ENHANCING ONCOLOGY MODEL

EOM PAYMENT METHODOLOGY WEBINAR

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

Slide 1

Hello, welcome to the Enhancing Oncology Model Payment Methodology Webinar. My name is Lisa Lihs with the Enhancing Oncology Model Technical Assistance Team. I am now going to turn the call over to my Enhancing Oncology Model colleague, Becky Metzger. Becky, the virtual floor is now yours.

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Thank you so much, Lisa. And thank you all for taking the time to attend today and learn more about the EOM Payment Methodology. We appreciate everybody attending today's EOM Payment Methodology webinar, and I'd like to start by introducing our presenters for today. First, we have Batsheva Honig, our EOM Model Lead. Joining us today as well we have Elizabeth Ela, and she is the EOM Payment Lead, and Sam Cox, an EOM Team Member. They'll be leading the presentation regarding the EOM Payment Methodology today.

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Before we dive into the details of the EOM Payment Methodology, I wanted to provide a brief overview of the agenda for today's webinar. First, we'll provide a brief EOM overview and review EOM's key concepts. Next, our presenters are going to walk us through the EOM Payment Methodology and provide some really helpful examples. We'll have time at the end for open question and answers to answer any questions that attendees may have. Finally, we'll provide some additional resources which may be helpful for both current participants as well as Cohort 2 applicants. And with that I'm going to pass the floor to Batsheva, our EOM Model Lead. Batsheva, please go ahead.

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Thanks, Becky, and good afternoon. Thank you for joining us for the EOM Payment Methodology Webinar, as Becky mentioned, my name is Batsheva Honig, and I am the model lead for EOM. I'll start the webinar by doing a quick overview of EOM and going over some key concepts that will be helpful for the conversation today.

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EOM is a voluntary payment and delivery model designed to test innovative payment strategies and promote equitable high-quality evidence-based cancer care to Medicare fee-for-service beneficiaries with certain cancer diagnoses undergoing cancer treatment. The model test began July 1, 2023, with the First Cohort, and we are excited to offer a second application period to begin July 1, 2025. The model will go through June 2030 for both cohorts. The target participants for EOM are oncology, physician, group practices that function under a TIN or Tax Identification Number as well as other payers. This is a multi-payer model.

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Quality is tied to payment in two key ways as part of the model. The first is through a Monthly Enhanced Oncology Services payment, or MEOS. This is a per beneficiary per month payment that EOM participants are eligible to bill for to support and help furnish a number of care transformation, enhanced services, such as care planning, patient navigation, HRSN screening to eligible EOM beneficiaries. We will talk a bit more about this during the MEOS slides coming up soon. The second is the potential to earn a performance-based payment (PBP) or owe a performance-based recoupment (PBR) to CMS based on the total cost of care and performance on a set of quality measures. We also link quality to payment, in that EOM participants owing CMS a performance-based recoupment may have their recoupment amount reduced by performing well on quality measures. We will also go into more details on this in coming slides.

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I'll now go over a few key concepts and terms that we'll use today. EOM has seven included cancer types, including high-risk breast cancer, chronic leukemia, small intestine/colorectal cancer, lung cancer, lymphoma, multiple myeloma, and high-risk prostate cancer. Each episode begins with a beneficiary's receipt of initiating cancer therapy and must include a qualifying E&M or Evaluation and Management service during the six-month period that follows. We will maintain an initiating cancer therapies list and share this. Episodes as just mentioned last for 6 months and begin with the triggering of a cancer therapy claim. Episodes that have a number of inclusions for the episodes, and those are beneficiaries that are treated with CAR T-cell therapy, or by specific antibodies as well as COVID-19 diagnoses.

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The model baseline spans episodes initiating July 1, 2016, to June 30, 2020. The baseline is subdivided into individual baseline periods or BPs, which you will see above.

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This slide is the model performance period that begins with episodes initiating July 1, 2023, to December 31, 2029. As a reminder, episodes are 6 months, and this graphic here shows a breakdown of the episodes initiating dates of each performance period and is a helpful resource.

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As part of participation in EOM two or more participants may form a pool, meaning that they are combining their information for purposes of reconciliation. Pools may be voluntary or mandatory. Mandatory pools occur due to billing overlap in excess of the mandatory pooling threshold. For each performance period pooled members select a single risk arrangement, episodes attributed are reconciled together, and the pool receives a single target amount and may earn a single PBP or owe a single PBR or fall in 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 helpful and something to consider for EOM participants with fewer attributed episodes. More information on pooling arrangements will be outlined in the participation agreement. I will now hand over the slides to Sam Cox to speak more about payment methodology. Sam, the floor is yours.

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Thanks, Batsheva. As Batsheva mentioned. My name is Sam Cox, and I'm a member of the EOM Model Team. And thanks again to everyone who's joining us today, we really appreciate your interest in EOM, and we're happy to be sharing more details about the EOM Payment Methodology with you. We won't be able to cover every technical detail today, but we do hope to leave you with a strong sense of the fundamentals and the EOM Payment Methodology document is also available on the EOM website, which contains further details.

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So, I'll start off here by summarizing the payment strategy at a high level and introducing an example that we'll return to later as we delve into more details. I first want to note that Medicare fee-for-service billing will continue during the model and EOM will include two additional payment incentives. EOM participants will have the option to bill from MEOS payments to support the provision of enhanced services. Beginning in 2025 the base MEOS payment amount will be $110 per beneficiary per month and CMS will pay an additional $30 per dually eligible beneficiary per month. And this $30 is excluded from the total cost of care and reflects the complex needs of the dually eligible patient population. Providing additional resources to EOM participants who are caring for dually eligible beneficiaries is one element of the model's health equity strategy. EOM participants in pools will be responsible for the total cost of care, including drugs, for each attributed episode. Based on their total expenditures and quality performance participants or pools may either earn a performance-based payment, owe a performance-based recoupment, or fall into the neutral zone.

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So, throughout this webinar, we'll be following the experience of a hypothetical EOM participant during a hypothetical performance period. I want to stress that this example does not contain information about any real practice or patient, and that all reconciliation data provided in this example are entirely fictional. So, with that disclaimer, I'll go ahead and introduce you to our hypothetical practice, which we'll call Practice A. Practice A is a hypothetical, multi-specialty physician group practice (PGP) located in Northern California. Practice A is participating in EOM as a single PGP, rather than being part of a pool, and they also participate in Primary Care First, which is another CMS model. And about 12% of Practice A's patients are dually eligible for Medicare and Medicaid. This hypothetical performance period includes episodes that initiate from July 1st through December 31st, and for this performance period 16 EOM episodes are attributed to Practice A, including 10 breast cancer episodes and 6 lung cancer episodes. And in just a minute we'll meet two of the hypothetical EOM beneficiaries that Practice A is caring for during this performance period.

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So, our first hypothetical EOM beneficiary, Cynthia, is 68 years old, and is receiving treatment for breast cancer. Her breast cancer is HER2-negative and was never metastatic during her episode. Cynthia is dually eligible for Medicare and Medicaid and is participating in a clinical trial. David is 74 years old and is receiving treatment for lung cancer. His lung cancer was metastatic at the time of diagnosis. David has hypertension and a history of prior chemotherapy, and he is not dually eligible. David is simultaneously a beneficiary in Primary Care First, which again, is another CMS model. And we'll be coming back to Cynthia and David shortly.

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So, in this next section we'll be providing some more information specifically about MEOS payments.

Slide 16

An EOM participant may bill Medicare for up to six MEOS payments for each EOM episode attributed to them. The permissible dates of service range from 30 days prior to the start of the episode, to 30 days after the end of the episode. And there is flexibility there around the dates of service because we realize it may be challenging to pinpoint the exact start and end dates of an episode in real time. EOM participants can bill for MEOS payments, either in real time or within 12 months following the date of service, and MEOS payments are intended to support the provision of enhanced services. The base amount of each MEOS payment billed for an EOM beneficiary is included in the total cost of care as a Part B expenditure. So, starting in 2025, that's a $110 base amount included in the total cost of care. But the additional $30 included in each MEOS payment, billed for a dually eligible beneficiary, is excluded from the total cost of care. And please also note that EOM participants and their practitioners are prohibited from collecting beneficiary cost sharing from MEOS payments.

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MEOS payments will be prohibited in certain situations which will be detailed in the participation agreement. Some examples of prohibited circumstances include the following: when more than 6 MEOS payments were billed for a single episode, when MEOS was billed with a date of service after the date on which an EOM beneficiary elected hospice or died, the EOM participant failed to make enhanced services accessible to EOM beneficiaries, multiple MEOS payments were made for the same beneficiary with a date of service in the same calendar month, the beneficiary was not in an episode attributed to the EOM participant or in the 30 days before or after such an episode, MEOS was billed with a date of service after the EOM participant terminated from the model or under a legacy TIN, and by legacy TIN here we mean a TIN that an EOM participant previously used to bill Medicare for qualifying E&M services, but no longer uses to bill for these services. And finally, MEOS is prohibited if the EOM participant billed Medicare for restricted Chronic Care Management or care coordination services for an EOM beneficiary with a date of service during the same calendar month as the date of service on a MEOS claim for that beneficiary. And I'll note that this is

not an exhaustive list, and that the participation agreement will contain further details about the prohibited MEOS payments, and any MEOS payments received under prohibited circumstances will be recouped.

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So, after each performance period, CMS will issue a MEOS payment recoupment report to each EOM participant detailing any MEOS payments to be recouped. First participants will receive the preliminary report based on at least one month of claims run-out, after the end of the performance period. Participants will also receive a true-up report, based on 13 months of claims run-out, after the end of their performance period. The preliminary report is not contestable, but EOM participants will have the opportunity to review and contest any suspected errors in the true-up report before the report becomes final and the amounts owed become due. So now that we've covered some of the technical details of the MEOS payments, we're going to take a look at the MEOS payments that our hypothetical EOM participant Practice A billed on behalf of Cynthia and David.

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So, as mentioned, Practice A has the option to bill up to 6 MEOS payments for each of their 16 attributed episodes. For episodes like Cynthia's, that involve a dually eligible beneficiary, the amount of each MEOS payment is $140. For episodes like David's, in which the beneficiary is not dually eligible, the amount of each MEOS payment is $110. Practice A billed 6 MEOS payments for Cynthia's episode, totaling $840, and also billed 6 MEOS payments for David's episode totaling $660, and the figure here on the slide provides some more information about the timing of these MEOS payments. Again, the performance period here includes episodes that initiate between July 1st and December 31st. Cynthia's episode starts in mid-July and ends in mid-January. Possible dates of service for Cynthia's MEOS payments include the period from mid-June until mid-February. This includes the duration of her episode, and 30 days before and after her episode. We see 6 MEOS payments for Cynthia, and each payment has a date of service in a separate calendar month. Practice A can submit claims for these MEOS payments either in real time or up to 12 months following the date of service. David's episode starts in mid-October and ends in mid-April. Possible dates of service for David's MEOS payments include the time period from mid-September to mid-May. Again, this includes the duration of the episode, and the 30 days before and after the episode. Again, we see 6 MEOS payments for David each in a separate calendar month. Note that Practice A did not bill MEOS payment for David in October. October falls within the window in which MEOS payments are allowed, but if Practice A had billed a MEOS payment for David in October they would have had to omit one of the other MEOS payments because only 6 MEOS payments are allowed per episode. And with that we can go to the next slide, and I'll hand the call over to Liz Ela.

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Thanks, Sam. This next section will focus on performance-based payments, performance-based recoupments, and also the reconciliation process.

Slide 21

For each performance period, EOM participants and pools have the potential to earn a performance-based payment (PBP), to owe a performance-based recoupment (PBR) or fall into the neutral zone, and neither earn a PBP nor owe a PBR. EOM participants or pools may earn a PBP if their total expenditures for attributed episodes are below a target amount. Earning a PBP is also contingent on quality performance and some other eligibility criteria. EOM participants or pools will owe a performance-based repayment recoupment if total expenditures for attributed episodes exceed their threshold for recoupment. And finally, EOM participants or pools will fall into the neutral zone if total expenditures for attributed episodes are above or equal to the target amount, but they're below or equal to the threshold for recoupment.

Slide 22

During the reconciliation of each performance period, CMS determines whether each EOM participant or pool has earned a performance-based payment owes a performance-based recoupment or falls into the neutral zone. CMS also calculates PBP and PBR amounts as applicable. The major steps of this reconciliation process are described below. We'll provide details about each step in the subsequent slides. In the upper right-hand corner of the following slides, you'll see a breadcrumb highlighting the stage of reconciliation that each slide relates to.

Slide 23

Episode attribution is based on qualifying cancer-related E&M services. The EOM RFA includes the full set of criteria for E&M services to count towards episode attribution. But in broad strokes a qualifying E&M service means evaluation and management of an EOM beneficiary during their episode, that's billed with CPT Codes that fall within certain ranges, and also with the diagnosis code for an EOM cancer type. Episodes are attributed to the oncology PGP that provides the first qualifying E&M service after the initiating cancer therapy if that PGP also provides at least 25% of all the qualifying E&M services for that beneficiary during their episode. If it turns out that the oncology PGP that provides the first qualifying E&M service does not provide at least 25% of all qualifying E&M services during the episode, then that episode is instead attributed to the oncology PGP that provides the plurality of qualifying E&M services during the episode. An episode may be attributed either to an EOM participant or to a non-EOM oncology PGP.

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Now we'll return to our example. Cynthia's and David's EOM episodes are both attributed to Practice A. For Cynthia, Practice A provided the very first E&M service after her initiating cancer therapy and Practice A also provided 45% of Cynthia's E&M services throughout her entire EOM episode. So, her episode is attributed to Practice A because Practice A provided both her first E&M, and then at least 25% of all qualifying E&M's. David's situation is a little different. His first E&M service was actually provided by a different oncology PGP, but David ended up seeking a second opinion from Practice A and received a majority of his care during the episode from Practice A, including 90% of all of his qualifying E&M services. So even though Practice A did not provide David's first qualifying E&M, David's episode is attributed to Practice A based on plurality.

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After determining the attribution for each episode in a given performance period, CMS will establish a risk-adjusted benchmark price for each episode. We use cancer type specific price prediction models to obtain the predicted expenditures for each episode and from there we apply a series of benchmarking adjustments. The graphic below depicts each step of this calculation. We will cover each of these steps in more detail, and then we're going to work together to calculate the benchmark prices for Cynthia's and David's episodes.

Slide 26

So, we start by determining the predicted expenditures for each episode. CMS uses cancer type, specific price prediction models, that are developed from the baseline period episodes for each included cancer type. I do want to flag that this is a little different from our predecessor model OCM, which used a single price prediction model for all cancer types. Cancer type-specific models in EOM capture, the specific relationship between model covariates and episode expenditures for each included cancer type. They also allow for differences in the covariate list between the different cancer types. These are refinements that should improve the precision of EOM benchmarks. The covariates in the price prediction models include traits of both the beneficiary and their episode that tend to vary systematically among practitioners, are likely to affect the cost of oncology care, and are generally beyond a practitioner's control. Examples include beneficiary sex and age, dual eligibility, Part D enrollment, and low-income subsidy. Certain non-cancer, comorbid conditions, the receipt, some cancer-directed treatments such as surgeries, bone marrow transplants or radiation therapy during the episode, or participation in a clinical trial. I'll note the list on this slide is not exhaustive. As I mentioned, the covariates may differ by cancer type and are also subject to change. Additional details about the covariates are provided in the EOM Payment Methodology document and will also be provided in the participation agreement.

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So, returning to our example. Cynthia is being treated for breast cancer. So, CMS will use the price prediction model that is specific to breast cancer, to establish the predicted expenditures for her episode. These predicted expenditures will reflect her age, her dual eligibility for Medicare and Medicaid, her clinical trial participation, and some other characteristics of her episode. The predicted expenditures for this hypothetical episode are $79,183. David is being treated for lung cancer, so, CMS will use the price prediction model for lung cancer to establish his predicted expenditures. His prediction will reflect factors such as his age, his hypertension, and his history of prior chemotherapy. His predicted expenditures are $49,143. So, having determined the predicted expenditures for these episodes, we'll now start to apply a series of benchmarking adjustments.

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The predicted expenditures for each episode are multiplied by an experience adjuster. The experience adjuster is specific to each EOM participant. Because those price prediction models we just saw are identical for all participants, are based on a national set of baseline episodes, and capture national spending patterns, the experience adjuster accounts for regional and participant-

specific variation. The EOM participants with higher episode volume at baseline will have an experienced adjuster that gives more weight to their own historical patterns versus their regional patterns. But EOM participants with lower episode volume during the baseline period will have an experienced adjuster that gives more weight to their regional spending patterns. For all participants, the cancer types are weighted according to the specific participants baseline case mix with their most common cancer types, carrying the most weight in their own experience adjuster. This is a pretty high-level discussion of the experience adjuster and it's quite a technical topic, and I want to let you know that there are more technical details available about the calculation of the experience adjuster in the EOM Payment Methodology document. And I also want to call your attention to the EOM experience adjuster fact sheet. Both of these documents are available now on the EOM website. So, returning to our example, Practice A's experience adjuster is 0.983. Since Cynthia's and David's episodes are both attributed to Practice A. The predicted expenditures for both of their episodes are multiplied by Practice A's experience adjuster.

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For certain cancer types only, the predicted expenditures are multiplied by clinical risk adjusters. We adjust for ever-metastatic status for breast cancer, lung cancer, and small intestine/colorectal cancer. Ever metastatic, for the purposes of EOM, means metastatic disease either at the time of diagnosis or at some point during the EOM episode. Breast cancer episodes are also adjusted for human epidermal growth factor receptor 2 status (HER2).

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Cynthia and David are both being treated for cancer types that have applicable clinical adjusters. So, their predicted expenditures will be multiplied by the clinical adjuster that's applicable to their cancer type and their disease state. For Cynthia, breast cancer episodes are adjusted for ever-metastatic status, and for HER2 status. The clinical adjuster for a non-metastatic HER2-negative breast cancer episode like Cynthia's is 0.86. For David, we'll look at the lung cancer adjuster. Lung cancer episodes are adjusted for ever-metastatic status. The adjuster for an ever-metastatic lung cancer episode like David's is 1.06.

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The predicted expenditures for every episode are multiplied by a cancer-type specific trend factor. Trend factors account for systematic changes in a cost of oncology care between the end of the model baseline period and the specific performance period that's being benchmarked. We apply trend factors to avoid holding participants responsible for expenditure growth that would have occurred anyway during the same time period, even in the absence of the model. This may include changes in drug costs, changes in the standard of care for a particular cancer type, inflation, or other factors. Because the EOM benchmarks are trended, it's possible to achieve savings relative to the benchmark by slowing down the rate of expenditure growth even if the absolute expenditures for oncology care are increasing over time. The trend factors are based on the change in the average expenditures among episodes of a given cancer type attributed to non-EOM oncology PGPs, and that's very important so I'm going to repeat it. The trend factors are based on episodes that are attributed to non-EOM oncology PGPs. And that's to avoid disadvantaging EOM participants based on savings achieved in earlier performance periods. So, if EOM participants collectively reduce costs

over time, this will not hold down the trend factor in later performance periods. So, let's take a look at Cynthia and her breast cancer episode. In this hypothetical situation the trend factor for breast cancer in this performance period is 1.14. A trend factor of 1.14 means that breast cancer episodes attributed to non-EOM oncology PGPs are 14% more costly in this hypothetical performance period than they were at the time of the baseline period. As such, the trend factor will increase the benchmark price for every breast cancer episode in this performance period by 14%. For David, David's episode will get the trend factor for lung cancer. The trend factor for lung cancer in this hypothetical is 1.09.

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EOM participants in pools can receive a novel therapy adjustment for their attributed episodes of a specific cancer type if their expenditures for that cancer type include an above average share of expenditures for newly FDA approved oncology drugs. Newly approved drugs may be significantly more expensive than older therapies. Over time those trend factors we just looked at are going to account for the introduction of new therapies and their impact on spending. However, some EOM participants may adopt new treatment approaches more rapidly than their non-EOM peers, whose episodes inform the trend factor, so it may be helpful to think of the novel therapy adjustment as an enhancement to the trend factor for early adopters. For each included cancer type in each performance period, CMS will compare an EOM participant's or pool's share of expenditures from new drugs to the average share among all episodes of that cancer type attributed to non-EOM oncology PGPs in that performance period. Novel therapy adjustments are cancer type specific, so in a given performance period, a participant or pool may qualify for a novel therapy adjustment for certain cancer types and not for others. I want to stress that a novel therapy adjustment can only ever result in a higher benchmark price for the episode. It will never lower a benchmark price. More technical details about the calculation of novel therapy adjustments are provided in the EOM Payment Methodology document.

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So, we saw earlier that Practice A's attributed episodes for this performance period include 10 breast cancer episodes and 6 lung cancer episodes. During reconciliation, CMS looks at each cancer type separately to determine whether Practice A qualifies for a novel therapy adjustment for that cancer type. So, let's start with breast cancer. CMS will look at all of the breast cancer episodes attributed to Practice A and calculate the share of expenditures from new oncology drugs for breast cancer. CMS will also look at all the breast cancer episodes attributed to non-EOM oncology PGPs in the same performance period and calculate the share of those expenditures that come from new oncology drugs for breast cancer. After comparing those two percentages, CMS determines that Practice A had a higher share of expenditures from new drugs in their breast cancer episodes than the non-EOM oncology PGPs did. As a result, Practice A will qualify for a novel therapy adjustment for breast cancer episodes. In this case the adjustment is 1.05. Now, CMS will look at the lung cancer episodes attributed to Practice A. In these episodes Practice A actually had a below average share of expenditures from new oncology drugs for lung cancer. That means that Practice A does not receive a novel therapy adjustment for lung cancer for this performance period, at least. We've now covered all the steps needed to calculate the benchmark price for each episode. On the next slide. We'll put all these pieces together, and we'll find the benchmark prices for Cynthia's episode and then for David's episode.

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Let's start on the left with Cynthia. Hopefully, these numbers look familiar, we're going to start with Cynthia's predicted expenditures which again came from that that cancer type-specific price prediction model for breast cancer and gave us a prediction of $79,183. We'll multiply that set of predicted expenditures by each of the benchmarking adjustments, including Participant A's experience adjuster, which was 0.983. We'll multiply by the clinical adjuster for a non-metastatic, HER2-negative breast cancer episode, which is point 0.86. We'll multiply by the trend factor for breast cancer, which was 1.14. And finally, we'll multiply by Participant A's novel therapy adjustment for breast cancer, which is 1.05. This results in a final benchmark price of $80,127 for Cynthia's episode. Now let's take a look at David. David's predicted expenditures were $43,269. To get his benchmark price, we need to multiply those predicted expenditures by Participant A's experience adjuster, which was 0.983, we'll multiply by the clinical adjuster for an ever-metastatic lung cancer episode, which is 1.06, and finally, we'll multiply it by the trend factor for lung cancer, which was 1.09. If you recall Participant A did not qualify for a novel therapy adjustment for lung cancer for this performance period. So now we can go ahead and multiply those numbers, get the benchmark price for David, which turns out to be $49,143.

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After determining the benchmark price for each episode, CMS determines the benchmark amount for each participant and pool for that performance period. For an EOM participant who is not in a pool, the benchmark amount is the sum of the benchmark prices for all the episodes attributed to that EOM participant in a given performance period. For a pool, the benchmark amount is the sum of the benchmark prices for each episode attributed to all of the EOM participants who are members of that pool in that performance period. So, remember, a pool gets a single benchmark amount.

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Next, we'll calculate the target amount. This is the amount that you're aiming for in order to earn a performance-based payment if your expenditures are below this amount. The target amount for an EOM participant or pool is their benchmark amount less the EOM discount. That means that the exact target amount actually depends in part on the selected risk arrangement. In Risk Arrangement 1 (RISK ARRANGEMENT 1), which is the default, the target amount is 96% of the benchmark amount. In Risk Arrangement 2 (RISK ARRANGEMENT 2), the target amount is 97% of the benchmark amount. The figures below show the placement of the target amount and other financial parameters for both risk arrangements as percentages of the benchmark amount. And I know we may have some folks on the call today from both the original EOM Cohort, and also folks who are considering applying as part of the second EOM Cohort, so I do want to note that the threshold for recoupment that's indicated on this slide, which is 100% of the benchmark amount, applies beginning in Performance Period 4, which actually starts on January 1, 2025. So that's a flag for this for the First Cohort folks who might be with us today. For the Second Cohort, the 100% benchmark amount will be in effect, as the threshold for recoupment, when you join the model next July.

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All right, we're going to return to Practice A. so Practice A's benchmark amount for this performance period is the sum of the benchmark prices for all 16 episodes that were attributed to them in this performance period, so that includes Cynthia and David's episodes, it also includes the other 14 episodes that we didn't look at quite so closely. So, in the end, Practice A's benchmark amount for this performance period is $1,000,000. Practice A has selected Risk Arrangement 1 for this performance period, in Risk Arrangement 1, the target amount is 96% of the benchmark amount, or $960,000.

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EOM participants are accountable for the total cost of care for each episode attributed to them. EOM participants in a pool are jointly accountable for the total cost of care for all of the episodes that are attributed to participants who are in that pool. The episode expenditures will include nearly all Medicare expenditures for items and services that are provided to the EOM beneficiary during their episode by any Medicare providers or suppliers. This includes all Medicare Part A and Part B fee-for-service expenditures that are not specifically excluded. It includes certain Part D expenditures that are claims based and beneficiary specific. It includes certain payments from overlapping participation and other CMS models and initiatives, and it includes the base amount of each MEOS payment that's billed for the episode. The episode expenditures exclude certain MS-DRGs, any Part D expenditures that are not specifically included, any OCM specific payments and recoupments, the additional $30 that's included in each MEOS, payment for a dually eligible beneficiary, and some payments from overlapping participation in other CMS models and initiatives that are not directly based on expenditures, so, for instance, certain payments that are based on quality.

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During an episode, a beneficiary may receive drugs that were purchased at a discounted price through the 340B drug pricing program. When calculating the episode expenditures and benchmark prices CMS uses the standardized payment amounts that remove the impact of 340B pricing. That is, the standardized payment amounts reflect what the non 340B payment would have been. As a result, 340B participation, past or current, is neither an advantage nor a disadvantage with respect to EOM benchmarking or financial performance.

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When determining the actual expenditures, CMS will make certain adjustments to account for overlap between EOM and other CMS programs and initiatives. For instance, EOM participants may be simultaneously participating in additional CMS models or EOM beneficiaries may be aligned to some other CMS model or initiative, even if the EOM participant themselves is not. We make adjustments that ensure that expenditures reflect the amounts that would have been paid by Medicare in the absence of these other CMS initiatives, and that payments or recoupments are not double counted.

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CMS will sum the included expenditures for each performance period episode. These episode expenditures reflect certain adjustments, such as the overlap adjustments and also a Winsorization adjustment to limit the influence of outliers. The actual expenditures for a performance period, for a participant who is not in a pool, are the sum of the included expenditures for all episodes attributed to that participant. For a pool, the actual expenditures are the sum of the included expenditures for all episodes attributed to all of the EOM participants who are members of that pool.

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The episode expenditures for Cynthia's episode include the base amount of 6 MEOS payments. They exclude, however, the additional $30 per beneficiary per month that are added to MEOS payments when a beneficiary is dually eligible. David's episode expenditures also include 6 MEOS payments. They include care that David received for his hypertension from a different Medicare provider, and they reflect certain adjustments for overlap between Primary Care First and the Enhancing Oncology Model. Practice A's actual expenditures for this performance period are the sum of the included expenditures for all 16 attributed episodes.

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For each performance period CMS will compare each EOM participant's or pool's total expenditures to their target amount and to the threshold for recoupment to determine whether they earn a PBP, owe a PBR, or fall into the neutral zone. As a reminder a participant or pool may earn a PBP if their actual expenditures are below their target amount. They'll owe a PBR if their actual expenditures are above the threshold for recoupment. If your PGP joins the EOM as part of the Second Cohort, starting in July 2025, your threshold for recoupment will be 100% of your benchmark amount in both risk arrangements, which is what is shown on this slide in these figures. Again, for participants in the original cohort, the threshold for recoupment was 98% of the benchmark amount for the first 3 performance periods, but it will increase to 100% of the benchmark amount, starting with Performance Period 4, which begins next January. If the actual expenditures fall in between the target amount and the threshold for recoupment, the participant or pool will fall into the neutral zone. And again, the neutral zone means that they neither earn a performance-based payment nor owe a performance-based recoupment.

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EOM participants or pools whose actual expenditures are below their target amount, must also meet some additional criteria in order to receive their performance-based payment. Some of these criteria include quality performance above the minimum performance threshold, submission of required data elements, and implementation of participant redesign activities. These criteria will be detailed in the participation agreement.

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If an EOM participant or pool has earned a performance-based payment, CMS will calculate their savings relative to their target amount as the first step of calculating the PBP amount. The PBP amount is based on the smaller of two amounts, it's either the savings relative to the target amount or the stop-gain under the selected risk arrangement. This amount is multiplied by the PBP performance multiplier, which is based on quality performance, and also by a geographic adjustment and a sequestration adjustment, to obtain the final PBP amount. We'll be covering the EOM quality strategy in our webinar on August 15th. So, for now I'll just note that participants and pools can maximize their potential PBP amount if they achieve high quality scores.

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If an EOM participant or pool owes a performance-based recoupment, CMS starts by calculating the portion of their expenditures that's above the threshold for recoupment. The PBR amount is based on the smaller of two amounts. It's either based on the portion of expenditures that exceed the threshold for recoupment, or the stop-loss under the selected risk arrangement. This amount is multiplied by the PBR performance multiplier which is also based on quality, a geographic adjustment, and a sequestration adjustment. Regarding the PBR performance multiplier, I'll add that participants or pools that owe a performance-based recoupment can potentially have the amount of the PBR they owe reduced through a high-quality performance. I also want to emphasize that the stop-loss limits the size of any potential PBRs, so any further expenditures above the stop-loss will not continue increasing the amount that's owed to CMS.

Slide 47

So, practice A's benchmark amount in this hypothetical performance period was $1,000,000. We're going to take a look at their reconciliation results under three different expenditure scenarios. The details on this slide actually apply to all three scenarios that follow. Their target amount, which is 96% of their benchmark amount, was $960,000. Their threshold for recoupment is equal to 100% of their benchmark, so it's also $1,000,000. The neutral zone is that corridor in between the target amount and the threshold for recoupment. So anywhere between $960,000 and $1,000,000. The stop-gain is $40,000, and the stop-loss is $20,000. Here are a few additional details that may become important in some of the scenarios that follow. Practice A's quality performance for this performance period results in a PBP performance multiplier of 0.75 or a PBR performance multiplier of 0.95. Practice A met all other eligibility criteria to earn a performance-based payment such as submission of required data elements, and some of those other criteria I mentioned before. Based on their location, Practice A's geographic adjustment is 1.03, and I'll note that sequestration has been in effect throughout this performance period.

Slide 48

In Scenario 1, the actual expenditures for Practice A's attributed episodes were $925,000. This is less than their target amount of $960,000, and as we saw on the last slide, Practice A met all the other PBP eligibility criteria. That means that Practice A in this is going to receive a performance-based payment. So now we need to figure out what their savings actually were below the target

amount. And that those savings were $35,000. These savings are less than the stop-gain, which was $40,000 so that means their performance-based payment amount will be based on their actual savings. We multiply those savings of $35,000 by the PBP performance multiplier of 0.75, we multiply by the geographic adjustment of 1.03, and finally, by the sequestration adjustment of 0.98, and this results in a final performance-based payment amount of $26,497.

Slide 49

In Scenario 2, the actual expenditures for all of the attributed episodes totaled $1,050,000. These expenditures are above the threshold for recoupment, which is $1,000,000, and that means that Practice A in this scenario is going to owe a performance-based recoupment. So now we need to calculate the portion of those expenditures that are actually above the threshold for recoupment, which is $50,000. Now this amount does exceed that stop-loss of $20,000, and that means that the performance-based recoupment amount will be based only on the $20,000, which is the stop-loss and not on the entire $50,000. So, to calculate the final PBR amount, we'll start from the stop-loss of $20,000. We'll multiply by the PBR performance multiplier of 0.95, we multiply it by the geographic adjustment of 1.03, and finally, the sequestration adjustment. And this results in a final PBR amount of $19,179.

Slide 50

Finally, in Scenario 3, the actual expenditures for all of those episodes attributed to Practice A, totaled $975,000. These expenditures are above the target amount, but they are below the threshold for recoupment. So, in this scenario, Practice, A is going to fall into the neutral zone. They're not going to receive a performance-based payment for this performance period, but they're not going to owe a performance-based recoupment either.

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Throughout this example, we've really focused on Risk Arrangement 1, which is the default risk arrangement. We wanted to take a minute though, to think about how these same scenarios would have played out instead, if Practice A had actually selected Risk Arrangement 2. So, Practice A's benchmark amount for this performance period would still be $1,000,000. The risk arrangement has no bearing on the calculation of the benchmark itself, it does result in a slightly higher target amount though so, the target amount under Risk Arrangement 2 is 97% of the benchmark. So, their target amount is going to be $970,000. The threshold for recoupment doesn't change, is 100% of the benchmark under both risk arrangements. The stop-gain is now going to be $120,000, and the stop-loss is now going to be $60,000. So, under Risk Arrangement 2, Practice A has the potential to earn a larger performance-based payment amount. But they also have the potential to owe a larger performance-based recoupment amount. Now let's have a look at those same scenarios again. In Scenario 1, the expenditures were $925,000. Just like before, Practice A is going to earn a performance-based payment for this performance period and their payments going to be a little larger, and that's because with the higher target amount, they've achieved slightly higher savings. In Scenario 2, where our expenditures were $1,050,000. Again, we're going to see the same outcome of the reconciliation, the expenditures are above the threshold for recoupment. But the performance-based recoupment amount is going to be higher, and that's because in Risk Arrangement 2 the stop-

loss is higher. Finally, in Scenario 3, the expenditures were $975,000. This still falls in that corridor in between the target amount and the threshold for recoupment. So once again, under Risk Arrangement 2 Practice A would have fallen into the neutral zone.

Slide 52

We've now been through the entire reconciliation process. Each performance period will be reconciled twice. EOM Participants in pools will receive a reconciliation report, and then a true-up reconciliation report for each performance period. The initial reconciliation report will be based on at least one month of claims run-out after the end of the performance period. The true-up reconciliation will be based on 13 months of claims run-out after the end of the performance period. EOM participants will have the opportunity to review and contest any suspected errors in both the initial and the true-up reconciliation reports before they become final, and before any amounts owed become due. With that I'm going to pass the mic over to Alex, who will kick off the Q&A session.

Slide 53

Great. Thank you, guys, so much to Liz, Sam and Batsheva for that really helpful overview of the model. And I hope those example cases as well were especially helpful to our audience. I'm going to go ahead and help with the Q&A portion of this webinar now, and our first question, which came from multiple submissions as well, is related to the historical data. So specifically, the question here is, when will the historical data be available, and also what dates will the historical period cover, and will these data include actual costs or predicted costs? So, for that, I'm going to turn it over to Batsheva.

Slide 54

Batsheva Honig: Thanks, Alex, and thanks for this question. So, the EOM baseline period data is already available on the EOM website. And these are de-identified public use files that include all baseline period episodes nationwide that were initiating July 1, 2016, to June 30, 2020. And these are the episodes that inform the price prediction models and other elements of the benchmarking methodology, such as the trend factor. Please note, though, that the EOM technical payment resources also available on the website, include documentation relevant to these data files, such as the list of initiating therapies applicable to the model baseline period. Later this fall CMS will be offering an applicant HIPAA covered data disclosure requirement, or request, or DRA form, to provisionally accepted applicants to the Second EOM Cohort, by signing the applicant DRA in late fall of 2024, the Second Cohort of applicants will have the opportunity to receive participant-specific historical data prior to the signing and executing of the participation agreement in the spring of 2025. We have tentative plans to share participant specific beneficiary, identifiable historical data with provisionally accepted Second Cohort applicants towards the end of 2024, and these historical data will include episode level data and claims for attributed historical episodes initiating January 2020, through December 2022. The baseline period data and the historical period data will both include actual expenditures, and they also include the price prediction model covariates, so it is possible to use these data to calculate the predicted expenditures for each episode. To do this you'd have to also need to refer to the price prediction, model coefficients which are included in the EOM technical payment resources file. That is also already available on the EOM website. Thanks, Alex.

Alex Chong: Great. Yes, thanks, so much. Batsheva. I actually just want to add on to that a little bit because again, we received this question through multiple users, and one or one participant, or one listener had asked again, so will CMS be providing the practice specific baseline detail prior to the final decision date. And so hopefully, for this participant who is listening, we just provided that response and to reiterate it again, yes, we are going to be providing practice specific historical episode data and that data we plan on hopefully, tentatively sharing at the end of this calendar year. This listener also had some additional question here, which is, how will that baseline detail be adjusted for the DME billing fraud? For that we just wanted to acknowledge that we are definitely aware of the DME, or capital fraud billing issue and it is something that we are actively monitoring. Okay, I want to go back up to the top. Okay, great looks like we also had a little bit more of live questions related to the MEOS billing, and whether or not that MEOS billing is included in the expenditures or not, or in this particular case, just for a little bit more clarification. But, Sam, I'm going to turn this one to you. Someone had asked, did I understand correctly that MEOS will be excluded from total targeted price, if you could help clarify that one.

Sam Cox: Thanks, Alex. So, the base MEOS payment amount for attributed EOM episodes, that is included in the total cost of care calculation, but the additional $30 for beneficiaries who are dually eligible for Medicare and Medicaid, is not included in the total cost of care calculation. And just as a reminder for what the base MEOS amount is, the base payment amount will be $110 starting in January 2025, and for MEOS payments that are billed with a date of service prior to January 1, 2025 they'll have a base amount of $70 and this only applies to EOM participants from the First Cohort as the Second Cohort participants will begin their participation after the increased MEOS amount has gone into effect.

Alex Chong: Excellent. Thank you so much, Sam, for clarifying that both in terms of the base MEOS amount as well as the MEOS amount for the dually eligible. And again, how that applies for the different cohorts. This next question is on comorbidities, Liz, if I could turn this one to you, this question asks, are the comorbidities based on what is coded during the episode or is it from the prior calendar year to when the episode started, such as it sounds like the approach or methodology that we used in the Oncology Care Model, or in OCM.

Liz Ela: Yes. So, the comorbidities are based on diagnoses that were coded during the previous calendar year. So, it's the similar approach to how we did the risk adjustment in the Oncology Care Model.

Alex Chong: Great. Thank you for that clarification. There is another one here. That asked, could you please update or provide more information if the baseline period for the PBP, the PBR, and neutral zone are the same or different? And, Liz, could you help us answer this one too?

Liz Ela: Sure. So, the target amount, the stop-loss, the stop-gain all of these different parameters of the risk arrangement are all calculated as percentages of that benchmark amount that we looked at. So again, that benchmark amount is the sum of all of the benchmark prices for the episodes that are attributed to you. The benchmark amount itself is calculated, as we saw, it's based on the model baseline period that informs those price prediction models, and then all those benchmarking adjustments that we use to adjust the predicted expenditures to get the benchmark prices. So, we calculate the benchmark prices for every episode. We total them up to get the benchmark amount, and then that benchmark amount is the number that we proceed from in order to calculate the target amount, which is going to be either 96% or 97% of the benchmark amount and that benchmark

amount is also how we calculate things like the stop-gain, the stop-loss the threshold for recoupment. I realize we threw a lot of numbers at you, so I do want to flag that these slides are going to be available after the presentation. There's also in the EOM Payment Methodology document, which is already on the EOM website, you'll see a version of that same figure that we looked at during the slides earlier. That shows where all those different financial parameters for the two risk arrangements are placed as a percentage of that benchmark amount. And of course, you're always welcome to send follow-up questions about this to the help desk once you've had a chance to digest everything we've thrown at you this afternoon.

Alex Chong: Great. And thanks again, Liz, for that reference to all of our materials. We also have a question here in terms of what the maximum amount is that a participant can lose. And I mean, this is in reference to our down-sided risk arrangement. So, something to just keep in mind here is along these risk arrangements, we have parameters with the stop-loss, which is the again referencing the amount that a practice may have to owe CMS, or the maximum amount as well as a stop-gain, which is the maximum performance-based payment that a practice may potentially earn through their PBP. But the stop-loss is actually a percentage of the benchmark amount. So, under EOM, our current stop-loss is 2% of the benchmark amount under Risk Arrangement 1 and 6% of the benchmark amount under Risk Arrangement 2. I think it might be helpful for the audience to also hear just a little bit more insight, as well on some continued questions that we have received to get around 340B. So, Liz, I'm going to turn to you on this one, which is, can you tell us just a little bit about how the historical total cost of care will be calculated for 340B institutions.

Liz Ela: Sure. And this is a bit of a frequent flyer question, so happy to have a chance to address it with so many folks on the line. So, when calculating episode expenditures both for baseline period episodes and also for performance period episodes, CMS uses standardized claims, and these standardized claim payment amounts remove the impact of 340B pricing which means that instead, they reflect the amount that would have been paid on that claim in the absence of 340B. So, what that means in effect, is that the impact of 340B pricing is just completely wiped away from all EOM payment calculations, and that includes the price prediction models, the experience adjusters, the actual expenditures in performance period episodes, as well as elements of the methodology based on the baseline or performance period episodes such as trend factors. So, what this all means for you is that past or current 340B participation or non-participation is neither an advantage nor a disadvantage in EOM.

Alex Chong: Thanks for reiterating some of that information as well, Liz. So, we actually also got a question related to the quality adjuster. So Batsheva, flagging that, I'm going to direct this question to you. How is the quality adjuster determined? So, for instance, it like it looks like it'd be examples when we use the 0.75 in the 0.95.

Batsheva Honig: Yes, thanks for that question. So that's based on performance on EOM quality measures, and we have more details described in the Payment Methodology document specifically in Section 7. I also just want to put a quick plug in, for we'll also have a quality webinar August 15th, we'll be going into more detail on the quality measures there, as well.

Alex Chong: Okay, thanks for that reference. Batsheva. Let me see, just looking through here. Okay, here we go. So, someone had wanted to just confirm that if a patient is diagnosed with Covid during an episode, then that episode becomes invalid, and the MEOS that were billed will need to be recouped for that patient during that episode. Is that correct, Liz?

Liz Ela: Yes, that's correct. If there's a COVID-19 diagnosis code on any claim that appears during the episode within those episode dates, then that episode is no longer valid. And when an episode turns out to not be valid, then any MEOS payments that were billed for that episode are going to eventually be recouped and as you mentioned before, you'll receive a MEOS recoupment report that's going to detail the payments, if any, that are going to be recouped and the reason. So, if that's the reason that MEOS is being recouped, you'll have that documented in your report.

Alex Chong: Okay. And I think, continuing on for some questions around the MEOS. Sam, I'm going to direct this question to you because someone had asked would it be allowed to not bill for MEOS for just non-dually eligible patients?

Sam Cox: Yes. Thanks, Alex. Yes, that would be allowed. The purpose of the MEOS payments are to support practices in the provision of enhanced services. And so, we leave that to practice's discretion on if they'd like to bill for MEOS or not, because that that does count towards the total episode expenditures. So, it is practice's choice if they choose to bill for MEOS or not bill for MEOS.

Alex Chong: Yes, that is absolutely correct. So, thank you for verifying that. Sam. Okay, want to continue on here. Let's see. Okay Liz let's talk a little bit more about accounting for the price of drugs. If that's okay, can you talk to us a little bit about how EOM accounts for the increasing price of drugs?

Liz Ela: Sure. So EOM has really two major mechanisms for accounting for the increasing price of drugs. One of these is the trend factor, and one of these is the novel therapy adjustment. So, I'm going to start with the trend factor. The trend factor automatically raises the benchmark prices for each cancer type at whatever the pace is that episode expenditures are increasing for that cancer type outside of the model. So, among episodes with the same cancer type that are attributed to non-EOM oncology PGPs. So, let's say, we're reconciling Performance Period 5. We determined that in Performance Period 5, the lung cancer episodes attributed to non-EOM oncology PGPs are 15% more costly than they were in the baseline period. Then in Performance Period 5, every benchmark price for a lung cancer episode is going to be increased by 15%. So, this trend factor adjusts for price changes for existing drugs. It adjusts for the impact of the adoption of new drugs as the standard of care for a particular cancer type and any other broad changes that are occurring across the oncology field as a whole for that particular cancer type. Now, I want to say a little more about new drugs, which is a really important topic when we're talking about oncology care. So, the trend factor on its own will adjust for the impact of a new drug on episode expenditures when usage of that new drug by an EOM participant is pretty similar or below the usage level among non-EOM oncology PGPs, because, again, those trend factors are based on the non-EOM oncology PGPs, episodes. However, during the period immediately after a new drug receives FDA approval and is entering the market. It's very possible that some EOM participants are going to outpace their non-EOM peers in the adoption of that drug. The way we see it, the decision to participate in a model like EOM is already a pretty strong indicator that a PGP sort of tends to be an early adopter of new and innovative treatment approaches. So, this brings me to the novel therapy adjustment, which is our second mechanism for responding to changes in in drug costs. So, the novel therapy adjustment is a cancer type specific adjustment that specifically responds to the costs from newly FDA approved drugs. And it's going to pick up where the trend factor for that particular cancer type left off. So, in any given performance period, the novel therapy adjustment eligibility for a particular cancer type, is going to start as soon as an EOM participant or pools share of expenditures from new drugs starts to exceed the share of new drug spending among non-EOM oncology PGPs. So, it's just going to pick

right up where once the trend factor has made the adjustment that the trend factor can. And I do want to say about the novel therapy adjustment, CMS actually maintains a list of the novel therapies that count as new drugs for the purpose of calculating novel therapy adjustments and drugs are potentially eligible for inclusion in that novel therapies list, if they have an indication for an EOM cancer type that received FDA approval within the past two years, and that can potentially include drugs that have already existed on the market previously but have a new FDA indication for an EOM cancer type. And the most recent version of the novel therapies list is always posted on the EOM website, and it's updated fairly, frequently to catch new approvals as they hit the market. So, if you have questions about this, I'd encourage you to take a look on the EOM website. And you'll see the most recent novel therapies list there.

Alex Chong: Excellent. Thank you so much for that in-depth explanation, Liz. I do want to shift gears just a little bit, because I know several of you submitted some questions during the registration. Some of these questions are a little bit more geared towards just overall model policy, as opposed to specific questions related to the Payment Methodology. We're still going to go ahead and answer them here now, because we think that'll be beneficial to everyone. This first one is, I'm going to direct this one to you, Batsheva. Someone had asked, given the downsided risk arrangement for providers, are there any escrow or cash reserve requirements to participate in EOM?

Batsheva Honig: This one's a pretty straightforward one. We do not have any requirements here.

Alex Chong: Great. Thank you so much. Let me look, continue to look through here on some of the registration questions that we received. Okay. So, this one is a little bit lengthier as well. And but again, I think just kind of speaks to a little bit about the general theme of the questions that we have been getting from users. But this specific question asked, and, Liz, I'm going to turn this one to you, but maybe you could talk just a little bit again about the information that we share ahead of the calculations as well as what's going to be available in the reconciliations itself. But in the registration, somebody had asked how practices can calculate potential downside or risk costs. Can you break that down just a little bit more for the audience?

Liz Ela: Sure. So, the first thing I want to say about this is that both EOM risk arrangements include a stop-loss, and that stop-loss is going to limit the maximum amount of any performance-based recoupment. So, the placement of that stop-loss depends on your risk arrangement, as we saw before Risk Arrangement 2 is a little more high-risk high reward compared to Risk Arrangement 1, and you have the option to choose either one and to move between them. So, the stop-loss is set at 2% of the benchmark amount in Risk Arrangement 1, and it's set at 6% of the benchmark amount in Risk Arrangement 2. And then, in the event that a practice owes a performance-based recoupment those amounts are based on that total the portion of those expenditures that exceed the threshold for recoupment, which is 100% of the benchmark. So, you know we start by figuring out how much of the expenditures were above the benchmark. But again, with the stop-loss, if that portion of expenditures is higher than the stop-loss then that performance-based recoupment amount is calculated, based on the stop-loss only. So, what that means is that additional expenditures beyond the stop-loss amount do not further increase the amount of the PBR that's owed, and that benchmark amount itself is calculated retrospectively after the conclusion of the performance period during as part of the reconciliation process. So provisionally accepted applicants to the Second Cohort, are going to have an opportunity later this year, as Batsheva mentioned, to request identifiable episode level and claims level data for their attributed historical episodes. Certain

elements of the benchmark calculation are not available for historical episodes due to data limitations. So, for instance, the clinical adjusters are based on clinical data that are reported by you by the participants. And that means that when we're looking at historical episodes using historical claims, we don't have the clinical data needed to calculate the clinical adjusters if data aren't available to us. There are still things that are useful that you can learn from this historical data, though you can use those data to learn about your recent case volume, your recent case mix among the Medicare beneficiaries that have been in treatment for the EOM cancer types, and it will also be possible to use these data to calculate the predicted expenditures for recent historical episodes, because those historical data will include all of the prediction model covariates. So that will give you a sense of the predicted expenditures, and about how many episodes you can expect at least, based on the most recent data that we have available. And that will help you start to get a picture of what your EOM participation might look like.

Alex Chong: Great. Thank you for that, Liz. We also have another question here, just asking if there's any way to know how current participants have done in Cohort 1, so just want to flag as we've mentioned before, that at this time CMS has not completed the reconciliation for Performance Period 1. That is one of the ways that we assess performance, the final episodes as a reminder for Performance Period 1, they just recently concluded on June 30th of 2024, and we anticipate delivering the initial reconciliation results for that first performance period in the model, with the First Cohort to those participants in early 2025. Okay looks like we probably just have enough time here for one or two questions. I do want to go back to some of the registration questions again, this one is a little bit more specific to just model requirements in in general. But Batsheva, can I ask you a question about the practitioner lists? Someone had asked, can PGPs modify their EOM practitioner list after application submission, and can you modify the list before performance period?

Batsheva Honig: Thanks, Alex. So yes, participants will be able to modify their practitioner list during the model. You can remove NPIs from your practitioner list at any time, and you can only add NPIs to your practitioner list during specified open submission windows which will take place before each performance period, so there will be opportunities before the model starts to do that.

Alex Chong: Okay, excellent. Want to just, I think, address one final question here before we close out. And I think this is a good one as I think we've been speaking with different types of practices. Sam, I'm going to direct a question to you just about multi-specialty practices and their TINs, and especially with attribution, I think this is especially important both for MEOS but also for episode costs of course. If a PGP is a multi-specialty TIN, are we only looking at visits to medical oncologists when determining attribution? Can you talk a little bit about that, Sam?

Sam Cox: Yes, thanks, Alex. So, the answer is, no. When we look at qualifying E&M services to determine attribution, we do so at the TIN level rather than looking at any specific providers. So, E&M visits with non-oncologists could still potentially count. Also important to note that qualifying E&M visits must be billed with a diagnosis code for an EOM cancer type.

Alex Chong: Great. Thank you so much, Sam. I think this then concludes our Q&A portion of the event. Just want to thank everyone so much for all of the insightful questions that you all have submitted here during the event as well as during the registration. I'm now going to turn things back over to Becky Metzger to help us close this out.

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We're going to just review a few additional resources that are available to both participants and applicants.

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So, if you should have additional questions or need additional information beyond what we were able to answer here today. There's a variety of different ways to reach out or stay abreast of what's going on with EOM. At any time you can reach out to the EOM help desk, and that is EOM@cms.hhs.gov. Please do feel free to reach out through the help desk and the phone number is also listed on the screen. We also encourage folks considering applying for Cohort 2 to subscribe to the EOM listserv that's available here on the screen as well. In addition, for EOM participants you can get information through EOM Connect and chat with other participants, access resources, and of course, there's always lots of great information, including the EOM Payment Methodology, the de-identified baseline data and many more resources on the EOM website. So, these are all different ways to keep informed of what's going on with EOM.

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We have a few additional events currently coming up. These are targeted at our potential applicants for the Cohort 2 EOM. So, on August 1st we'll be having an EOM Second Cohort Application Period Office Hours. Batsheva did mention on August 15th we'll be having a Quality Health Equity and Clinical Data Strategy Webinar to share more information related to those topics, and then on August 29th we'll also be having a second Office Hours for our potential Cohort 2 applicants.

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Again, for our folks attending who are considering applying for Cohort 2, we did want to just share the different resources available. So, the application period is currently open. It will be open through September 16th at 11:59 pm ET, and you may apply at any time. We have the link here to submit an application https://app.innovation.cms.gov/EOM. There's also a PDF version of the application available on the EOM website, just for your reference. You do have to submit through the portal, but it may be helpful to review the PDF version prior to submitting your application to make sure that you have all of your information available. We do have the link to the application portal here, and additional details are available on the EOM website, and again, also encourage folks to sign up for the EOM listserv. That is how we are reaching out to potential applicants related to events, updates, and additional news.

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In addition, we have an appendix with this slide deck which is currently available on the EOM website, and this has some additional resources that you may find beneficial and may want to review. So, we won't go over these slides today as we are running out of time, but this is available on the EOM website for your review and your reference, and with that I'm going to turn it over to Lisa

to close out our call. Thank you, Becky, and thank you for joining. And that concludes today's webinar. Enjoy your day.