*Please note this list is not exhaustive. For additional information on how EOM differs from OCM, refer to Appendix A of the EOM RFA

MODEL BASELINE PERIOD AND MODEL PERFORMANCE PERIOD

Anticipated Model Baseline Period*:

Episodes Initiating July 1, 2016 — June 30, 2020

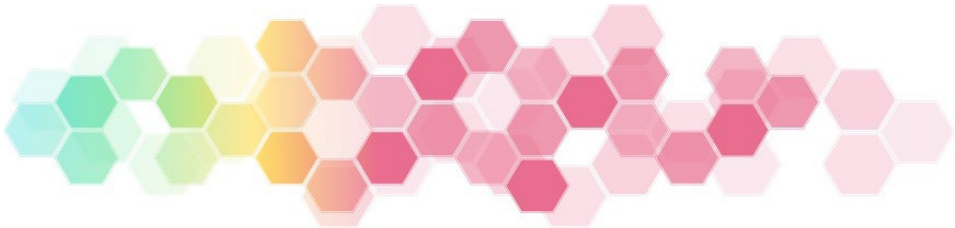
BP1	July 1, 2016, to December 31, 2016
BP2	January 1, 2017 to June 30, 2017
BP3	July 1, 2017 to December 31, 2017
BP4	January 1, 2018 to June 30, 2018
BP5	July 1, 2018 to December 31, 2018
BP6	January 1, 2019 to June 30, 2019
BP7	July 1, 2019 to December 31, 2019
BP8	January 1, 2020 to June 30, 2020

Model Performance Period:

Episodes Initiating July 1, 2023 — December 31, 2027

PP1	July 1, 2023 to December 31, 2023
PP2	January 1, 2024 to June 30, 2024
PP3	July 1, 2024 to December 31, 2024
PP4	January 1, 2025 to June 30, 2025
PP5	July 1, 2025 to December 31, 2025
PP6	January 1, 2026 to June 30, 2026
PP7	July 1, 2026 to December 31, 2026
PP8	January 1, 2027 to June 30, 2027
PP9	July 1, 2027 to December 31, 2027**

*CMS will finalize the model baseline period before the start of EOM.
**Model performance period ends on June 30, 2028 when all PP9 episodes have ended.



EOM EPISODES

INCLUDED CANCER TYPES

Seven cancer types will be included in EOM: breast cancer, chronic leukemia, small intestine/colorectal cancer, lung cancer, lymphoma, multiple myeloma, and prostate cancer.

INITIATING CANCER THERAPIES

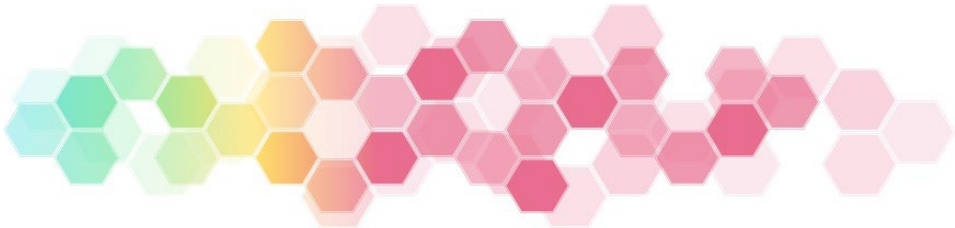
Each episode will begin with a **beneficiary's receipt of an initiating cancer therapy** and **must include a qualifying Evaluation & Management (E&M) service** during the 6-month period that follows. CMS will maintain a list of initiating cancer therapies.

EPISODE DURATION AND SCOPE

Episodes will last for **6 months** after a beneficiary's triggering chemotherapy claim.

EPISODE EXCLUSIONS

- Episodes during which a beneficiary is treated with a chimeric antigen t-cell therapy (CAR T-cell therapy) will be excluded.
- CMS will make a final determination about episodes with a COVID-19 diagnosis before the start of the model.



DEFINING ELIGIBLE BENEFICIARIES

Eligible Beneficiary

CMS will include a Medicare FFS beneficiary in EOM in the event that they satisfy the below criteria and are in an episode attributed to an EOM participant.

Beneficiary Eligibility Criteria:

- Has a diagnosis for an included cancer type
- Receives an initiating cancer therapy that triggers an episode
- Receives a qualifying E&M service from an oncology PGP during the episode
- Is eligible for Medicare Part A and enrolled in Medicare Part B for the entirety of the episode
- Is not enrolled in any Medicare managed care organization, such as Medicare Advantage, at any point during the episode
- Is not eligible for Medicare on the basis of an End Stage Renal Disease (ESRD) diagnosis at any point during the episode
- Medicare is the primary payer for the entirety of the episode

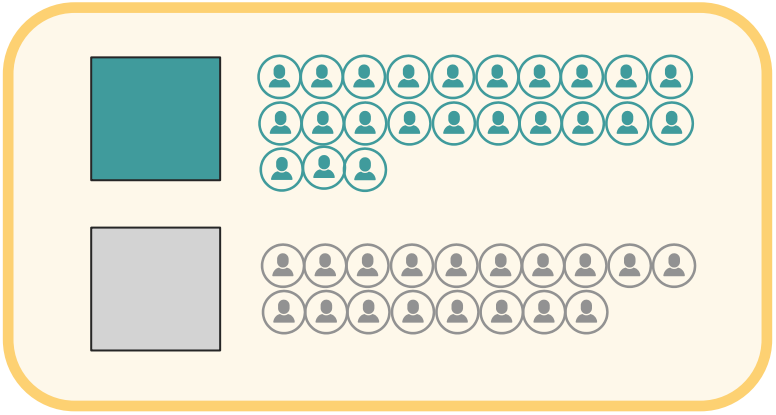
POOLING ARRANGEMENTS

Two or more EOM participants may choose to **form a pool**. EOM participants who pool together combine their information for reconciliation calculations.

For each performance period:

- Pooled participants select a **single risk arrangement** for their pool
- Episodes attributed to EOM participants in the pool are all **reconciled together**
- The pool receives a **single target amount** and may earn a **single PBP**, owe a **single PBR**, or fall into the neutral zone

Benchmark amounts, actual expenditures, eligibility for novel therapy adjustments, and quality performance are determined by a larger set of episodes when EOM participants pool together.



This may be especially helpful for EOM participants with fewer attributed episodes:

- more predictable benchmarking
- performance less sensitive to atypical episodes

The participation agreement will outline the requirements for a pooling arrangement.

RISK ARRANGEMENT OPTIONS

EOM will features **two risk arrangement options** that both include **downside risk** from the start of the model. EOM participants and pools can move between risk arrangements before the start of each performance period.

	Risk Arrangement 1 (RA1)	Risk Arrangement 2 (RA2)
EOM Discount	4% of the benchmark amount	3% of the benchmark amount
Target Amount	96% of the benchmark amount	97% of the benchmark amount
Threshold for Recoupment	98% of the benchmark amount	98% of the benchmark amount
Stop-loss / Stop-gain	2% Stop-Loss 4% Stop-Gain	6% Stop-Loss 12% Stop-Gain
Anticipated APM Status	✓ MIPS APM ✗ Advanced APM	✓ MIPS APM ✓ Advanced APM

DATA SHARING AND HEALTH IT

EOM PARTICIPANT DATA SHARING

DATA COLLECTION STRATEGY

Electronically enabled mechanism to report model-related data abstracted from the EOM participant's own health IT

TYPES OF DATA

1. Quality measure data
2. Clinical and staging data
3. Beneficiary-level sociodemographic data

TIMING

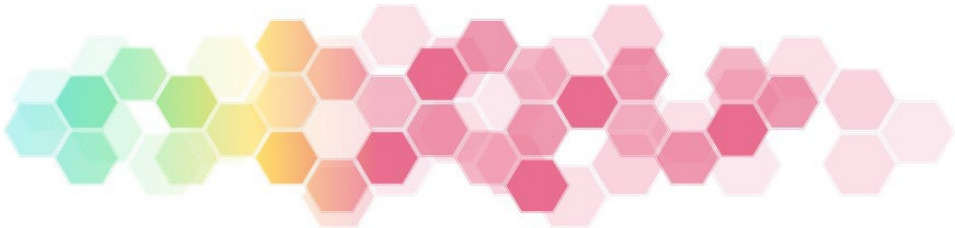
EOM participants will be required to report data at a time and manner specified by CMS, but no more than **once per performance period**

CMS DATA SHARING WITH PGPs

QUARTERLY FEEDBACK REPORTS

SEMIANNUAL RECONCILIATION REPORTS, ATTRIBUTION LISTS, AND EPISODE-LEVEL FILES

MONTHLY CLAIMS DATA



CLINICAL DATA ELEMENTS

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

EOM participants required to report the clinical data elements to CMS on at least a **minimum of 90%** of attributed episodes in a given performance period

List of Clinical Data Elements[1]

- ICD-10 Diagnosis Code and Initial Diagnosis Data
- Current Clinical Status and Current Clinical Status Date
  - Initial Diagnosis
  - No Evidence of Disease/Remission
  - Responding
  - Stable Disease
  - Progressive Disease
  - Metastasis
  - Local or Regional Recurrence/Relapse
  - Deceased
- Primary Tumor, Nodal Disease, Metastasis (TNM Staging)
- Estrogen Receptor
- Progesterone Receptor
- HER2 Amplification
- Histology

[1] List subject to change; this list represents the minimum data elements that CMS may collect. CMS continues to explore ways to align with other reporting standards (e.g., mCODE, USCDI) and is open to feedback and suggestions on the above list.

SOCIODEMOGRAPHIC DATA ELEMENTS

Finally, EOM participants will be required to collect and submit sociodemographic data on EOM beneficiaries[1] to CMS:

- Race
- Ethnicity
- Preferred Language
- Sex (Assigned at Birth)
- Gender Identity
- Sexual Orientation

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

APPLICATION REVIEW PROCESS

An internal committee will review completed applications

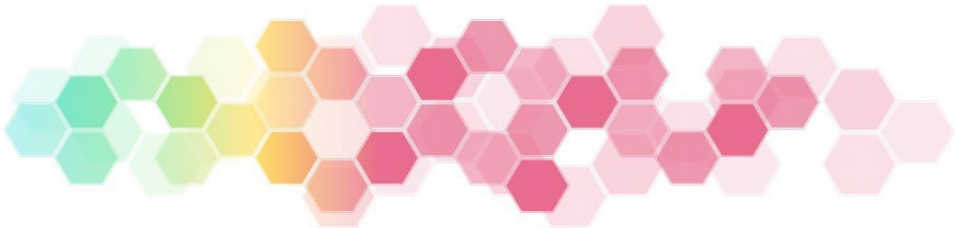
Applications to participate in/partner with CMS in EOM will be accepted on the basis of completeness, quality of narratives, and the result of a program integrity screening.

Prior to the application approval, CMS will also conduct a program integrity (PI) screening.

PROGRAM INTEGRITY (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.



ELIGIBILITY: DEFINING EOM PARTICIPANTS AND PRACTITIONERS

EOM Participant

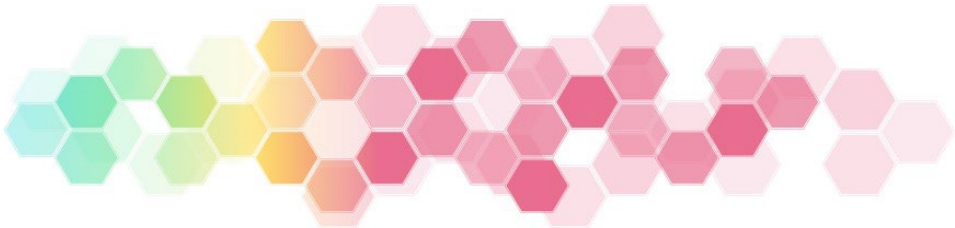
Must be a **Medicare-enrolled oncology PGP** identifiable by a unique federal Taxpayer Identification Number (TIN).

- EOM Practitioner List: Must identify **one or more EOM practitioner(s)**, including at least one EOM practitioner must be an oncology practitioner with a specialty code of Hematology/Oncology or Medical Oncology.
- Excluded: Oncology PGPs that routinely refer beneficiaries to Prospective Payment System (PPS)-Exempt Cancer Hospitals (PCH) for chemotherapy services are not eligible to participate.
- For EOM, unlike OCM, we plan to have participation requirements that allow a limited degree of flexibility for EOM practitioners simultaneously billing under the TIN of the EOM participant and the TIN of another PGP, while still preserving program integrity.

EOM Practitioner

Must be a **Medicare-enrolled physician or non-physician practitioner** (e.g., Nurse Practitioner) identified by an individual National Provider Identifier (NPI) who:

1. Furnishes E&M services to Medicare beneficiaries receiving chemotherapy for a cancer diagnosis.
2. Bills under the TIN of the PGP for such services.
3. Reassigned his or her right to receive Medicare payments to the PGP.
4. Appears on the participant's EOM Practitioner List (to be updated semiannually).



CARE PARTNERS AND POOLING OF PARTICIPANTS

Care Partner

EOM participants may elect to enter into financial arrangements with certain individuals or entities called "Care Partners." For purposes of EOM, the term "Care Partner" means **any Medicare-enrolled provider or supplier that:**

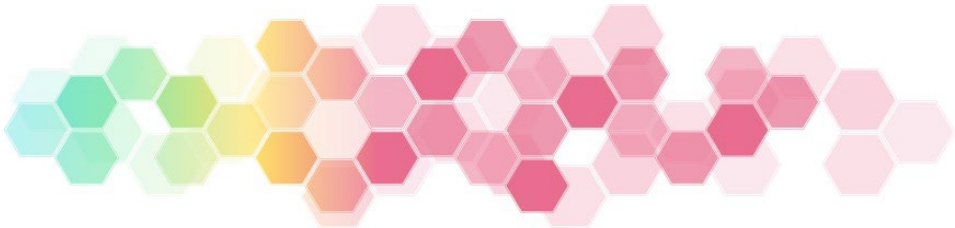
1. Engages in at least one of the PRAs during a performance period
2. Has entered into a Care Partner arrangement with an EOM participant;
3. Is identified on the EOM participant's Care Partner list; and
4. Is not an EOM practitioner

Pooling of EOM Participants

Pooling in EOM will mean that the episode expenditures for **two or more EOM participants** are considered together for the reconciliation calculations:

- To set the benchmark prices
- To determine PBP or PBR amounts

EOM participants will be allowed to voluntarily form a **pooling relationship** with one or more EOM participants governed by a pooling arrangement. Participation in a pool under EOM may be voluntary or mandatory.



MODEL OVERLAP

Model Overlap

Oncology PGPs participating in **other CMS models and programs** that provide health care entities with opportunities to improve care and reduce spending during the model performance period (July 2023-June 2028) will **also be eligible to participate.**

Baseline & Performance Period

CMS will make adjustments to the **baseline period episode expenditures** and **performance period episode expenditures** to account for overlaps and **enable participation in both models.**

When calculating the baseline & performance period episode expenditures adjustments will be made to **reflect the amount that would have been paid** by Medicare in the absence of fee reductions and/or to **avoid double counting payment amounts.**

CMS expects situations where an EOM beneficiary **in a performance period episode will also be attributed to or aligned to another CMS payment model or initiative.**

Planned Adjustments

- ACO Initiatives
- BPCI Advanced and CJR
- Primary Care First (PCF)
- Radiation Oncology (RO)
- Maryland TCOC and PARHM
- Community Health Access Rural Transformation (CHART)

See EOM RFA for specific adjustments for each overlapping model

PAYER ALIGNMENT

EOM is a **multi-payer model.**

Goal: Payers align their oncology value-based payment models with EOM in key areas (e.g., commitment to health equity, alignment on payment approach, and data sharing with EOM participants and CMS) to promote a consistent approach across payers and patient populations.

The following payers are eligible to apply:

Payers must partner with at least one EOM participant **throughout the entirety of the model** to continue participating in EOM.

To the extent permitted by law, CMS will provide **payers with data and resources** including opportunities to collaborate and engage with other payers and learning activities.

See EOM RFA for specific criteria for each of these payer types.