

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

EOM Goals

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

Available Benefit Enhancements



Telehealth¹

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



Post-Discharge Home Visits

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



Care Management Home Visits

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

Benefit Enhancements Process



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

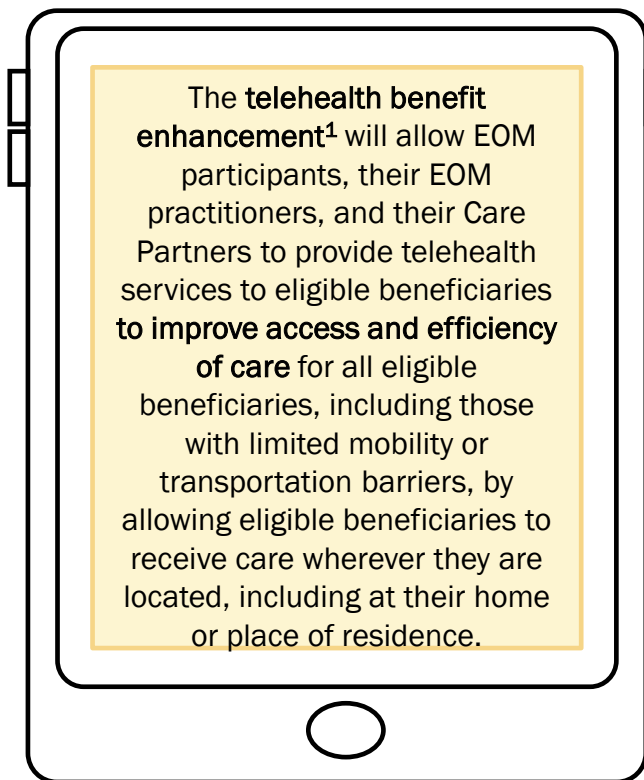


- CMS **must approve the EOM participant's selection** to participate in a given benefit enhancement before the EOM participant may implement the benefit enhancement.
- After CMS approval, **the EOM participant, its EOM practitioners, and its Care Partners may furnish services** pursuant to the benefit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



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

Telehealth Benefit Enhancement



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

The originating site requirements with respect to telehealth services furnished to eligible beneficiaries
Section 1834(m)(4)(C) of the Social Security Act and 42 CFR § 410.78(b)(3)-(4)

The originating site requirement in the eligible telehealth individual provision with respect to telehealth services being “furnished at an originating site”
Section 1834(m)(4)(B) of the Social Security Act

The originating site facility fee provision with respect to telehealth services furnished to an eligible beneficiary at his/her home or place of residence
Section 1834(m)(2)(B) of the Social Security Act and 42 CFR § 414.65(b)

Post-Discharge Home Visits Benefit Enhancement

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

42 CFR § 410.26(b)(5)

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

Claims Eligibility

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

Care Management Home Visits Benefit Enhancement

The care management home visits benefit enhancement conditional waiver allows for **payment for certain home visits** that are furnished to eligible beneficiaries by auxiliary personnel under the general supervision of a physician or other practitioner **proactively and in advance of potential hospitalization**. The items and services provided as part of these home visits are those that would be covered under Medicare Part B.

42 CFR § 410.26(b)(5)

Beneficiary Eligibility

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

Claims Eligibility

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

Additional Information

EOM Website:

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

EOM Helpdesk

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