ENHANCING ONCOLOGY MODEL

Payment Methodology Webinar

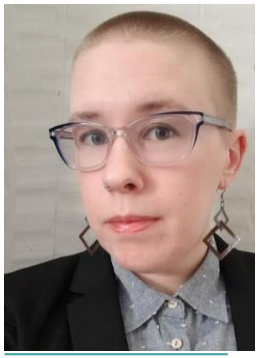
July 26, 2022

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

TODAY'S PRESENTERS

Alexandra Chong
EOM Team Lead

CMS Innovation Center



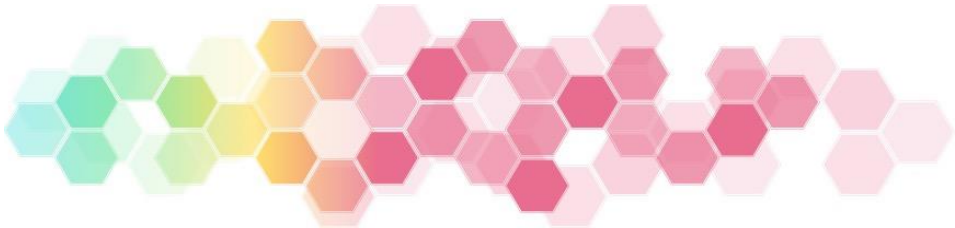
Elizabeth Ela
EOM Payment Lead

CMS Innovation Center

AGENDA

This webinar will provide an introduction of the Enhancing Oncology Model (EOM) payment methodology. The following topics will be discussed:

1. Overview of EOM & Key Concepts
2. Payment Methodology Overview & Examples
3. Q&A
4. Close & Additional Resources



OVERVIEW OF EOM AND KEY CONCEPTS

OVERVIEW OF ENHANCING ONCOLOGY MODEL (EOM)

EOM aims to drive care transformation and reduce Medicare costs

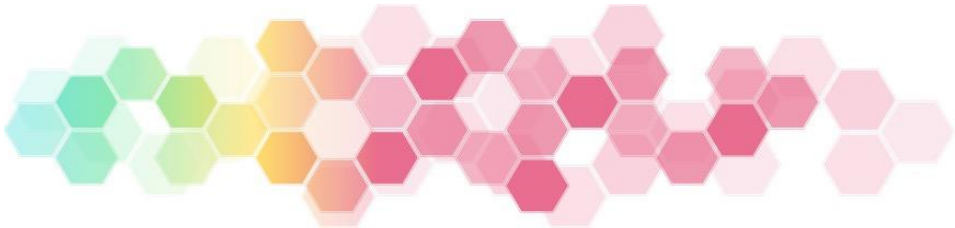
FOCUS

Five-year, **voluntary payment and delivery model** scheduled to begin July 2023 and conclude June 2028, that focuses on innovative payment strategies that promote high-quality, person-centered, equitable care to Medicare FFS beneficiaries with certain cancer diagnoses who are undergoing **chemotherapy treatment.**

PARTICIPANTS

Physician Group Practices (PGPs) and **other payers** (e.g., commercial payers, state Medicaid agencies) through multi-payer alignment.

Oncology PGPs participating **in other CMS models and programs** that provide health care entities with opportunities to improve care and reduce spending during the model performance period (July 2023-June 2028) will be **eligible to participate.**



OVERVIEW OF ENHANCING ONCOLOGY MODEL (EOM)

EOM aims to drive care transformation and reduce Medicare costs

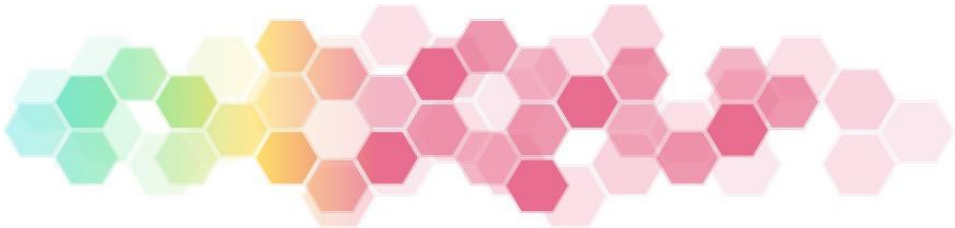
PAYMENT

EOM participants are paid FFS with the addition of **two** financial incentives to **improve quality** and **reduce cost**:

- Option to bill a **Monthly Enhanced Oncology Services (MEOS)** payment to support Enhanced Services.
- Potential **performance-based payment (PBP)** or **performance-based recoupment (PBR)** based on the total cost of care (including drugs) and quality measures during 6-month episodes that begin with the receipt of chemotherapy.

QUALITY

Payment will also be tied to quality measures. A future webinar will review the quality strategy of EOM.



EOM EPISODES

INCLUDED CANCER TYPES

Seven cancer types will be included in EOM: breast cancer, chronic leukemia, small intestine/colorectal cancer, lung cancer, lymphoma, multiple myeloma, and prostate cancer.

INITIATING CANCER THERAPIES

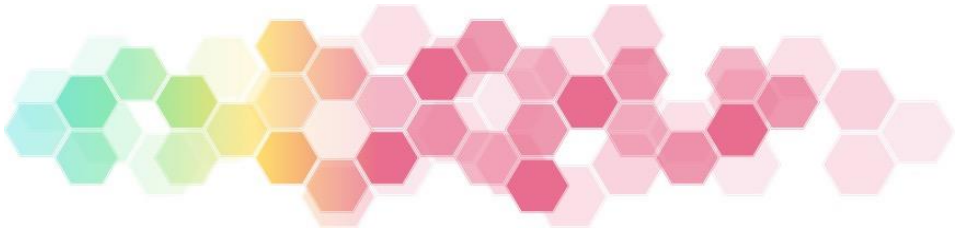
Each episode will begin with a **beneficiary's receipt of an initiating cancer therapy** and **must include a qualifying Evaluation & Management (E&M) service** during the 6-month period that follows. CMS will maintain a list of initiating cancer therapies.

EPISODE DURATION AND SCOPE

Episodes will last for **6 months** after a beneficiary's triggering chemotherapy claim.

EPISODE EXCLUSIONS

- Episodes during which a beneficiary is treated with a chimeric antigen t-cell therapy (CAR T-cell therapy) will be excluded.
- CMS will make a final determination about episodes with a COVID-19 diagnosis before the start of the model.



MODEL BASELINE PERIOD AND MODEL PERFORMANCE PERIOD

Anticipated Model Baseline Period*:

Episodes Initiating July 1, 2016 — June 30, 2020

BP1	July 1, 2016 to December 31, 2016
BP2	January 1, 2017 to June 30, 2017
BP3	July 1, 2017 to December 31, 2017
BP4	January 1, 2018 to June 30, 2018
BP5	July 1, 2018 to December 31, 2018
BP6	January 1, 2019 to June 30, 2019
BP7	July 1, 2019 to December 31, 2019
BP8	January 1, 2020 to June 30, 2020

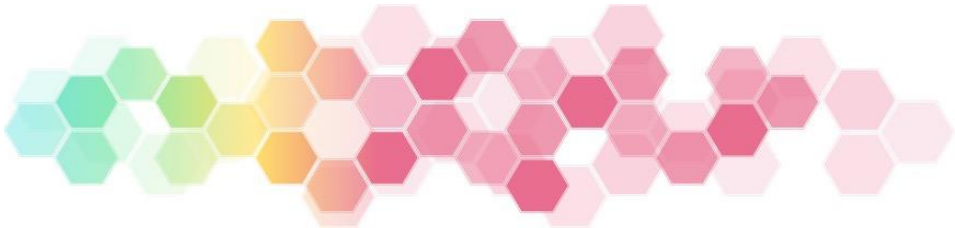
Model Performance Period:

Episodes Initiating July 1, 2023 — December 31, 2027

PP1	July 1, 2023 to December 31, 2023
PP2	January 1, 2024 to June 30, 2024
PP3	July 1, 2024 to December 31, 2024
PP4	January 1, 2025 to June 30, 2025
PP5	July 1, 2025 to December 31, 2025
PP6	January 1, 2026 to June 30, 2026
PP7	July 1, 2026 to December 31, 2026
PP8	January 1, 2027 to June 30, 2027
PP9	July 1, 2027 to December 31, 2027**

*CMS will finalize the model baseline period before the start of EOM.

**Model performance period ends on June 30, 2028 when all PP9 episodes have ended.



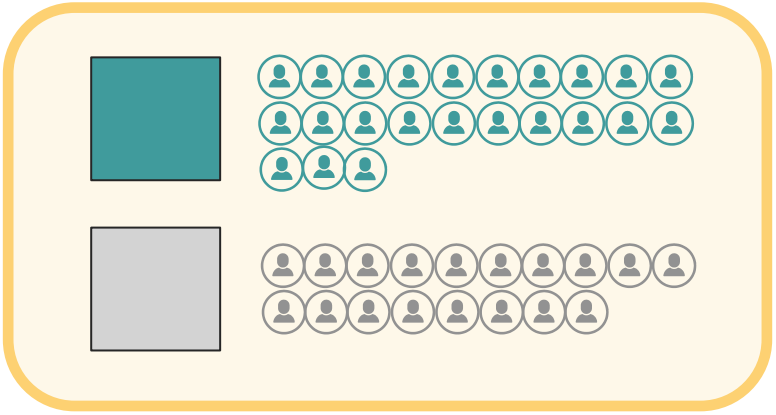
POOLING ARRANGEMENTS

Two or more EOM participants may choose to **form a pool**. EOM participants who pool together combine their information for reconciliation calculations.

For each performance period:

- Pooled participants select a **single risk arrangement** for their pool
- Episodes attributed to EOM participants in the pool are all **reconciled together**
- The pool receives a **single target amount** and may earn a **single PBP**, owe a **single PBR**, or fall into the neutral zone

Benchmark amounts, actual expenditures, eligibility for novel therapy adjustments, and quality performance are determined by a larger set of episodes when EOM participants pool together.



This may be especially helpful for EOM participants with fewer attributed episodes:

- more predictable benchmarking
- performance less sensitive to atypical episodes

The participation agreement will outline the requirements for a pooling arrangement.

PAYMENT METHODOLOGY OVERVIEW

OVERVIEW OF PAYMENT STRATEGY

Two Part Payment Approach*

Monthly Enhanced Oncology Services (MEOS) Payment

EOM participants will have the option to bill **MEOS payments** for **Enhanced Services** furnished to EOM beneficiaries.

The base MEOS payment amount will be **$70 per beneficiary per month**. CMS will pay an additional **$30 per dually eligible beneficiary** per month that is **excluded from the total cost of care.**

+ Retrospective Performance-Based Payment (PBP) or Recoupment (PBR)*

EOM participants and pools will be responsible for **the total cost of care (TCOC)** (including drugs) for each attributed episode. Based on total expenditures and quality performance, participants or pools may:

- **+** Earn a PBP
- **−** Owe a PBR
- **=** Fall into the Neutral Zone

*FFS billing will continue during the model.

EXAMPLE: PRACTICE A

Practice A:

- Hypothetical multispecialty physician group practice located in northern California
- Participating in EOM as a single PGP (not in a pool)
- Also participates in Primary Care First
- About 12% of Practice A's patients are dually eligible for Medicare and Medicaid

This hypothetical performance period includes episodes initiating July 1 — December 31. For this performance period, **16 EOM episodes** are attributed to Practice A: **10 breast cancer episodes** and **6 lung cancer episodes**.

Example is provided for illustrative purposes only and does not depict any real practice or patient

EXAMPLE: EOM BENEFICIARIES RECEIVING CARE FROM PRACTICE A

Cynthia

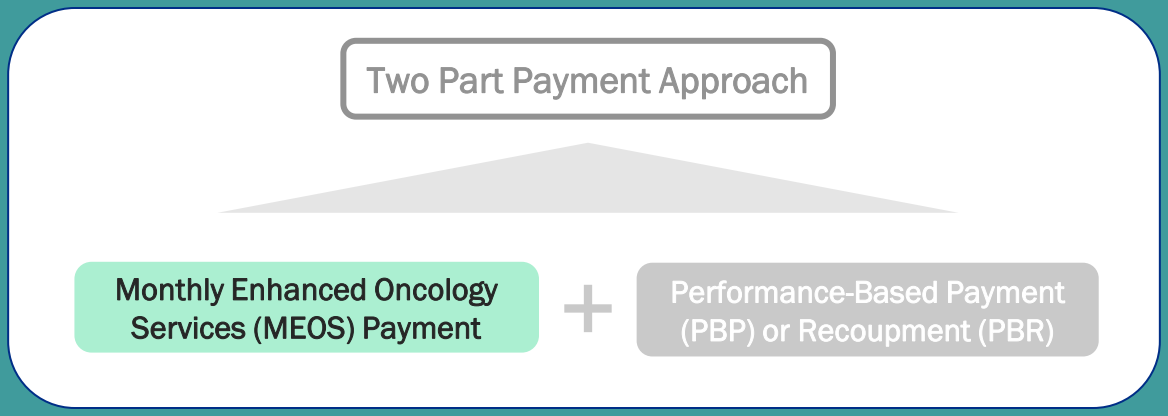
- Age 68
- Receiving treatment for breast cancer
- HER2-negative, never metastatic during episode
- Dually eligible for Medicare and Medicaid
- Participating in a clinical trial

David

- Age 74
- Receiving treatment for lung cancer
- Cancer metastatic at time of diagnosis
- Has hypertension
- History of prior chemotherapy
- Not dually eligible
- Also a beneficiary in Primary Care First (another CMS initiative)

Example is provided for illustrative purposes only and does not depict any real practice or patient

MONTHLY ENHANCED ONCOLOGY SERVICES (MEOS)



MEOS PAYMENT

Optional Monthly Payment

An EOM participant may bill Medicare for **up to six MEOS payments** for each EOM episode attributed to them.

Timing of Billing

Permissible dates of service range from 30 days prior to the start of the episode to 30 days after the end of the episode. EOM participants can bill for MEOS payments **either in real time or within 12 months following the date of service.**

Purpose of MEOS

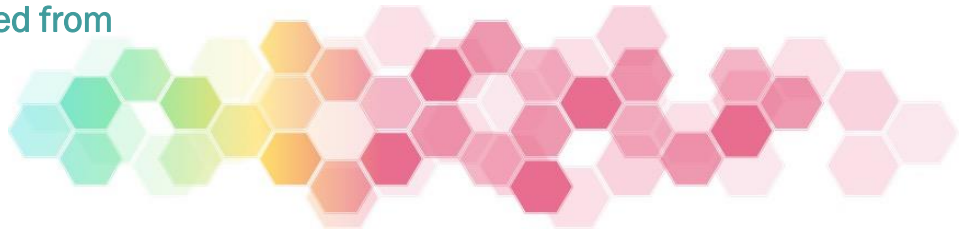
The EOM MEOS payment is intended to **support the provision of Enhanced Services.**

MEOS Payments & Total Cost of Care Responsibility

Included in total cost of care: the base amount ($70) of each MEOS payment billed for an EOM beneficiary

Excluded from total cost of care: the additional ($30) included in each MEOS payment billed for a **dually eligible beneficiary**

EOM participants and their EOM practitioners are prohibited from collecting beneficiary cost-sharing for MEOS payments.



PROHIBITED MEOS PAYMENTS

MEOS payments will be **prohibited in certain situations** to be detailed in the participation agreement. Examples of prohibited circumstances include:

- **>6** MEOS payments were billed for a single episode
- MEOS was billed with a date of service after the date on which an EOM beneficiary elected hospice or died
- The EOM participant failed to make Enhanced Services accessible to EOM beneficiaries
- Multiple MEOS payments were made for the same beneficiary with a date of service in the same calendar month
- The beneficiary was not in an episode attributed to the EOM participant or in the 30 days immediately before or after such episode
- MEOS was billed with a date of service after the EOM participant terminated from the model or under a legacy TIN
- The EOM participant billed Medicare for Chronic Care Management (CCM) services for an EOM beneficiary with a date of service during the same calendar month as the date of service on a MEOS claim

MEOS payments received under prohibited circumstances will be recouped.

MEOS PAYMENT RECOUPMENT REPORT

After each performance period, CMS will issue a **MEOS payment recoupment report to the EOM participant detailing any MEOS payments to be recouped.** This report will be issued twice for each performance period.

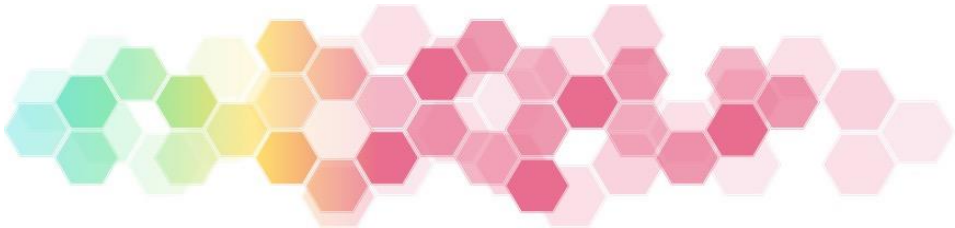
1 Initial Report

Based on at least **1 month** of claims run-out after the end of the performance period

2 True-Up Report

Based on **13 months** of claims run-out after the end of the performance period

EOM participants will have the **opportunity to review and contest suspected errors** in each MEOS payment recoupment report **before the report becomes final and the amounts owed become due.**

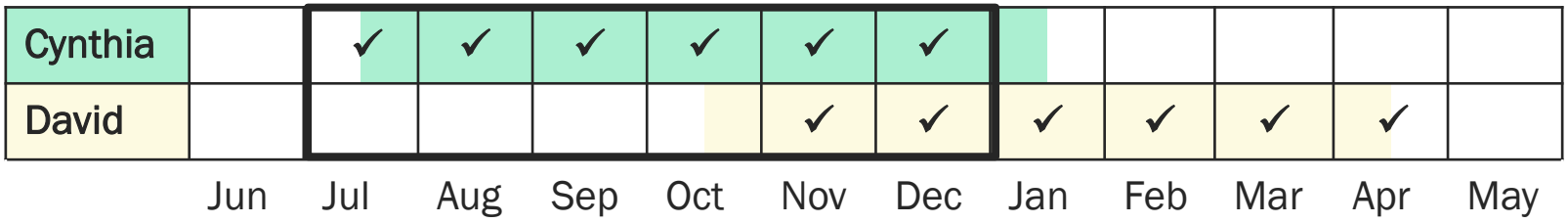


EXAMPLE: MEOS PAYMENTS

Practice A has the option to bill **up to 6 MEOS payments** for each of their 16 attributed episodes.

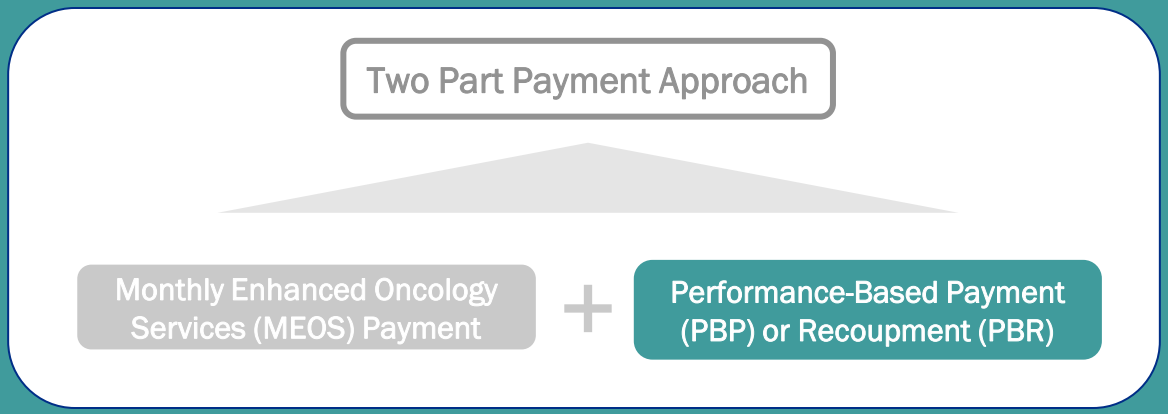
For episodes like Cynthia's that involve a **dually eligible beneficiary**, the amount of each MEOS payment is $100. For episodes like David's in which the beneficiary is **not dually eligible**, the amount of each MEOS payment is $70.

Practice A billed 6 MEOS payments for Cynthia's episode ($600 in total) and billed 6 MEOS payments for David's episode ($420 in total).



Example is provided for illustrative purposes only and does not depict any real practice or patient

PERFORMANCE-BASED PAYMENT (PBP) OR RECOUPMENT (PBR)



PBP, PBR, AND NEUTRAL ZONE

For each performance period, EOM participants and pools have the potential to earn a **performance-based payment (PBP)**, owe a **performance-based recoupment (PBR)**, or fall into the **neutral zone** (neither earning a PBP nor owing a PBR).

+ PERFORMANCE BASED PAYMENT

Total Expenditures < Target Amount
EOM participants or pools may earn a PBP if total expenditures for attributed episodes are below a target amount.

− PERFORMANCE BASED RECOUPMENT

Total Expenditures > Threshold for Recoupment
EOM participants or pools will owe a PBR if total expenditures for attributed episodes exceed the threshold for recoupment.

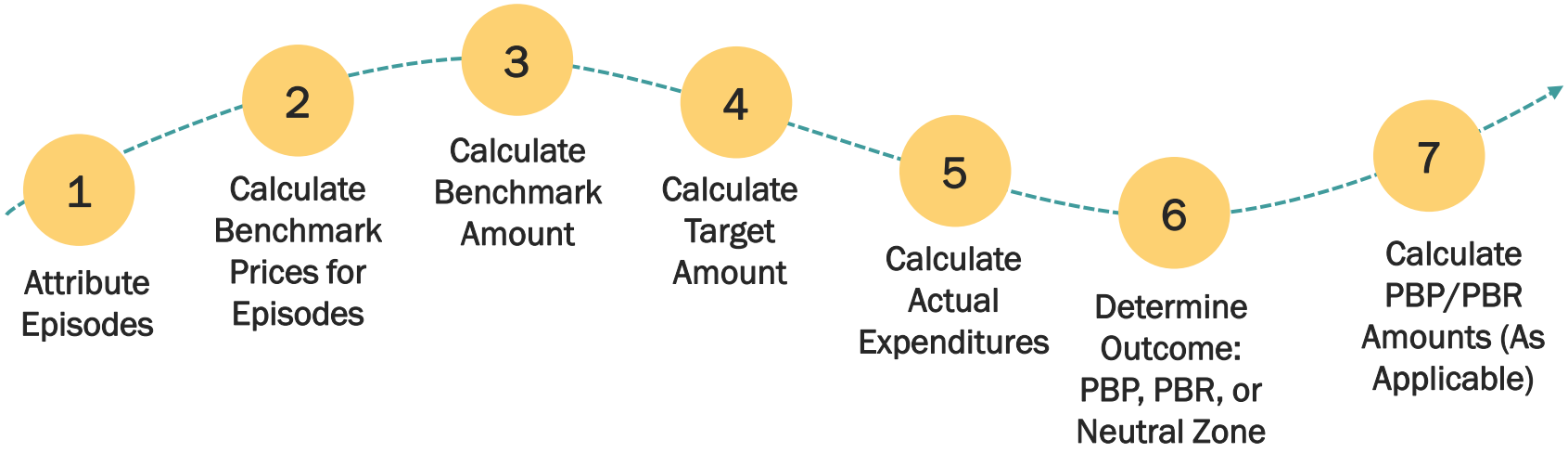
= NEUTRAL ZONE

Target Amount < Total Expenditures ≤ Threshold for Recoupment
EOM participants or pools will fall into the neutral zone if total expenditures for attributed episodes are above or equal to the target amount and below or equal to the threshold for recoupment.

THE RECONCILIATION PROCESS

During the reconciliation of each performance period, CMS determines whether each EOM participant or pool has earned a PBP, owes a PBR, or falls into the neutral zone. CMS also calculates PBP and PBR amounts as applicable.

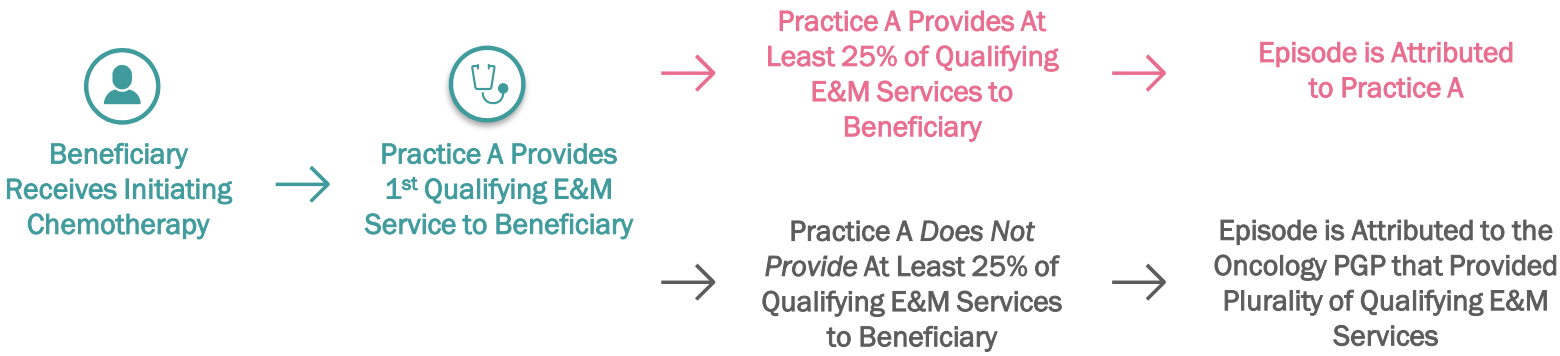
The major steps of the reconciliation process are described below. We provide details about each step in the subsequent slides.



ATTRIBUTION OF EOM EPISODES

EPISODE ATTRIBUTION RULES

- Episode attribution is based on **cancer-related E&M services**
- Episodes are attributed to the oncology PGP that provides the first qualifying E&M service* after the initiating chemotherapy, IF that PGP provides **at least 25% of all qualifying E&M services** to that beneficiary during the episode
- If the oncology PGP that provides the first qualifying E&M service *does not provide at least 25% of qualifying E&M services* during the episode, then the episode is attributed to the oncology PGP that provided **the plurality** of qualifying E&M services
- An episode may be attributed to an EOM participant or to a non-EOM oncology PGP



* See EOM RFA for the full set of criteria for qualifying E&M services

EOM BENEFICIARIES RECEIVING CARE FROM PRACTICE A

Cynthia's and David's EOM episodes are both attributed to Practice A

Cynthia

- Practice A provided Cynthia's first E&M after her initiating chemotherapy
- Practice A provided 45% of Cynthia's E&Ms throughout her entire EOM episode

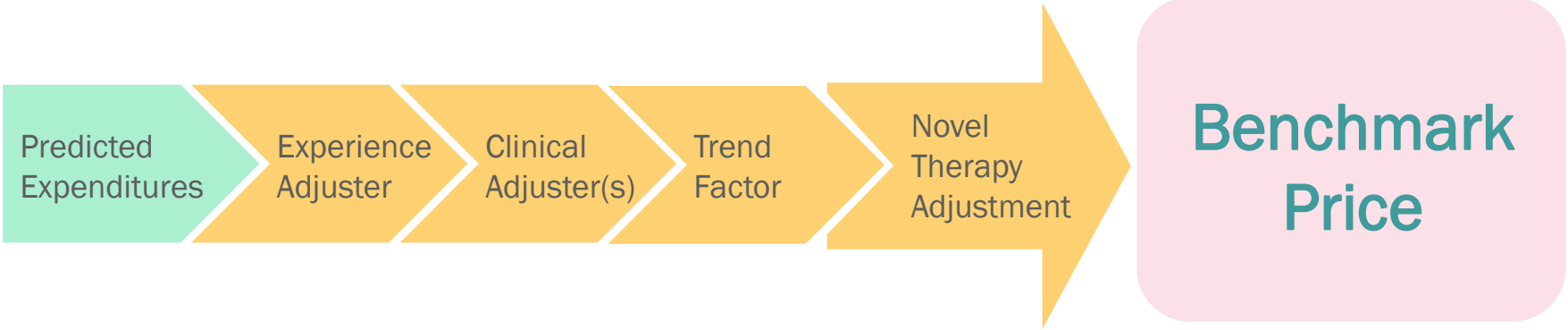
David

- David's first E&M was provided by a different oncology PGP
- David sought a second opinion from Practice A and received the majority of his care during the episode (90% of qualifying E&Ms) from Practice A

Example is provided for illustrative purposes only and does not depict any real practice or patient

CALCULATE BENCHMARK PRICES OF EPISODES

CMS will establish a risk-adjusted **benchmark price** for each performance period episode. We will use **cancer type-specific** price prediction models to obtain the **predicted expenditures** for each episode and then apply a series of **adjustments.**



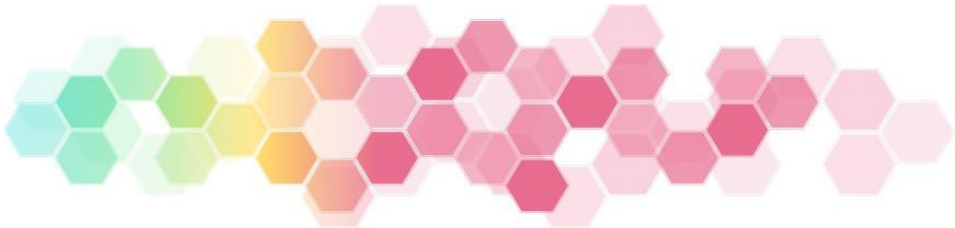
DETERMINE PREDICTED EXPENDITURES

CMS will create a separate **price prediction model** for **each included cancer type.** These price prediction models are **developed from baseline period episodes** (anticipated to include episodes initiating from July 1, 2016, through June 30, 2020).

Covariates*

Covariates include certain beneficiary and episode characteristics that **vary systematically among practitioners**, are likely to affect the cost of oncology care, and are generally beyond a practitioner's control. Examples include:

- Sex
- Age
- Dual eligibility for Medicare and Medicaid
- Part D enrollment & Low-Income Subsidy (LIS)
- Selected non-cancer comorbidities
- Receipt of selected cancer-directed treatments (e.g., surgeries, bone marrow transplant, radiation therapy)
- Participation in a clinical trial



** Not an exhaustive list*

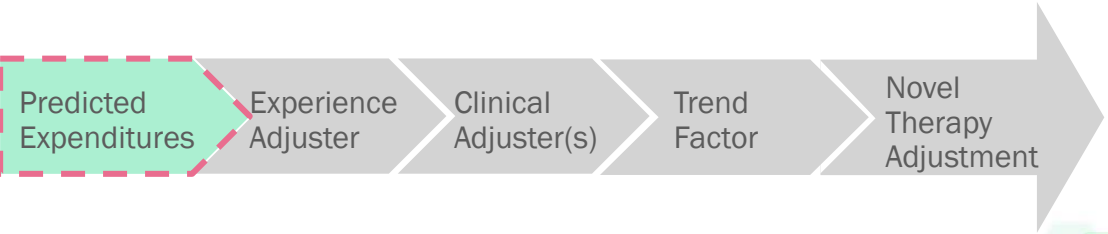
EXAMPLE: ESTABLISH PREDICTED EXPENDITURES

Cynthia

- CMS uses **the price prediction model for breast cancer** to establish the predicted expenditures
- The predicted expenditures reflect her **age, dual eligibility, clinical trial participation,** and other characteristics of her episode.
- **Predicted expenditures: $79,183**

David

- CMS uses the **price prediction model for lung cancer** to establish the predicted expenditures
- The predicted expenditures reflect factors such as his **age, hypertension,** and **history of prior chemotherapy**.
- **Predicted expenditures: $49,143**

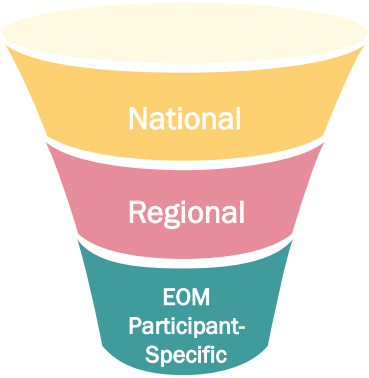


Example is provided for illustrative purposes only and does not depict any real practice or patient

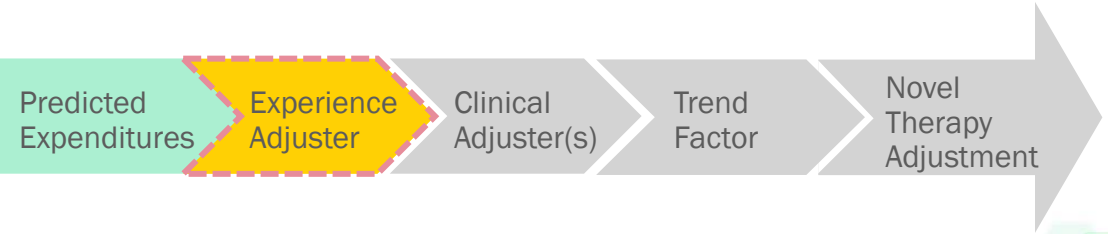
EXPERIENCE ADJUSTER

Predicted expenditures for each episode are multiplied by an experience adjuster that:

- Is specific to the EOM participant
- Adjusts for regional and participant-specific variation in cost of oncology care
- Is a weighted average of national, regional, and EOM participant-specific adjusters (weights depend on episode volume and cancer type distribution during model baseline period)



Practice A's experience adjuster* is **0.983.** Since Cynthia's and David's episodes are both attributed to Practice A, the predicted expenditures for each of their episodes are multiplied by Practice A's experience adjuster (0.983).



Benchmark Price

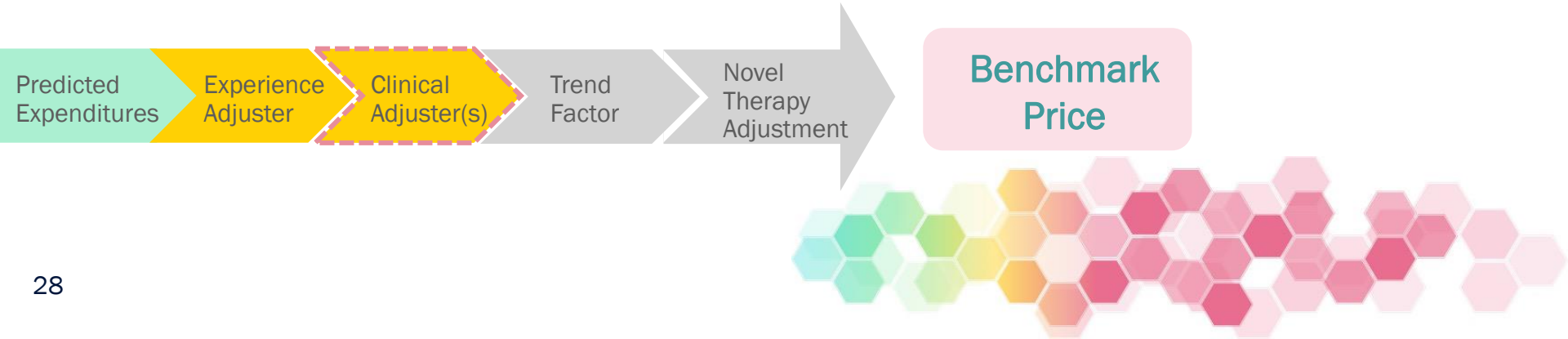
Example is provided for illustrative purposes only and does not depict any real practice or patient

CLINICAL ADJUSTERS

For certain cancer types only, predicted expenditures are multiplied by clinical risk adjusters.

Ever-metastatic status: breast cancer, lung cancer, and small intestine/colorectal cancer

Human epidermal growth factor receptor 2 (HER2) status: breast cancer



EXAMPLE: APPLY CLINICAL ADJUSTERS

Cynthia and David are both being treated for cancer types with applicable clinical adjusters. Predicted expenditures for their episodes will be multiplied by the clinical adjuster applicable to their cancer type.

Cynthia

- Breast cancer episodes are adjusted for ever-metastatic status and HER2 status
- In this example, the adjuster for non-metastatic, HER2-negative breast cancer episodes like Cynthia's is **0.86***

David

- Lung cancer episodes are adjusted for ever-metastatic status
- In this example, the adjuster for ever-metastatic lung cancer episodes like David's is **1.06***

** Actual values of EOM clinical adjusters are not yet available and will be announced before the start of the model.*

Example is provided for illustrative purposes only and does not depict any real practice or patient

TREND FACTORS

Predicted expenditures for each episode are multiplied by a **cancer type-specific** trend factor.

Trend factors account for ***systematic changes*** in the cost of oncology care between the **final baseline period** and a **specific performance period**:

- Based on change in average expenditures among episodes of a given cancer type attributed to non-EOM oncology PGPs
- A unique set of trend factors is calculated for each performance period

Predicted expenditures for Cynthia's episode are multiplied by the trend factor for breast cancer: **1.14**

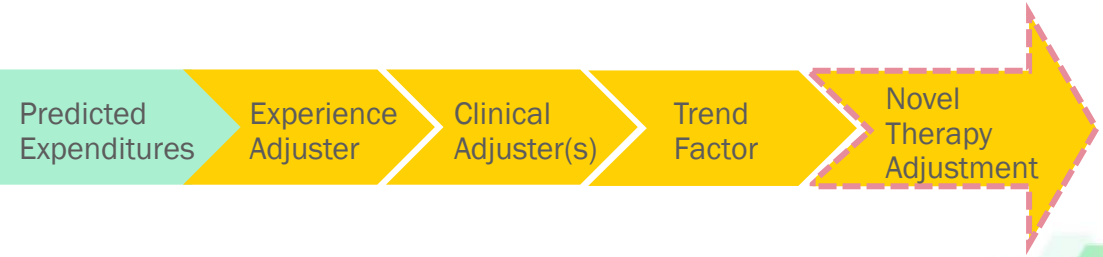
Predicted expenditures for David's episode are multiplied by the trend factor for lung cancer: **1.09**

Example is provided for illustrative purposes only and does not depict any real practice or patient

NOVEL THERAPY ADJUSTMENT

EOM participants and pools will receive a novel therapy adjustment for attributed episodes of a specific cancer type if their expenditures for that cancer type include an above-average share of expenditures for newly FDA-approved oncology drugs.

- For each included cancer type in each performance period, CMS will compare an EOM participant's or pool's **share of expenditures from new drugs** to the **average share among all episodes** of that cancer type attributed to non-EOM oncology PGPs
- A novel therapy adjustment **will *always* result in a higher benchmark price for the episode**, never a lower benchmark price



EXAMPLE: APPLY NOVEL THERAPY ADJUSTMENT(S) AS APPLICABLE

Breast Cancer Episodes Attributed to Practice A

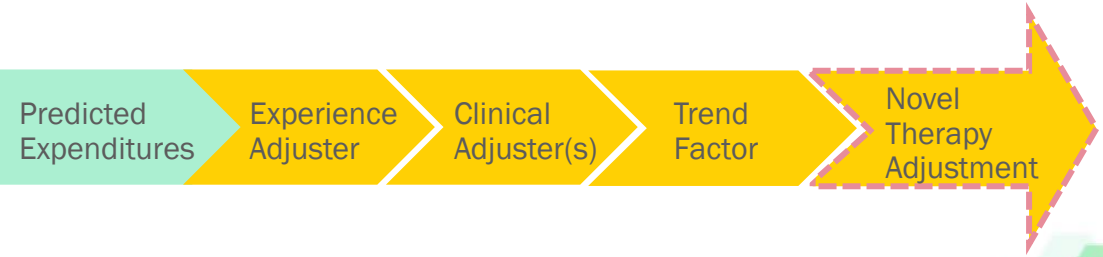
- High share of expenditures from new oncology drugs (above the average share among episodes attributed to non-EOM oncology PGPs)
- Practice A receives a novel therapy adjuster of 1.05 for breast cancer this performance period

Predicted expenditures for Practice A's breast cancer episodes (including Cynthia's episode) are multiplied by **1.05**

Lung Cancer Episodes Attributed to Practice A

- Low share of expenditures from new oncology drugs
- Practice A does not receive a novel therapy adjustment for lung cancer this performance period

Predicted expenditures for Practice A's lung cancer episodes (including David's episode) do not receive a novel therapy adjustment



Benchmark Price

Example is provided for illustrative purposes only and does not depict any real practice or patient

EXAMPLE: CALCULATE BENCHMARK PRICES FOR EPISODES

BENCHMARK PRICE FOR CYNTHIA'S EPISODE

Predicted expenditures	$79,183
X	
Participant A's experience adjuster	0.983
X	
Clinical adjuster for non-metastatic, HER2-negative breast cancer episode	0.86
X	
Trend factor for breast cancer	1.14
X	
Participant A's novel therapy adjustment for breast cancer	1.05
=	
Benchmark price	$80,127

BENCHMARK PRICE FOR DAVID'S EPISODE

Predicted expenditures	$43,269
X	
Participant A's experience adjuster	0.983
X	
Clinical adjuster for ever-metastatic lung cancer episode	1.06
X	
Trend factor for lung cancer	1.09
X	
Participant A's novel therapy adjustment for lung cancer (N/A)	--
=	
Benchmark price	$49,143

Example is provided for illustrative purposes only and does not depict any real practice or patient

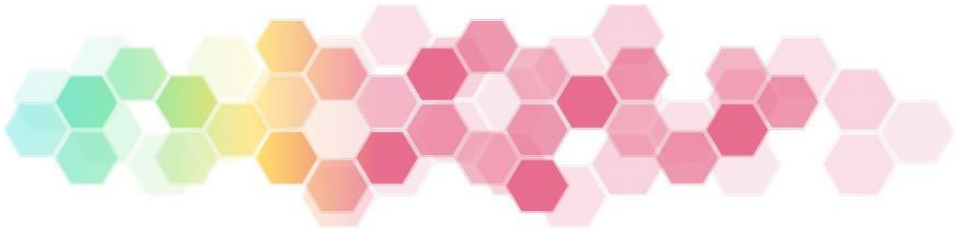
BENCHMARK AMOUNT

For an EOM Participant Not in a Pool

The benchmark amount is the sum of the benchmark prices for all episodes attributed to the EOM participant for a given performance period.

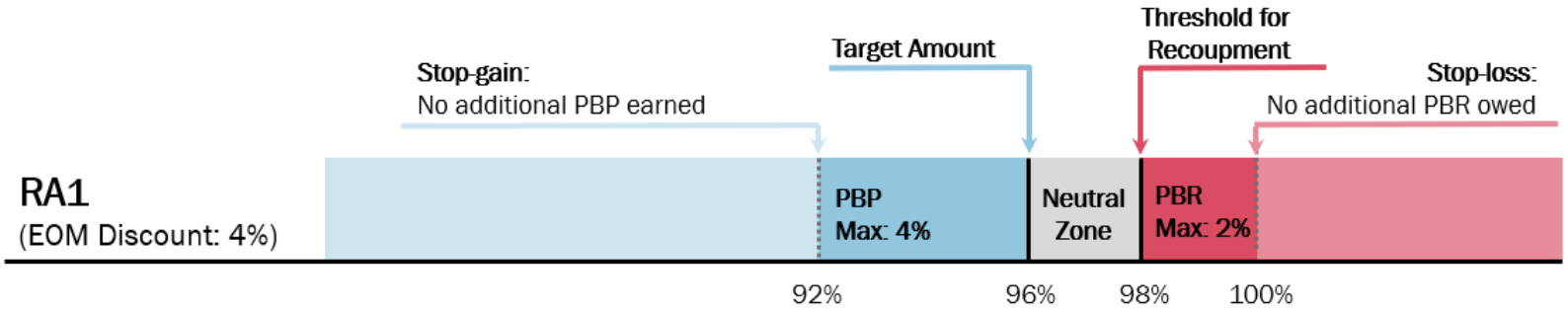
For a Pool

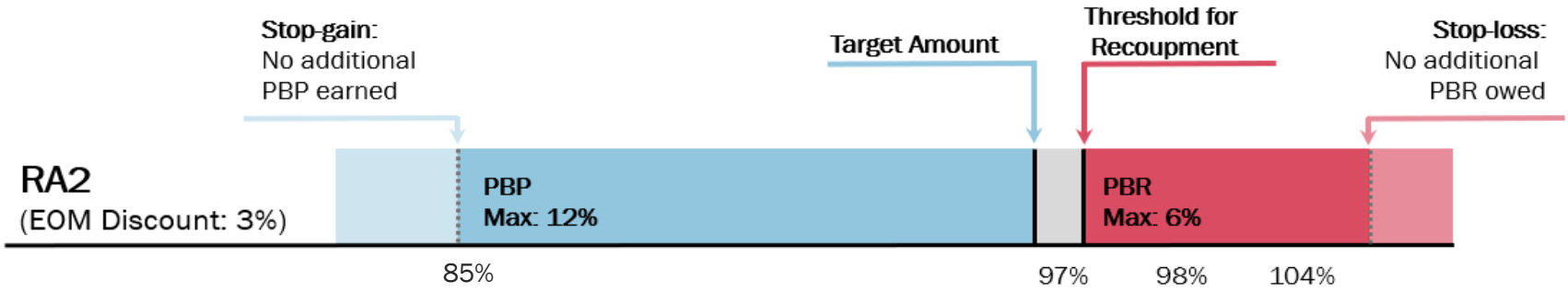
The benchmark amount is the sum of the benchmark prices for all episodes attributed to all EOM participants in the pool for a given performance period.



CALCULATE TARGET AMOUNT

The target amount for an EOM participant or pool is their **benchmark amount less the EOM discount.** Therefore, the target amount depends on the selected risk arrangement:





EXAMPLE: CALCULATE BENCHMARK AMOUNT AND TARGET AMOUNT

Practice A's benchmark amount for this performance period is the sum of the benchmark prices for all 16 episodes attributed to them:

Practice A's benchmark amount for this performance period is **$1,000,000**.

- Practice A has selected **RA1** for this performance period
- In RA1, the target amount is 96% of the benchmark amount
- Practice A's target amount: **$960,000**

Example is provided for illustrative purposes only and does not depict any real practice or patient

CALCULATE ACTUAL EXPENDITURES

EOM participants are accountable for the **total cost of care** for each attributed episode. EOM participants in a pool are **jointly accountable** for the total cost of care for all episodes attributed to participants in the pool.

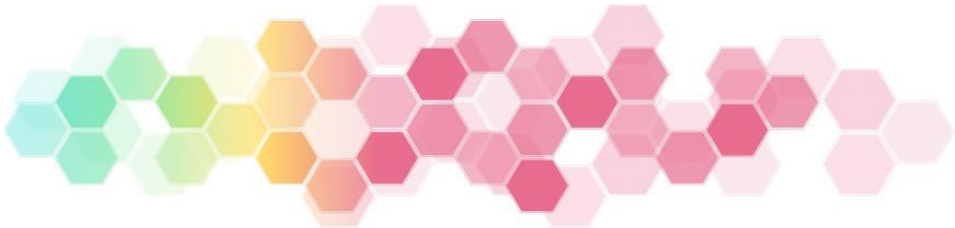
Episode expenditures will **include all Medicare expenditures for all items and services** provided to the **EOM beneficiary** during the episode **by any Medicare providers or suppliers.**

Included

- ✓ All non-excluded Medicare Part A and Part B FFS expenditures
- ✓ Certain Part D expenditures
  - — The Low-Income Cost-Sharing Subsidy amount
  - — 80% of the Gross Drug Cost above the Out-of-Pocket Threshold
- ✓ Certain payments from overlapping participation in other CMS initiatives
- ✓ The base amount ($70) of each MEOS payment billed for the episode

Excluded

- Certain MS-DRGs
- Any Part D expenditures not specifically included
- OCM-specific payments and recoupments (MEOS & PBP)
- The additional $30 included in each MEOS payment for a dually eligible beneficiary
- Payments from overlapping participation in other CMS initiatives that are not based on expenditures (e.g., based on quality)



OVERLAP WITH OTHER CMS PROGRAMS AND INITIATIVES

Overlap Adjustments

When determining actual expenditures, CMS will make adjustments to **account for overlap** between EOM and other CMS programs and initiatives:

- EOM participants may be participating in additional CMS initiatives
- EOM beneficiaries may be aligned to another CMS initiative

These adjustments ensure that expenditures **reflect amounts that would have been paid** by Medicare in the absence of other CMS initiatives, and that payments or recoupments are not **double counted.**

CMS initiatives that may overlap with EOM*

- ✓ Medicare ACOs
- ✓ OCM
- ✓ BPCI, BPCI Advanced, CJR, and MCCM
- ✓ Comprehensive Primary Care Plus (CPC+)
- ✓ Maryland TCOC and PARHM

* Not an exhaustive list; see EOM RFA for additional details about overlap

CALCULATE ACTUAL EXPENDITURES

CMS will sum the included expenditures for each performance period episode.

Episode expenditures reflect certain adjustments, such as:

- ✓ Overlap adjustments
- ✓ Winsorization adjustment to limit influence of outliers

Actual Expenditures for a Performance Period

For non-pooled EOM participants:

Sum of included expenditures for all episodes attributed to the participant

For Pools:

Sum of included expenditures for all episodes attributed to all EOM participants in the pool

EXAMPLE: CALCULATE ACTUAL EXPENDITURES

Cynthia's Episode Expenditures

- Include the base amount ($70) of six MEOS payments ($420 total)
- Exclude the additional $30 PBPM added to MEOS payments for a dually eligible beneficiary ($180 total)

David's Episode Expenditures

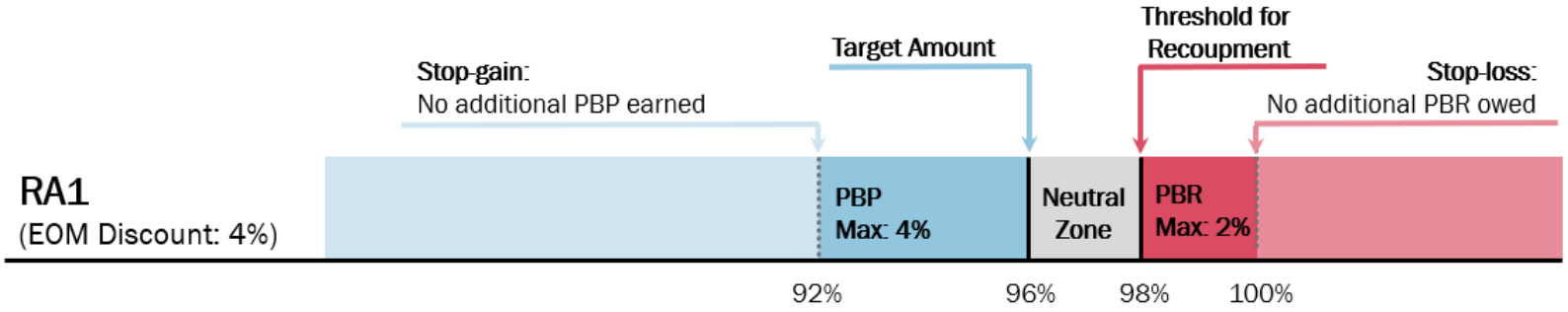
- Include six MEOS payments ($420)
- Include care David received for hypertension from a different Medicare provider.
- Reflect adjustments for overlap between Primary Care First and EOM.

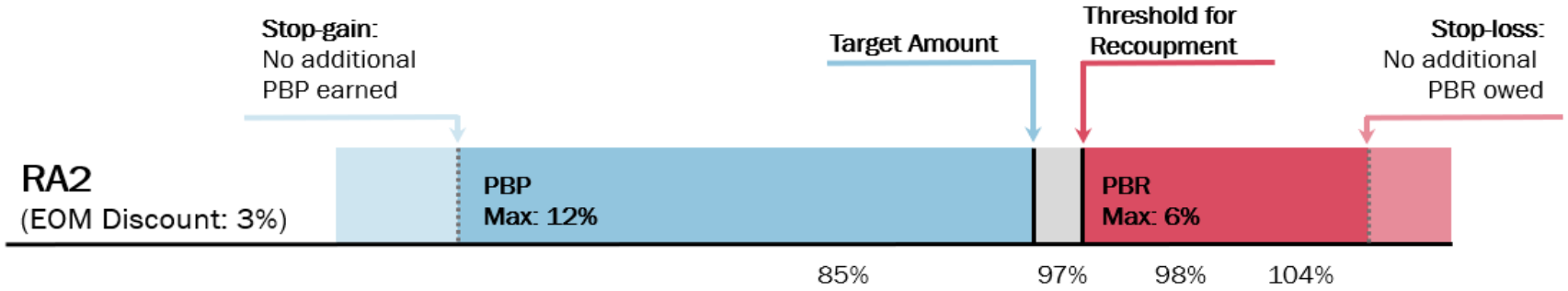
Practice A's actual expenditures for this performance period are the sum of the included expenditures for all 16 attributed episodes.

Example is provided for illustrative purposes only and does not depict any real practice or patient

DETERMINE OUTCOME: PBP, PBR, OR NEUTRAL ZONE

For each performance period, CMS will compare each EOM participant's or pool's **total expenditures** to their **target amount** and **threshold for recoupment** to determine whether they earned a PBP, owe CMS a PBR, or fall into the neutral zone.





DETERMINE OUTCOME: PBP, PBR, OR NEUTRAL ZONE

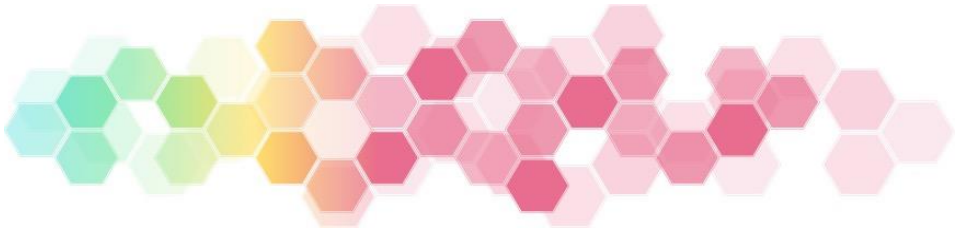
EOM participants or pools whose actual expenditures are below their target amount must meet additional criteria in order to receive a PBP. For a pool to receive a PBP, all EOM participants in the pool must meet the PBP eligibility criteria.

Eligibility to Receive PBP

The EOM participant or pool must satisfy all PBP eligibility requirements, including but not limited to:

- **Achieve an aggregate quality score (AQS)** that meets or exceeds the minimum performance threshold
- **Accurate, complete, and timely submission of data** in the time and manner specified by CMS on all of the required data elements
- **Implement the required participant redesign activities (PRAs)** during the relevant performance period, including furnishing Enhanced Services to EOM beneficiaries and using Certified Electronic health Record Technology (CEHRT) and data for continuous quality improvement (CQI)

PBP eligibility criteria will be detailed in the participation agreement.



CALCULATE PBP AMOUNT

If an EOM participant or pool has earned a PBP, CMS calculates their savings relative to their target amount.

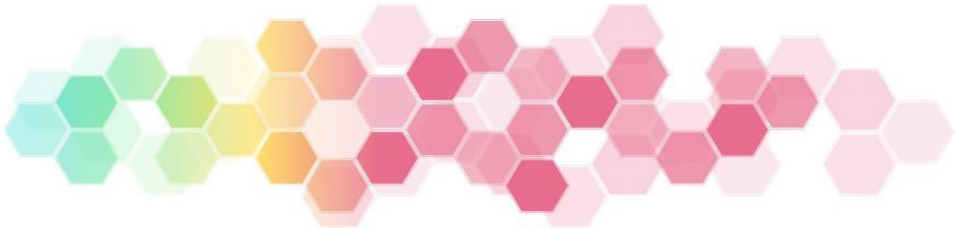
Savings = Target Amount – Actual Expenditures

PBP amount is based on **smaller of two amounts:**

- Savings relative to target amount
- Stop-gain under the selected risk arrangement

Risk Arrangement	Stop-Gain
RA1	**4%** of benchmark amount
RA2	**12%** of benchmark amount

This amount is multiplied by the **PBP performance multiplier** (based on quality performance), a **geographic adjustment**, and a **sequestration adjustment** to obtain the **final PBP amount**.



CALCULATE PBR AMOUNT

If an EOM participant or pool owes a PBR, CMS calculates their expenditures above the threshold for recoupment.

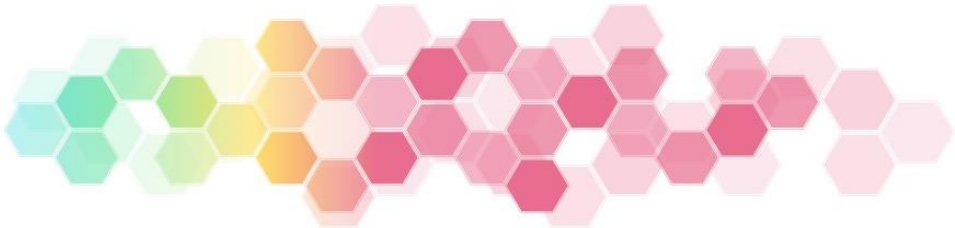
Expenditures Above Threshold for Recoupment = **Actual Expenditures - Threshold for Recoupment**

PBR amount is based on the **smaller** of two amounts:

- Expenditures above threshold for recoupment
- Stop-loss under the selected risk arrangement

Risk Arrangement	Stop-loss
RA1	2% of benchmark amount
RA2	6% of benchmark amount

This amount is multiplied by the **PBR performance multiplier** (based on quality performance), a **geographic adjustment**, and a **sequestration adjustment** to obtain the **final PBR amount**.



EXAMPLE: RECONCILIATION

Practice A's benchmark amount for this performance period is **$1,000,000**

Under Risk Arrangement 1 (RA1), this benchmark amount corresponds to:

Target amount	$960,000
Threshold for recoupment	$980,000
Neutral zone	Between $960,000 and $980,000
Stop-gain (4% of benchmark amount)	$40,000
Stop-loss (2% of benchmark amount)	$20,000

Additional Details:

- Practice A's quality performance for this performance period results in:
  - PBP performance multiplier of 0.75
  - PBR performance multiplier of 0.95
- Practice A met all other eligibility criteria to earn a PBP
- Practice A's geographic adjustment is 1.03.
- Sequestration has been in effect throughout the performance period

This information applies to all three scenarios on the following slides.

Example is provided for illustrative purposes only and does not depict any real practice or patient

EXAMPLE: SCENARIO 1

Actual expenditures for Scenario 1: $925,000

Less than the target amount ($960,000)

Outcome: Practice A has earned a PBP

Savings below target amount: $960,000 - $925,000 = $35,000

Practice A's savings are less than the stop-gain ($40,000), so the PBP amount is based on these savings.

PBP amount calculation:

$35,000 (Savings relative to target amount)	X	0.75 (PBP performance multiplier)	X	1.03 (Geographic adjustment)	X	0.98 (Sequestration adjustment)

Final PBP amount: $26,497

Example is provided for illustrative purposes only and does not depict any real practice or patient

EXAMPLE: SCENARIO 2

Actual expenditures for Scenario 2: $1,025,000

Above the threshold for recoupment ($980,000)

Outcome: Practice A owes a PBR

Expenditures above threshold for recoupment

$980,000 - $1,025,000 = $45,000

This amount exceeds the stop-loss ($20,000), so the PBR will based on the stop-loss.

PBR amount calculation:

$20,000 (Stop-loss) X 0.95 (PBR performance multiplier) X 1.03 (Geographic adjustment) X 0.98 (Sequestration adjustment)

Final PBR amount: $19,179

Example is provided for illustrative purposes only and does not depict any real practice or patient

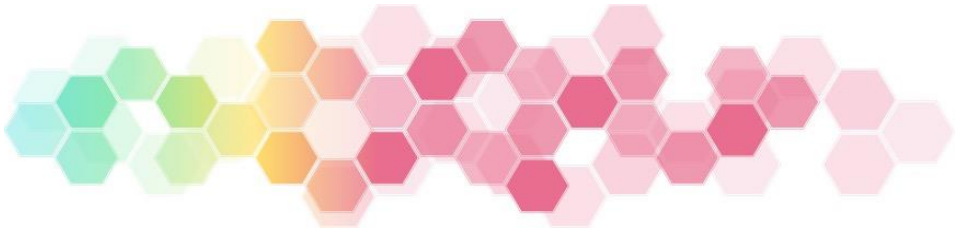
EXAMPLE: SCENARIO 3

Actual expenditures for Scenario 3: $975,000

Above the target amount ($960,000)
Below the threshold for recoupment ($980,000)

Outcome: Practice A falls into the neutral zone

Practice A does not earn a PBP or owe a PBR for this performance period.



Example is provided for illustrative purposes only and does not depict any real practice or patient

WHAT IF PRACTICE A HAD SELECTED RA2?

Practice A's benchmark amount for this performance period is $1,000,000

	RA1	RA2
Target Amount	$960,000	$970,000
Threshold for Recoupment	$980,000	$980,000
Stop-Gain	$40,000	$120,000
Stop-Loss	$20,000	$60,000
Scenario 1: Expenditures = $925,000		
Reconciliation Outcome	PBP	PBP
Final PBP Amount	$26,497	$34,067
Scenario 2: Expenditures = $1,025,000		
Reconciliation Outcome	PBR	PBR
Final PBR Amount	$19,179	$43,152
Scenario 3: Expenditures = $975,000		
Reconciliation Outcome	Neutral zone	Neutral zone

Example is provided for illustrative purposes only and does not depict any real practice or patient

RECONCILIATION TIMING AND REPORTS

Each performance period will be reconciled twice. EOM participants and pools will receive a **reconciliation report** and a **true-up reconciliation report** for each performance period.

1 Initial Reconciliation

Based on at least **1 month** of claims run-out after the end of the performance period

2 True-Up Reconciliation

Based on **13 months** of claims run-out after the end of the performance period

Q&A SESSION

EOM MODEL OPEN Q&A

Open Q&A

Please **submit questions via the Q&A pod** to the right of your screen.
Specific questions about your organization can be submitted to EOM@cms.hhs.gov.

ADDITIONAL RESOURCES

RESOURCES AND CONTACT INFO

For more information about the EOM and to stay up to date on upcoming model events:

Visit EOM's Website

innovation.cms.gov/innovation-models/enhancing-oncology-model

EOM Overview Webinar Recording and Materials are available on EOM's website.

Help Desk

EOM@cms.hhs.gov

1-888-734-6433 Option 3

Follow

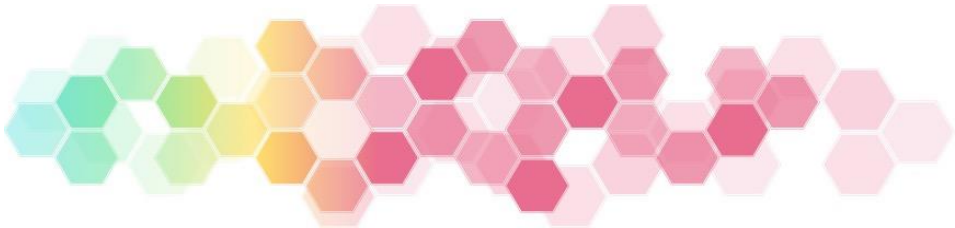
@CMSinnovates

Listserv

Sign up for the EOM listserv at this listserv registration link

UPCOMING EVENTS

EOM Event	Planned Date[1]
EOM Application Support + Office Hour	August 2, 2022
Quality Strategy Webinar	August 2022
Office Hours	September 2022



[1] Dates are subject to change

HOW TO APPLY

Application period for EOM is currently open
All EOM applications must be submitted by 11:59 pm Eastern Daylight Time on September 30, 2022. CMS may not review applications submitted after the deadline.

Submit application to https://app.innovation.cms.gov/EOM.
Submission of the PDF version of this application will not be accepted.

Refer to https://innovation.cms.gov/innovation-models/enhancing-oncology-model for directions on how to access the EOM RFA Application Portal
Once logged into the portal, there are further instructions on how to navigate the application included on the right-hand side of the home page by selecting the "User Manual" link.

Refer to the RFA on EOM website for further details
Further details regarding participation requirements and application submission criteria are available in the RFA on the https://innovation.cms.gov/innovation-models/enhancing-oncology-model. Applications will be reviewed for completion of all required fields and a signed and dated application certification.

Sign up for the EOM listserv
EOM will host additional recruitment events and release more resources during Summer/Fall 2022 to help potential participants understand the model before the application deadline. Sign up for the EOM listserv to learn about these materials as they are announced.

APPENDIX

SUMMARY OF STEPS TO CALCULATE BENCHMARK AMOUNT

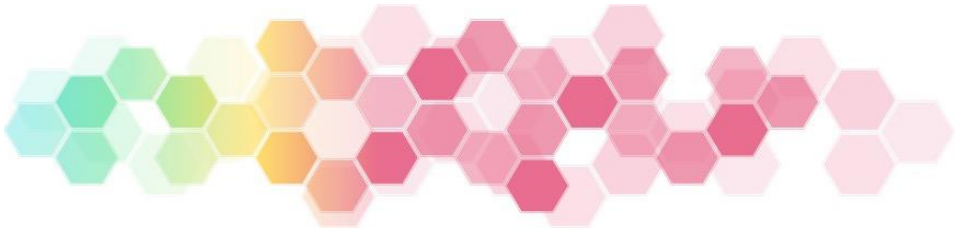
For each performance period, CMS will calculate a **benchmark price** for each episode and **total the benchmark prices** for all attributed episodes to obtain the benchmark amount for each EOM participant or pool.

1. Establish predicted expenditures for each performance period (PP) episode, using cancer type-specific price prediction models created from baseline period episodes
2. Apply EOM participant's experience adjuster
3. Apply clinical risk adjustments (for certain cancer types)
4. Apply cancer type-specific trend factor
5. Adjust for EOM participant's cancer type-specific use of novel therapies (if applicable) to obtain benchmark price for each performance period episode

---

6a ***For EOM participants not in a pool*:** Sum benchmark prices for all performance period episodes attributed to the EOM participant to calculate the benchmark amount

6b ***For pools*:** Sum benchmark prices for all performance period episodes attributed to all EOM participants in the pool to calculate the benchmark amount



OCM TO EOM HIGH LEVEL COMPARISON

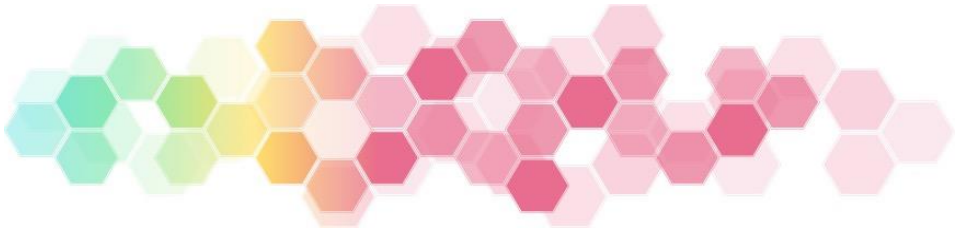
	OCM	EOM
Health equity	No explicit focus	Key element of design and implementation
Beneficiary population	Beneficiaries with all cancer types who receive chemotherapy or hormonal therapy	High-risk beneficiaries with certain cancer types receiving systemic chemotherapy only
Use of ePROs	No requirement	Required gradual implementation
MEOS payment	$160 PBPM for each OCM beneficiary	$70 PBPM for beneficiaries not dually eligible for Medicaid and Medicare $100 PBPM for beneficiaries dually eligible for Medicaid and Medicare
Attribution	Based on plurality of E&M claims	Based on initial care plus at least minimum care over time
Benchmark and novel therapy calculations	At the practice level; limited use of clinical data to inform risk adjustment	At the cancer type level; more robust use of clinical data to inform risk adjustment
Risk arrangements for performance-based payment	One-sided risk in performance period 1, followed by the option for one- or two-sided risk in performance periods 2-7 Participants earning a performance-based payment by the initial reconciliation of PP4 have the option to stay in one-sided risk in PP8—PP11; other participants must either accept two-sided risk in PP8—PP11 or be terminated from the model	Two downside risk arrangement options

*Please note this list is not exhaustive. For additional information on how EOM differs from OCM, refer to Appendix A of the EOM RFA

HEALTH EQUITY

EOM seeks to improve quality of care and equitable health outcomes for all EOM beneficiaries, including but not limited to:

	EOM Requirement	Description
1	Incentivize care for underserved communities	**Differential MEOS payment** to support Enhanced Services (base: $70 PBPM; $30 PBPM, outside of TCOC accountability, for dual eligible beneficiaries) TCOC benchmark will be **risk adjusted for multiple factors**, including, but not limited to, dual status and low-income subsidy (LIS) status
2	Collect beneficiary-level sociodemographic data	EOM participants will collect and report **beneficiary-level sociodemographic data** to report to CMS for purposes of monitoring and evaluation
3	Identify and address health-related social needs (HRSN)	EOM participants will be required to use **screening tools** to screen for, at a minimum, three **HRSN domains**: transportation, food insecurity, and housing instability Example HRSN screening tools: • NCCN Distress Thermometer and Problem List • Accountable Health Communities (AHC) Screening Tool • Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences (PRAPARE) Tool **Collect ePROs** from patients, including a HRSN domain*
4	Improved shared decision-making and care planning	EOM participants will be required to **develop a care plan** with the patient, including discussion of prognosis and treatment goals, a plan for addressing psychosocial health needs, and estimated out-of-pocket costs
5	Continuous Quality Improvement (CQI)	EOM participants will be required to develop a **health equity plan** as part of using data for CQI



RISK ARRANGEMENT OPTIONS

EOM will features **two risk arrangement options** that both include **downside risk** from the start of the model. EOM participants and pools can move between risk arrangements before the start of each performance period.

	Risk Arrangement 1 (RA1)	Risk Arrangement 2 (RA2)
EOM Discount	4% of the benchmark amount	3% of the benchmark amount
Target Amount	96% of the benchmark amount	97% of the benchmark amount
Threshold for Recoupment	98% of the benchmark amount	98% of the benchmark amount
Stop-loss / Stop-gain	2% Stop-Loss 4% Stop-Gain	6% Stop-Loss 12% Stop-Gain
Anticipated APM Status	✓ MIPS APM X Advanced APM	✓ MIPS APM ✓ Advanced APM

FINANCIAL ARRANGEMENTS

Pooling Arrangements

EOM will involve voluntary and mandatory pooling relationships between EOM participants.

In these relationships, the EOM participant will enter into a financial arrangement with one or more other EOM participants, where one EOM participant is designated as the pooled payee.

The pooled payee will receive PBPs or be responsible for the PBR on behalf of the pool.

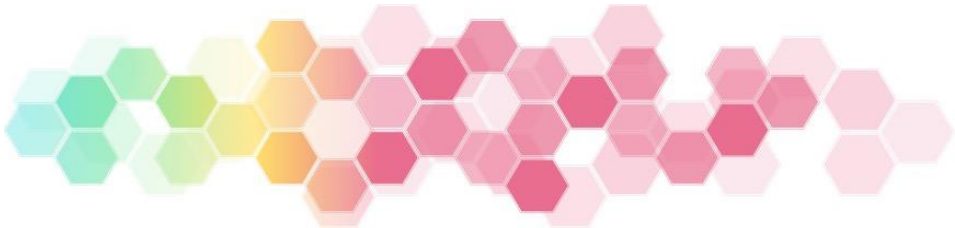
The “pooling arrangement” will permit each EOM participant party to the pooling arrangement to distribute PBPs to, or collect the PBRs from, other EOM participants in the pooling arrangement.

The participation agreement will outline the requirements for a pooling arrangement

Care Partner Arrangements

EOM participants may want to enter into financial arrangements with one or more Care Partner. Under such Care Partner arrangements, an EOM participant may share all or some of the PBPs they receive from CMS with its Care Partners and their Care Partners may share the responsibility for repaying PBRs to CMS.

If an Applicant wishes to enter into a Care Partner arrangement, it must submit a proposed Care Partner List during the application process



ELIGIBILITY: DEFINING EOM PARTICIPANTS AND PRACTITIONERS

EOM Participant

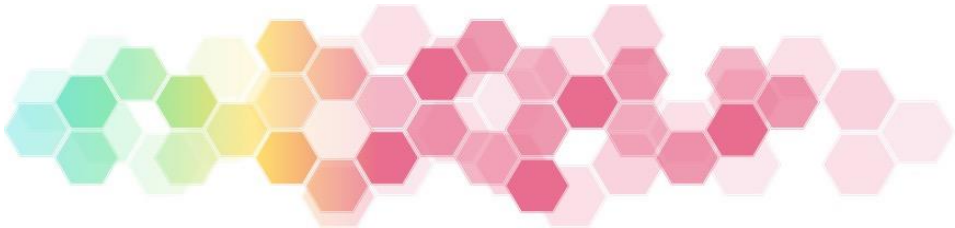
Must be a **Medicare-enrolled oncology PGP** identifiable by a unique federal taxpayer identification number (TIN).

- EOM Practitioner List: Must identify **one or more EOM practitioner(s)**, including at least one EOM practitioner must be an oncology practitioner with a specialty code of Hematology/Oncology or Medical Oncology.
- Excluded: Oncology PGPs that routinely refer beneficiaries to Prospective Payment System (PPS)-Exempt Cancer Hospitals (PCH) for chemotherapy services are not eligible to participate
- For EOM, unlike OCM, we plan to have participation requirements that allow a limited degree of flexibility for EOM practitioners simultaneously billing under the TIN of the EOM participant and the TIN of another PGP, while still preserving program integrity.

EOM Practitioner

Must be a **Medicare-enrolled physician or non-physician practitioner** (e.g., Nurse Practitioner) identified by an individual National Provider Identifier (NPI) who:

1. Furnishes E&M services to Medicare beneficiaries receiving chemotherapy for a cancer diagnosis
2. Bills under the TIN of the PGP for such services
3. Reassigned his or her right to receive Medicare payments to the PGP
4. Appears on the participant's EOM Practitioner List (to be updated semiannually)



DEFINING ELIGIBLE BENEFICIARIES

Eligible Beneficiary

CMS will include a Medicare FFS beneficiary in EOM in the event that they satisfy the below criteria and are in an episode attributed to an EOM participant.

Beneficiary Eligibility Criteria:

- Has a diagnosis for an included cancer type
- Receives an initiating cancer therapy that triggers an episode
- Receives a qualifying E&M service from an oncology PGP during the episode
- Is eligible for Medicare Part A and enrolled in Medicare Part B for the entirety of the episode
- Is not enrolled in any Medicare managed care organization, such as Medicare Advantage, at any point during the episode
- Is not eligible for Medicare on the basis of an End Stage Renal Disease (ESRD) diagnosis at any point during the episode
- Medicare is the primary payer for the entirety of the episode

DATA SHARING AND HEALTH IT

EOM PARTICIPANT DATA SHARING

DATA COLLECTION STRATEGY

Electronically enabled mechanism to report model-related data abstracted from the EOM participant's own health IT

TYPES OF DATA

1. Quality measure data
2. Clinical and staging data
3. Beneficiary-level sociodemographic data

TIMING

EOM participants will be required to report data at a time and manner specified by CMS, but no more than **once per performance period**

CMS DATA SHARING WITH PGPs

QUARTERLY FEEDBACK REPORTS

SEMIANNUAL RECONCILIATION REPORTS, ATTRIBUTION LISTS, AND EPISODE-LEVEL FILES

MONTHLY CLAIMS DATA