ENHANCING ONCOLOGY MODEL

COHORT 2 APPLICATION SUPPORT OFFICE HOURS

August 1, 2024

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

Slide 1

Hello! Welcome to the Enhancing Oncology Model, Cohort 2 Application Support Office Hours. 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.

Slide 2

Thanks so much, Lisa. If we can go to the next slide, please. Hello again, and welcome to the Enhancing Oncology Model Cohort 2 Application Support Office Hours. I'm Becky Metzger. To kick us off today, I just wanted to start out by reviewing the agenda. In today's event, the EOM team is going to provide a brief overview of EOM, provide additional details and information related to the application process and application timeline. most of the time in today's event is intended to address questions from our audience or attendees after our Q&A session, we'll share some helpful resources and close out the office hours. I'll now hand the call over to our CMS presenter, Batsheva Honig. Batsheva, please go ahead.

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Thank you, Becky, and Hello. My name is Batsheva Honig, and I am the Model Lead. As a refresher, EOM is a voluntary payment and delivery model designed to test innovative payment strategies and promote equitable high quality person-centered evidence-based cancer care to Medicare fee-for-service beneficiaries with certain cancer diagnoses, undergoing cancer treatment. The model tests began July 1, 2023, with the Cohort 1 and the second application period is open now until September 16th with the cohort starting July 1, 2025. The model will go to June 2030 for both cohorts. Key model goals include putting the patient at the center of the care team, advancing value-based care in oncology and promoting high quality person-centered care as well as achieving savings over the course of the model.

Slide 4

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 payment. This is a per beneficiary per month payment that EOM participants are eligible to bill for to help support care transformation by providing enhanced services, such as care, planning patient navigation, health-related social needs screening to eligible eon beneficiaries. The base MEOS is $110, with an additional $30 for dually eligible beneficiaries. The second is the potential to earn a performance-based recoupment or earn a performance-based payment or owe a performance-based recoupment to CMS based on the total cost of care and performance on a set of quality measures. We also link quality to payment, and that EOM participants owing a CMS performance-based recoupment may have the recoupment amount reduced by performing well on quality measures.

Slide 5

In addition to extending the model two years for both the Cohort 1 and Cohort 2 as part of the second application period, we have made a number of refinements to the payment methodology including increasing the amount that is being paid for providing enhanced services via a MEOS payment and that is an increase from 70 to $110 per beneficiary per month, and we continue to offer the $30 for dually eligible beneficiaries outside of total cost of care, responsibilities for a total of $140 per month for these beneficiaries. We have also increased the threshold for recoupment to 100 of the benchmark. In other words, participants will now pay CMS back costs related to their patient's care when it exceeds 100% of the calculated benchmarks as opposed to the current payback in the model, which is 98% of the benchmark. These policy updates will be effective starting January 1, 2025 for current EOM participants and starting July 1, 2025 for the Cohort 2 of EOM [participants. As I mentioned, applications are now open and will be accepting applications through our online application portal until September 16, 2024. We welcome both physician group practices and payers to join the second application period to begin July 1, 2025. EOM continues to the administration's commitment to improving cancer care for all Americans in adding a Cohort 2 of participants extending the model and updating payment policies. More patients undergoing cancer treatment and their families will have access to the enhanced services offered under the model and access to high quality care. We hope that more members of the oncology community will also participate to help shape the future of cancer care. We are excited to offer this opportunity for additional oncology practices to gain experience in value-based care, and we believe the experience gained through participation in EOM will better position oncology practices for the future of where cancer care and payment reform is headed.

Slide 6

In these next few slides. I'll be going over some helpful information. As a reminder an EOM participant must be in Medicare-enrolled oncology physician group practice or PGP, identifiable by a unique TIN or Taxpayer Identification Number. To be eligible for participation, you must have at least one EOM practitioner that is an oncology practitioner with a specialty code of hematology oncology, or medical oncology in EOM we do allow for limited billing overlap should a practitioner provide care under other TINs. However, CAHs FQHCs, RHCs and oncology PGPs who routinely refer beneficiaries to PPS exempt cancer hospitals are not eligible for participation in EOM.

Slide 7

EOM Participants may choose to enter into financial arrangements with individuals or entities called care partners, for example, to support furnishing Participant Redesign Activity (PRA). Participants may also enter into voluntary pools, that is, when two practices combine their information for reconciliation. For example, to address low patient volume among other reasons, practices may be asked to form a mandatory pool if they have high billing overlap.

Slide 8

EOM is also a multi-payer model, meaning that private payers state Medicaid agencies and Medicare advantage plans are all invited and encouraged to apply to participate in the model. In EOM, payers align their own oncology value base care models in key areas to promote a consistent approach across payers and patient populations, some key areas for alignment or required alignment, that we see our payers make commitments to include health equity as well as data sharing with EOM participants. We also expect payers to align with EOM's overall payment structure. So payers, for example, should have some type of per beneficiary per month payment similar to the MEOS payment for the provision of enhanced services, as well as some lump sum performance payment. But I will note they are not limited to EOM-specific parameters and can have flexibility in their approach as well. Payers that are in EOM must partner with current, or at least one EOM participant at all times in order to participate in the model and to the extent permitted by law. CMS also provides payers with data and resources pertaining to EOM. EOM features payer workgroup to support collaboration and sharing of best practices between payers within the model as well. I will now hand it over to my colleague, Mike Berkery, to describe more about the application process and timelines associated.

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Thanks, Batsheva. So, in the following slides, I'll go over the application process steps for both PGPs and payers and also discuss available resources and guides.

Slide 10

This slide provides information on how to apply to the RFA, which again, is currently live and closes September 16th. This list also directs applicants to the EOM website, where you can access the PDF version of the RFA ,and the new EOM Application Portal Guide, which provides step by step instructions for completing the application in the portal. We also encourage you all to sign up for the CMS Listserv to receive updates on future events, as well as Cohort 2 information and guidance. A quick note about the RFA application portal – please make sure to select the correct RFA application since there's one for PGPs and one for payers.

Slide 11

This application overview shows the various sections of the PGP application, and it's a useful reference to help prepare you all for the application in the portal. Some items to highlight: for the applicant PGP information the legal entity provided must be the same legal entity that would enter into a formal participation agreement with CMS upon acceptance into the model. For contact information, the primary contact will be responsible for addressing any questions related to the application and will receive all model related communications. For PGP profile information and PGP information, applicants are required to list all the organizational NPIs is that bill under their TIN, provide their organizational structure such as hospital based or community based, and describe geographic areas where they provide care among other items. For more detailed information, please reference the EOM Application Portal Guide.

Slide 12

This shows what the application process looks like in the EOM RFA portal. These are the three sections you'll see at the top of the application portal screen when you log in and access it. As you complete and save each section, the portal will track and show what percentage is complete and incomplete. This is a helpful reference as you respond to each section over time and go in and out of the RFA application in the days and weeks ahead.

Slide 13

This overview provides the various sections of the payer application. So, like I said, there's two distinct applications, one for the PGPS and one for the payers. For contact information, the portal includes a drop-down option to quickly search your organization's legal name as well as an option to add a new organization if your name cannot be found. Like the PGP contact information, the payer primary contact will be responsible for addressing any questions related to the application and will receive all model related communications. The payer information section asks for the organization's line of business such as Commercial, Medicare Advantage, managed care to name a few, state license information, and the PGPS the payer intends to partner with for EOM. Please note that while the payer partnership question is optional currently in the portal, we do this in case a payer has not yet identified a PGP partner before the application deadline. Payers must eventually partner with the PGP to participate in the model. Payers may also add as many additional PGP partners as they choose. The Quality Strategy and Data Sharing sections ensure that a payer's quality metrics and data feedback strategies are aligned with EOM core elements with flexibility to specify exact approaches that fit their population. For more details about the payer application sections, please see the EOM Application Portal Guide.

Slide 14

So, like the PGP slide we showed before, this shows the sections for the payer form in the application portal with the ability to see and track completeness just like the PGP application.

Slide 15

After the September 16th deadline, a CMS review committee will evaluate the submitted applications. Reviewers with subject matter expertise will assess overall completeness, quality of narrative responses, and program integrity vetting results. The subsequent slide contains further details about the program integrity screening process. After the review accepted applicants will be notified later this year, probably by mid to late winter.

Slide 16

To mitigate potential program integrity or PI risks, CMS will conduct a thorough PI screening for applicants. This will provide an informed, non-arbitrary assessment of an applicant's suitability for the model and identify issues related to business practices, solvency, or program integrity, while also confirming eligibility for the model. This chart shows a list of potential PI screening items, such as

delinquent Medicare or Medicaid debt, compliance with other CMS models, and administrative audits or investigations.

Slide 17

So, here's a timeline of upcoming EOM webinars for the remainder of the summer. We have a bunch coming up this month, which is exciting, as well as other milestones such as the application deadline, review and selection process, data disclosure and attestation or DRA submission, and when we'll provide historical data for accepted applicants who've signed the DRA. Feedback from EOM Cohort 1 applicants inform this new data sharing process. They noted it would have been helpful to have more time to review their historical data before deciding whether or not to join the model. At the bottom of this timeline, you'll see and again, as Batsheva mentioned a number of times, the Cohort 2 begins July 1st, 2025. It's now time to hold our open Q&A session, so, I'd like to invite my colleague Alex to facilitate this portion for us. Alex, take it away.

Slide 18

Alex Chong: Great. Thank you, guys, so much. And Batsheva and Mike, thank you for that overview of both the conceptual portion of the model itself, and then Mike an overview as well of the application process. We're going to go ahead and do some Q&As now for the audience and I want to, so it's going to be a little bit of a mix, and I want to start off first with some questions that we have received from our audience through the registration. I'm going to actually start here with a little bit of a hefty one focused on payment. I think that makes sense, especially because this is a payment model, one of the first questions that we received in the registration. I'm going to point this one to you, Liz, who is our Payment Lead for EOM. Someone had noted in our registration that they are still not really quite clear on how the total cost of care standard is determined and how this actually relates to costs and patients. Liz, can you help provide an answer here at a high level on how this is a total cost of care model and how those expenditures are calculated?

Liz Ela: Sure. And like Alex said, this is a pretty hefty question. So, I am going to answer at a high level. But before I do, I just want to call everyone's attention to some resources that will have more information about everything I'm about to say. So, first we have a EOM Payment Methodology document that is posted on the EOM website. This is sort of the compendium of all of the payment methodology, and it is on the long side. So completely understand if you don't want to start right there by diving into that document. Another good place to seek out some information is the benchmarking fact sheet that we've put together and posted on the EOM website and that summarizes the steps that are involved in calculating the benchmark price for every episode. And then a few weeks ago we held a payment webinar and those webinar slides, and recording are also posted on the EOM website. And I really encourage folks to refer back to that, whether or not you were able to attend the payment webinar in July, there's a lot of good information in there. and it includes an example which might help make all of the calculations less abstract. So, with that said, I'm going to talk a little bit about both the episode expenditure side of things, so the total cost of care that a practice would be taking on and then also the benchmarking side of things, which is what those expenditures are actually compared to. And I'm actually going to start on the expenditures side of the equation.

So, EOM practices are taking on accountability for what we call the total cost of care for episodes that are attributed to them. And that total cost of care or the episode expenditures include most Medicare spending for the beneficiary within the dates of their episode. And that's not solely included, limited to oncology care. This is the total part, part of total cost of care, it's most Medicare spending for that beneficiary that includes most Part A expenditures, most Part B expenditures and it includes the beneficiary specific components of Part D expenditures, so that could include any low-income subsidy amounts for Part D enrollment. It would also include Medicare's contribution to drug spending that's above the catastrophic threshold. And I'll just say briefly that there are other adjustments applied to those episode expenditures, including an outlier adjustment, potentially some adjustments based on overlapping participation in other models. I'm not going to get into all those details right here and now, but again, there's more information about that in some of the resources I mentioned. So, for a given episode, we'll total up from claims those expenditures for the beneficiary and that's how we get to the episode expenditures side of the equation. On the benchmarking side of things, so what are we comparing the real spending to? CMS will calculate a benchmark price for every episode. And that benchmark price, it starts with the predicted expenditures and those come from a price prediction model. The price prediction model is based on episodes during the EOM baseline period. So, we've identified all of the episodes occurring nationally during the model baseline period for each cancer type. And we've built a price prediction model separately for each of the seven cancer types, and that price prediction model captures spending levels for that given cancer type, but also the variation in spending based on all the model covariates. And the model covariates are things like beneficiary age and sex, and certain non-cancer comorbidities, and a number of other covariates that again are summarized in some of those other payment resources.

So, we calculate predicted expenditures for a given episode and then we apply some other benchmarking adjustments that I'll describe just very briefly here. Those include an experience adjuster; those include a clinical adjuster that captures differences by things like metastatic status of the episode. We apply a trend adjustment to bring this prediction that's based on baseline levels of spending forward to match growth and expenditures up through the performance period that we're benchmarking, and there's also a novel therapy adjustment that may apply if the EOM participant uses a lot of newly approved therapies in their episodes. So, we calculate predicted expenditures, we apply this series of adjustments, again, those adjustments are summarized in that benchmarking fact sheet that I mentioned, and then we arrive at a benchmark price. So, every episode, every beneficiary is going to have a total of their actual expenditures and a benchmark price. And then during reconciliation, CMS will total up for all of the episodes, the sum of all the benchmark prices, which is the benchmark amount, and then the sum of all the actual expenditures. I know I gave a lot of information to you very quickly, I really do encourage folks to have another look at our various payment resources, to help all this information sink in and you can always send more specific questions to the EOM help desk. So really encourage folks to make use of that too.

Alex Chong: Excellent. Thank you so much, Liz. This is actually a really good segue to the next question that we got through our registration, which is talking a little bit more about our MEOS payment or Monthly Enhanced Oncology Service payment and how that plays into the total cost of care responsibility. So, Sam, I'm going to ask you this question that came in, which is are MEOS payments, are they included or are they excluded from this total cost of care, especially in consideration and in comparison to the target?

Sam Cox: Yes, thanks, Alex. So, the base payment amount of $110 for attributed EOM episodes will be included in the total cost of care calculation, but the additional $30 for beneficiaries who are dually eligible for Medicare and Medicaid will not be included in the total cost of care calculation.

Alex Chong: Fantastic, thank you for that. I am going to now move on to a few more questions that we were getting from the live chat, and this is a really good question, especially since we've been talking a lot about our multi payer strategy and our multi payer alignment in EOM. We received a question, actually we received a similar question from our last payment webinar for those of you who were with us during the payment webinar and then we received it from somebody else, so definitely understand wanting a little bit of clarity here. So, Mike, who was speaking earlier, he is actually our Payment Alignment Lead as well. And so, Mike, the audience wants to know, does Medicare managed care plan, so, for instance, like Humana or Freedom Health, are they included in EOM? Can you explain to us a little bit and in terms of what it means for instance, for these managed care plans, I think this is talking maybe specifically about like Medicare Advantage, and how that works from a payer who may have a Medicare Advantage plan within their payer structure or especially to for beneficiaries who are enrolled in Medicare Advantage.

Mike Berkery: Yes, thanks Alex and thank you Albert, for the question. So, if the question is if a Medicare Advantage plan could be a payer participant, then yes, an MA plan can join the model as a payer participant. As mentioned before, they would just need to partner with a PGP, and we definitely encourage them, interested payers including Medicare Advantage plans to submit an application for Cohort 2. If the question though, is it if beneficiaries enrolled in Medicare Advantage plans are eligible as EOM beneficiaries, beneficiaries enrolled in these plans unfortunately are not eligible for EOM. So, patients enrolled in Medicare Advantage at any point in the six months following the initiating cancer therapy are not eligible for EOM. But as we've talked about with multi payer alignment, I think we have a good array of payers interested in the Cohort 2 and currently at the table and previous models. So, there's a lot of great learning and peer-to-peer opportunities through EOM for the payers to come together around quality, and around data sharing, around HRSN, Health Equity, so there's some good, some great discussions, so encourage anyone to apply as a payer for Cohort 2.

Alex Chong: Great. Thank you, Mike. I'm going to turn to a few more questions now actually where I think we've covered these in previous events that we've had. But there are questions that we still continue to receive and want to make sure that the word is out there on the latest information. So, one of the things that we do within this model of course, and those who are currently a part of EOM and in the Cohort 1 have experienced or if you are a part of OCM have experience as well as we do share data with our participants on beneficiaries and we do also share data prior to the start of the model, these are baseline episode data. So Batsheva, I'm going to turn this question to you, which we've been getting frequently, which is, in relation to Cohort 2, when exactly is that historical episode data going to be available, what exactly are the dates to those historical period and is that data going to include actual costs or predicted costs? Can you talk a little bit about tentative data sharing plans for Cohort 2 participants who are going to start a little under a year from now?

Batsheva Honig: Yes, happy to Alex. And I just want to make a distinction between the baseline data and the historical data before I dive too much into the historical data. So, the EOM baseline data is data that's already available on our EOM website and these are de-identified public use files that include all baseline period episodes nationwide, so those initiating 7/1/2016 to 6/30/2020 and these are the episodes that inform the price prediction models and other elements of the

benchmarking methodology such as the trend factor. And I'll note that the EOM technical payment resources are also available on our website and that includes documentation relevant to these data files, such as listing of the initiating therapies applicable to the model baseline period. Later this fall, we will be offering an applicant, and I might've mention this earlier, an applicant HIPAA covered data disclosure request or DRA that is a form for provisionally accepted applicants in the Cohort 2 to submit at the time, and by signing this form in late fall of 2024, the Cohort 2 of applicants will have the opportunity to receive what you mentioned Alex, the participant specific historical data prior to signing and executing a participation agreement in the spring of 2025. So, we tentatively plan to share the participant specific beneficiary identifiable historical data professionally accepted Cohort 2 applicants toward 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. So, 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 also possible to use that data to calculate the predicted expenditures for each episode.

Alex Chong: Great, Thanks for going over that again, Batsheva. I am now going to turn this next question over to Sam again, just to talk a little bit more about our payment methodology. We received another question and again, there are a lot more details within the payment methodology webinar and associated resources that Liz talked about at the beginning of this Q&A. So, and I think those might have been dropped in the chat or again can be. But Sam, can you cover again just one more time, kind of the changes that we have to the payment methodology? So, it looks like they want to ask a little bit more about the neutral zone or how that works with the threshold for recoupment and also the stop loss and stop gain. But I think also just reiterating some information about changes that we've made on the MEOS payment as well would be helpful here.

Sam Cox: Yes, for sure, thanks, Alex. So as Alex mentioned, one of our major changes is to the MEOS payment amount and that payment amount is being increased from $70 per beneficiary per month to $110 per beneficiary per month and payment for dually eligible beneficiaries that will continue to include the additional $30 per beneficiary per month for a total of $140 per beneficiary per month. And the other significant change to the payment methodology is that the thresholds for recoupment has been changed from 98% of the benchmark amount up to 100% of the benchmark amount under both risk arrangements. And again, as Alex mentioned, the payment methodology as well as materials from our previous payment webinar are available on the EOM website for you to take a look at.

Alex Chong: Thanks, Sam. And would also reiterate here again, we did make some changes on that threshold for recoupment. So again, it's equal to the benchmark now, it was previously 90% of the benchmark, but there are no changes though in terms of the stop loss or the stop gain. Let's switch gears just a little bit and talk a little more about eligibility, especially for those of you out there who you know are considering applying. So Batsheva, I'm going to ask you this question on the different types of practices. And one thing that I do want to note too, is that within our oncology models, both in OCM and in EOM, we do have a very heterogeneous array of types of practices. So, this is a really good question. Somebody had asked, we're a hospital-based oncology practice, our tax ID number, we usually refer to this as a TIN, (Tax Identification Number) and that's actually how we define participation in EOM. It's part of the hospital, how does that affect our eligibility, can they still apply and be a part of the model? So Batsheva, can you explain a little bit here?

Batsheva Honig: Yeah, and thanks for this question. So, hospital-based oncology practices are welcome and eligible to apply for EOM provided that they meet other criteria including having one or more practitioners with the specialty code of either hematology oncology or medical oncology that I mentioned earlier. As this is a TIN based model, we suggest you take into consideration how your practice interacts with the hospital and the EOM policies. For instance, we have certain policies related to the timing of TIN changes. So, for example, advance notice to CMS and these policies will be outlined in the EOM, they are outlining EOM RFA and then the PA and we encourage participants to review those carefully.

Alex Chong: Excellent. This next question then, I think there has actually been quite a bit of questions from interested participants in regards to what it means to participate in EOM as well as being a part of QPP, or Quality Payment Program. And so, this one is related a little bit about that, especially because participation in EOM, especially if you are taking on the more advanced risk arrangement or more a little like financially advanced Risk Arrangement 2, then you are eligible as an advanced APM. But Sam, I want to ask you this question that has come in before, which is, are all clinicians who have a designation of oncology, right, even if there are no patients that are attributed or aligned to them within the same TIN. And so, remember we define participation in this model by TIN, are they considered advanced APM participants, and then if so, does that just then make them exempt from MIPS?

Sam Cox: Thanks, Alex. So as Alex just mentioned, participants do need to be in Risk Arrangement 2 in order to be eligible as an advanced APM. And then in order to reach QP status, the participant would also have to reach the QP threshold. And QP determinations are generally determined at the APM entity level. So, all eligible clinicians that are billing under and EOM TIN of a participant in Risk Arrangement 2 will all be assessed with QP status together. And that is regardless of whether any patients are aligned to a specific provider or not. And if you do reach QP status, you would be exempt from reporting to MIPS. But more information regarding eligibility for advanced APM status can all be found on the QPP website.

Alex Chong: Excellent, thank you, Sam. Switching gears just a little bit more, I'm going to point this next question to Mike about the application process. We do recognize that there were some applicants who are interested in EOM when the model first started, but then maybe ultimately did not participate. So, we did receive a question here where they want to know if they applied initially, can they reinstate that application or do they have to redo that whole submission? Can they use their previous responses? Mike, could you walk us through a little bit on how that would work if they maybe they've already submitted some information to us during an initial application of the model.

Mike Berkery: Sure, and thanks, Alex. And the quick answer is that they're going to be required to submit the whole application again. But a couple details about that to help make it less onerous, right? So, if a practice submitted an application during the Cohort 1 and they'd like to see that previous application for reference, which is reasonable and fair, they can reach out to EOM at cms.hhs.gov and then we can help provide their previous application in a PDF form as reference. And they can look back in that and help inform their application now. But please note there are differences in the Cohort 2 RFA, so the one that's live right now. So, you will need to complete and submit a new application for this application period. And we also encourage previous applicants to carefully review their narrative, including their implementation plan and financial plan if using information from their previous application and update the current application as appropriate.

Alex Chong: Great. Thank you for providing a little bit more context to that application submission process. Let's move on a little bit more now. Again, just talking through some of the policy changes that we are implementing as part of Cohort 2 as well, but again, this actually applies to all cohorts. Batsheva, can you talk a little bit about, you mentioned earlier in your overview that we're actually extending the model for two more years. Why are we doing that?

Batsheva Honig: I'm so glad you asked, Alex. So, the model is being extended so that both cohorts will have at least five years to participate in the model test. So a seven year model test will allow all EOM participants to have sufficient time to engage in investments, resources and learnings to not only implement the model requirements, but to plan strategically for potential long term care transformation.

Alex Chong: Excellent. As I mentioned as well at the beginning of this Q&A, EOM is an alternative payment model, and it is a total cost of care model and this is a model in which we rely on benchmarking to determine what the expected costs might be of the care that is being provided. And so, a really common question that we also get as well is when are we going to then release these benchmarks? And so Liz, can you, and I think to answer this question, there needs to be a little bit more context on when this benchmark information is going to be shared and a little bit more context on the retrospective aspect of our benchmarking reasoning for why we have it set up that way. So, Liz, could you talk about that a little bit?

Liz Ela: Sure, happy to. So, EOM, similar to OCM for folks who may have participated in OCM, is a model with a retrospective benchmarking methodology. So, the benchmark prices for episodes that we described earlier along with benchmark amounts and expenditures and the other financial parameters are going to be shared in the reconciliation report for each performance period. And you can expect that initial reconciliation report approximately eight months after the conclusion of the final episodes from that performance period. And the reason why our benchmarking is retrospective and why we can't provide the benchmark sooner, is that many elements of the benchmark price actually depend on claims data and participant submitted data that CMS can actually only obtain after the end of the performance period. Starting even with something as sort of seemingly simple as the episode dates, episodes are triggered by a claim for an initiating therapy, and that means you know that the apparent start date of the episode can fluctuate as new Medicare claims for initiating therapies are submitted. Because these episodes are triggered by an initiating therapy, there are often many claims for the beneficiary that all have the potential to be like the triggering claim if it turns out that they are the one with the earliest date of service. So, there can be quite a bit of apparent fluctuation until we have taken the time and the claims data have come in so that we can identify the start date of the episode. Furthermore, the predicted expenditures, so this is what comes from that price prediction model, they're risk adjusted for a number of events that could happen during the episode that would be linked to higher expenditures. So, this could mean a surgery, it could mean a bone marrow transplant, it could mean radiation therapy, all these different events that could happen during the episode but that we have to use claims data to identify, which means we have to wait for those claims data for the claims to be submitted, and then to be available to us.

The clinical adjuster I mentioned, which are an adjustment for ever-metastatic status during the episode and also for breast cancer HER2 status are based on participant reported clinical data elements and participants submit these clinical data elements after the performance period once CMS has identified and attributed the episodes, because EOM participants only submit data for their attributed episodes, not for every patient that they're seeing. So those clinical data are not available

until well after the end of the performance period. And then the trend factors are based on episode expenditure data that are from non-EOM oncology PGPs but are from during the same performance period that we're calculating benchmarks for. So, I do want to acknowledge that the retrospective benchmarking poses challenges for model participants. But in order to calculate benchmark prices and benchmark amounts that are responsive to high-cost cancer treatments like surgeries that are, fully appropriate for that patient, and in order to respond, adjust appropriately for things like metastatic status HER2 status, as well as market trends like increasing drug prices throughout our performance period. We do need to wait for all these different data elements to become available because they all play a critical role in our benchmark calculation so that we're able to calculate fair benchmarks.

Alex Chong: Excellent. Thank you so much for that overview, Liz. And so also as a reminder to the audience, EOM is not only a payment model, but quality is also a huge part of this model as well. We are looking for our participants to improve quality. And so, we also received a question here just asking a little bit more about how the quality adjustment works, especially in context of that lump sum potential performance-based payment or performance-based recoupment. I think more details of this are going to be shared in our quality webinar, which I believe is August 15th. But just as a quick preview over here or as a refresher from previously, I'm going to turn to Priya Chatterjee, who is the quality lead of EOM. Priya, can you just walk us through very quickly here or just briefly exactly how the quality adjuster is determined or again how quality plays into performance metrics?

Priya Chatterjee: Yeah, I'd be happy to. So, after points have been assigned for each of the six quality measures that are included as part of EOM, all of those burn points will be summed up and divided by the EOM participant or pools total possible points to calculate what we call the Aggregate Quality Score or AQS. So that AQS helps us determine what we're calling the performance multiplier that can be applied to either a performance-based adjustments or recoupment or a payment. And we have more information about this in a table under Section 7 of the payment methodology that crosswalks how the AQS kind of translates to that performance multiplier, and we'll have lots of examples available in that quality webinar that Alex mentioned on August 15th.

Alex Chong: Excellent, Thank you, Priya. And so again, if you have further questions about the quality strategy or how the quality adjustments works, please definitely tune in for that webinar in a couple of weeks. Let's move on actually to again a subset of the quality strategies, which is one of our practice redesign activity requirements that we have in EOM, which is a new practice redesign requirement, especially for those of you who are familiar with OCM, who have participated in OCM and that is actually the collection of ePROs or electronic Patient Reported Outcomes. This is a requirement that we have, and it is a, we expect a gradual implementation of our EOM participants to collect ePROs from their EOM beneficiaries. And within understanding that this is one of the requirements, one of the questions that we tend to get is, do practices actually have to obtain like a certain percentage of ePRO collected from the EOM beneficiaries, what exactly is it that we're looking for from CMS? So, I'm going to turn this question over to Kirsten, who leads our ePROs work. Can you talk a little bit about what those requirements may look like or like what we may expect, Kiersten?

Kiersten Lawrence: Sure. Thanks, Alex. So currently there's no set minimum for the requirement of ePROs data collection. This is a newly emerging field, and we recognize that. So, we provide or allow for flexibility within the practices as they transition to collecting ePROs data. And the intent is that we see a gradual increase in patient engagement with ePROs and in the collection of ePROs

over time. So, there's again, there's no set minimum, but again, the intent is that it increases over time as you engage more and more with your patients.

Alex Chong: Excellent. Thank you, Kiersten. Let's see here. We do have a few minutes left, so again, just want to encourage you all if you have any questions or if there are any further clarifications that we can make on the content that we've discussed thus far, please drop those in the Q&A. Maybe I will actually take this one here just because we're talking about like participation in EOM and I think we recognize too, right, I mentioned that there is really just such a wide array of the types of participants that we may have, and what that means is that your practice may be part of a larger health system or an academic center or, also manage other illnesses and may also be interested in participating in other models up here at the CMS Innovation Center. And the common question that we receive is can I apply to EOM if I'm participating in another model? And just want to reiterate, yes, you are generally allowed to participate in EOM even if you're participating in another CMS model or program during the duration of the test of EOM in itself, we do account for the overlap of participating in different models. It is something that we want to encourage. I think also, in terms of expanding the reach of participation across multiple models, we may for instance, when we are doing our calculations for performance or reconciliations, there may be adjustments that are made to those episode expenditure calculations to account for overlap with other models, particularly at the participant or beneficiary level. We do have a lot more details on exactly how \or just further details on specific model overlap policies in the RFA or the request for application document which is available on our website. And if you end up participating in our model itself, it is also described in the participation agreement.

Alex Chong: OK, I'm going to pause here just for a minute or two just to scan to see if there are any additional questions that we may receive here in the last few minutes as well as to see maybe if there's any additional questions that we may want to cover for you all. OK, I think that may be set in, in terms of the content and questions. Oh, looks like we need to have something else here. Ok great. So, somebody asked here and Liz, I may turn to you for this one because this is a question about risk arrangements. So, can you talk a little bit about the changes to the risk arrangements? Again, I think we went over this earlier or like a lot of the changes I think is focused on the threshold for recoupment. But then you know maybe if there's any changes here in the downside of risk arrangements for Cohort 2 versus Cohort 1. So, if you could just clarify that?

Liz Ela: Sure. So, like Alex mentioned, the main change here is that we have raised the threshold for recoupment from 98% of the benchmark amount to 100% of the benchmark amount. And that's true for both risk arrangements. So, Risk Arrangement 1 and Risk Arrangement 2. Effectively, what that means is that you would have to have your total expenditures for all of your episodes would need to exceed your total benchmark amount before you would owe a recoupment as part of the downside risk in EOM. So previously that level was 98% of the benchmark amount, now it's 100% of the benchmark amount. Effectively, that expands the size of the neutral zone. The other financial parameters from Risk Arrangement 1 and Risk Arrangement 2 have not changed. So, there are no changes to target amounts, which is that amount that you need to save underneath in order to earn a performance-based payment. There are also no changes to either the stop gain or the stop loss. And I'm going to, I'll talk about the stop loss for a second since part of the original question here was about, the downsided risk and you know, potentially a recoupment. So, both of the EOM risk arrangements do include a stop loss and that stop loss limits the maximum amount of any performance-based recoupment that you could potentially owe. So that stop loss is set at 2% of the benchmark amount in Risk Arrangement 1 and 6% of the benchmark amount in Risk Arrangement 2.

So, like I said, that is not changed from the start of the model. We didn't change the stop loss or the stop gain. In the event that practice had total expenditures that were above 100% of the benchmark amount, which is the new threshold for recoupment, any recoupment amount would be based on the portion of the total expenditures that is above that threshold for recoupment. So only the part that exceeds 100% of the benchmark amount. But where the stop loss comes in is that if that portion of expenditures that's above 100% of the benchmark is also larger than the stop loss, then the recoupment amount is calculated based on the stop loss only. So, you could potentially owe a recoupment, but only up to any recoupment based on the amount of the stop loss. And any additional expenditures above the stop loss amount do not further increase the recoupment amount. So, there's a built-in cap on how much you could potentially owe as a recoupment in a given performance period and that's based on the stop loss. And you know, the exact level will depend on your chosen risk arrangements.

Alex Chong: Excellent. Thank you so much, Liz, for clarifying some more details about our risk arrangements in EOM as well as how the stop loss works. Also want to note here, it looks like there were some, there's a resource file on our payment methodology webinar that we held a couple of weeks ago, so, a recording of that and again, we also have the Payment Methodology Paper available on our website. I think this brings us to the end of our Q&A session for this office hours. I really want to thank everyone for your very thoughtful questions. If there was a question later that you think of or again you maybe you want some more clarification on whatever it is that we talked about today, please feel free to reach out to us at our help desk, which is EOM at cms.hhs.gov. And with that, I want to turn it over to Becky Metzger to continue to talk a little bit more about the resources that we have out there and to help with the transition to close us out. Thank you all so much.

Thanks so much, Alex. Next slide, please.

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And thanks for everybody who participated today in your great questions. We're always here to answer your questions and hope we provided some helpful resources. This slide, which is also posted on the EOM website is available and has links to a lot of helpful resources. If you're considering applying to EOM learning more, there's information specific to Cohort 2 application process. There's also the EOM factsheets, which are high level documents that are available on the EOM website that provide information about specific topics. And then we have some of our more detailed as we discussed earlier, our payment methodology as well as guides to many of our PRAs and data reporting requirements and drug lists associated with the initiating cancer therapies included in EOM. So, all of this again is available in the slides that are available on the EOM website. And these things will take you right to the resource you're looking for.

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We do have a couple upcoming events continuing to support potential Cohort 2 applicants. So, in August, on August 15th, we'll have the Quality Health Equity and Clinical Data Submission Strategy webinar and that will be occurring on August 15th. That information is available already on the EOM website for registration. So please feel free to go ahead and register there. There will also be some additional emails reminding folks and providing that registration link, but that again is available on

the EOM website. In addition, we'll be hosting a second application support office hours on August 29th, and so, if folks still have questions prior to the close of the application, want to make sure we have an opportunity to support you in answering those questions. So that event will be on August 29th.

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As Alex mentioned, there's lots of different ways to keep in contact with us. First, just want to point out that if you do have any questions that weren't answered today or you're reviewing materials and have additional questions, please feel free to reach out to the EOM help desk. That's EOM@cms.hhs.gov or you can call as well. Definitely a great resource, so always happy to answer any of your questions. You can visit the EOM website where many of those resources that we just touched on are available. And we do encourage people to subscribe to the EOM listserv. You can also follow CMS at CMS Innovates as well.

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And with that, I just wanted to say thank you again for everybody participating today and we'll be turning it over to Lisa to close us out. Thank you, Becky, and thank you all for joining. That concludes today's webinar. Enjoy your day.