



EOM QUALITY MEASURES GUIDE

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Introduction

The Enhancing Oncology Model (EOM) is a Center for Medicare & Medicaid Innovation (Innovation Center) alternative payment model designed to promote high quality, person-centered care, encourage better care coordination, improve access to care, reduce costs, and improve outcomes for Medicare fee-for-service (FFS) beneficiaries with cancer who receive cancer treatment. EOM builds on lessons from the Oncology Care Model (OCM; an Innovation Center model that preceded EOM and concluded on June 30, 2022) and shares certain features with OCM, including episode-based payments that financially incentivize physician group practices (PGPs) to improve care and lower costs.

EOM participants are oncology PGPs that prescribe and administer cancer therapy for included cancer types. The model is centered on 6-month episodes of care triggered by the receipt of a qualifying Initiating Cancer Therapy for an included cancer type. 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 cancer

Quality measures are one key mechanism that the Centers for Medicare & Medicaid Services (CMS) use 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 performance-based payment (PBP) or performance-based recoupment (PBR) calculation. EOM adjusts the PBP or PBR for each performance period based on the EOM participant's performance on a range of quality measures. Additional information on performance periods and PBP/PBR is available in the [EOM Payment Methodology](#) document.

This guide provides EOM participants with the information described below:

- [Section 1](#) provides a high-level overview of the measures selected for EOM. This section provides foundational information, including measures that are reported by EOM participants, as well as measures that are administered or calculated by CMS.
- [Section 2](#) provides guidance on the submission of participant-reported quality measure results, including measure-specific reporting requirements and an overview of the Innovation Support Platform (ISP) Health Data Reporting (HDR) application.
- [Section 3](#) gives a high-level overview of how quality measure results are used to inform the

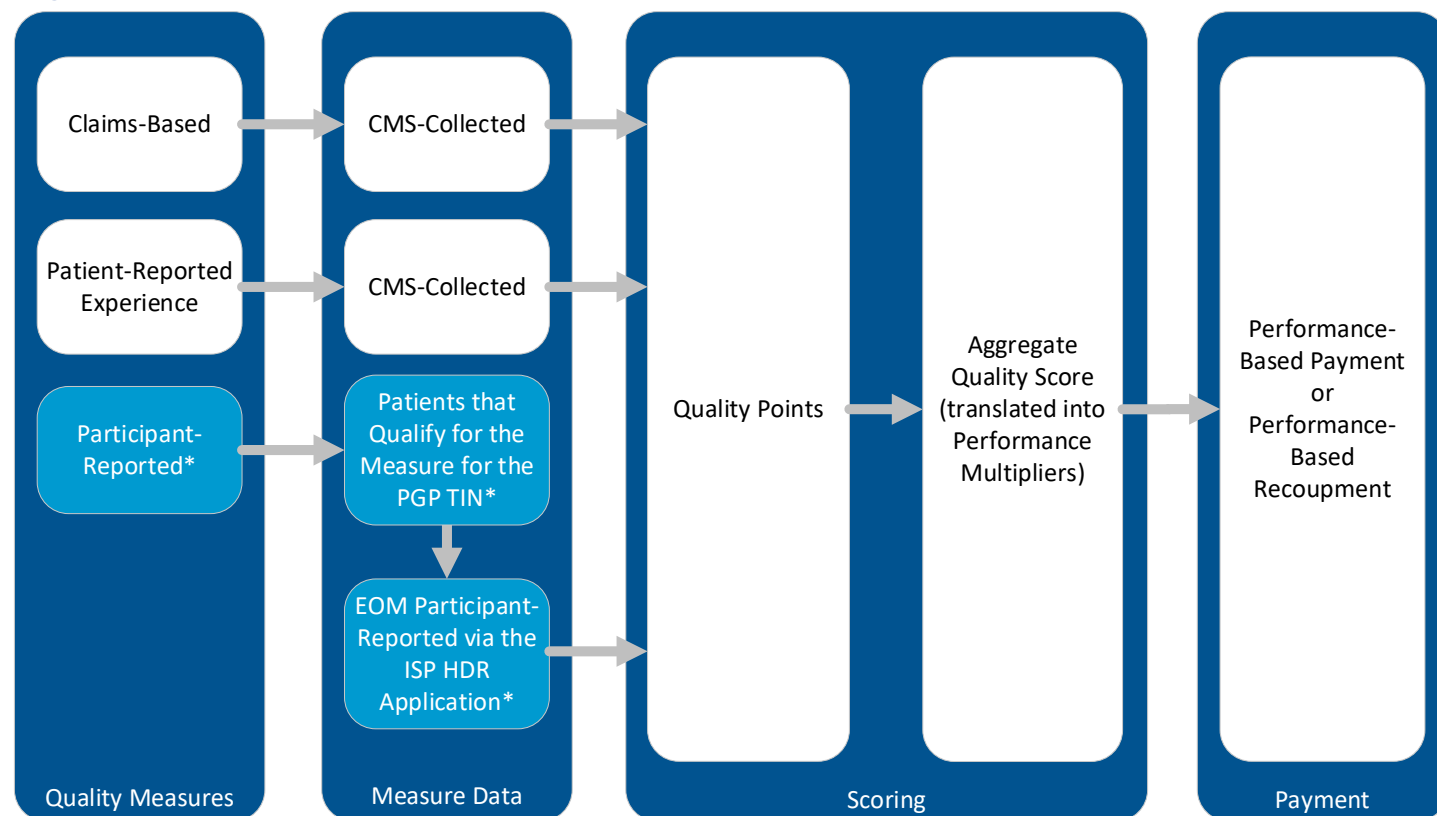
* Low-risk breast cancer and low-intensity prostate cancer are not included in EOM. For the purposes of EOM, low-risk breast cancer is defined as breast cancer treated with only long-term oral endocrine chemotherapy; and low-intensity prostate cancer is defined as prostate cancer treated with androgen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

PBP and PBR, including the application of the performance multiplier.

- [Section 4](#) provides an overview of EOM supporting documents related to quality measures.
- [Section 5](#) contains additional EOM program resources for quality measure reporting, including links to relevant websites and contact information for support.
- [Section 6](#) contains a list of acronyms used in this guide.

An overview of the EOM quality measures that are 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 Social Security 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 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.

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

To the extent possible, EOM uses existing data such as claims data or 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 (CBE 0384; CMS Quality ID # 143) b) Oncology: Medical and Radiation - Plan of Care for Pain (CBE 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
Preventive Care and Screening: Screening for Depression and Follow-Up Plan (CMS Quality ID #134)	EOM-5	Management of psychosocial health	EOM Participant-reported	Reported in aggregate across all patients

Measure Title	EOM Measure Number	Domain	Measure Source	Type of Reporting by EOM Participant
Patient-Reported Experience of Cancer Care Survey (PECCS)	EOM-6	Patient Experience	Patient-reported	None. Patient-reported; CMS fields survey

[Table 2](#) and [Table 3](#) summarize the approach for phasing in the measures over each performance period for cohort 1 and cohort 2, respectively. 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 and subsequent performance periods will include all six quality measures listed in [Table 1](#).

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

Table 2: Cohort 1 EOM Measure Phase-in

EOM Measure Number	Performance Period 1	Performance Periods 2-13
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

Table 3: Cohort 2 EOM Measure Phase-in

EOM Measure Number	Performance Periods 1-4	Performance Period 5	Performance Periods 6-13
EOM-1	NO	YES	YES
EOM-2	NO	YES	YES
EOM-3	NO	YES	YES
EOM-4	NO	NO	YES
EOM-5	NO	NO	YES
EOM-6	NO	YES	YES
# Measures	0	4	6

1.1 Claims-Based Measures

CMS selected a set of claims-based measures (EOM-1, EOM-2, and EOM-3) to be used in pay-for-performance. [Table 1](#) provides an overview of the quality measures, the data source for each measure, and the reporting requirements associated with each measure. While the claims-based measures are based on National Quality Forum (NQF) or Outpatient (OP) measure specifications, they have been respecified and tailored to 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 historical Medicare claims data for EOM participants and non-EOM oncology PGPs. The claims-based measures are limited to EOM attributed beneficiaries. The detailed specifications are available on [EOM Connect](#).

EOM participants are not responsible for reporting data related to these quality measures; 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](#)). The participant-reported measures are EOM-4 (comprised of EOM-4a and EOM-4b) and EOM-5. **All participant-reported measures are reported at the aggregate level, meaning the EOM Participant must evaluate the measure results for each encounter (EOM-4) or patient (EOM-5) and sum (i.e., aggregate) the results.** The aggregate measure results are reported annually via the HDR application as described in [Section 2](#).

To minimize EOM participant reporting burden and to align with CMS' and the Innovation Center's quality strategy, the participant-reported quality measures follow the Merit-based Incentive Payment System (MIPS) Clinical Quality Measure (CQM) specifications and guidelines for reporting where feasible, including annual reporting requirements. In alignment with MIPS, the EOM participant-reported quality measure reporting completeness threshold will be 75 percent of the denominator (eligible population) eligible encounters or patients. This completeness threshold is intended to provide flexibility if measure data cannot be reported for all expected beneficiaries, but this is not intended to support sampling of beneficiaries. EOM-4 and EOM-5 will not be scored against the published MIPS benchmarks. EOM has established benchmarks and scoring methodology which are available in section 7.2.2 of the [EOM Payment Methodology](#).

To streamline data collection, and in alignment with other model requirements, participants may consider using their electronic Patient Reported Outcomes (ePROs) to collect encounter data for EOM-5. To include an ePROs assessment as part of EOM-5 depression screening reporting, the assessment must be an age-appropriate standardized depression screening tool (e.g., the Patient Health Questionnaire [PHQ]) and must be completed on the date of the encounter, or up to 14 days prior to the encounter. Depression screenings completed more than 14 days prior to the encounter or after the encounter do not meet the EOM-5 numerator (performance met) criteria. If the depression screening information submitted through ePROs is positive, a follow-up plan must be documented on the date of the encounter. Use of an ePROs depression screening is allowable when the ePROs screening and results are integrated within the electronic medical record (EMR). EOM participants are still required to report this data as part of the quality measure submission requirements via the HDR. ePROs is currently not an allowable form of data collection for EOM-4 reporting since the measure requires the assessment of pain to be completed during the encounter, which may not align with ePROs administration.

Additional EOM-specific reporting requirements applicable to the encounter-based and patient-based measures can be found in [Section 2.3.1](#) and [Section 2.3.2](#).

1.3 Patient-Reported Experience Measure

EOM-6 is a patient-reported measure. PGPs are not required to provide information or take any action for this measure. CMS will use a multi-item survey to assess patients' experience with cancer care for each EOM Participant. Survey items used in the calculation of the patient-reported experience measure for the PBP or PBR calculation are 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.

The patient experience survey will be administered by the IMC each wave to a sample of the beneficiaries who received cancer care at each EOM participant in a 6-month period. Performance rates for the patient-reported experience measure are calculated using aggregated composite-level scores to create one summary score of "patient experience of care." More information about EOM-6 scoring is available in section 7.2.3 of the [EOM Payment Methodology](#).

Section 2: Participant-Reported Quality Measure Results

The intent of Section 2 is to educate EOM participants on the requirements for reporting aggregate quality measure results via the HDR. The following subsections provide an overview of the reporting requirements:

- [Section 2.1](#) provides an overview of the HDR application.
- [Section 2.2](#) covers the performance years for quality measure reporting.
- [Section 2.3](#) covers the annual reporting requirements for EOM-4a, EOM-4b, and EOM-5.

2.1 HDR Application

EOM participants use a centralized reporting platform, called the ISP. The EOM HDR application, part of the ISP, is a web-based data submission and collection tool that EOM participants use to submit their practice-level quality measures data, as well as their beneficiary-specific clinical data elements (CDEs) and beneficiary-specific sociodemographic data elements (SDEs). For more information, please see the EOM Sociodemographic Data Elements Guide, the EOM Clinical Data Elements Guide, and the HDR User Guide, available on [EOM Connect](#).

EOM participants are required to submit aggregate quality measure data for EOM-4a, EOM-4b, and EOM-5 for each performance year via the HDR application.

2.2 EOM Performance Years

Each performance year begins January 1 and ends December 31, as shown in [Table 4](#). EOM participants have January and February following the performance year to report quality measure results via the HDR. Participants will have an opportunity to gain familiarity with reporting via the HDR application prior to each reporting period.

Note:

- **Cohort 1:** Reporting of participant-reported quality measures is required beginning with the 2024 performance year, reported in January and February 2025.
- **Cohort 2:** Reporting of participant-reported quality measures is required beginning with the 2026 performance year, reported in January and February 2027.

Table 4: 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 and February 2025*
Performance Period 4 Performance Period 5	January–December 2025	January and February 2026*
Performance Period 6 Performance Period 7	January–December 2026	January and February 2027
Performance Period 8 Performance Period 9	January–December 2027	January and February 2028
Performance Period 10 Performance Period 11	January–December 2028	January and February 2029
Performance Period 12 Performance Period 13	January–December 2029	January and February 2030
Performance Period 13	January–June 2030	N/A

*Cohort 2 reporting of participant-reported measures is not required for performance years 2024 or 2025.

2.3 Measure-Specific Reporting Requirements

EOM participants are required to report aggregate quality measure results for all patients that qualify for the measure for the PGP Taxpayer Identification Number (TIN) using the MIPS CQM specifications. 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 pools will have all their episodes combined and treated as if all the pool's episodes belong to one participant for the purpose of quality scoring. This means that the numerator (performance met) and denominator (eligible population) for each participant in the pool will be summed before calculating pooled performance rates for each measure.

EOM participants have access to detailed specifications which 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 (once on the Quality Payment Program (QPP) Resource Library

page, in the “Full Resource Library” section, search for “Clinical Quality Measure Specifications”). 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, 2026, and ends December 31, 2026, were posted late 2025.

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

- Denominator (eligible population)
- Denominator exclusion (eligible population exclusion)
- Numerator (performance met)
- Numerator exclusion (performance met exclusion)
- Denominator exception (eligible population exception)

For each measure, EOM participants are required to report aggregate counts for each of the above measure populations (if applicable, per the measure specifications).

EOM quality measures encompass both encounter-based ([Section 2.3.1](#)) and patient-based ([Section 2.3.2](#)) measures as outlined below.

2.3.1 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 measures is encounter-based (EOM-4) and contains two components (EOM-4a and EOM-4b). In an encounter-based measure, the encounter is identified in the denominator (eligible population), 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.

2.3.2 Patient-Based Measures

Measures that evaluate the care of a patient over a period of time and assign the patient to one or more measure populations are called patient-based measures. One of the EOM participant-reported measure specifications is patient-based (EOM-5). **All the information in the patient’s medical record that is referenced in the measure specifications 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 whether 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 (eligible population) once per performance year.

In a patient-based measure, the patient criteria for measure inclusion are identified in the denominator (eligible population). The requirement to report measure results once per performance year may result in reporting on denominator (eligible population) 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 must be provided.

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

Detailed information regarding calculation of performance rates, PBR, and PBP is available in the [EOM Payment Methodology](#) document. This guide provides a high-level overview of these topics.

Scoring, or the process of assigning quality points to each quality measure, is based on the EOM participants' reporting of quality measure data and/or quality performance relative to set thresholds. EOM quality measure data derived from claims, aggregate measure results reported via the HDR application, and patient experience survey data, are used to calculate the quality score or Aggregate Quality Score (AQS). Once the AQS is calculated, it is translated into a performance multiplier. This performance multiplier is used as part of the PBP or PBR calculation. More information is available in Section 7 of the [EOM Payment Methodology](#) document.

Section 4: EOM Quality Measure Reporting Supporting Documents

This section provides an overview of EOM supporting documents that:

- [Section 4.1](#): Explains the payment methodology used to calculate EOM PBP and PBR.
- [Section 4.2](#): Lists the Healthcare Common Procedure Coding System (HCPCS) and National Drug Codes (NDCs) needed to identify patients and episodes for EOM claims-based measure reporting.
- [Section 4.3](#) and [Section 4.4](#): Provides measure specifications and patient-reported measure code lists.
- [Section 4.5](#): Helps EOM participants abstract quality measure data in preparation for reporting to the HDR application.
- [Section 4.6](#): Compiles FAQs sent by participants.

4.1 EOM Payment Methodology

The EOM Payment Methodology includes technical details for the methodology used to calculate EOM performance rates and PBP and PBR. For each performance period, EOM participants 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 has potentially earned a PBP, we compare the actual episode expenditures for attributed episodes (or for episodes attributed to all EOM participants) to the participant's target amount for the performance period. EOM participants 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 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. More information about how measures are scored, how the AQS is calculated, how the performance multiplier works, and the benchmarks and scoring methodology used for the EOM quality measures is available in Section 7 of the [EOM Payment Methodology](#). This document is available on the [EOM website](#) and [EOM Connect](#).

4.2 EOM Technical Payment Resources

The EOM Technical Payment Resources document is 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 HCPCS codes (in the “Initiating Therapy-HCPCS Codes” tab) and 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

This document is available on the [EOM website](#) and [EOM Connect](#).

4.3 EOM Measure Specifications

Each measure specifications document includes a description, guidance, Numerator (Performance Met), and Denominator (Eligible Population) definitions, and where applicable, Denominator Exclusion (Eligible Population Exclusion), Denominator Exception (Eligible Population Exception), and Numerator Exclusion (Performance Met Exclusion) definitions. These narrative descriptions of the population criteria represent the data that will be used to calculate these measures. When provided, the diagram provides a flow chart and narrative representation of the measure specifications.

The EOM-1, EOM-2, and EOM-3 measure specifications are available on the [EOM website](#) and [EOM Connect](#). The MIPS CQM specifications used for EOM-4a, EOM-4b, and EOM-5 are available on the [QPP website Resource Library](#) (in the “Full Resource Library” section, search for “Clinical Quality Measure Specifications”).

4.4 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 on the [QPP website Resource Library](#) (in the “Full Resource Library” section, search for “Clinical Quality Measure Specifications”). Each of the participant-reported measures can be found by filtering the “Measure ID” column to the applicable MIPS CQM’s Quality ID number.

4.5 EOM Quality Measure Abstraction Tool

The EOM Quality Measure Abstraction Tool is an optional tool designed to aid EOM participants in the collection and calculation of aggregate quality measure data for the participant-reported measures EOM-4 and EOM-5. The tool may be used to collect data prior to manual entry into the HDR application. The tool was developed in alignment with the MIPS CQM specifications; all instructions and guidance in the specifications must be followed when abstracting data into the tool. This document is available on [EOM Connect](#).

4.6 EOM FAQ

The EOM FAQ document includes frequently asked questions from EOM participants regarding all aspects of EOM. This document is available on [EOM Connect](#).

Section 5: EOM Quality Reporting Model Resources

CMS EOM Website:

- <https://www.cms.gov/priorities/innovation/innovation-models/eom>

EOM Connect:

- <https://app.innovation.cms.gov/CMMIConnect/IDMLLogin>

Innovation Support Platform (ISP) Health Data Reporting (HDR) Application, accessed through the CMS Enterprise Portal:

- <https://portal.cms.gov>

EOM Help Desk:

- EOM@cms.hhs.gov

MIPS Clinical Quality Measure Specifications and Supporting Documents, available on the QPP website:

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

Section 6: Acronyms

Table 5: Acronyms

Acronym	Term
AQS	Aggregate Quality Score
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CAR-T	Chimeric Antigen Receptor-T cell
CBE	Consensus-Based Entity
CDE	Clinical Data Elements
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CQM	Clinical Quality Measure
ED	Emergency Department

Acronym	Term
EOM	Enhancing Oncology Care Model
EMR	Electronic Medical Record
ePROs	Electronic Patient Reported Outcomes
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
IMC	Implementation and Monitoring Contractor
ISP	Innovation Support Platform
MIPS	Merit-based Incentive Payment System
NDC	National Drug Code
NQF	National Quality Forum
OCM	Oncology Care Model
OP	Outpatient
PBP	Performance-Based Payment
PBR	Performance-Based Recoupment
PGP	Physician Group Practice
PHQ	Patient Health Questionnaire
QPP	Quality Payment Program
SDE	Sociodemographic Data Elements
TIN	Taxpayer Identification Number

Appendix A: EOM Measure Descriptions and Populations

Table A-1: EOM Measure Description and Population Summary

Measure Name	Measure Description	Denominator (Eligible Population) Summary	Denominator Exclusions (Eligible Population Exclusions) Summary	Numerator (Performance Met) Summary	Denominator Exceptions (Eligible Population 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.	<ul style="list-style-type: none"> 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 (a combination of NQF 0215 and NQF 0216). The measure specifications were changed for use in EOM. NQF has not reviewed or approved the revised measure specifications.

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Measure Name	Measure Description	Denominator (Eligible Population) Summary	Denominator Exclusions (Eligible Population Exclusions) Summary	Numerator (Performance Met) Summary	Denominator Exceptions (Eligible Population Exceptions) or Numerator Exclusions Summary
EOM-3†: Percentage of Patients who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life**	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 (CBE 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 (CBE 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 EOM. NQF has not reviewed or approved the revised measure specifications

^ The MIPS CQM specifications for the 2026 performance year were used to populate the measure description, denominator (eligible population), numerator (performance met) and (where applicable) denominator exclusions (eligible population exclusion) and denominator exceptions (eligible population exception) in this table.

**For EOM respecified and adapted measures, the term chemotherapy refers to all cancer treatments included in the EOM initiating cancer therapies lists.

Enhancing Oncology Model (EOM) Quality Measures Guide

Measure Name	Measure Description	Denominator (Eligible Population) Summary	Denominator Exclusions (Eligible Population Exclusions) Summary	Numerator (Performance Met) Summary	Denominator Exceptions (Eligible Population Exceptions) or Numerator Exclusions Summary
EOM-5[^]: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (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 performance period with at least one qualifying encounter during the performance period	Documentation stating the patient has had a diagnosis of 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: <ul style="list-style-type: none"> • Patient reason(s) • Medical reason(s)
EOM-6: Patient-Reported Experience of Cancer 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 CQM specifications for the 2026 performance year were used to populate the measure description, denominator (eligible population), numerator (performance met), and (where applicable) denominator exclusions (eligible population exclusions) and denominator exceptions (eligible population exceptions) in this table.

Appendix B: Measure Population Definitions

Denominator (Eligible Population): The *Denominator (eligible population)* 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.

Denominator Exclusion (Eligible Population Exclusion): Events (e.g., patients, visits) that should be removed from the measure *Denominator (eligible population)* before determining if *Numerator (performance met)* criteria are met. *Denominator Exclusions (eligible population exclusions)* are used to narrow the *Denominator (eligible population)* (e.g., patients diagnosed with bipolar disorder would be listed as a *Denominator Exclusion (eligible population exclusion)* for a measure that screens for depression except in patients with bipolar disorder).

Numerator (Performance Met): The *Numerator (performance met)* criteria are the processes or outcomes expected for each patient, procedure, or other unit of measurement defined in the *Denominator (eligible population)* (e.g., a *Numerator (performance met)* listing the number of visits where pain intensity was quantified and a *Denominator (eligible population)* indicating the number of visits with a cancer diagnosis receiving chemotherapy in a specific time period).

Numerator Exclusion (Performance Met Exclusion): *Numerator Exclusions (performance met exclusions)* are generally used when the improvement notation is a “lower score indicates better quality.” *Numerator exclusions* remove events from the *Numerator (performance met)* population while retaining them in the *Denominator (eligible population)*. For example, a *Numerator (performance met)* listing patients admitted as inpatient or seen in an emergency department within 30 days after outpatient chemotherapy and a *Numerator Exclusion* for patients with a chemotherapy claim less than 31 days before the end of the episode.

Denominator Exception (Eligible Population Exception): *Denominator Exceptions (eligible population exceptions)* are those conditions that should remove a patient, procedure, or unit of measurement from the *Denominator (eligible population)* of the performance rate only if the *Numerator (performance met)* criteria are not met. *Denominator Exceptions (eligible population exceptions)* allow for adjustment of the calculated score for those participants with higher risk populations. *Denominator Exceptions (eligible population 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 (eligible population 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 *Denominator Exceptions (eligible population exceptions)* (medical, patient, and/or system reasons for not achieving a quality action) are applicable to a measure, the *Denominator Exceptions (eligible population exceptions)* are only applied when the quality action is not performed.

Revision History

Revision #	Revision Date	Description of Change
1.0	05/01/2023	Initial Version
1.1	01/15/2025	<p>Updated “Denominator” to “Denominator (eligible population),” “Denominator exclusion” to “Denominator Exclusion (eligible population exclusion),” “Numerator” to “Numerator (performance met),” and “Denominator Exception” to “Denominator exception (eligible population exception)” throughout document.</p> <p>Section 1.2 Participant-Reported Measures: Added information regarding the reporting completeness threshold. Added information about ePRO reporting being used for reporting EOM-5 but not for EOM-4a and EOM-4b.</p> <p>Table 2 Planned EOM Performance Years and Submission Windows: Added PP10, PP11, PP12 and PP13.</p> <p>Table 3 Cohort 1 EOM Measure Phase-in: Updated from “Performance Periods 2-9” to “Performance Periods 2-13.”</p> <p>Added Table 4 Cohort 2 EOM Measure Phase-in.</p> <p>Added Section 4.6 EOM Quality Measure Abstraction Tool.</p>
1.2	06/06/2025	Updated Appendix A EOM-6 measure name from “EOM-6: Patient-Reported Experience of Care Survey” to “EOM-6: Patient-Reported Experience of Cancer Care Survey.”
1.3	03/11/2026	<p>Revision History: Moved to the end of the document.</p> <p>Introduction: Added footnotes to Breast and Prostate cancer types.</p> <p>Figure 1 EOM Quality Measures Overview: Added “Measure Data” label to second column.</p> <p>Table 1 Quality Measures for Determination of Performance-Based Payment: Removed MIPS and NQF footnotes; for EOM-4a, updated NQF 0384 to CBE 0384; for EOM-4b, updated NQF 0383 to CBE 0383; for EOM-5, removed NQF 0418.</p> <p>Table 2 Cohort 1 EOM Measure Phase-in and Table 3 Cohort 2 EOM Measure Phase-in moved from Section 2 to Section 1.</p> <p>Section 2 EOM HDR Application: Title updated to “Participant-Reported Quality Measure Results.”</p> <p>Added new Section 2.1 HDR Application.</p> <p>Section 2.2 Reporting of EOM Participant Reported Quality Measure Results: Content merged into Section 2.3 Measure-Specific Reporting Requirements.</p> <p>Section 2.3.1 Definitions: Moved to Appendix B Measure Population Definitions.</p> <p>Section 4 EOM Quality Measure Reporting Supporting Documents: Added links to supporting documents throughout section.</p> <p>Section 5 EOM Quality Reporting Model Resources: Removed EOM Help Desk phone number.</p>

Revision #	Revision Date	Description of Change
		Section 6 Acronyms: Added several acronyms to Table 5 Acronyms. Appendix A Table A-1 EOM Measure Description and Population Summary: Updated column header “Denominator Exclusions Summary” to “Denominator Exclusions (Eligible Population Exclusions) Summary;” for EOM-4a, updated NQF 0384 to CBE 0384; for EOM-4b, updated NQF 0383 to CBE 0383; for EOM-5, removed NQF 0418.