ENHANCING ONCOLOGY MODEL

EOM COHORT 2 APPLICATION SUPPORT OFFICE HOUR #2

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

Slide 1

Hello! Welcome to the EOM Cohort 2 Application Support Office hours # 2. We are incredibly grateful and humbled by all of you for taking the time to join us today. 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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Hello again and thank you again for attending today's Enhancing Oncology. Model Cohort 2 Application Support Office hours # 2. I'm going to start today's meeting by reviewing the agenda for the office hours today. Just a note, our primary objective of today's office hours is to ensure we have time to answer any remaining questions from potential EOM applicants. We'll start out today with a brief overview of EOM, and from then go into the application timeline and then move to our Q&A session. Finally, we'll review some resources that may be very helpful and informative for potential applicants, and then we'll close out today's webinar. I'm going to start the call off by handing it over to Liz Ela from the EOM model team. Please go ahead, Liz.

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Thank you, Becky.

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EOM is a voluntary payment and care delivery model, focused on innovative payment strategies to promote high quality person-centered and equitable care to Medicare fee-for-service beneficiaries with certain cancer diagnoses who are undergoing cancer treatment. EOM began on July 1, 2023. A second application period is now open for a new cohort of participants to begin their participation on July 1, 2025. For both cohorts, the new model end date is now June 30, 2030. EOM participants are oncology physician group practices who care for Medicare beneficiaries. Other payers, such as commercial payers or state Medicaid agencies are eligible to partner with EOM participants as part of our multi-payer alignment strategy. EOM participants are paid fee for service for the services they provide to EOM beneficiaries. But EOM also incorporates two model-specific payments. The Monthly Enhanced Oncology Services or MEOS payment supports the provision of enhanced services. Starting in 2025, the base MEOS amount will be $110 per beneficiary per month. Participants can receive an additional $30 per beneficiary per month for EOM beneficiaries, who are dually eligible for Medicare and Medicaid. This additional $30 per bene per month for duals is excluded from EOM participants total cost of care responsibility. Second, EOM participants may earn a performance-based payment or owe a performance-based recoupment based on the total cost of care for six months episodes of oncology care that begin with the receipt of an initiating cancer therapy. Total expenditures are compared to a risk adjusted benchmark, and any payments or recoupments will be adjusted for quality performance.

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As you may be aware, CMS announced several updates to EOM policies earlier this summer, one of which was the announcement of the Cohort 2, which is hopefully the reason why we're all here this

afternoon. If your PGP joins EOM is part of the Cohort 2, these other policy updates will already be in effect by the time you begin your participation in July 2025. Starting with a 2-year extension of the model, so, as I mentioned on the prior slide, the new end date for EOM is now June 30, 2030. We also announced an increase to the MEOS payment amount. Originally the base amount of the MEOS payment was $70 per beneficiary per month. MEOS payments with a date of service on or after January 1, 2025, will have a base amount of $110 per beneficiary per month. For beneficiaries who are dually eligible for Medicare and Medicaid, we will continue to include an additional $30 per beneficiary per month that is not part of the total cost of care responsibility. This additional payment for duals is not changing, but the higher base payment means that the total MEOS amount for a dually eligible beneficiary will increase from $100 to $140 per dually eligible beneficiary per month. Finally, the threshold for recoupment will increase from 98% of the benchmark amount to 100% of the benchmark amount, beginning with PP4, meaning this change applies to all episodes initiating on or after January 1, 2025. If you'd like to refresh your memory about how the benchmark amount and the threshold for recoupment are calculated, you can review the slides or the recording of the EOM payment webinar we held in July. These are all posted on the EOM website along with our payment methodology document. Now, I'm going to hand the call over to my colleague, Mike Berkery, to talk a bit more about the application process.

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Thanks, Liz. So, in the following slides I'll go over the application timeline and discuss available resources and guides.

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So, here's a timeline of upcoming EOM events and milestones, including 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 informed this new data sharing process. They noted it would have been helpful to have more time to review their historical data before deciding whether to join the model. Finally, at the bottom of this timeline, you'll see that the Cohort 2 begins on July 1, 2025, as Liz mentioned as well.

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This slide provides information on how to apply to the RFA, which again, we can't reiterate enough, is currently live and closes on September 16th which is coming up. This list also directs applicants to the EOM website where you can access the PDF version of the RFA. And the EOM Application Portal Guide, which provides step by step instructions for completing the application in the portal. We also encourage you 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, please make sure to select the correct RFA application, since there's one application for practices and one application for payers. So, it's now time to hold our open Q&A session, I'd like to invite my colleague Alex, to facilitate this portion for us. Alex, over to you.

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Great. Thank you so much, Mike and Liz, for that nice overview of the model. Some of the policy changes that we are implementing as part of the Cohort 2, and then going through our upcoming timeline and milestones and just a reminder again, in terms of our application portal being open. I want to start off with a couple of the questions that were submitted prior to the event during the registration. So, thank you so much to those folks for sending over those questions.

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One of the first questions that we received is, are there costs associated with the program? So, for instance, things like reporting to CMS, the maybe costs related to various documentations that need to be managed and certifications. And the answer to that question is, there are not specific, direct costs, to participate direct cost to CMS to participate in EOM specifically, but you may just want to keep in mind that, we have a pretty diverse range of participants ranging from small community practices to larger health systems. So really, each participant in the model will have varying degrees of cost related to maintaining some of the practice redesign requirements, and that's going to vary a lot. So again, there could be costs associated with implementation of some of these requirements, and it really just depends on your practice's current processes that you already have in place, or maybe current investments that you already have in place, or investment towards resources to implement the model requirements. One example of this is, we have care navigation as a requirement in the model, and it's possible that some practices without having participated in any of our oncology models may already have care navigators in place, but other practices may require additional staff to support care navigation. This could also be the case again when you think about our requirements around data collection and also in collecting quality measures. So, for the data collection of quality measures, we also require a submission of clinical data elements as well as socio demographic elements. This, and as part of our redesign activities or enhanced services, a gradual implementation of ePROs, or electronic Patient Reported Outcomes, and administrating health related social needs or assessing and addressing health related social needs. So, when sort of thinking about all these activities that we're requiring as part of the model, for some practices, again, you may have a lot of these processes in place already; this may already be a part of your costs. Others may need to incur these costs to support again, implementation of these requirements depending on like which you have already focused on or not. Also, as a reminder, we've talked a lot about this in our previous office hours and learning events is the Monthly Enhanced Oncology Service payment, or what is described as the MEOS payment. So, as Liz mentioned earlier on the call, this is a $110 per beneficiary per month for the 6-month episodes of non-dual eligible beneficiaries, so that's the base amount, and then we include the additional $30 for the dually eligible beneficiaries. The purpose of these payments is intended to provide financial support for implementation of some of these enhanced services. So hopefully that helps to answer that question.

Moving on to the second question. On that we received in the preregistration someone had asked, Can the oncology physician, group practice share an organizational TIN with other multi-specialty practices and facilities. Again, another great question, because we do define participation by the TIN or Tax Identification Number, and the answer to this is yes, an oncology PGP or physician group provider can share an organizational TIN with another practice or facility, but you really need to think about as this is a TIN based model. Take into consideration just how that your practice interacts with that other facility and the EOM policies, so really recommend that you read through some of the

billing overlap policies as well as pooling policies that we have in the RFA. So, we have certain policies as well related to the timing of TIN changes if you're undergoing any type of TIN changes in the way of, let's say, an acquisition. Or maybe there's not a change in control, but just changing over for your billing TIN. The policies, again, are outlined in the EOM RFA. And we encourage you all to read those carefully. Okay. We also received a question, sounds like there are some people may have had some errors in the process of submitting your application through the portal. So, it's a lot of technical issues. So, let's say, for those particular questions around these technical issues, can you continue working with the help desk and don't hesitate to continue to reach out to the help desk until a resolution has been found. I'm going to turn things over, I think this might be one of our last registration questions, and this one is talking a little bit about benchmark costs related to the seven cancer types of cancer being treated. So, Liz, who gave an overview earlier, is actually also our payment lead for EOM. So, Liz, I'm going to direct this question to you, which is, how will our target or benchmark costs be determined for patients who may have more than one of the seven cancer types that are being treated?

Liz Ela: Yes, great question. So many elements of the benchmark price calculation are cancer type specific in EOM, which means that each episode needs to be classified by cancer type, and CMS identifies the cancer type for the episode based on the diagnosis codes on the qualifying E&M services that were provided to the beneficiary during their episode. and I'm going to say parenthetically, that a qualifying E&M service is an evaluation and management service that's provided to an EOM beneficiary during their episode and billed by an oncology TIN with a diagnosis code for an EOM cancer type, and HCPCs codes within certain ranges. And there's more information on that definition in our payment methodology document. So, we're looking at the qualifying E&M services provided to that beneficiary during their episode. And we're looking at the diagnosis codes and if an EOM beneficiary was being treated for two or more of the included EOM cancer types during their episode, CMS will classify that episode based on the cancer type that's indicated on the plurality of the qualifying E&M services during their episode. And I'm going to give you an example of that which will hopefully make that a bit less abstract. So, let's say, a beneficiary received six qualifying E&M services over the course of their episode. Five of those included the diagnosis code for lung cancer and one of them included the diagnosis code for breast cancer. So, because the plurality of the qualifying E&Ms during that episode were for lung cancer it's going to be categorized as a lung cancer episode. So, when we're calculating the benchmark price for that episode, CMS is going to use the price prediction model for lung cancer. We're going to apply the clinical adjusters that are applicable to lung cancer. The trend factor for lung cancer and potentially, the EOM participants novel therapy adjustment for lung cancer if applicable. The short answer, and if you'd like to read more about this methodology, the EOM payment methodology document describes the assignment of cancer types in Section 1.2.3, and that payment methodology document also describes the benchmark price calculation for an EOM episode in Sections 4.1 and 4.2. So that's in our technical document on the website, the large EOM payment methodology document, and so that's posted publicly on the website, and there's also a benchmarking fact sheet. that's maybe a more approachable place to start that summarizes the steps in the bench in the benchmark price calculation.

Alex Chong: Great thanks. So much for that walk-through Liz, I know it gets a little complex with multiple cancer diagnoses. I want to move on to a few of the questions that we're seeing coming in through the chat, and again, really encourage you all to continue to add these questions. As you think a little bit about some of the other questions we've been going through, and some of the model content that we covered earlier. This is a really great question that we received, which is, if we apply and are approved for participation, can we decide to not participate; if we can, what is the timeframe

or deadline date to decline participation? So as a reminder, EOM is a voluntary model, so again, your participation is completely voluntary, submitting an application to participate in EOM does not bind you to the participation itself, it's really just showing us that you have interest in participating in the model. Would also note as well that during the time period in which, after you've submitted your application, and so actually let me backtrack just a little bit here. So, once you submit your application, we then do a review of those application, and also go through a program integrity screening of the applications and also the practitioners. And then at that point we will offer a participation agreement if you've been accepted into that model. So again, you have different time points in which you can accept the participation or accept the participation agreement and have the choice and volition to decline if you if you choose to. We anticipate that we will be offering this participation agreement to provisionally accepted participants sometime in the spring of 2025. We want to ensure that there is enough information and time for applicants to consider your participation. Again, the timing of when the model would start for the Cohort 2 of participants would be July 1, 2025. But even after you sign the participation agreement, a participant again may terminate or withdraw from the Enhancing Oncology Model with advanced notice. And there's obligations related to that termination, but you may terminate at any time point. Okay. Let's see here looks like we have again, another question in terms of maybe submitting the application as a payer but it should be a practice mission, again, could we, can continue to follow up with you to make sure that technical issue is resolved. We received another question that says, do you have a list of managed care payers who have already applied for EOM enrollment? So, at this time we do. We don't share information in terms of applications for EOM but shortly prior to the model launch we will be sharing information in the final list of participants, and that includes the payer participants, and that information will be available on our website. Oh, this is a very good one, and a good question that I just saw come in and I'm going to direct this one to Liz again, our payment lead someone to ask, can a 340B program participating practices join EOM Cohort 2? Liz, can you get into that a little bit?

Liz Ela: Sure, great question. It actually dovetails with another question that we received in advance, so, I'm going to sort of answer them both together. So, the first question, if you are part of the 340B program, or you work with facilities that are part of the 340B program, are you eligible for EOM? And that answer is yes, and that was true in the Cohort 1 as well. And the question that I want to sort of tie to this one was about whether 340B participation or non-participation is any kind of advantage or disadvantage in the model. And the answer to that question is no. So, when we're calculating opposite expenditures for the baseline period and the performance period TINs uses the standardized Medicare claims, and these standardized payment amounts actually remove the impact of 340B pricing. So instead of the real 340B price, they reflect the amount that would have been paid on that claim without 340B. So, this means that the impact of 340B pricing is actually removed from all EOM payment calculations, including the price prediction models, the experience adjuster, the actual expenditures for performance period episodes, the trend factors, any element of the methodology based on expenditures. So, this means that past or current 340B participation is neither an advantage nor a disadvantage in EOM. I want to build on that and just point out that EOM participants are not competing against each other in any way, so our benchmarking methodology does not pit you against each other. Your financial performance is not judged relative to other EOM participants. So, every EOM participant is sort of running their own race and trying to achieve savings relative to their risk adjusted benchmark and target amount which is calculated specifically for their set of performance period episodes in a given performance period. So, if you achieve savings relative to your target amount that doesn't have any impact on the benchmarking or expenditures for other EOM participants. And at the risk of straying from the original set of questions I also want to emphasize that as an EOM participant you're also not competing directly against your

own past selves. because benchmarks are informed by historical spending patterns in the national set of baseline period episodes, not just the spending levels in your PGP's own smaller set of baseline episodes. So, you're not even really competing against yourself to the extent that you're competing against anyone you're going to be competing against sort of a national status quo and to tie it back to the original question, your 340B status really has no bearing on your performance.

Alex Chong: Thanks so much, Liz, for one explaining a little bit or confirming that yes, 340B entities can participate in EOM, but also just walking through a little bit in terms of how our benchmarking works. I want to talk a little bit about a common question that we've been receiving, I think, especially within the Cohort 2, and you know, understanding that potential participants want to have a lot of information and good understanding of what your practice's expenditures and utilization patterns look like, and so, a common question that we receive is, when is it that we're going to actually share that historical data for applicants and potential participants? And so, we describe this as historical data, that is a definition of episodes prior to your start date. And so, what exactly is those historical episode periods going to cover, and will this data include actual costs, or is it going to be predicted costs? So, I want to start off by actually just distinguishing the difference between when we refer to as historical data versus a term that you may have heard being thrown around, which is the EOM baseline period data. So, EOM baseline period data is the set of episodes that we use for that benchmarking that Liz has been talking about, and that data is actually already available on the EOM website. These are de-identified public use files that includes all the baseline period episodes nationwide. So, these are episodes of data in which the episodes initiated on July 1, 2016, and ranging from July 1, 2016, to June 30, 2020. So, these are the episodes that inform price prediction models. And we can actually talk a little bit about price prediction models later, but also other elements of the benchmarking methodology like the trend factor. Also note that the EOM technical payment resources again, that information is available on our public website, it includes documentation that's relevant to those data files such as, the list of initiating therapies that have triggered those episodes or are applicable to those model baseline period. Later this fall, however, we are going to offer an applicant HIPAA covered data disclosure request, or as we shorten it to DRA. This is a form we're going to offer this to provisionally accepted applicants of the Cohort 2 when you sign this applicant DRA. So, this is a form for the data disclosure request in late fall of 2024 will then be able to have an opportunity to request to see this historical period of data. So again, not the baseline period, but it's a historical period of episodes of data in the spring of 2025. So, this information then, again, is not de-identified but it's actually specific to your practice. So, we'll show you the beneficiary identifiable historical data towards the end of 2024, it's going to include episode level data. Again, this episode level data is going to be unique to your practice and your beneficiaries. These will be for the historical episodes that are initiating in January of 2020, through December of 2022, so a little bit before when the model actually started. The baseline period data and the historical period data it's going to include actual expenditures. So, it gives you a nice reflection of what expenditure patterns looked like for unique to your practice prior to when the model started. It's also going to include price prediction model covariates, so it's possible to use this data to calculate the predicted expenditures for each episode. But to do this, you do need to refer to the price prediction model coefficients which are already included in the EOM technical payment resources file and are available on the website. Okay, and maybe actually, because I am referring a little bit to the price prediction models, maybe we can skip to another question that does talk about that. So, Liz, I'm going to turn to you again, and I'm just scrolling down. So, I mentioned before that the price prediction models are available on the public website. But, Liz, can you talk a little bit at a high level on what you know the price prediction? Models are.

Liz Ela: Sure. So, the price prediction models are cancer type, specific regret, regression models that predict expenditures for episodes, and they are created from the national cohort of baseline period episodes for each cancer type. So, one model per cancer type, seven models. And these models reflect or based on the spending patterns that are specific to each cancer type, and they risk adjust for many factors that were associated with the episode expenditures during that model baseline period that Alex was just describing. So just to give you some examples, some of the model covariates are things like beneficiary age, cancer related surgeries that beneficiaries received during episodes of dual eligibility for Medicare and Medicaid, or a number of comorbid conditions that are linked to higher spending in oncology episodes that's not an exhaustive list. There's more information about those covariates elsewhere, and I'm going to mention that in a second. So how do we use these models: When CMS is calculating a benchmark price for each EOM episode the first step in that process is to use the price prediction model for the appropriate cancer type to generate the predicted expenditures. So that's based on the specific characteristics of that beneficiary and their episode and the coefficients in those price prediction models. So, we apply the model to that episode, and then we obtain the predicted expenditures which are the output of that model. Now, if you'd like to refresh your memory on the price prediction models or the benchmarking process writ large. There are several resources on the EOM website that may be helpful. And we've mentioned some of these already today. But I'm going to go ahead and mention them again. So, there's a benchmarking fact sheet that walks through the steps to calculate the benchmark price of an episode. So, the first step like I mentioned is the calculation of the predicted expenditures using the price prediction models and then from there are a number of adjustments that are applied to obtain the final benchmark price for an episode. And that fact sheet walks through each of those steps at a relatively high level. To understand how we get to the benchmark price. There's also on the website slides, and a recording from the payment webinar that we held in July. and this webinar includes information on MEOS payments. the benchmarking methodology and the reconciliation process and finally, the EOM payment methodology document includes more detailed technical information about all of these topics and more. So, there's actually an appendix of that payment methodology document that has a lot of detailed information about the specific variables that are included as covariates in that price prediction model, and how they're created. And as always, really encourage you to take a look at those documents, and you can always contact the help desk if you have questions about what you're reading, to make sure that you understand how this whole process works. So, we're happy to help you out with those.

Alex Chong: Great thanks. So much, Liz. So, we talked earlier in terms of sharing what data that we would share with participants and applicants prior to their start of the model itself. Let's talk a little bit about what data that we, that actual participants can expect to receive once they are in the model and become a participant. So, I'm going to turn it back over to Mike, who is also our data sharing lead. Mike, can you tell the audience a little bit more about what data will be available through EOM once they actually become a participant?

Mike Berkery: Sure, and thanks, Alex. So, EOM participants will be provided monthly claims data to their data custodians as designated by the participant's DRA, that form and process that Alex mentioned. This includes beneficiary level claims data. In addition, claims data associated with the feedback reports and dashboards will also be available. These data could include but are not limited to beneficiary characteristics, expenditures like Alex said, utilization, and end of life measures following the conclusion of each performance period, EOM participants will receive reconciliation reports along with the underlying Medicare claims data and episode files for their attributed episodes.

Alex Chong: Okay, perfect. And, Mike, while we have you on the line, maybe can you also tell the audience a little bit about what once we actually once an applicant becomes a participant in EOM, can you talk a little bit about kind of like the learning support that we have for our participants. I think just understanding it's a lot of information out there, there's a lot of model requirements that, again, are going to different practices and have varying degrees of experience. So, tell us a little bit about our learning system in terms of the peer-to-peer learning supports, and again, just the opportunities that participants and the wealth of knowledge that participants would have access to meet the model requirements and share their experiences.

Mike Berkery: Yes, it's a great question, Alex, because, as you mentioned, this model has a lot of moving pieces, and we try to take it kind of step by step, it could feel daunting. But the good news is, there's lots of support through the TA side. But as you mentioned Alex, we also have a robust peer to peer learning system and community that identifies and shares resources and promising practices to support care transformation. And this is ongoing and continuous so, it isn't just once every once in a while. We try to have some frequent touch points with the participants and really be responsive to their needs and feedback. So, the learning system incorporates that feedback and ideas from the participants themselves. And we also leverage biannual survey data to inform learning materials, so this would be twice a year a survey that we'd send out and get data back from participants. So, this effort puts EOM participants at the center of the learning community and allows for bidirectional communication and knowledge sharing. Specific EOM learning system resources could also include online collaboration platform that we've developed case studies. We have innovation spotlights, we also host virtual learning events to go along with the virtual TA events, and we have quarterly affinity groups which are a little bit more smaller targeted, the idea being it's a little more of an intimate setting for the participants to speak peer to peer, and we work to group them by whether they're community-based hospital based. So, they're talking to not only their peers in the model, but that have similar structures, staffing, just similarities. So that's the goal of that component of the learning system. Thanks, Alex.

Alex Chong: Fantastic thanks. So much, Mike. And actually, just one more for you, Mike. Again, based on your position as a lead in in data sharing. And just because we talked a lot about the data that's available to our participants, the data that we are sharing to participants. But really, this is a bi-directional data sharing relationship that we have between CMS and our participants. So, we want to know what is the data sharing component of EOM, like in terms of like how participants will have to share data to us, for instance, reporting data.

Mike Berkery: Yes, another great question. So, I'll start with how participants submit their data to CMS to us and our team. So, for EOM participants and their EHR vendors will report all clinical data elements (CDEs) applicable to the ICD-10 diagnosis code for the cancer type using one of two reporting options. So, we have the first is a low-tech option which uses a template available within the EOM health data reporting or HDR application, while the other is a high-tech option via FHIR based API. I know it's a lot of acronyms, a lot of jargon and lingo, but again, we work really closely with EHR vendors and participants to make this as seamless and painless as possible. There's again, a lot of moving pieces to this, but we work iteratively, and we strive not to just expect this thing all at once. We work to create that feedback loop with the vendors that you all are working with locally and then with the participants themselves, of course. So, we've got a great team to help support this effort. Talk a little bit about FHIR base API, so reporting via FHIR based API, which is kind of a newer concept around the health, IT data space in the past few years enables the electronic sharing of healthcare data across systems. So basically, this allows different healthcare systems, such as hospitals or specialty clinics to share patient data seamlessly and securely so with

FHIR based API, EOM participants can use different healthcare applications really to talk to each other more easily, which improves interoperability and coordination of oncology care, APIs are have been common around for a long time, so anyone using you know their iPhones, their smart devices. similar applications, it's that same concept being operationalized for the model, and this applies also the SDE data can also be submitted via these two options with the Excel templates low-tech or the FHIR for the high-tech option. And then, in terms of getting data from CMS, what we send back to you all participants, EOM allows participants to request data from CMS to support continuous quality improvement and care planning. So, the types of data that EOM participants can request are things coming through like a quarterly feedback reports, semiannual reconciliation reports. As I mentioned previously, they're underlying claims, attribution lists, episode level files and monthly claims data. Again, this is done in partnership and collaboration, so the idea is that this isn't just getting pushed out there. We're thinking thoughtfully about what the mechanism and infrastructure looks like to actually get this data, so it is a thoughtful approach and the goal for both, all of this for data sharing is to minimize administrative burden and stress and make it as seamless as possible to support the requirements for the model and support your work. Thanks, Alex.

Alex Chong: Excellent, yes. Thank you so much, Mike. And to our audience, just as a high-level reminder, Mike talked to a little bit about some of the mechanisms of the data that's expected to be submitted was for CMS, we have in general, three data, 3 components of data that we expect to receive from our participants. And I think a couple of weeks ago we had a quality measures webinar so definitely go back into our resources and take a look at that. And then I think in a few weeks we'll talk a little bit more about two of our data submissions, which is surrounding sociodemographic elements that we require to be submitted, and we're actually planning on again, we need this data or we are requiring this data so that the data that we push back out to you all is much more richer in nature and ties it more specifically back to your patient population. And so for those of you who are familiar with, or have heard of our DFT, which is our dashboard feedback tool, but it's our dashboard data that oversees your beneficiary population, and having that stratified with sociodemographic elements to, I think, address again, ways and information and addressing your health equity strategy, which I'm going to get to there in in just a minute. And then we also again require our submission of clinical data elements that's used as a specific adjustment as part of your benchmarking, and then, of course, we have a set of quality measures that we also require to be submitted, and quality is tied to payment in terms of assessing what performance is looking like across the model. So, I know that kind of encapsulates a lot of information, but I do think it's a good segue to dive in a little bit deeper about a couple of those things. So, I'm going to actually turn these next couple of questions to Priya, who is our quality lead for EOM. And just at a really high level, Priya, can you talk more on how CMS calculates quality performance for EOM?

Priya Chatterjee: Thanks, Alex. So, CMS will compare an EOM participants performance on each measure to the measure's benchmarks. We would then calculate the EOM participants aggregate quality score, or what we call an AQS. And we crosswalk that to the EOM participants either performance-based payment, performance multiplier or performance-based recoupment performance multiplier as appropriate. And those details are located in our payment methodology on our website.

Alex Chong: Okay, fantastic. And Priya, I talked a little bit about the SDEs or sociodemographic elements and mentioned how that ties into our health equity, strategy. Can you tell the audience in terms of whether or not EOM, what the requirements are around a health equity plan, will EOM participants be required to submit one?

Priya Chatterjee: Yes, sure. So yes, as part of EOM, we do require a HEP to be developed and submitted as part of our using data for continuous quality improvement requirements. And so that that requirement is an iterative process, so we expect the HEP to be submitted annually. And we do encourage practices to use that as a kind of a living document, to make updates as needed on data sources and new interventions, and we have more exciting details about that forthcoming.

Alex Chong: Great? So, let's now actually talk a little in terms of when these data submissions are due to us in for CMS. So, for this question, I'm going to turn to Kiersten. Kiersten, could you tell the audience, or just help to clarify a little bit on what the reporting frequency is for the participant reported data?

Kiersten Lawrence: Sure, absolutely. So, when reporting clinical data elements and your sociodemographic data elements, that occurs twice per year for each performance period, and then the quality measure reporting that occurs annually. So, for quality reporting Cohort 2 will be responsible to report for the full calendar year of 2026, at the beginning of 2027.

Alex Chong: Yes, thanks, Kiersten, for talking to that timeline, especially for our second cohort. I want to switch gears just a little bit to talk about our MEOS payments or Monthly Enhanced Oncology Service payments. We receive a lot of questions around these, because these are really kind of the immediate questions or the immediate payments that practices are billing, especially in this startup of your implementation of the model requirements. And I think just recognizing that for the MEOS payment, this is a model specific payment that really the fundamentals of it is focused on care coordination, and patient navigation, ensuring that your patients have access to your clinicians and so forth. But we do also have across for Medicare other types of care coordination payments, and these are described as CCM codes. I wanted to ask this question to Sam Cox, who helps to oversee our MEOS payments for the model. Sam, could you tell the audience or just clarify for the audience, when thinking about again, just how a lot of these codes are floating around for services that are somewhat similar to one another, could a participant bill for those care coordination management codes, the CCM codes, or other care coordination codes in addition to the MEOS payments for the same beneficiaries, and what about the new service codes that were introduced in 2024? So specifically, the principal illness navigation codes, and things like that.

Sam Cox: Yes, sure. Thanks, Alex. So, there are some restrictions on billing for CCM codes and certain other care coordination codes in tandem with MEOS. Participants are not able to bill for these certain restricted codes and for MEOS for the same EOM beneficiary in the same calendar month, and those specific restricted codes will be listed in the participation agreement. But the new service codes that were introduced in 2024 are not restricted, so that includes the community health integration services, the principal illness navigation services, and the social determinant of health risk assessment codes all of those are permitted to be built concurrently with MEOS.

Alex Chong: Excellent. Thank you so much for that, Sam. I do also want to acknowledge that some applicants or participants may be concerned about comorbidities and issues related to COVID-19. And so, Sam, can you talk a little bit then about if a patient is diagnosed with COVID-19 during an episode of care, what does that mean for that episode of a patient that has COVID-19 in our model? And what does that also mean in terms of MEOS, can they bill for that MEOS?

Sam Cox: Yes. So, if the beneficiary is diagnosed with COVID-19 during an episode that would not be considered a valid episode. And so MEOS would be recouped for that episode.

Alex Chong: Okay, excellent. I'm going to just give it a minute or two here to see if there's any last-minute questions that are submitted, and in the meantime going to think a little bit more about maybe one or two questions that we think would be helpful to you all. So definitely encourage you again to put any questions if you think of any. Okay let's talk a little bit more then on I think, we just want to clarify again, what information is going to be available to applicants prior to the start of the model, and just a reminder in terms of the methodology that we have in place for EOM and why. And so, a common question that we receive is, does CMS plan to release benchmarks for the model? And so, I'm going to turn this one over to Liz again to give a little bit of insight on again our payment methodology, and when benchmark data will actually be available.

Liz Ela: Sure. So is a model with a retrospective, benchmarking methodology. So the benchmark prices, which are for individual episodes, and the benchmark amount which is the sum of all the benchmark prices for a given participant, and some other financial parameters will all be shared in the reconciliation report, and you can expect the initial reconciliation report approximately 8 months after the conclusion of the final episodes from a given performance period. And perhaps anticipating a question here, the reason that we can't provide the benchmark sooner than that is that many elements of that benchmark price for an episode actually depend on claims data and participant reported data that CMS can only obtain after the performance period is over. So even just starting with the episode dates, episodes start with the receipt of an initiating cancer therapy. But in many cases an episode could contain many claims for the drugs that all qualify as initiating therapies. So, if you think about a patient who's receiving multiple rounds of chemo, each of those individual administrations might potentially qualify as an episode trigger, and the start date is going to be the date of the first claim. So as new Medicare claims for initiating therapies are submitted over time, the apparent start and end date of an episode can kind of fluctuate. So, another uncertainty is that predicted expenditures, as I mentioned before, are risk adjusted for things like surgeries during the episode, bone marrow transplants during the episode. Some certain kinds of events during the episode that are likely to predict higher expenditures, but they can only be identified from claims after the fact. So, we need to wait in an appropriate amount of time for those claims to come in so that we can risk adjust the episode appropriately. The clinical adjusters for ever-metastatic status, and for HER2 status for breast cancer, are determined by participant reported clinical data elements, and those are submitted by the EOM participants after the performance period, once their episodes for that performance period have been identified and attributed. Another example is trend factors that are based on episode expenditure data among non-EOM oncology PGPs during that same performance period being benchmarked. So, we need to wait for those expenditures to be calculated before we can calculate an accurate trend factor. And I just want to acknowledge that we understand that retrospective benchmarking poses challenges for model participants. And we're very sympathetic to that, but in order to calculate benchmarks that respond appropriately to high-cost cancer treatments like surgeries, metastatic and HER2 status, and also market trends like increasing drug prices, we really need to wait for those really important data elements to become available so that we are able to appropriately benchmark your episodes. So that's the reason why we have this retrospective strategy, and again, you'll receive a reconciliation report approximately eight months after the conclusion of the final episodes from a performance period that will detail all of these different elements of the benchmark and your performance.

Alex Chong: Thank you so much for that insight, Liz, and that response. We're going to go ahead and close the Q&A for this office hours session for today. However, if later, you think of additional questions, or would like some more clarification or access to resources that we've mentioned here today during the webinar. Please do not hesitate to contact the EOM help desk at EOM@cms.hhs.gov and so we can go ahead and assist you with your specific question that you

think of later. This concludes our open Q&A session for today's office hours. I am now going to pass the call back to Becky Metzger, so Becky, if you could, please go ahead.

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Thanks so much, Alex, and we greatly appreciate everybody's great questions today.

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Next, we're going to just highlight some of the resources which may be helpful for your practice, as you're considering participating in EOM Cohort 2. All of these resources are available on the EOM model website. Just highlighting that there are several resources available for Cohort 2 specifically under Cohort 2 section and those are available and definitely beneficial for folks to take a look at. There are also EOM fact sheets, and those are great resources that give a high-level overview of some of the specific areas of the model and are very helpful for folks to take a look at. Additional resources include things like the EOM payment methodology that was referenced several times today. The EOM Clinical Data Element Guide, Quality Measures Guide, Sociodemographic Data Guide, Health Related Social Needs Screening Guide, ePROs guide, as well as the Health Equity Plan Guide, so all of those resources are available to participate to potential applicants on the EOM model website. In addition, the drug lists that are currently out there are also available which includes the EOM Initiating Cancer Therapies List and the EOM Novel Therapies List.

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As Alex mentioned, we definitely encourage folks to reach out. If you do have additional questions after this webinar, or at any point in time during your application process, you can again visit the EOM website. If you're looking for resources. And you can reach out to the help desk at EOM@cms.hhs.gov or the number is listed there as well, and we're happy to answer your questions. You can also subscribe to the EOM listserv that will ensure that you're included on continuing communication related to EOM.

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We want to thank you all again for your participation today. And with that I'm going to turn it over to Lisa to close us out.

Thank you, Becky, and thank you all for joining again. That concludes today's webinar. Enjoy your day.