EOM QUALITY MEASURES GUIDE

Version 1.0

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Revision History

Revision #	Revision Date	Description of Change
1.0	05/01/2023	Initial Version

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Introduction

The Enhancing Oncology (EOM) is a CMMI alternative payment model designed to promote high quality, person-centered care, advance health equity, promote better care coordination, improve access to care, reduce costs, and improve outcomes for Medicare fee-for-service (FFS) beneficiaries with cancer who receive chemotherapy. EOM builds on lessons from the Oncology Care Model (OCM) and shares certain features with OCM, including episode-based payments that financially incentivize physician group practices (PGPs) to improve care and lower costs. EOM incorporates a two-part payment system for EOM Participants and Pools as follows:

1. Monthly Enhanced Oncology Services (MEOS) payment to assist EOM Participants and Pools with effectively managing and coordinating care for oncology patients during episodes of care (see your EOM Participation Agreement for additional information on MEOS payments).
2. Potential retrospective performance-based payment (PBP) or performance-based recoupment (PBR) for episodes of chemotherapy care to incentivize EOM Participants and Pools to lower the total cost of care and improve the quality of care for beneficiaries (additional information on PBP/ PBR is available in the "EOM Payment Methodology" document).

EOM targets oncology PGPs that prescribe chemotherapy for cancer and is centered on 6-month episodes of care (performance periods) triggered by receipt of chemotherapy. Seven cancer types are included in the model:

1. breast cancer*
2. chronic leukemia
3. lung cancer
4. lymphoma
5. multiple myeloma
6. prostate cancer*
7. small intestine / colorectal

Additional information on performance periods is also available in the "EOM Payment Methodology" document.

Quality measures are one key mechanism that CMS uses to verify clinical improvements, assess patient health outcomes and appropriate coordination of care, and ensure continued quality of care for patients. Quality measures are a component of the EOM PBP or PBR calculation. EOM adjusts PBP or PBR for each performance period based on the EOM Participant's or Pool's performance on a range of quality measures. This guide provides EOM Participants and Pools with the information described below:

- Section 1 provides a high-level overview of the measures selected for EOM. This section provides foundational information that will be built upon in subsequent sections, including measures that

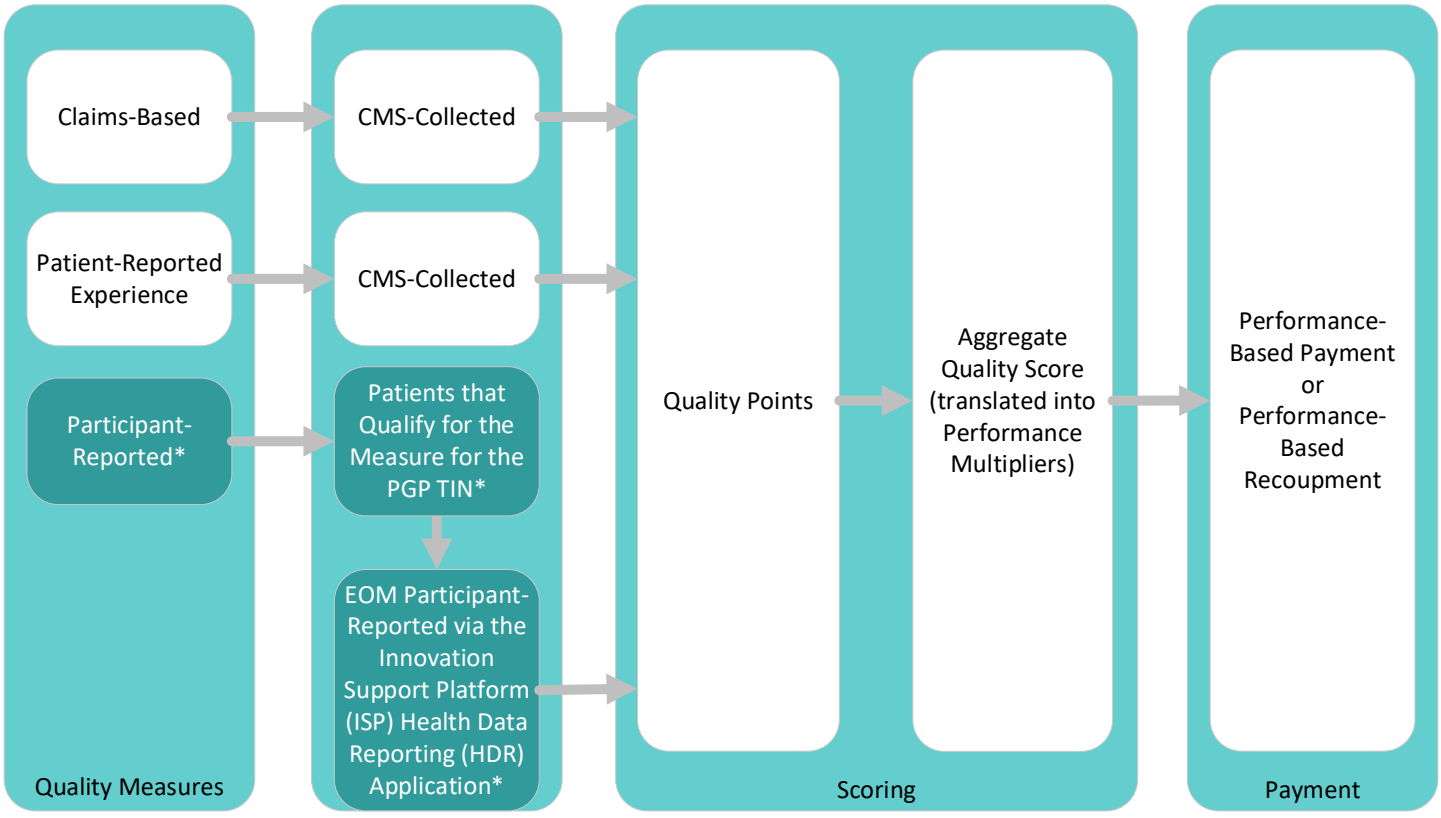
* Low-risk breast cancer and low-intensity prostate cancer are not included in EOM. For the purposes of EOM, low-risk breast cancer is defined as breast cancer treated with only long-term oral endocrine chemotherapy; and low-intensity prostate cancer is defined as prostate cancer treated with either androgen deprivation and/or anti-androgen therapy without any other chemotherapy.

are reported by EOM Participants and Pools, as well as measures that are administered or calculated by CMS.

- Section 2 provides guidance on EOM Participant responsibilities related to the submission of quality measure results. This section directs EOM Participants and Pools regarding how to identify qualifying patients within the PGP TIN for EOM quality measure reporting. This section also provides EOM Participants and Pools direction regarding quality measure results that are required to be reported via the Innovation Support Platform (ISP) Health Data Reporting (HDR) application for each performance year.
- Section 3 gives a high-level overview of how quality measure results are used as part of the PBP and PBR, including the application of the performance multiplier.
- Section 4 provides an overview of EOM supporting documents related to quality measures, as well as links to the documents.
- Section 5 contains additional EOM program resources for quality measure reporting, including links to relevant web sites and contact information for support.

An overview of the EOM quality measures that will be covered in this guide is provided in Figure 1.

Figure 1: EOM Quality Measures Overview



* The EOM Participant is responsible for reporting these items.

Section 1: EOM Quality Measures Overview

The EOM quality strategy focuses 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, CMS prioritizes 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 the CMS and Innovation Center quality strategy. The quality measure set is similar to measures included in Oncology Care Model (OCM). CMS 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.

EOM performance rates on the quality measures will be calculated according to the specifications for each measure. Performance rates for claims-based measures (EOM-1, EOM-2, and EOM-3) will be calculated using Medicare administrative data only. Performance rates for the patient-reported experience of care measure (EOM-6) will be calculated using the survey data collected by the Implementation and Monitoring Contractor and a methodology agreed upon by the Implementation and Monitoring Contractor and CMS. Performance rates for EOM participant reported measures (EOM-4 and EOM-5) will be calculated using data submitted via the ISP HDR application by the EOM Participants and Pools.

To the extent possible, EOM utilizes existing data such as claims data and data collected for other CMS programs as part of its PBP or PBR calculation to reduce burden on EOM Participants. Additional information regarding these data sources is provided in Section 1.1, Section 1.2, and Section 1.3.

Table 1: Quality Measures for Determination of Performance-Based Payment

Measure Title	EOM Measure Number	Domain	Measure Source	Type of Reporting by EOM Participant
Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy (OP-35 Respecified)	EOM-1	Avoidable acute care utilization	Claims-based	None. Calculated by CMS using Administrative Data
Proportion of Patients who Died who Were Admitted to Hospice for 3 Days or More	EOM-2*	Management of end-of-life care	Claims-based	None. Calculated by CMS using Administrative Data
Percentage of Patients who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life	EOM-3†	Management of end-of-life care	Claims-based	None. Calculated by CMS using Administrative Data
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	Patient Reported	None. Patient-reported; CMS fields survey

* Please note that this measure was adapted from an NQF-endorsed measure (Combination of NQF 0215 and NQF 0216), the measure specifications were changed for use in the Enhancing Oncology Model. NQF has not reviewed or approved the revised measure specifications.

† Please note that this measure was adapted from an NQF-endorsed measure (NQF 0210) the measure specifications were changed for use in the Enhancing Oncology Model. NQF has not reviewed or approved the revised measure specifications

^ The MIPS specifications for the 2023 performance year were used to populate the measure description, denominator, numerator and (where applicable) denominator exclusions and denominator exceptions in this table. EOM participant reported measures are not included until the 2024 performance year. The measure specifications are released annually and any updates to the specifications will also be reflected here.

1.1 Claims-Based Measures

CMS selected a set of claims-based measures to be used in pay-for-performance. Table 1 provides an overview of the quality measures, the source of data utilized for each measure, and the reporting requirements associated with each measure. While the claims-based measures have been based on NQF or OP measure specifications they have been respecified to align with EOM.

Performance rates for claims-based measures used in pay-for-performance are calculated by CMS using only Medicare administrative data and scored based on performance compared to national benchmarks. The claims-based measures are limited to EOM attributed beneficiaries. The detailed specifications will be available soon on **EOM Connect**.

EOM Participants and Pools are not responsible for reporting any data related to these quality measures, as CMS uses claims data to monitor EOM Participant performance and calculate the performance rates.

1.2 Participant-Reported Measures

CMS selected a set of participant-reported measures to be used for pay-for-performance (Table 1). **All participant-reported measures are reported at the aggregate-level, meaning the EOM Participant will combine the measure results for each patient and then add those results together to submit.** The aggregate measure results are reported annually via the CMS ISP HDR application as described in Section 2. To minimize EOM participant reporting burden and to align with the CMS and the Innovation Center's quality strategy, the participant reported quality measures will follow the MIPS Clinical Quality Measure (CQM) specifications and guidelines for reporting. The participant-reported measures are EOM-4 (comprised of EOM-4a and EOM-4b) and EOM-5.

Additional EOM-specific reporting requirements applicable to the patient-based and encounter-based measures can be found in Section 2.3.2 and Section 2.3.3.

1.3 Patient-Reported Experience Measure

CMS will use a multi-item survey to assess patients' experience with chemotherapy care for each EOM Participant. Survey items used in the calculation of the patient-reported experience measure for the PBP or PBR calculation will be based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) for cancer drug therapy [CAHPS Cancer Care Survey: Drug Therapy (ahrq.gov)]. Additional survey items will be drawn from various validated instruments, including, but not limited to, items from the CAHPS Cancer Care Supplemental Survey [CAHPS ® Cancer Care Supplemental Items (ahrq.gov)] and from other validated surveys to assess end-of-life and hospice care (CAHPS® Hospice Survey | CMS). These additional survey questions will be used to support evaluation of EOM, but these items will not be used for scoring purposes.

Performance rates for the patient-reported experience measure will be calculated for pay-for-performance using aggregated composite-level scores to create one summary score of "patient experience of care." The survey data will be collected by the Implementation and Monitoring Contractor.

Section 2: CMMI Innovation Support Platform (ISP) Health Data Reporting (HDR) Application for Quality Measure Reporting

EOM Participants are required to utilize the CMMI Innovation Support Platform (ISP) Health Data Reporting (HDR) application to submit aggregate quality measure data. HDR is a web-based data submission application. The intent of Section 2 is to educate EOM Participants on the performance years and the requirements for reporting aggregate quality measure results via HDR. EOM Participants are required to report data annually for all patients that qualify for the measure for the PGP TIN, as outlined in Section 2.2.

2.1 EOM Performance Years

Each performance year begins January 1st and ends December 31st, as shown in Table 2. EOM Participants and Pools will have six weeks from the last day of each performance year (January – Mid-February) to report quality measure results via HDR for that performance year.

Note: No reporting of participant-reported quality measures is required for the 2023 performance year as EOM begins July 2023.

Table 2: Planned EOM Performance Years and Submission Windows

Performance Period (Based on Episode Initiation Dates)	Performance Years	Aggregate Measure Result Submission Windows
Performance Period 1	July-December 2023	N/A
Performance Period 2 Performance Period 3	January-December 2024	January – Mid-February 2025
Performance Period 4 Performance Period 5	January-December 2025	January – Mid-February 2026
Performance Period 6 Performance Period 7	January-December 2026	January – Mid-February 2027
Performance Period 8 Performance Period 9	January-December 2027	January – Mid-February 2028
Performance Period 9	January-July 2028	N/A

Table 3 summarizes the approach for phasing in the measures over each performance period. The performance multiplier in the first performance period will include the three claims-based measures (EOM-1, EOM-2, and EOM-3) and the patient-reported measure (EOM-6). The performance multiplier in the second performance period and after, will include all six quality measures listed in Table 1.

Note that the EOM-participant reported measures (EOM-4 and EOM-5) *are not included* in the first performance period scoring.

Table 3: EOM Measure Phase-in

EOM Measure Number	Performance Period 1	Performance Periods 2-9
EOM-1	YES	YES
EOM-2	YES	YES
EOM-3	YES	YES
EOM-4	NO	YES
EOM-5	NO	YES
EOM-6	YES	YES
# Measures	4	6

2.2 Reporting of EOM Participant Reported Quality Measure Results

EOM Participants are required to report aggregate quality measure results for all patients that qualify for the measure for the PGP TIN using the MIPS Clinical Quality Measure specifications (CQMs). EOM Pools will have all of their episodes combined and treated as if all the pool's episodes belong to one participant for the purposes of quality scoring. This means that the numerators and denominators for each participant in the pool will be summed before calculating pooled performance rates for each measure. For the quality measures reported for EOM, as indicated in Table 1, EOM Participants are required to report aggregate measure results for EOM-4a, EOM-4b and EOM-5 for each performance year. EOM Participants are required to:

- Report the denominator for each measure
- Report the denominator exclusion (if applicable) for each measure
- Report the numerator for each measure
- Report the numerator exclusion (if applicable) for each measure
- Report the denominator exception (if applicable) for each measure

EOM Participants and Pools have access to detailed specifications which will provide information on all clinical data required for quality measure calculations. The detailed specifications are located in the MIPS CQM for each measure and the data elements and corresponding codes are located in the MIPS CQM Single Source for each measure. These documents are updated annually and released at the end of the year prior to the performance year. For example, the documents that will be used for the performance year that begins January 1, 2024, and ends December 31, 2024, will be posted late 2023. Participants and Pools will be notified when these documents are available for each performance year.

2.3 Measure-Specific Reporting Requirements

The EOM Quality Measures include populations that contain criteria used to calculate the measure performance rate. While not all populations will be used in each measure, the available measure populations are:

- Denominator
- Denominator Exclusion
- Numerator
- Numerator Exclusion
- Denominator Exception

EOM quality measures encompass both patient-based (Section 2.3.2) and encounter-based (Section 2.3.3) measures as outlined below.

2.3.1 Definitions

- **Denominator** – The *Denominator* refers to all events (e.g., patients, visits) to be evaluated by a specific performance measure that shares a common set of specified characteristics within a specific measurement set to which a given measure belongs. Details often include information based on specific age groups, diagnoses, diagnostic and procedure codes, and enrollment periods. Different measures within a measure set may have different *Denominators*.
- **Denominator Exclusions** – Events (e.g. patients, visits) that should be removed from the measure *Denominator* before determining if *Numerator* criteria are met. *Denominator Exclusions* are used to help narrow the *Denominator* (e.g., patients diagnosed with metastatic cancer would be listed as a *Denominator Exclusion* for a measure requiring a primary diagnosis).
- **Numerator** – The *Numerator* criteria are the processes or outcomes expected for each patient, procedure, or other unit of measurement defined in the *Denominator* (e.g., a *Numerator* listing the number of visits where the current medication list was documented and a *Denominator* indicating the number of visits in a specific time period).
- **Numerator Exclusions** - *Numerator Exclusions* are generally used when the improvement notation is a "lower score indicates better quality." Numerator exclusions remove events from the numerator population while retaining them in the denominator. For example, a *Numerator* listing at least one short-term acute care hospital admission and a *Numerator Exclusion* for patients admitted for certain cancer-related surgeries.
- **Denominator Exceptions** – *Denominator Exceptions* are those conditions that should remove a patient, procedure, or unit of measurement from the *Denominator* of the performance rate only if the *Numerator* criteria are not met. *Denominator Exceptions* allow for adjustment of the calculated score for those providers with higher risk populations. *Denominator Exceptions* allow for the exercise of clinical judgment and should be specifically defined where capturing the information in a structured manner fits the clinical workflow. Generic *Denominator Exception* reasons fall into three general categories:
    - Medical reasons (e.g., contraindicated, drug allergy, treatment changed)
    - Patient reasons (e.g., drug declined, financial problem, refusal of treatment)
    - System reasons (e.g., drug not available/out of stock, patient transfer, loss of benefits)

**Please note when exceptions (medical, patient, and/or system reasons for not achieving a quality action) are applicable to a measure, the exceptions are only applied when the quality action is not performed.

2.3.2 Encounter-Based Measures

Measures that evaluate the care during a patient-provider encounter and assign the encounter to one or more populations are called encounter-based measures. One of the EOM participant-reported measure specifications is encounter-based (EOM-4) and is composed of two components (EOM-4a and EOM-4b). In an encounter-based measure, the encounter is identified in the Denominator, and each qualifying

encounter during the performance year is to be reported separately for that patient. Please reference the detailed code lists available in the "MIPS CQM Single Source" for specific qualifying encounter codes for each encounter-based measure.

2.3.3 Patient-Based Measures

Measures that evaluate the care of a patient over a period of time and assign the patient to membership in one or more measure populations are called patient-based measures. One of the EOM participant-reported measure specifications is patient-based (EOM-5). **All of the information in the patient record referenced in the measure must be considered when calculating a patient-based measure for each performance year.** This includes care provided by any clinician at the practice, regardless of if the clinician is an EOM Practitioner. The criteria for inclusion of a patient in a measure population may require that information from multiple encounters during that performance year be considered, but the patient should only be included in the denominator once per performance year.

In a patient-based measure, the patient criteria for measure inclusion are identified in the Denominator. The requirement to report measure results once per performance year may result in reporting on Denominator eligible patients prior to completion of a measure's specified time frame to complete the appropriate care. Timeframes for delivery of clinically appropriate, high quality care are addressed in each individual measure specification based on nationally recognized clinical guidelines. The requirement to report measure results for each measure does not change the timeframes in which high quality clinical care may be provided.

Section 3: Determination of Performance-Based Payment or Performance-Based Recoupment

Detailed information regarding calculation of performance rates, PBR and PBP is located in the "EOM Payment Methodology" document. This guide provides a high-level overview of these topics.

EOM quality measure data derived from claims, aggregate measure results reported via the ISP HDR application, and patient experience survey data, are utilized to determine the quality score used in calculation of the performance multiplier. Scoring, or the process of assigning quality points to each quality measure, is based on the EOM Participants' and Pools' reporting of quality measure data and/or quality performance relative to set thresholds. Once quality points are assigned, an Aggregate Quality Score (AQS) will be calculated and translated into a performance multiplier. This performance multiplier is used as part of the PBP or PBR calculation.

Section 4: EOM Quality Measure Reporting Supporting Documents

This section provides an overview of several EOM supporting documents that are used to:

- Explain the methodology used to calculate EOM PBP and PBR
- Identify qualifying patients and episodes for EOM quality measure reporting

- Assist EOM Participants and Pools with reporting quality measure data at the aggregate level to the EOM ISP HDR application

These documents will be located on **EOM Connect** soon.

4.1 EOM Payment Methodology

This document includes technical details for the methodology used to calculate EOM performance rates and PBP and PBR. For each performance period, EOM Participants and Pools have the potential to earn a PBP, owe a PBR, or fall into the neutral zone (neither earning a PBP nor owing a PBR.)

To determine whether an EOM Participant or Pool has potentially earned a PBP, we compare the actual episode expenditures for attributed episodes (or for episodes attributed to all EOM Participants in the Pool) to the Participant's or Pool's target amount for the performance period. EOM Participants and Pools may earn a PBP if their actual episode expenditures are below their target amount (although PBPs are contingent upon quality performance and other PBP eligibility criteria detailed in the participation agreement). EOM Participants and Pools owe a PBR if the actual episode expenditures are higher than the threshold for recoupment threshold. The amount of the PBR is contingent upon quality performance; that is, high performance on quality measures during the performance period may reduce the amount owed. For more information see the "EOM Payment Methodology" document.

4.2 EOM Technical Payment Resource (used for EOM Claims-based measures only)

This document includes a general list of EOM-qualifying ICD-10-CM cancer diagnosis codes in the 'Cancer Type Mapping' tab. This information will be used to:

- Identify patients that have a qualifying cancer diagnosis code

This document also includes a list of Healthcare Common Procedure Coding System (HCPCS) codes (in the 'Initiating Therapy-HCPCS Codes' tab) and National Drug Codes (NDCs) (in the 'Initiating Therapy-NDC Codes' tab) that have been identified as qualifying initiating cancer therapy codes. This information will be used to:

- Identify patients that have a qualifying initiating cancer therapy code

4.4 EOM Measure Specifications

Each measure specifications document includes Description, Guidance, Numerator and Denominator definitions, and where applicable, Denominator Exclusion and Denominator Exception definitions. These narrative descriptions of the population criteria represent the data that will be used to calculate these measures. Each measure flow provides a flow chart and narrative representation of the individual EOM Measure Specifications.

4.5 EOM Participant Reported Measure Code Lists

The codes that make up the population criteria for the participant reported measures can be found in the "MIPS CQM Single Source" document. Each of the participant-reported measures can be found by filtering the 'Measure ID' column to the applicable MIPS measure ID.

4.10 EOM FAQ

This document includes frequently asked questions from EOM Participants and Pools regarding all aspects of EOM.

Section 5: EOM Quality Reporting Program Resources

CMS EOM Website

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

EOM Connect:

- https://app.innovation.cms.gov/CMMIConnect/IDMLogin

Innovation Support Platform (ISP) Health Data Reporting (HDR) Application:

- https://portal.cms.gov

EOM Help Desk:

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

MIPS Clinical Quality Measure Specifications and Supporting Documents:

- https://qpp.cms.gov/resources/resource-library

Section 6: Acronyms and Abbreviations

Table 4: Acronyms and Abbreviations

Acronym	Literal Translation
AQS	Aggregate Quality Score
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
E&M	Evaluation and Management
CQM	Clinical Quality Measure
EOM	Enhancing Oncology Care Model
FFS	Fee-for-Service
HCPCS	Healthcare Common Procedure Coding System
HDR	Health Data Reporting
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
ISP	Innovation Support Platform
MIPS	Merit-based Incentive Payment System
NDC	National Drug Code
NQF	National Quality Forum
PBP	Performance-Based Payment
PBR	Performance-Based Recoupment

Appendix A

Table A-1: EOM Measure Description and Population Summary

Measure Name	Measure Description	Denominator Summary	Denominator Exclusions Summary	Numerator Summary	Denominator Exceptions or Numerator Exclusions Summary
EOM-1: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy (Respecified OP-35)	The Centers for Medicare & Medicaid Services (CMS), through its Center for Medicare and Medicaid Innovation (The Innovation Center), respecified a quality measure to assess complications occurring for cancer patients receiving outpatient chemotherapy. This measure is intended for practices participating in the Enhancing Oncology Model (EOM).	The denominator is six-month patient-episodes for patients with a diagnosis of one of the following seven specific cancer types and receiving chemotherapy treatment. The seven cancer types are: breast cancer, chronic leukemia, lung cancer, lymphoma, multiple myeloma, prostate cancer, and small intestine/colorectal cancer.	• Patients who do not have continuous enrollment in Medicare FFS Part A and Part B in the 30 days after the chemotherapy treatment (with the exception of enrollment truncation due to death). • Patients with CAR-T therapy at any point during the episode	The numerator/outcome definitions are the number of patients admitted at least once as an inpatient or seen in an ED within 30 days after a qualifying chemotherapy treatment in an outpatient setting for one of ten qualifying conditions. The ten conditions are anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, and sepsis, and must be in the primary discharge diagnosis position or as a secondary diagnosis with cancer as primary diagnosis.	**Numerator Exclusions:** Qualifying chemotherapy claims occurring less than 31 days before the end of the episode will not be considered as chemo events that could start a 30-day outcome assessment period.
EOM-2* Proportion of Patients who Died who Were Admitted to Hospice for 3 Days or More	Proportion of episodes ending in death in which the beneficiary was enrolled in hospice for at least 3 days immediately before death	Patients who died during the episode	None	All patients who were enrolled in hospice for at least 3 days immediately before death, for beneficiaries in the denominator population for this measure	None

* Please note that this measure was adapted from an NQF-endorsed measure (Combination of NQF 0215 and NQF 0216) the measure specifications were changed for use in the Enhancing Oncology Model. NQF has not reviewed or approved the revised measure specifications.

Measure Name	Measure Description	Denominator Summary	Denominator Exclusions Summary	Numerator Summary	Denominator Exceptions or Numerator Exclusions Summary
EOM-3†: Percentage of Patients who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Live	Percentage of patients who died during the episode receiving chemotherapy in the last 14 days of life	Patients who died during the episode	None	Patients who received chemotherapy in the last 14 days of life	None
EOM-4a^: Oncology: Medical and Radiation – Pain Intensity Quantified (NQF 0384: CMS Quality ID # 143)	Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified	All patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy	None	Patient visits in which pain intensity is quantified	None
EOM-4b^: Oncology: Medical and Radiation – Plan of Care for Pain (NQF 0383: CMS Quality ID # 144)	Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain	All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain	None	Patient visits that included a documented plan of care to address pain	None

† Please note that this measure was adapted from an NQF-endorsed measure (NQF 0210) the measure specifications were changed for use in the Enhancing Oncology Model. NQF has not reviewed or approved the revised measure specifications

^ The MIPS specifications for the 2023 performance year were used to populate the measure description, denominator, numerator and (where applicable) denominator exclusions and denominator exceptions in this table. EOM participant reported measures are not included until the 2024 performance year. The measure specifications are released annually and any updates to the specifications will also be reflected here.

Measure Name	Measure Description	Denominator Summary	Denominator Exclusions Summary	Numerator Summary	Denominator Exceptions or Numerator Exclusions Summary
EOM-5^: Preventive Care and Screening: Screening for Depression and a Follow-Up Plan (NQF 0418: CMS Quality ID # 134)	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter	All patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period	Patients who have been diagnosed with depression or have been diagnosed with bipolar disorder	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter	**Denominator Exceptions:** • Patient reason(s) • Medical reason(s)
EOM-6: Patient-Reported Experience of Care Survey	Please refer to section 7.3.3 of the "EOM Payment Methodology" document	N/A	N/A	N/A	N/A

^ The MIPS specifications for the 2023 performance year were used to populate the measure description, denominator, numerator and (where applicable) denominator exclusions and denominator exceptions in this table. EOM participant reported measures are not included until the 2024 performance year. The measure specifications are released annually and any updates to the specifications will also be reflected here.