EOM OVERVIEW AND APPLICATION SUPPORT WEBINAR

June 24, 2024

ENHANCING ONCOLOGY MODEL

Slide 1

Hello! Welcome to the Enhancing Oncology Model Overview and Application Support Webinar. We are very grateful and humbled by all of you for taking the time to join us today. Now, I am going to turn the call over to my Enhancing Oncology Model colleague, Becky Metzger, Becky, the virtual floor is now yours. Thanks so much, Chris. Hello, and welcome again to the Enhancing Oncology Model Overview and Application Support Webinar. My name is Becky Metzger, and I'm going to be kicking off today's event. We're excited you're here, and we're very excited that you're interested in participating in the Enhancing Oncology Model.

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Before we dive into the content, let me give you a brief overview of the agenda for today's webinar. We'll begin with some opening remarks from Batsheva Honig, the EOM Model Lead, followed by an overview of the Enhancing Oncology Model provided by the CMS EOM team. We'll share more information on the goals of EOM and its design elements, then we'll provide a brief demonstration of the EOM Application Portal to assist applicants in understanding the submission process. We'll share a timeline of EOM's Application and Implementation schedule, followed by a brief Q&A session where our team will answer questions submitted by audience members.

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I'd like to introduce our CMS Innovation Center speakers for today. We have four speakers in total, including Batsheva Honig, the EOM Lead; Elizabeth Ela, the EOM Payment Lead; Priya Chatterjee, the EOM Health, Equity and Quality Lead, and Mike Berkery, the EOM Payer and Learning Lead. With that I'll turn the presentation over to Batsheva Honig to dive into the topics for today. Batsheva, take it away.

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Good afternoon and thank you all for joining us today. My name Batsheva Honig, and I'm the Model Lead for EOM. First, I just want to say how excited we are to talk with you all today this afternoon, whether you've been with us through the oncology care model, have had interests and are currently participating in EOM or newer to value-based care and oncology. I want to welcome you all to today's webinar. Importantly, I want to recognize the wide range of external partners and pillars of the oncology community joining us today. Critical to our success is our partnership with you all, from patients themselves, to oncologists, nurses, and the whole care team, to other payers, and to many other individuals, organizations and others in the oncology community, I just want to emphasize that we consider you to be vital to EOM, and we want to hear from you all as you learn about the model and the second application period. We're looking forward to collaborating with you all in the weeks, months, and years to come. Finally, before we dig into the model design, I want to emphasize that, just to be clear from the get-go why we're here. The Enhancing Oncology Model is centered around the patient. We are focused on delivering the best possible outcomes and experience for all cancer patients, which is all too often, many times includes ourselves and our loved ones.

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Our statutory authority for testing models states that purpose of the center is to test innovative payment and service delivery models in order for us to reduce program expenditures while preserving or enhancing the quality of care for individuals under such titles. All of the models that are coming out of CMMI are striving to meet this goal. We have three scenarios for success based on this statute, for all of the models coming out of CMMI, including EOM. These three scenarios for success include one, if we see through our model tests that quality improved, but that cost is neutral. The second scenario is, if a model test shows that quality is neutral, but we see the costs are reduced. Finally, the third scenario is that we hope to see that both quality improves, and cost is reduced. This is the best-case scenario, and this is, of course, what we're hoping to see in EOM.

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The Innovation Center, as I touched on, is created for the purpose of testing and delivering innovative healthcare payment and service delivery models for Medicare, Medicaid and CHIP programs nationwide. For our strategic refresh established in 2022, we have five key areas that we hope to meet. EOM addresses all five pillars in some way across all of these: driving accountable care, advancing health equity, supporting innovation, addressing affordability, and partnership for care transformation. In EOM we see alignment in driving accountable care through total cost of care, responsibility, addressing affordability by inserting lower cost sharing for care and treatments for beneficiaries, and, of course, as well as advancing health equity through strategies such as screening for health-related social needs, as well as providing additional funds for dually eligible beneficiaries. There's a lot of disparities that exist within cancer care itself, including, but not limited to things such as differences or delays in the initiation of cancer therapy and more advanced stage of diagnosis. There's also underrepresentation and access to clinical trials, decrease in medication, adherence among certain populations, as well as more frequent hospitalizations and lower enrollment in hospice. For EOM, we strive to close and reduce some of these gaps that exist. We hope to drive transformation in oncology care by preserving or enhancing the quality of care furnished to beneficiaries undergoing treatment for certain cancer types with the expectation that such transformations will reduce Medicare expenditures. The importance of addressing many of these disparities and issues within cancer care have been emphasized within President Biden's Cancer Moonshot. EOM supports the main pillars of the Cancer Moonshot as well as the Innovation Center's specialty strategy building on the momentum on condition and episode-based models.

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I'm now going to touch on more details on the concepts and goals of EOM. We recognize, especially through our experience with EOM’s First Cohort and OCM, that much dedicated efforts have been made amongst you all in the cancer care community. But there is still much to be done. As so many of you know, and unfortunately many have been touched personally, cancer is one of the most common and devastating diseases in the US. It is estimated that over 1.9 million people have been diagnosed with cancer, and it is also noted that over 609,000 deaths have been estimated due to cancer in 2023, with cancer being the second leading cause of death.

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EOM is a voluntary total cost of care model for cancer therapy episodes that is designed to test innovative payment strategies that promote equitable, high-quality, evidence-based cancer care. At a high-level overview of EOM, we hope to continue to drive care transformation and focus on the patient. EOM is a voluntary payment and delivery model that began with our first Cohort in July 1, 2023. We are now offering a second application period for Cohort 2 with participation for Cohort 2 beginning in July 1, 2025, the model will end for both cohorts on June 30, 2030. Implementation of the model is already in progress for Cohort 1, and we have already begun focusing on the innovative payment strategies and promoting high quality, person-centered care to Medicare fee-for-service beneficiaries. The target participants for EOM are oncology physician group practices that function under a TIN, or Tax Identification Number, as well as other payers, given that this is a multi-payer model which we'll go into more in coming slides. A little insight on quality and payment, EOM has two financial incentives to improve quality and reduce costs in order to help support care transformation, we are providing once again a Monthly Enhanced Oncology Services payment or MEOS payment. We'll talk about this more in the coming slides. For the second financial prong of EOM, there is potential for the earning of a performance-based payment, or participants may owe CMS a performance-based recoupment based on total cost of care. This also includes drugs, and we also link quality to payment, and that EOM participants owing CMS performance-based recoupment may have their recoupment amount reduced by performing well on quality measures. We will talk a bit further about risk arrangements in the payment methodology section.

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As those in attendance are aware, we have been very excited to announce the second round of applications for additional practices and payers to join the model. Beginning in July of 2025, applications will open for submission in our online application portal next week, July 1, 2024, and the submission deadline is September 16, 2024. In addition, for those who may be familiar with the original EOM design and methodology, we've recently announced several refinements to the model's payment policies that would apply for both cohorts. This announcement also included an extension of the model by two years, to conclude in June 30, 2030, for both cohorts as mentioned on the previous slide. Turning to some of the refinements to the payment methodology, these include an increase to the amount that's being paid for providing enhanced services via the MEOS, or the Monthly Enhanced Oncology Services payment, which is really designed to provide additional support to practices to support your success in EOM. Specifically, the base MEOS payment has been increased from $70 to $110 per beneficiary per month. We continue to offer an additional $30 for dually eligible beneficiaries outside of total cost of care responsibilities for a total of $140 per beneficiary per month for these patients. Another policy change is that participants will now pay CMS back costs related to their patient's care when it exceeds 100% of the calculated benchmarks as opposed to the current payback when costs exceed 98% of the benchmark. We'll go into more detail on this in later slides as well. These policy updates will be effective starting January 1, 2025, for current EOM participants, and starting July 1, 2025, for the second Cohort of EOM participants. EOM continues the administration's commitment to improving cancer care for all Americans and adding a second cohort of participants, extending the model and updating payment policies, more patients undergoing cancer treatment and their families will have access to the enhanced services offered under the model and high quality of care, and more members of the oncology community will

be able to help CMS shape the future of cancer care. We are excited to offer another opportunity for additional oncology practices to gain experience in value-based care. We believe the experience gained through participation in EOM will better position oncology practices for the future of where cancer care and payment reform is headed.

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Next, we'll go into more details regarding the model design and goals.

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All right, let's talk a little bit about eligibility, and who is eligible to participate in EOM. To apply as an EOM participant, you must be a Medicare enrolled oncology physician group practice that is identifiable by a unique federal Taxpayer Identification Number (TIN). Participation is TIN based in EOM. That means that within your PGP or oncology practice you need to have at least one EOM practitioner in your PGP that bills under your TIN, and that oncology practitioner must have a specialty code of hematology oncology or medical oncology. Entities such as oncology PGPs that routinely refer beneficiaries to PPS exempt hospital centers' cancer treatments, are not eligible to participate. In addition, clinical access hospitals, FQHCs and Rural Health Centers are also excluded for participation in EOM. EOM participants are allowed to have limited billing overlap with other oncology TINs meaning their practitioners can provide some oncology care under the TINs of another oncology PGP. For more information about EOM billing policies and overlap policies please see the EOM Payment Methodology document which is available on the model website. For eligibility requirements for an EOM practitioner, this must be a Medicare enrolled physician or non-physician practitioner, such as a nurse practitioner, that is identified by an individual NPI or National Provider Identifier. As an EOM practitioner, you would be furnishing E&M services for Medicare beneficiaries, receiving and initiating cancer therapy for cancer diagnosis. You must be billing under the TIN of the PGP for such services, and you must reassign your right to receive Medicare payments through the PGP itself to the practice itself, and you must also be included in the participants or in your PGPs EOM practitioner list, which is updated on a semiannual basis.

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EOM has seven included cancer types. These cancer types include high-risk breast, chronic leukemia, small intestine/colorectal and colorectal, lung cancer, lymphoma, multiple myeloma and high intensity prostate cancer. These are the only cancer types that are included for the model itself. For an episode to initiate it starts with the beneficiary receiving and initiating cancer therapy for those cancer types and must include a qualifying E&M during a six-month period. EOM maintains and prepares a list of what the initiating cancer therapies are for each performance period. The current list of initiating cancer therapies is available on the model website. As an episode-based model, attribution is based on an eligible oncology PGP, that provides the first qualifying E&M service. After the initiation for that initiating cancer therapy as long as you are PGP or the TIN that provided the first E&M service for the initiating cancer therapy for that episode of care and you also provided at least 25% of the cancer related E&Ms, then you would be attributed that episode. If the initiating oncology PGP did not bill for at least 25% of the cancer E&M services related to that episode of care for a given beneficiary, then attribution will move on to the plurality of whoever has

the most cancer-related E&M services. That could include a non-EOM oncology PGP or another EOM oncology PGP. An EOM episode requires a qualifying E&M service meaning that the evaluation and management of a new or established patient furnished to an eligible beneficiary with included cancer type. Eligible beneficiary criteria includes: has a diagnosis for an included cancer type, received in initiating cancer therapy that includes triggers an episode, receives a qualifying E&M service from an oncology PGP during the episode, is eligible for Medicare Part A, enrolled in Medicare Part B for the entirety of the episode, is not enrolled in a Medicare-managed care organization such as Medicare Advantage at any point during the episode, is not eligible for Medicare on the basis of end-stage renal disease diagnosis at any point during the episode, and has Medicare as his or her primary for the payer for the entirety of the episode. I'll now turn to Mike Berkery, who will be going over payer alignment.

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Thanks, Batsheva, and good afternoon, everyone. In this section. I'll briefly go over the payer alignment aspect of EOM. EOM is a multi-payer model, meaning that private payers, state Medicaid agencies and Medicare Advantage Plans are encouraged to participate in the model. In EOM payers can align their own oncology value-based payment models to promote a consistent approach across payers and patient populations. Some key areas for payer alignment include a commitment to health equity and data sharing efforts with EOM participants. We also expect payers to align with EOM's overall payment structure. This means the payer should have some type of per beneficiary per month payment for the provision of enhanced services similar to EOM's MEOS payments, as well as a lump sum performance payment. However, payers are not limited by EOM-specific parameters, such as the amount for the PBPM or risk arrangements. Also, EOM payers must always partner with at least one EOM participant to continue participating in the model, to the extent permitted by law, CMS also provides payers with data and resources pertaining to EOM. Finally, EOM features a payer workgroup to support collaboration and sharing of best practices between payers. Currently, EOM has three active payers participating in the model, and will allow additional payers to participate in the second Cohort as well. I'll now turn it over to my colleague Priya, to cover quality, health equity, and participant redesign activities.

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Thank you, Mike. I'm Priya Chatterjee, and I'll be walking through the next few slides discussing EOM’s quality strategy. This slide has a visual of three important elements that EOM incorporates into its quality strategy. The first is that EOM participants will transform oncology care through Participant Redesign Activities (PRAs). The next slide lists out the eight PRAs that EOM participants will implement to drive transformation in oncology care. The second element of the strategy is about quality measures and data reporting. EOM features, a quality measure set that includes valid, reliable, meaningful measures. CMS includes a FHIR API, which is short for Fast Healthcare Interoperability Resources Application Programming Interface, which is an electronically enabled way to report various model-related data to CMS. It is extracted directly from the EOM participant's own healthcare IT. We’ll have more information about that functionality a little later on in our presentation. EOM participants are required to report three types of data to CMS. The first is quality measured data, the second is clinical data like from your EHR, and a third is beneficiary-level, socio-demographic data. The third element of our quality strategy is advancing health equity. This element aligns with CMS's commitment to reducing health disparities and achieving health equities. EOM is

designed to advance health equity within all stages of the model from implementation through evaluation. We will discuss all elements of the quality strategy in more detail in the following slides.

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This slide lists the PRAs which are required under EOM. EOM participants are required to implement PRAs to drive higher quality care. The first six PRAs are defined as enhanced services when furnished to a beneficiary during the period that begins 30 days prior to the start of an episode and ends 30 days after the last day of the episode. Practices have the opportunity to submit claims for a Monthly Enhanced Oncology Service (MEOS) payment or enhanced services furnished to EOM beneficiaries. The OCM evaluation reports note that oncologists and their clinicians in OCM practices felt that OCM practice redesign activities improved patient care and patients had better information about their treatment because of their practice's participation in OCM. There are several positive care transformation stories reported by OCM practices and the OCM evaluation reports that highlight the role of PRAs in improving patient care and the patient care experience. EOM builds on and incorporates those best practices from the experience in OCM. We believe that PRAs are relevant, evidence-based and critical for high quality care in oncology. Now, I'm going to spend some time walking through each of these PRAs. The first is that EOM participants must provide beneficiaries with 24/7 access to an appropriate clinician with real-time access to the practice's medical records. As many patients have complex medical needs that may change over the course of treatment, we believe that continuous availability of patient provider communication in real time is fundamental to EOM. The second PRA is that EOM participants must provide patient navigation, as appropriate, to EOM beneficiaries. As evidenced in OCM we believe that patient navigation allows most EOM participants to positively support beneficiaries with the goal of overcoming barriers to timely quality care. Minimum requirements for patient navigation are included in Appendix C of the RFA. The third PRA is that EOM participants must document a care plan for each EOM beneficiary. A care plan must contain the 13 components of the Institute of Medicine Care Management Plan. We know documenting care plans are an integral component to providing high quality care. Care plans facilitate communication between healthcare providers and their patients, while simultaneously allowing for shared decision-making and navigating cancer care together. The fourth PRA is that EOM participants must treat beneficiaries in a manner consistent with nationally recognized clinical guidelines. CMS only approves guidelines that are nationally recognized, developed by clinicians with relevant disease experience, evidenced with links to supporting literature, and patient focused with alternative treatment options that account for patient variability and preferences and comorbidities. Examples of clinical guidelines that meet these criteria are also available in the RFA. The fifth PRA is that EOM participants must identify EOM beneficiaries with health-related social needs using HRSN screening tools or surveys. We define HRSNs as the adverse social conditions that negatively impact a person's health or healthcare. Evidence shows identifying and addressing social determinants of health as essential to reducing health disparities. EOM participants are required to screen EOM beneficiaries at a minimum for HRSNs in the following domains: food insecurity, transportation, and housing. Although we encourage EOM participants to screen for additional HRSNs to meet the needs of their unique patient populations, which is including but not limited to, social isolation, emotional distress, interpersonal safety, and financial toxicity. The sixth PRA requires that EOM participants gradually implement electronic Patient-Reported Outcomes (ePROs). ePROs are measurements based on reports that come directly from the patient without amendment or interpretation of the patient's response. It can aid processing quality and outcome quality improvements, including raising the clinician's awareness of concerning changes and being

aware of the patient's clinical status on a timely basis. EOM participants are required to implement ePROs capabilities in a stepwise manner over the course of the model. We believe it is important to remain flexible, so EOM participants can prepare themselves in a way that is appropriate for their practice needs. Therefore, for Cohort 2, the first two years of participation and model will be optional pre-implementation years. Beginning in Cohort 2 Participation Year 3, or our Model Year 5. CMS will require gradual implementation of ePROs by Cohort 2 EOM participants. We require that those participants obtain standardized beneficiary level, ePROs response data for a percentage of beneficiaries that increases each model year. Beginning with Participation Year 3 or Model Year 5. The seventh PRA is that EOM participants must utilize data for continuous quality improvement, including the development of a Health Equity Plan (HEP). We believe that the use of data for CQI positively enhances EOM participants' ability to improve their performance and achieve the goals of the model. EOM participants are required to develop and submit a HEP that identifies where health disparities currently exist for their patient population and describes strategies that they will explore to address these disparities. Finally, the eighth PRA is that EOM participants must use Certified Electronic Health Records, Technology or (CEHRT). We believe that the use of CEHRT facilitates the delivery of the enhanced services described before in EOM. There is also a requirement for any model or a track of the bottle to qualify as an advanced APM. More information on all of these requirements is available in the EOM RFA.

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A key component of EOM's quality strategy includes quality measures and data reporting. EOM includes valid, reliable, meaningful claims-based, participant-reported, and survey measures. Participants' performance in these areas are linked to payment. The quality measures focus on several domains, including patient experience, avoidable acute care utilization, management of symptoms toxicity, management of psychosocial health, and management of end-of-life care. The specific measures used in EOM are available on the Health Equity Factsheet or in the EOM Quality Measures Guide. Both of these resources are available on the EOM website now. In EOM, high performance on quality measures can result in a Performance-Based Payment (PBP), if they're eligible, but there's also possibility for performance-based recoupment, even with high performance on quality measures. In the event that a participant owes a recoupment, high quality performance will reduce the amount they must pay back to CMS. EOM participants are also required to collect and to submit to CMS certain beneficiary-level clinical data elements not available in claims or captured in the quality measures. For example, EOM participants must report ever-metastatic status, or HER2 status for the applicable included cancer types. Of note, CMS calculates clinical risk adjusters for certain cancer types, including ever-metastatic status, and HER2 status. Participants are required to collect and report beneficiary-level sociodemographic data which are used for the purposes of model monitoring activities to ensure equitable access and treatment is provided to all applicable subpopulations of beneficiaries in EOM. CMS may stratify aggregate de-identified data by demographic variables in the participant dashboards and feedback reports to support participants as they work to identify addressing disparities in their own beneficiary populations.

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This slide covers the third arm of the EOM quality strategy, advancing health equity. Identifying disparities and advancing health equity is a key focus in EOM. EOM seeks to improve the quality of care and achieve equitable health outcomes for all EOM beneficiaries. As such, EOM has

introduced a number of policies to promote health equity. EOM features a differential MEOS payment to support enhanced services for dually eligible beneficiaries. Dually eligible beneficiaries qualify for both Medicare and Medicaid. We believe that this adjustment helps mitigate any potential disincentive of a total cost of care model to serve dually eligible beneficiaries who historically account for a disproportionate share of Medicare expenditures and are associated with higher episode expenditures. Moreover, the benchmark amount is risk adjusted for multiple factors, including dually eligible status and low-income subsidy status. Another important area the model focuses on for health equity is data collection. As mentioned earlier participants are required to collect and report beneficiary-level sociodemographic data to CMS for monitoring and evaluation purposes. EOM participants are also required to screen for a minimum of three health-related social needs domains that I mentioned earlier: transportation, food insecurity and housing. Examples of potential HRSN and screening tools are listed in the HRSN Guide available now on the EOM website. However, HRSN screening tools included there and in the RFA are examples, and do not constitute endorsement by CMS or CMS affiliates. EOM participants have flexibility to use other HRSN screening tools beyond what we have listed in our guidance. Furthermore, CMS encourages EOM participants to develop local community partnerships to address identified needs from these screenings. As discussed earlier, participants are required to collect ePROs from patients, including an HRSN domain. We do encourage EOM participants to screen EOM beneficiaries through ePROs. However, we allow for additional flexibility should an EOM participant choose to screen for HRSNs outside of ePROs. To satisfy the HRSN screening enhanced service requirements. Participants can separately use other HRSN screening tools to satisfy the enhanced service requirements. EOM aims to improve shared decision-making and care planning. As such, EOM participants are required to develop a care plan with the patient, including the discussion of the prognosis and treatment goals, a plan for addressing psychosocial health needs, and to estimate out-of-pocket costs. EOM features several mechanisms to support continuous quality improvement, including a requirement that EOM participants build a health equity plan as part of using data for CQI within the model. Another important feature that we wanted to mention is patient navigation, it's also that it fits into the health equity strategy nicely. We require EOM participants to provide patient navigation as appropriate to EOM beneficiaries. Navigation services should include, but are not limited to, facilitating linkages to follow-up services and community resources to bridge other gaps in care to reduce health disparities, such as access to relevant clinical trials and connections to other health specialists or community resources. And as discussed earlier, we encourage EOM participants to develop relationships with partner local organizations to accomplish this goal. My last point on equity, the Innovation Center's evaluation team plans to examine outcomes for subpopulations such as patients living with a disability or patients with language preferences other than English as feasible depending upon data availability and sample size consideration. With that I will turn it back to Mike, who will discuss data sharing and health information technology elements for EOM.

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Thanks, Priya. So, for EOM, participants and their EHR vendors must report all CDEs applicable to the ICD-10 diagnosis code for the cancer type, using one of two reporting options. One is the low-tech option using the template available within the EOM Health Data Reporting (HDR) application, while the other is the process that Priya mentioned earlier, the high-tech option is the FHIR based API. Reporting via FHIR-based API enables the electronic sharing of healthcare data across systems. It also allows different healthcare systems, such as hospitals and specialty clinics to share patient data seamlessly and securely. With FHIR-based API, EOM participants can use different

healthcare applications to talk to each other more easily, which improves interoperability and coordination of oncology care. SDE data can also be submitted via these options with the excel templates or the FHIR-based API. In support of the White House Cancer Moonshot the EOM Implementation Guide (IG) also uses US Core Data for Interoperability (USCDI) plus cancer standards which are a set of cancer data classes and data elements. This also ensures that EOM data can be integrated across healthcare systems. Collaborating with the US Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, also known as ONC, CMS also identified EOM as an initial use case for the USCDI plus cancer initiative. Engaging with the EOM IG ensures that the EOM participants and their vendors can share and receive the core USCDI plus cancer data elements. This allows a robust exchange of cancer data via FHIR API. It also provides the ability to work with the critical core set of cancer data that are foundational for future USCDI plus cancer initiative use cases, such as clinical trial matching, tracking adverse events and improving clinical data registry reporting. Finally, EOM allows participants to request data from CMS to support continuous quality improvement and care planning. The types of data that EOM participants can request are on the bottom half of the slide seen here. This includes quarterly feedback reports, semi-annual reconciliation reports and their underlying claims, attribution lists, episode level files, and monthly claims data. With that I'll turn the presentation over to Liz to cover the payment aspects of EOM.

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Thanks, Mike, and thanks again to everyone who joined the webinar today. My name is Liz Ela, and I'm the Payment Lead for EOM. I want to mention right at the outset that we will be holding another webinar next month on July 18th that will be dedicated specifically to payment. We'll have time in that webinar to get into more examples and details so today's presentation will stick to a fairly high-level summary of the EOM Payment Methodology. As previously mentioned, EOM episodes last for 6 months. I want to note that episodes are excluded if the beneficiary was diagnosed with COVID-19 during the episode, received CAR-T therapy during the episode, or was treated with bispecific antibodies during the episode. In addition to fee-for-service billing, EOM participants have the option to bill a monthly payment called a MEOS payment to support the provision of enhanced services to EOM beneficiaries. The base amount of this MEOS payment will be $110 per beneficiary per month. For episodes involving a beneficiary who's dually eligible for Medicare and Medicaid, CMS pays an additional $30 per beneficiary per month for a total MEOS of $140 per dually eligible beneficiary per month. This additional $30 for duals is excluded from the total cost of care. EOM participants are otherwise responsible for the total cost of care, including drugs and including the base amount of each MEOS payment for each episode attributed to them for a given performance period. Based on the total expenditures and quality performance during each performance period participants, or pools can potentially earn a Performance-Based Payment (PBP) owe a Performance-Based Recoupment or (PBR) or fall into a neutral zone in which they neither earn a PBP nor owe a PBR.

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This slide describes the three possible outcomes following the reconciliation of a given performance period. The EOM participant or pool may earn a Performance-Based Payment if their total expenditures for all attributed episodes are below a risk-adjusted target amount. Earning a PBP is also contingent on quality performance and some other eligibility criteria. The participant or pool will owe a PBR if their total expenditures for eligible episodes exceed the threshold for recoupment.

Finally, the participant or pool will fall into the neutral zone if their total expenditures are above their target amount but do not exceed the threshold for recoupment. In this case, they will not earn a PBP but they will not owe a PBR either. The target amount and the threshold for recoupment are calculated as percentages of a risk-adjusted benchmark amount that is specific to the participant or pool and is also specific to each performance period.

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The amounts of any PBPs or PBRs are also calculated as a percentage of the benchmark amount. Conceptually, this benchmark amount represents the total projected cost of all the attributed episodes, if those episodes had occurred in the absence of the model. In our upcoming payment webinar in July, we will spend more time on the method for calculating this benchmark amount, including a detailed example. For now, I'll note that all the percentages on this slide refer to percentages of the benchmark amount. EOM has two possible risk arrangements that both require an outside risk. By default, EOM participants and pools are in Risk Arrangement 1 unless they specifically request to be in Risk Arrangement 2. You may switch from one risk arrangement to the other for a future performance period with advance notice to CMS. You'll have an opportunity to update your risk arrangement ahead of each performance period. Under Risk Arrangement 1, which again, is the default, the EOM discount will be 4% of your benchmark amount, meaning the target amount will be 96% of your benchmark amount. The threshold for recoupment will be 100% of the benchmark amount. The stop loss, which is the maximum PBR that could be owed, is 2% of the benchmark amount, and the stop gain, which is the maximum PBP that can be earned, is 4% of the benchmark amount. The neutral zone is that range in between the target amount and the threshold for recoupment. So, a participant in Risk Arrangement 1 would be in the neutral zone. If their total expenditures for their episodes were above 96% of their benchmark amount and below or equal to 100% of their benchmark amount. Under Risk Arrangement 2, the EOM discount will be 3% of the benchmark amount, meaning the target amount will be 97% of the benchmark amount. The threshold for recoupment is still 100% of the benchmark amount. The stop loss is 6% of the benchmark amount, and the stop gain is 12% of the benchmark amount. Finally, a participant in Risk Arrangement 2 will fall into the neutral zone if their total expenditures for attributed episodes exceed 97% of their benchmark amount, but do not exceed 100% of their benchmark amount.

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This slide is a more visual representation of the same two EOM risk arrangements that we saw in the previous slide. I want to note that the X-axis here represents the total expenditures for attributed episodes in a given performance period as a percentage of the benchmark amount. I'm not going to read the whole slide to you, because again, this is another way of presenting what we covered in the prior slide, I'll just note that the area shaded in blue represents savings relative to the target. So, this is the zone in which a participant or pool could earn a performance-based payment contingent on quality performance and other criteria. And the area shaded in red represents spending that exceeds the threshold for recoupment. So, this is the zone in which a participant or pool would owe a PBR and finally, that area shaded in gray represents the neutral zone. So, in this zone expenditures are too high to qualify for a performance-based payment, but the participant or pool would not owe a Performance-Based Recoupment. Now, as I mentioned earlier, we're holding a payment webinar on July 18th that will cover all of these topics in a lot more depth. So, for now I'll hand things back to Batsheva, who will take us through some more EOM design details.

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Thanks, Liz. I will now go over how the Quality Payment Program (QPP) and EOM are associated. The EOM Risk Arrangement 2 is considered an Advanced Alternative Payment Model. Your participation in EOM, if you participate under Risk Arrangement 2, is considered an advanced alternative payment model participation if your practice meets the QP threshold. In the 1st year of participation, EOM participants are not able to meet the QP threshold due to the nature of episode identification and attribution. However, in subsequent participation years, eligibility in meeting the QP threshold will be calculated for EOM participants. I highly encourage you all to read through a little bit more of the section on the advanced APMs in our RFA for additional information. We'll also cover this more in a future learning event. For MIPS, the Merit-Based Incentive Payment Program and System, either EOM risk arrangement meets the criteria for consideration as a Merit-Based Incentive Payment System APM or MIPS APM. We have a section within our Request for Application (RFA) that is available on our website for EOM, for additional details on the criteria for meeting both the advanced APM and MIPS APM.

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Next, we will talk about care partners and model overlap. EOM participants may select to enter into financial arrangements with certain individuals or entities, and we consider these as care partners. For the purposes of EOM, a care partner means any Medicare enrolled provider or supplier that engages in at least one of these participant redesign activities that Priya talked about earlier during a performance period. If the care partner has entered into a care partner arrangement with an EOM participant, and the care partner is identified on the EOM participant's care partner list; and they cannot be an EOM practitioner. Next, we want to touch on impacts to oncology PGPs who are participating in other CMS models and programs that provide healthcare entities with an opportunity to improve care or reduce spending. These PGPs are eligible to participate in EOM. We have a lot of additional details on how we handle model overlap across different CMS or CMMI initiatives, such as ACOs existing models like PCF or MCP just to name a few examples. We also cover this in a little bit more detail in the Payment Methodology webinar that Liz talked about during her slides. This is just an overview of potential overlap and just a flag that we have additional information on our RFA, if there are any additional questions on that, and please feel free to send any questions you have to our Help Desk as well.

Slide 25

In order for us to emphasize the high value services and to support the ability of EOM participants to manage the care of beneficiaries, especially in an era when we have endured the COVID-19 pandemic, EOM is utilizing the authority under the 1115A to conditionally waive certain Medicare payment requirements as a part of a benefit enhancements for testing EOM. What that means is that EOM participants are eligible to request or apply for three types of waivers. The first is a telehealth benefit enhancement, the second is a post-discharge benefit enhancement, and the third is a care management home visits benefit enhancement. For the telehealth benefit enhancement this would allow eligible EOM participants to provide telehealth services to eligible beneficiaries via telehealth outside of rural areas, including beneficiaries' homes allowing participants to conduct telehealth services that are not limited to the EOM site or the site of the PGP itself or the Physician Group

Practice. Additionally, these waivers will also allow for eligible beneficiaries who may have limited mobility or addressing transportation barriers to access to telehealth services more easily as well as allowing eligible beneficiaries to receive telehealth services, wherever they are located, including their home or at their place of residence. Just to note, currently CMS has more broadly extended telehealth coverage to all Medicare beneficiaries and providers. As a result, EOM does not offer the benefit enhancement at this time, as this is already addressed through a broader policy. However, if that broader coverage for telehealth is no longer available after December 2024, this benefit enhancement will be available through EOM. The post-discharge benefit enhancement allows EOM beneficiaries to receive up to nine post-discharge home visits within 90 days following discharge. If the beneficiary is readmitted within that 90 days of the initial discharge, and before receiving the nine home health visits, then the beneficiary may receive only nine visits in connection with the subsequent discharge. Finally, we are also making available the care management home visit benefit enhancement, which will allow EOM participants to bill CMS for certain home visits that are furnished to eligible beneficiaries by auxiliary personnel, under the general supervision of physician or other practitioner, proactively and in advance of a potential hospitalization.

Slide 26

CMS will conduct monitoring activities to ensure compliance by EOM participants, practitioners and care partners. The reason for this monitoring is designed to protect the beneficiaries and also potential program integrity risks. In order for us to conduct our monitoring activities, we may draw from data sources such as looking at claims, conducting interviews with anyone who is participating in EOM or engaged in PRA activities, interviews with EOM beneficiaries, site visits, and more. We also have an independent evaluation contractor we employ, to a non-randomized research design, using a match comparison group. This is so that we can determine any changes and effects of EOM in terms of utilization, cost, quality that may be due to EOM itself. Now I'll turn it back to Mike to outline the benefits of the learning community.

Slide 27

Thanks, Batsheva. So, the goals of the EOM learning system and community are to identify and share resources and promising practices to support care transformation. The learning system incorporates feedback and ideas from EOM participants and leverages biannual survey data to inform learning materials throughout the model. This collaborative effort puts EOM participants at the center of the learning community and allows for bi-directional communication and knowledge sharing. Specific EOM learning system resources include an online collaboration platform, case studies, innovation spotlights, virtual learning events, and quarterly affinity groups.

Slide 28

So now I'll briefly go over in the next few slides the timeline to apply for Cohort 2 of EOM, how to apply, and we're going to time permitting. Give a quick demo at the end of the Request for Application (RFA) in the portal.

Slide 29

So, this slide shows the timeline for Cohort 2. The RFA portal opens on July 1st, which is then when interested PGPs and payers can apply. The application deadline is September 16th at 11:59 PM ET. Final applicants will be notified in mid to late winter of 2024. We've also responded to feedback we received from Cohort 1 applicants, who asked for more time for selected applicants to review their historical data. As a result, eligible applicants will be able to sign a HIPAA-Covered Data Disclosure and Attestation form (DRA), allowing us to provide historical data in January 2025, and giving additional time with the data before participation begins. The participation agreement will be due in the spring of 2025, with a model beginning for Cohort 2 On July 1st, next year of 2025.

Slide 30

So, to save on time, I'm just going to briefly go over this. We'll skip this slide; you can all see this. The slides will be shared. As mentioned before, lots of useful information about how to apply and most importantly, in the future, we're going to have available an EOM application portal guide, so that more to come on that in the days and weeks to come.

Slide 31

So now, to explain how to submit your application, we'll share a live demonstration of the RFA portal. Santosh, please go ahead with the demonstration. Thank you, Mike. This is Santosh, and I will be demonstrating the EOM RFA portal experience and its key features. So, the new user needs to go under the new user registration in order to have registered to the portal and login. So once the username and password is created, we can log in using them, and there will be an OTV (one time) verification code sent to the email provided during the registration. So once you receive the verification code you can take that to login to the EOM RFA portal. And after logging in the portal, we will directly land on the EOM RFA homepage for the user, and the homepage consists of the information regarding the EOM PGP applications. So also, a note where it indicates that each page of the application will be timing out for 30 min of inactivity and need to save the work related. Also, the homepage consists of helpful links, such as User Manual and EOM website links, which will give an understanding regarding the portal. And there are application upcoming deadlines which I mentioned which are needed for the portal. And once you have logged in, we can start a new application using the 'Start New Application button', and that takes you to the EOM RFA questionnaire. And the RFA portal has three main sections: the 'Complete Profile', 'Complete Application' and 'Certify and Submit'. We have the different pages where that we can enter the organization information and the contact information, and going on to the complete application where different questionnaires are related to different topics, such as PGP Profile Information, PGP Information etc. So, all the sections need to be at 100% in order for you to certify in order for you to submit the RFA Application, and once you certify and submit, the RFA Application will be navigated to the homepage with success message. So, if there are any required questions or any validations, that will be shown in the application checklist, where you will need all the required questions and the application checklist to be completed in order to submit the application. And also, we have this is the PGP version of the portal, whereas we have a Payer version of the portal as well. Similar to the PGP where we have different sections, but different, related to the EOM Payer. And that concludes the demonstration for EOM RFA reporting, over to you.

Slide 32

Excellent. Well, thank you so much. As folks can tell we are running a bit short on time today. So, we have tried to answer some questions within the Q&A pod, so hopefully, folks are seeing those and appreciate everybody submitting your questions. Definitely, if you have questions that didn't get answered in this webinar, we're having additional sessions as well as Office Hours, but also please do feel free to submit your questions to EOM@cms.hhs.gov if we are unable to get to them today. We are going to try to get to one question really quick here, because it was a frequent question. So Batsheva, did want to turn this one over to you. Will baseline and/or historic data be provided to practices in advance of the deadline to sign the participation agreement? And if so, when will that be provided? Great. Thank you so much, Becky, and I'll try and be quick about this one, but it's a very important one, so thank you everyone for submitting your questions. So, baseline data are already available on the EOM website. These are de-identified and include all baseline period episodes nationwide, so I'll just separate that. And then the second data question around the historical data, that is data that includes historical episodes attributed to a specific PGP, and I'll say we tentatively expect CMS will be able to share practice-specific historical data towards the end of 2024. We would like to note that in comparison to how the historical data were shared in the first Cohort of participants through a participant DRA, Data Request Attestation, we plan on offering an applicant DRA for the second Cohort. What this means is that the second cohort of applicants will have the opportunity to sign a DRA initially and receive their practice-specific historical data prior to signing and executing our participation agreement. We recognize and understand that applicants need sufficient time and data to make an informed decision in participation in the model, and we hope this will help towards that effort. Thanks Becky. Great. Thank you so much, Batsheva for providing the answer to that question, I know it was certainly a frequent question, both in preregistration and the live event. So, we have run out of time unfortunately for Q&A. So, if we can go to the next slide, please.

Slide 34

We did want to provide some references that are hopefully helpful for folks considering applying to EOM. So, the EOM models' website is a great resource. All of the materials listed here are available on the EOM model website, but we've also provided direct links in the slides which are also available on the EOM website under the 'Upcoming Events and Timeline' section. So, lots of great resources here from both the RFA, a number of fact sheets, Cohort 2 FAQs, there's an Application Portal Guide for those completing the application, etc. So definitely want folks to review this and use these resources to assist you in your application process.

Slide 35

Upcoming events. So, we will as Liz mentioned earlier, be having a Payment Methodology webinar on July 18th from 1:00-2:30pm ET, I believe we may be extending that one, and then in August we'll have an Application Support Office Hours on August 1st, a Quality Health Equity and Clinical Strategy webinar on August 15th, and an Application Support Office Hours on August 29th.

Slide 36

And just wanted to keep everybody informed, different ways to reach out to us or to stay abreast of what's going on during the application period. Please again feel free at any time to reach out to the EOM Help Desk at EOM@cms.hhs.gov or the phone number is listed there as well. Encourage folks to subscribe to the EOM listserv, and the link is available in the slides. That will keep you informed of upcoming events and other things we'll be communicating with applicants, as well as keeping up with the EOM website. I think that wraps us up, and so I'll turn it over to Chris to close us out. Thank you for joining! That concludes today's webinar. Enjoy your day!