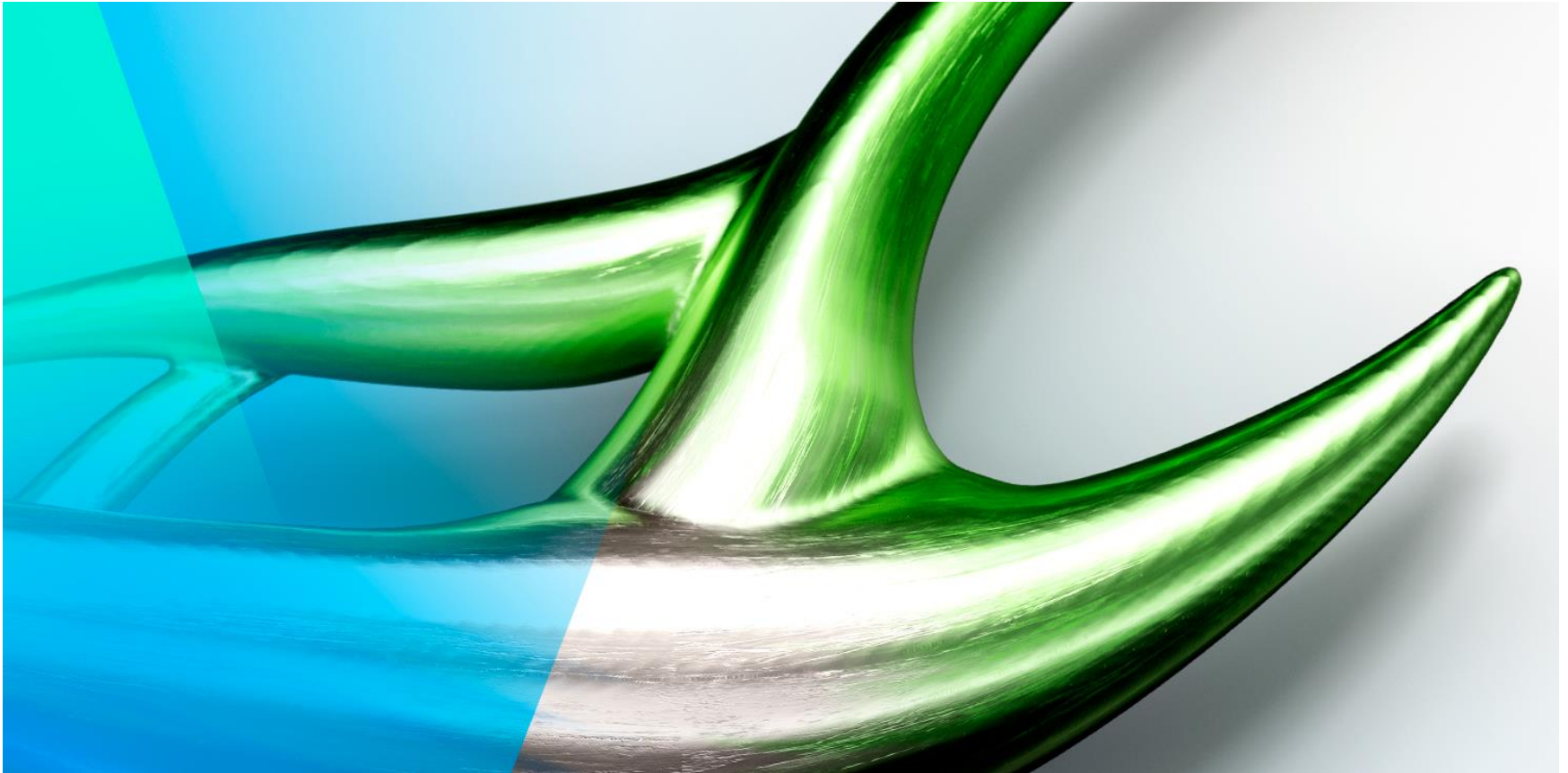


Assessing Practice Participation in the Enhancing Oncology Model (EOM)

EOM Variable Input Tool –
Webinar #1

Presented by COA & Avalere
February 14, 2023





EOM Variable Input Tool – Webinar #1

Prepared for COA

Avalere Health | Part of Fishawack Health
February 14, 2023

Speakers and Agenda



Maddi Davidson

Associate Principal

MDavidson@avalere.com



Melissa Morley

Principal

MMorley@avalere.com



Shelby Harrington

Principal

SHarrington@avalere.com



Blair Burnett

Consultant II

BBurnett@avalere.com

1 EOM Variable Input Tool Introduction

2 Introduction to the EOM

3 EOM Payment Methodology Overview

4 MACRA/MIPS Participation Overview

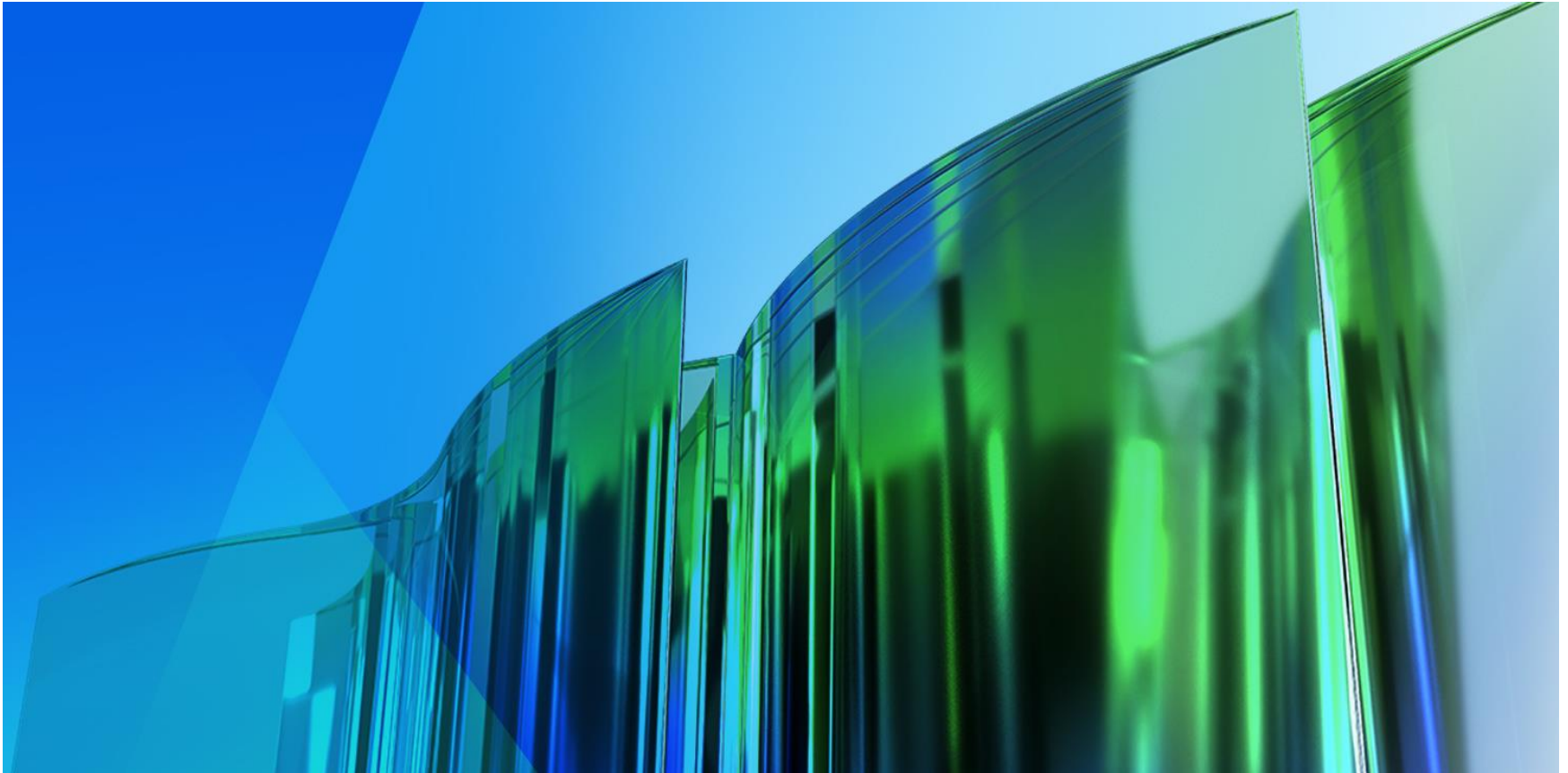
5 EOM Tool Inputs

6 EOM Tool Outputs

7 Glossary

Support for this tool provided by:





EOM Variable Input Tool Introduction

EOM Tool Provides Quantitative Data Points to Help Inform Practice Decision Making on Potential EOM Participation

Inputs	Output
<ul style="list-style-type: none">• Practice characteristics (type, region)• Number of episodes by EOM cancer type• Patient demographics (race and dual status)• Anticipated novel therapy adjustment and experience adjustor• Ability to adjust above or below the average benchmark and spend for each EOM cancer type based on practice case mix• MIPS/MACRA threshold considerations• EOM implementation costs• MIPS implementation costs	<ul style="list-style-type: none">• EOM net financial impact based on FFS payments, EOM specific payments, and EOM implementation costs, by risk arrangement• Historic performance patterns and proximity to key EOM payment thresholds (i.e., recoupment, safe zone, PBP thresholds)• Detailed EOM data by EOM cancer type• Cost components by cancer type• Under MACRA, expected QP, partial QP, or MIPS status• Expected conversion factor and MIPS adjustment by QP or MIPS status



Key Questions Your Practice Will Be Able to Answer

- By how much does my practice need to reduce spend to be successful in the EOM?
- What EOM risk arrangement might be the best fit for my practice?
- Will the costs to implement the EOM be offset by EOM-based payments (MEOS and PBP)?
- How might a more complex patient population impact EOM performance evaluation?
- What is my likely QP or MIPS status and what does that mean for future payment adjustment?
- Relative to practice redesign activities to meet EOM requirements and other practice priorities, what are the cost-related pros and cons of EOM participation?

EOM: Enhancing Oncology Model; PUF: Public Use File; MIPS: Merit-based Incentive Payment System; OCM: Fee-for-Service; MACRA: Medicare Access and CHIP Reauthorization Act; PBP: Performance-based Payment; QP: Qualifying APM Participant; MEOS: Monthly Enhanced Oncology Services



EOM Tool Is Based on Average Values and Results Should Be Viewed as Directional

Data Sources and Period

- EOM Deidentified Public Use Baseline; 2016-2020
- EOM Technical Payment Documentation
- EOM Payment Methodology (version 1.0)

Tool estimates are based on episode-level data from the public use file. The predicted price used the coefficients from the EOM technical documentation. All EOM prediction model risk adjustment covariates are included in the prediction.

Limitations

- Tool input and output values are based on averages from CMS public use file; individual practice results will vary
- Future practice patterns, drug availability, and the overall market may not be reflected in the model
- The model does not account for overlap with other CMMI demonstrations or value-based care programs (e.g., ACO REACH)
- Tool may not account for more complex patient populations, metastatic disease, or HER2 status; user may adjust the actual spend to address this limitation

Tool User Must Have the Following Data Available for EOM Tool Inputs

Practice Type	<ul style="list-style-type: none"> Community Hospital/Health System/Academic Medical Center 	
Census Region	<ul style="list-style-type: none"> Northeast South Midwest West 	Census Division Map
Urban or Rural	<ul style="list-style-type: none"> Urban: Most patients treated at urban or suburban practice location Rural: Most patients treated at rural practice location 	
Number of Patients by EOM Cancer Type by 6-Month Performance Period	<ul style="list-style-type: none"> Breast cancer Lung Cancer Multiple Myeloma Lymphoma Small Intestine / Colorectal Cancer Prostate Cancer Chronic Leukemia 	EOM Payment Methodology <ul style="list-style-type: none"> Section 1.2.1: Identification of Trigger Events EOM Technical Payment Resources <ul style="list-style-type: none"> Cancer Type Mapping Initiating Therapy-HCPCS Codes Initiating Therapy-NDC Codes
Part B Professional Services	<ul style="list-style-type: none"> Number of Medicare FFS beneficiaries receiving Part B professional services Total payments for Part B professional services across all 	

EOM: Enhancing Oncology Model; FFS: Fee-for-Service; HCPCS: Healthcare Common Procedure Coding System; NDC: National Drug Code

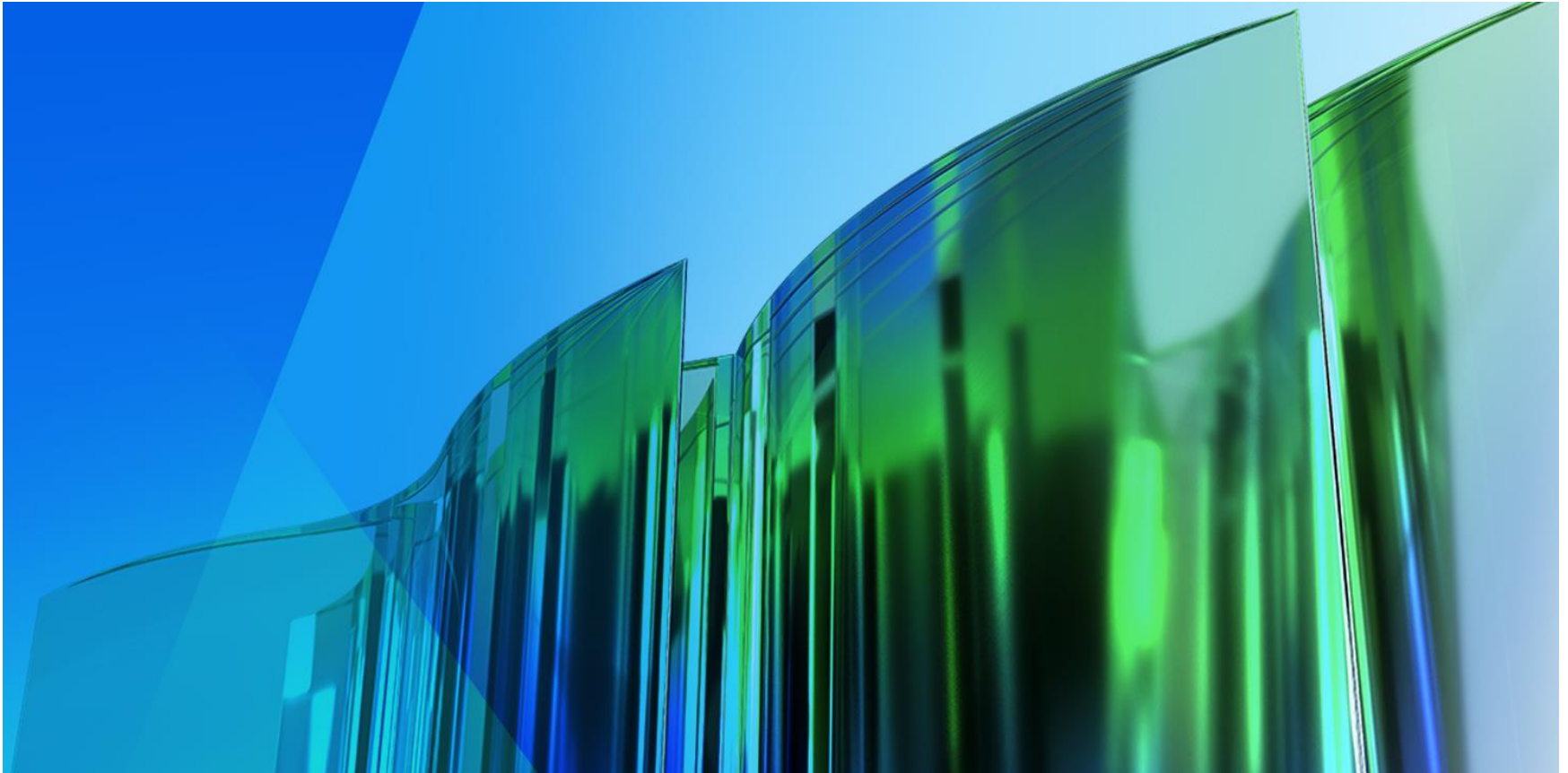


The Following Data Will Auto Populate From User Inputs, But User May Further Adjust to Match Practice Characteristics

Percent of Episodes by Race	<ul style="list-style-type: none"> • White • Black • Hispanic • Asian • North American Indian or American Native • Other/Unknown 	<p><i>Values are populated from averages of practice characteristics, including practice type, census region, rural/urban status, number of EOM applicable episodes</i></p>
Percent of Episode Who Are Dual Eligible	<ul style="list-style-type: none"> • Dual eligible for Medicare and Medicaid • Not dual eligible 	
Average EOM Benchmark Price by Cancer	<ul style="list-style-type: none"> • The average EOM benchmark price and average total expenditure will be broken down by the 7 EOM cancers: <ul style="list-style-type: none"> • Breast • Lung • Multiple Myeloma • Lymphoma • Small Intestine/Colorectal • Prostate • Chronic Leukemia 	<p><i>Values are populated from average benchmark and total expenditure data by cancer type and race; the average presented in the tool is a weighted average based on the case mix inputs</i></p>
Average EOM Total Expenditure by Cancer		

EOM Tool Considers EOM and MIPS Implementation Costs Relative to Payment Components to Inform Net Impact

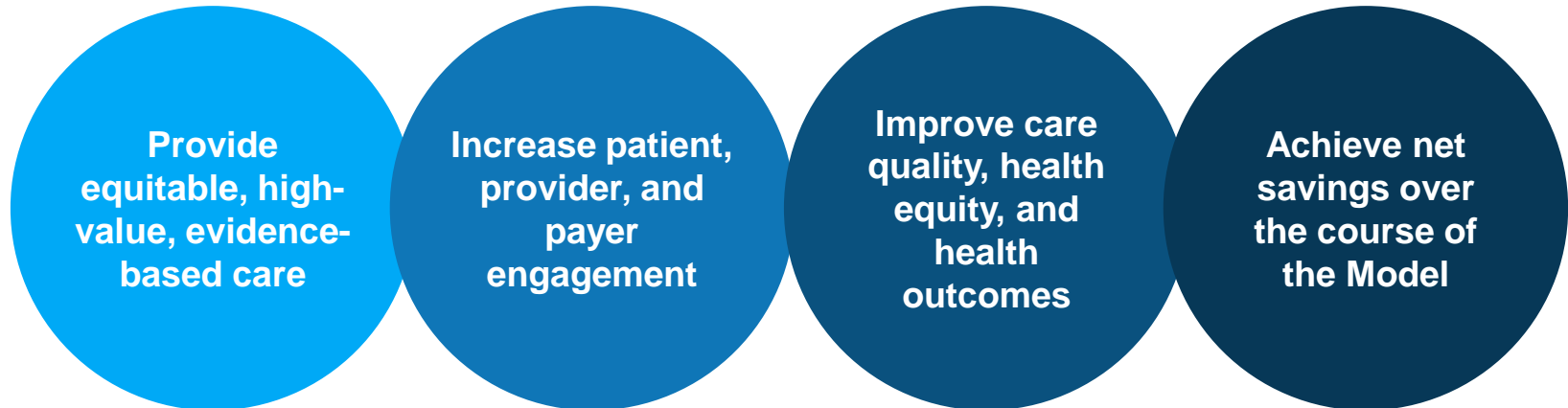
EOM Implementation Considerations	<ul style="list-style-type: none">• New staff and associated annual or hourly salary (i.e., additional clinical roles, nutrition counselor, social work, billing and coding, data analysts, etc.)• Additional technology costs, inclusive of both up-front/one-time processing or annual fees (e.g., EHR updates, technology interfaces, phone system update to accommodate nurse hotline, etc.)• Potential consultant or third-party vendor support, inclusive of both up-front/one-time processing or annual fees (e.g., ePRO support, data management services, etc.)• Reinsurance premium information based upon EOM episode count (where applicable)
MIPS Implementation Considerations	<ul style="list-style-type: none">• New staff and associated annual or hourly salary• Additional technology costs, inclusive of both up-front/one-time processing or annual fees



Introduction to the EOM

The Enhancing Oncology Model (EOM) is a Voluntary, 5-Year Oncology-Focused Alternative Payment Model from CMMI

EOM Goals



- EOM builds on lessons learned from CMMI's first oncology-focused APM, the Oncology Care Model (OCM), which began in July 2016 and ended June 2022
- EOM participants will share financial risk with Medicare and must provide specific practice transformation services to Medicare FFS beneficiaries in the Model
- Participants may earn a performance-based payment or owe a performance-based recoupment; the value of which will be based on total expenditures relative to a practice-specific benchmark and quality metrics
- The EOM is a voluntary, total cost of care (TCOC) model and will begin July 2023

EOM Builds Upon OCM, with Focus on Downside Risk and Social Determinants of Health

Seven Cancer Types

Includes 7 major cancer types: breast, lung, lymphoma, multiple myeloma, small intestine/colorectal, prostate, and chronic leukemia

- Limited to beneficiaries receiving systemic chemotherapy
- Excludes beneficiaries with only hormonal therapies
- Excludes beneficiaries who received CAR-T

6-Month Episodes

Defines episodes as 6-month long; episodes are initiated with receipt of an eligible Part B or Part D oncolytic – beneficiaries may initiate multiple episodes

Risk Arrangement

Participants will elect 1 of 2 downside risk options – there are 2 downside risk arrangements (RA1 and RA2); RA2 qualifies as an Advanced Alternative Payment Model under the Quality Payment Program (QPP) if volume thresholds met

MEOS

Include a \$70 per beneficiary per month MEOS payment plus an additional \$30 for dually eligible episodes (\$100 total). Only the \$70 MEOS payment counts towards EOM episode TCOC performance calculations

Care Transformation

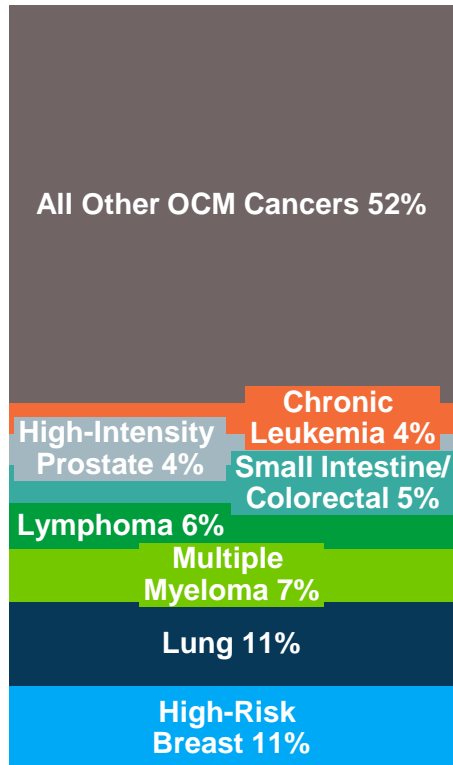
Includes the 6 transformation activities previously required in the OCM: 24/7 patient access, EHR, IOM care plan, patient navigation, continuous quality improvement, and adherence to clinical guidelines

Health Equity

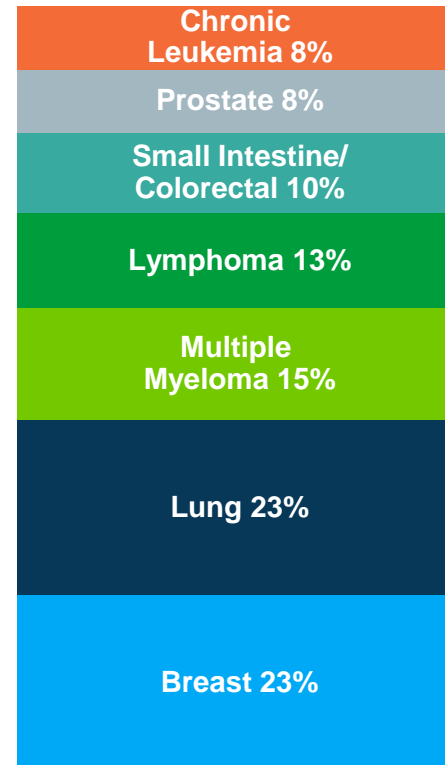
Requires health equity care plans to identify and address health disparities **and includes 2 care transformation activities to drive health equity:** HRSN screening and collection of sociodemographic data and ePROs

EOM Includes 7 Cancer Types That Made Up Less Than Half of OCM Cancer Episodes

OCM Cancer Mix
OCM Practices , PP5-PP8



EOM Cancer Mix
OCM Practices , PP5-PP8



With fewer beneficiaries eligible for EOM based on fewer included cancer types, practices may experience challenges meeting MACRA'S AAPM thresholds that would exempt them from MIPS

EOM Builds on OCM Practice Redesign Activities to Improve Quality, Access, and Focus on Health Equity

Included in OCM

24/7 Patient Access

- Provide 24/7 patient access to appropriate clinician with real-time access to practice's medical records

EHR

- Use of the ONC certified-EHRs technology aligned with Stage 2 meaningful use*

IOM Care Plan

- Document care plan for each EOM beneficiary using the 13 components of the Institute of Medicine (IOM) Care Management Plan

Patient Navigation

- Provide core functions of patient navigation, including coordinating appointments, maintaining communication, providing translation, and facilitating follow up services

Continuous Quality Improvement

- Utilize practice and Medicare claims data to improve performance and achieve goals of EOM
- Report EOM quality measures

Clinical Guidelines

- Follow nationally recognized clinical guidelines (e.g., NCCN or ASCO), and report when they deviate from guidelines

New to EOM

Electronic Patient Reported Outcomes

- Optional use of ePROs in years 1 and 2 of the EOM
- Required implementation by year 3
- Gradual implementation thru year 5

Health-Related Social Needs Screening

- Screen for at least 3 EOM social needs domains, such as transportation, food insecurity, and housing instability

Health Equity

- Develop health equity plan to identify health disparities in patient care plan
- Collect data to identify and address potential health disparities

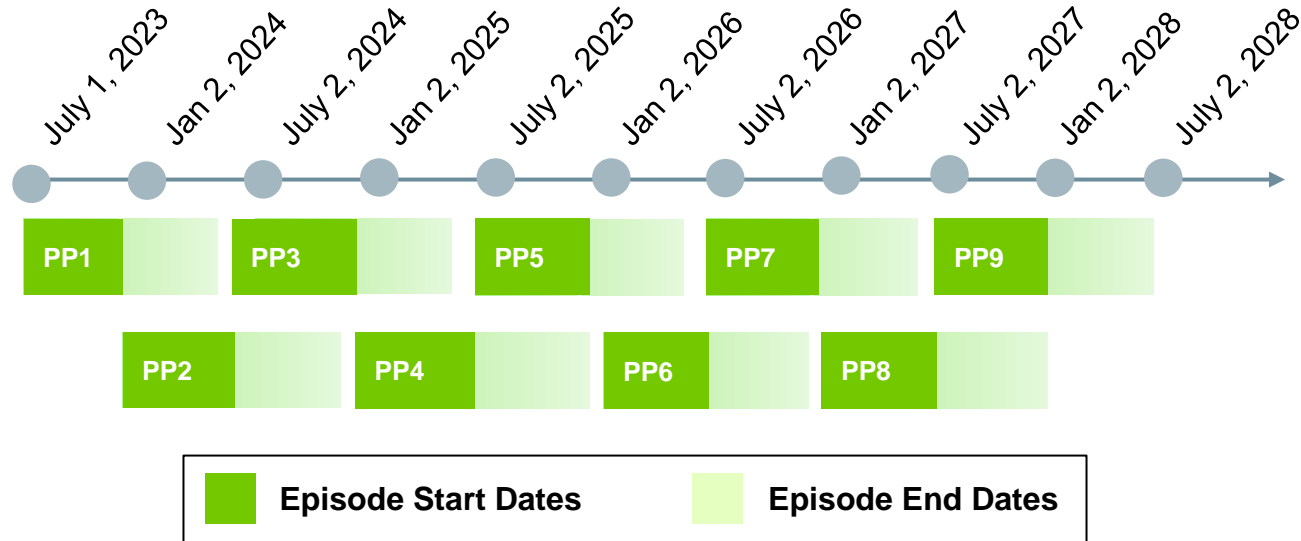
*Stage 2 Meaningful use focuses on capturing health information in structured format and increasing exchange of information during care transitions

EOM: Enhancing Oncology Model; EHR: Electronic Health Record; ONC: Office of the National Coordinator; IOM: Institute of Medicine; NCCN: National Comprehensive Cancer Network; ASCO: American Society of Clinical Oncology; ePRO: Electronic Patient Reported Outcomes

Source: CMS, Oncology Care Model Request for Applications. February 2015. Available [here](#).



EOM Episodes Will Be 6 Months Long and Assigned to Performance Periods Based on Episode Initiation Date



- 1** Episodes begin on date of service for initial Part B oncolytic treatment or date of script fill for Part D oncolytic treatment
- 2** Episodes are 6 months long. Beneficiaries who continue receiving treatment with an initiating therapy beyond 6 months initiate a new episode
- 3** Episode expenditures consist of all Medicare Part A and Part B expenditures and certain Part D expenditures for the 6-month episode*

Expenditures are compared to a risk-adjusted, practice-specific benchmark amount**

*EOM episode expenditures excludes Part A payments for certain inpatient admissions

**Part D expenditures that are included are Low Income Cost Sharing Subsidy amount and 80% of the Gross Drug Cost above the Catastrophic threshold

EOM: Enhancing Oncology Model; PP: Performance Period

Source: CMS, The Enhancing Oncology Model (EOM) Request for Applications. June 2022. Available [here](#).



EOM is a Total Cost of Care Model; All Oncology and Non-Oncology Costs Included in Total Expenditure Calculation

Total 6-Month Episode Expenditures

Part A

- Hospital inpatient*
- Skilled nursing facility/nursing home
- Hospice
- Home health

Part B

- Outpatient prescription drugs, including injectable and infused drugs
- Physician office visits
- Hospital outpatient
- MEOS
- Durable medical equipment
- Clinical research
- Ambulance services

Part D**

- Oral oncolytic drugs
- Other non-oncolytic Part D drugs

- Episode expenditures only include Medicare paid amount; does not include beneficiary OOP costs
- Winsorization is a 2-sided truncation that limits the impact of outliers on average expenditures. For each cancer type,
 - Episode expenditures below the 5th percentile will be set to the 5th percentile
 - Episode expenditures above the 95th percentile will be set to the 95th percentile

*EOM episode expenditures excludes Part A payments for certain inpatient admissions

**Part D expenditures that are included are Low Income Cost Sharing Subsidy amount and 80% of the Gross Drug Cost above the Catastrophic threshold

EOM: Enhancing Oncology Model; PP: Performance Period; OOP: Out of Pocket

Source: CMS, The Enhancing Oncology Model (EOM) Request for Applications. June 2022. Available [here](#).



EOM is Based in FFS Payments and Includes 2 Model Specific Payment Features

Medicare FFS payments (including ASP+6% for drugs*)



Monthly Enhanced Oncology Services (MEOS) Payment

- Reimburses practices for offering enhanced services such as 24/7 clinician access, patient navigation, care planning, etc.
- \$70 per beneficiary per month paid during the episode (included in participant's total cost of care responsibility)
- Additional MEOS payment of \$30 per month for dual eligible beneficiaries will not count toward participant TCOC responsibility
- Practices are eligible for payment each month of the episode, unless beneficiary dies or enters hospice

Performance-Based Payment (PBP) / Performance-Based Recoupment (PBR)

- EOM practices are eligible to receive a PBP when total episode spending is below the target amount and quality metrics are met
- EOM practices may owe a recoupment if total expenditures exceed recoupment threshold
- Retrospectively paid/owed after episodes end for each performance period
- Amount paid/owed determined through initial reconciliation and adjusted in "true-up"

Like OCM, EOM has a 3-part payment structure, but EOM require participants to take on more risk with lower MEOS payments and immediate downside risk

*Subject to sequestration; FFS: Fee-For-Service; ASP: Average Sales Price; PMPM: Per Member Per Month; MEOS: Monthly Enhanced Oncology Services; PBP: Performance Based Payment; PBR: Performance Based Recoupment; TCOC: Total Cost of Care; EOM: Enhancing Oncology Model
Sources: CMS, Oncology Care Model Introductory Webinar. February 2015. Available [here](#).
CMS, Oncology Care Model Overview. May 2018. Available [here](#).
CMMI, Enhancing Oncology Model Payment Methodology. July 2022. Available [here](#).

EOM Requires Immediate Participation in Downside Risk From Start of Model Via 2 Risk Tracks Available

Risk Arrangement 1 (RA1)

Does not qualify as AAPM
Requires Participation in MIPS

Risk Arrangement 2 (RA2)

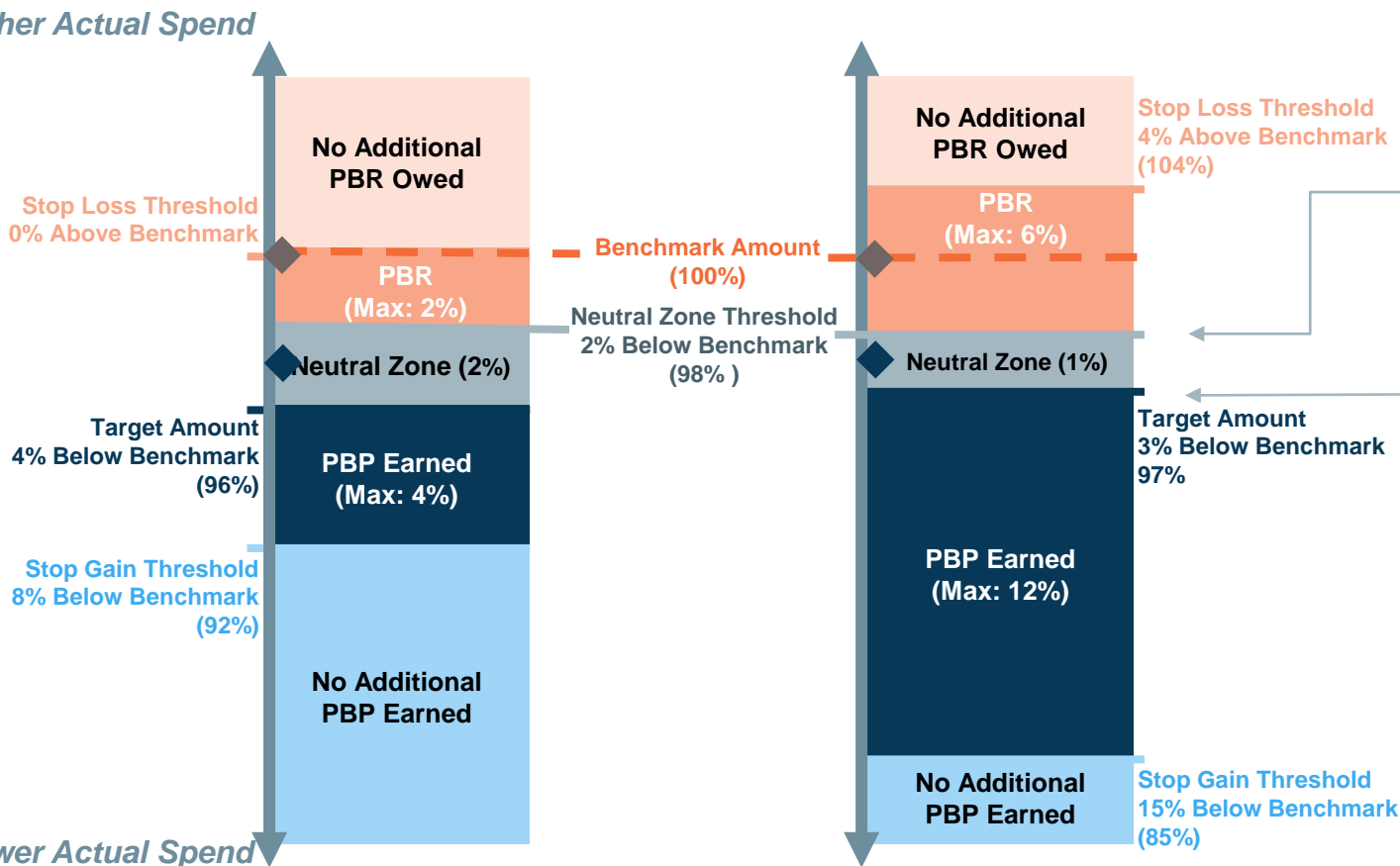
Qualifies as AAPM
May Require Participation in MIPS

Key Considerations

Practices must reduce actual expenditure by at least 2% of the benchmark amount to avoid owing a recoupment in both RA 1 and RA2

Discount rate in RA2 results in slightly higher target amount in RA2 than RA1

In both RA1 and RA2, the potential upside (i.e., PBP) is twice the downside (i.e., PBR)



*Illustrative graphs **not to scale**. Actual values for benchmark, target, stop loss, and stop gain dependent on practice specific variables.

EOM: Enhancing Oncology Model; OCM: Oncology Care Model; PBP: Performance Based Payment; PBR: Performance Based Recoupment; AAPM:

Advanced Alternative Payment Model

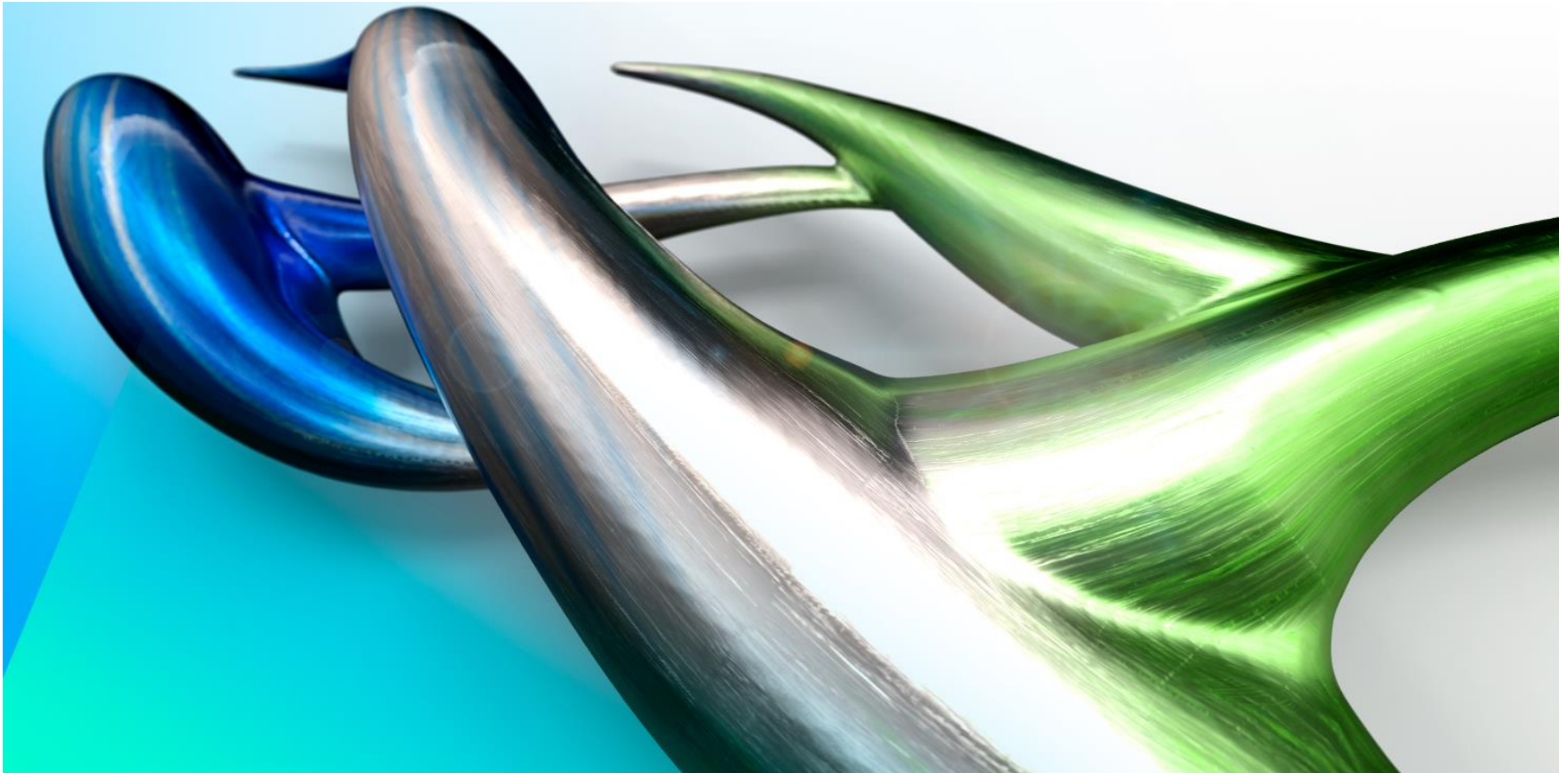
Source: CMMI, Enhancing Oncology Model Payment Methodology. July 2022. Available [here](#).



Avalere

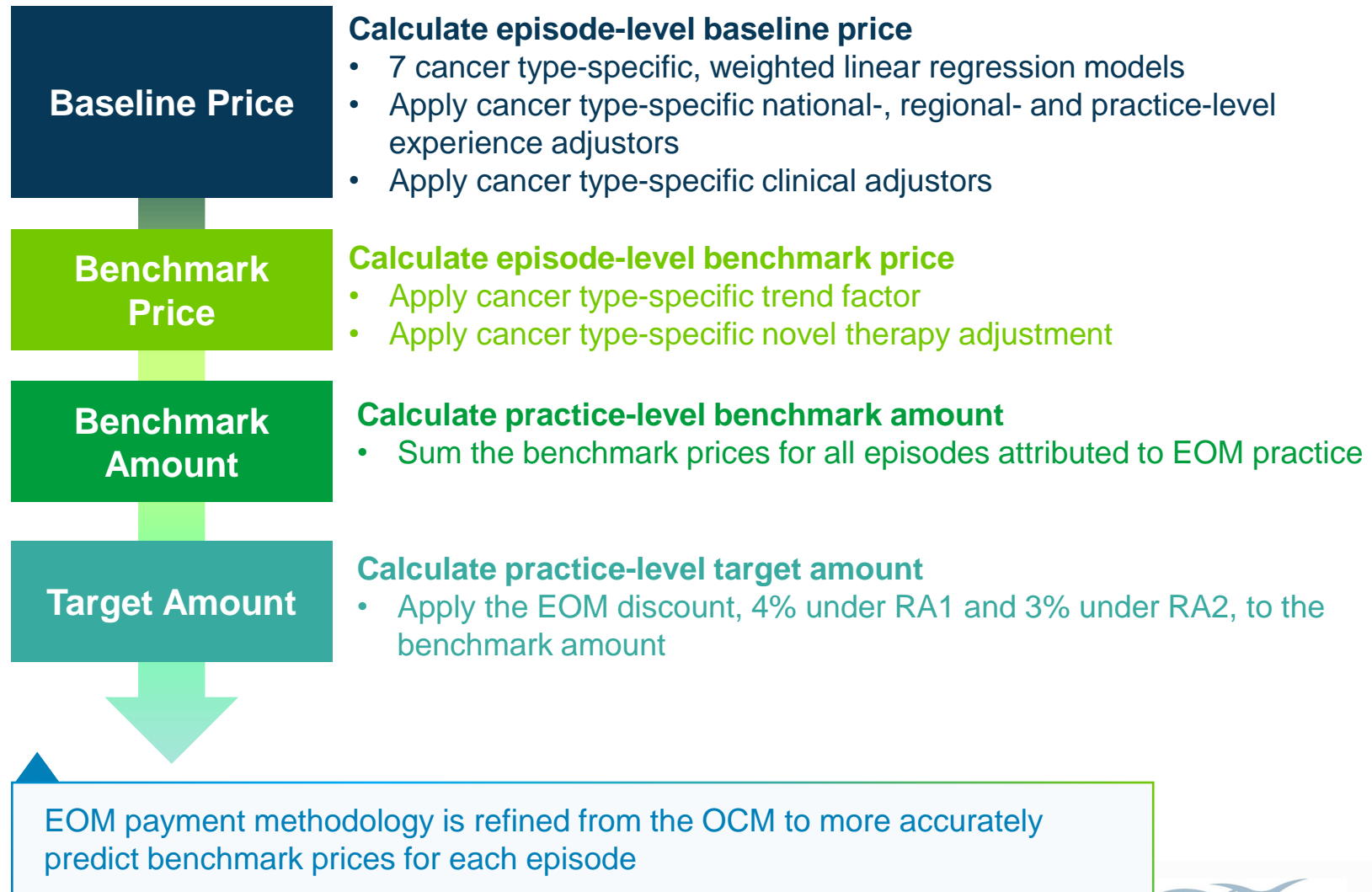
17

©2023. Avalere Health LLC. All Rights Reserved.



EOM Payment Methodology Overview

Participant's Target Price is Set Through a Series of Steps That Account for Patient, Provider, and Market Factors



Performance-Based Payment (PBP) Earned if Actual Expenditure is Below Target and Quality Metrics Met

$$\text{PBP} = (\text{Target} - \text{Actual})^1 * \text{PM} * \text{GA} * \text{S}$$

Target Amount

Projected Medicare expenditures for a practice during a PP

- Establish baseline period episodes' predicted price; adjust for beneficiary and practice factors
- Apply cancer type-specific trend factor
- Apply cancer type-specific NTA
- Winsorized
- Apply risk arrangement specific EOM discount (4% or 3%) to benchmark amount to obtain target amount

Actual Expenditures

- Actual practice expenditures during corresponding performance periods
- Episodes within performance periods aggregated using similar process to calculating target amount
- Winsorized

Performance Multiplier (PM)

- Tiered (0%, 50%, 75%, or 100%) based on aggregate quality score
- The PBP multiplier only decreases or maintains the amount of the PBP earned – will not increase PBP

Geographic Variation Adjustment (GA)

- Based on GPCI and HWI
- Removes effects of geographic variation

Sequestration (S)

- 2% payment adjustment²

Maximum payment adjustment capped at stop-gain and stop-loss amounts

Note: Subsequent slides provide additional details regarding key variables described

1. Stop gain limits how much a practice may earn in PBP. If the target amount minus the actual amount exceeds the stop gain, stop gain value is applied
2. Sequestration was suspended due to the COVID-PHE from May 2020 through December 2021. The sequestration adjustment is not included in the PBP formula for Performance Periods in which sequestration was not in effect.

PBP: Performance Based Payment; PM: Performance Multiplier; GA: Geographic Variation Adjustment; S: Sequestration; NTA: Novel Therapy Adjustment; GPCI: Geographic Practice Cost Index; HWI: Hospital Wage Index; EOM: Enhancing Oncology Model

Source: CMS, Enhancing Oncology Model (EOM) Payment Methodology. July 2022. Available [here](#).



Performance-Based Recoupment (PBR) Owed if Actual Expenditure Exceed Threshold for Recoupment

$$\text{PBR} = (\text{Actual} - \text{Threshold for Recoupment})_1 * \text{PM} * \text{GA} * \text{S}$$

Actual Expenditures

- Actual practice expenditures during corresponding performance periods
- Episodes within performance periods aggregated using similar process to calculating target amount
- Winsorized

Threshold for Recoupment

- 98% of the benchmark amount for both risk arrangements in EOM

Performance Multiplier (PM)

- Tiered (90%, 95%, 100%) based on aggregate quality score
- The PBR multiplier will only decrease the amount of PBR owed – will not increase PBR

Geographic Variation Adjustment (GA)

- Based on GPCI and HWI
- Removes the effects of geographic variation

Sequestration (S)

- 2% payment adjustment²

PBR amount owed is reduced for those that performed well on quality measures

1. Stop loss limits how much a practice may owe in PBR. If the actual amount minus the threshold for recoupment exceeds the stop loss, stop loss value is applied
2. Sequestration was suspended due to the COVID-PHE from May 2020 through December 2021. The sequestration adjustment is not included in the PBR formula for Performance Periods in which sequestration was not in effect.

Note, the calculations described above are based on EOM methodology, see tool “EOM Variable Input Tool Introduction” for detail on data sources, assumptions, and limitations of the variable input tool.

PM: Performance Multiplier; GA: Geographic Variation Adjustment

S: Sequestration; NTA: Novel Therapy Adjustment; GPCI: Geographic Practice Cost Index;

HWI: Hospital Wage Index; PBR: Performance Based Recoupment;

Source: CMS, Enhancing Oncology Model (EOM) Payment Methodology. July 2022. Available [here](#).



Baseline Price is Calculated by Adjusting the Predicted Price to Account for Practice Experience and Clinical Factors

Baseline Price

Benchmark Price

Benchmark Amount

Target Amount

$$\text{Baseline Price} = \text{Predicted Baseline Expenditures} \times \text{Experience Adjustor} \times \text{Clinical Adjusters}$$

Predicted Baseline Expenditures

1. Calculate Episode-level Expenditures

- Baseline period: July 2016 – June 2020
- Total expenditures include Parts A and B and some Part D expenditures; exclude OCM related payments
- Expenditures adjusted to account for model overlap and sequestration and winsorized to remove effect of outliers
- All baseline expenditures trended to final baseline period

2. Calculate Predicted Baseline Expenditures

- 7 cancer-type specific prediction models regressed on cancer-specific covariates
- Regression model weights later baseline periods more heavily to account for changing care patterns and COVID

Experience Adjustor

To account for regional and participant-specific variation not otherwise measured in price prediction model

- Unique to each EOM practice
- Experience adjustor is a weighted and blended value to incorporate variation in cancer type, geography, size, and experience

Clinical Adjusters

To adjust baseline prices for relevant clinical factors that impact total cost of care, as reported to EOM data registry

- Ever-metastatic status (breast, lung, small intestine/colorectal)
- HER2 status (breast)
- Clinical adjusters may be updated over time. As of August 2022, only above adjusters incorporated

Note, the calculations described above are based on EOM methodology, see tool "EOM Variable Input Tool Introduction" for detail on data sources, assumptions, and limitations of the variable input tool.

EOM: Enhancing Oncology Model; OCM: Oncology Care Model

Source: CMS, Enhancing Oncology Model (EOM) Payment Methodology. July 2022. Available [here](#).



EOM Prediction Models Are Cancer Type-Specific Weighted Regression Models

Baseline Price

Benchmark Price

Benchmark Amount

Target Amount

Prediction Model

- 7 cancer type-specific regression models
- Used to estimate baseline expenditures and control for the specific episode characteristics
- Baseline episode expenditures are regressed on covariates determined to influence episode expenditure; covariates vary by cancer type
- Baseline period is weighted toward more recent periods not impacted by COVID-19
- Episode-level comorbidities are captured in the prediction model through HCCs

Covariate Examples

Gender/age (e.g., Male age 65-69)	Receipt of select cancer-related surgery
Dual eligibility	Receipt of bone marrow transplant
Part D enrolment/LIS status	Receipt of radiation therapy
Institutional status	Clinical trial participation
Episode length	Prior chemo use/ “clean period”
Beneficiary comorbidities (HCC and RxHCC categories, count of costly HCCs)	

Note, the calculations described above are based on EOM methodology, see tool “EOM Variable Input Tool Introduction” for detail on data sources, assumptions, and limitations of the variable input tool.

The variable input model does not account for additional comorbidity adjustment because HCCs are captured and controlled for in the price prediction model.

EOM: Enhancing Oncology Model; HCC: Hierarchical Condition Category; RxHCC: Prescription Drug Hierarchical Condition Category; COVID: Coronavirus Disease

Source: CMS, Enhancing Oncology Model (EOM) Payment Methodology. July 2022. Available [here](#).



Benchmark Price is Calculated by Adjusting the Baseline Price by Cancer Specific Trend Factor and NTA

Baseline Price

Benchmark Price

Benchmark Amount

Target Amount

$$\text{Benchmark Price} = \text{Baseline Price} \times \text{Trend Factor} \times \text{Novel Therapy Adjustment}$$

Baseline Price

Episode-level predicted price with practice-level experience adjustor and episode-specific clinical adjustments applied

- Foundation for calculation of episode-level benchmark price

Trend Factor

Adjusts for inflation during model as well as additional spending patterns across EOM included cancer types between model baseline period and specific PP

- Cancer-type specific
- Derived from expenditures in EOM baseline period relative to PP expenditures that are attributed to non-EOM oncology PGPs

NTA

Accounts for newly-approved, more costly therapies by increasing benchmark prices for all episodes of a specific cancer when utilization greater than non-EOM PGPs

- Cancer-type specific
- Oncology drugs that received FDA approval after June 30, 2021, are considered for inclusion
- Oncology drugs are considered “new” for 2 years from FDA approval for that specific indication

Note, the calculations described above are based on EOM methodology, see tool “EOM Variable Input Tool Introduction” for detail on data sources, assumptions, and limitations of the variable input tool.

NTA: Novel Therapy Adjustment; EOM: Enhancing Oncology Model; PP: Performance Period; PGP: Physician Group Practice; FDA: Food & Drug Administration

Source: CMS, Enhancing Oncology Model (EOM) Payment Methodology. July 2022. Available [here](#).



Practice-Level **Benchmark Amount** and **Target Amount** Derived from Episode-Level Benchmark Prices

Baseline Price

Benchmark Price

Benchmark Amount

Target Amount

$$\text{Benchmark Amount} = \sum \text{Benchmark Price}$$

Benchmark Price

Episode-level baseline price with cancer type-specific trend factor and NTA applied

- Benchmark amount is the sum of all benchmark prices for episodes attributed to practices in given PP

$$\text{Target Amount} = \text{Benchmark Amount} \times (1 - \text{EOM Discount})$$

Risk Arrangement 1 EOM Discount

4% Below Benchmark

- PBP may be earned if expenditures are at least 4% below benchmark amount
- In RA1, maximum PBP is 4% of benchmark amount
- Stop gain threshold is 8% below benchmark amount

Risk Arrangement 2 EOM Discount

3% Below Benchmark

- PBP may be earned if expenditures are at least 3% below benchmark amount
- In RA1, maximum PBP is 12% of benchmark amount
- Stop gain threshold is 15% below benchmark amount

Note, the calculations described above are based on EOM methodology, see tool “EOM Variable Input Tool Introduction” for detail on data sources, assumptions, and limitations of the variable input tool.

PP: Performance Period; EOM: Enhancing Oncology Model; RA: Risk Arrangement; PBP: Performance Based Payment
Source: CMS, Enhancing Oncology Model (EOM) Payment Methodology. July 2022. Available [here](#).



The Novel Therapy Adjustment Increases the Benchmark Price to Account for Adoption of New Therapies

The EOM Trend Factor is calculated from non-participant episodes (i.e., EOM episodes attributed to non-participating practices) and does not capture EOM practice expenditures from newly approved, more expensive therapies. When an EOM participant's novel therapy spend exceeds the average novel therapy spend at non-EOM practices, the NTA increases the benchmark amount for the given EOM tumor type.

Novel Therapy Qualification

- NTA list is defined by CMMI each PP based on FDA approvals
- EOM NTA list will only include oncology products approved after June 30, 2021
- Oncology drugs are considered “new” for 2 years and are indication specific
- If approved for new indication, drug is added to NTA list based on approval date of new indication
- CMMI will automatically add new oncology products to the NTA list based on approval in given period; manufacturers may engage CMMI if product is not listed

Products could be added to the EOM NTA list under 2 conditions:

1. Pipeline products are approved for an EOM included cancer type
2. Current products are approved for a new indication for an EOM included cancer type

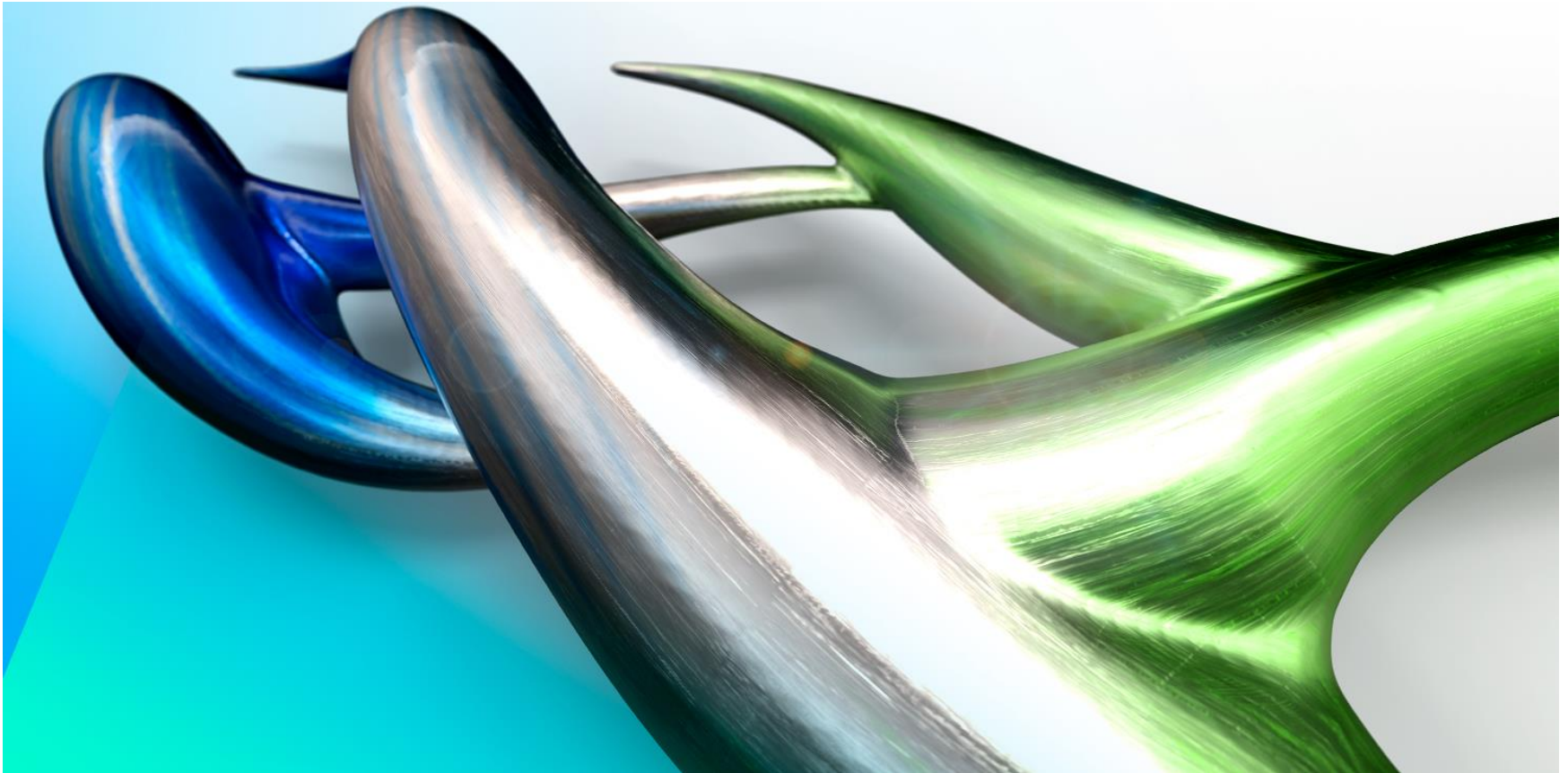
*Every episode of the same cancer type attributed to the same participant or pool receives the same NTA; however, the NTA may differ by cancer type

Note, the calculations described above are based on EOM methodology, see tool “EOM Variable Input Tool Introduction” for detail on data sources, assumptions, and limitations of the variable input tool.

NTA: Novel Therapy Adjustment; EOM: Enhancing Oncology Model; NSCLC: Non-Small Cell Lung Cancer






Source: CMS, Enhancing Oncology Model (EOM) Payment Methodology. July 2022. Available [here](#).





MACRA/MIPS Participation Overview

Practices Must Consider MACRA Implications Relative to Financial Upside/Downside of EOM Participation

	EOM RA1 MACRA: May select MIPS APM, traditional MIPS, or MVP reporting				
	No EOM Participation MACRA: MIPS (Traditional or MVP)		EOM RA2 MACRA: QP, Partial QP, or MIPS		
Reporting Requirements	 MIPS: Practice chooses measures at time of reporting	 EOM + MIPS (practice selects MIPS measures)			
MACRA Upside Potential	Very small; MIPS upside has not exceeded 2% as of 2020	Very small; MIPS upside has not exceeded 2% as of 2020	Additional 0.5% conversion factor increase	N/A	Same as RA1
MACRA Downside Potential	While unlikely, may be very high; up to -9%	While unlikely, may be very high; up to -9%	N/A	N/A	Same as RA1
EOM Upside Potential	N/A	Begins 2% below benchmark; max 4%	Begins 2% below benchmark; max 12%		
EOM Downside Potential	N/A	Begins 2% below benchmark; max 2%	Begins 2% below benchmark; max 6%		
Cost of Care Inclusion	30% of MIPS score	TCOC model + (if chooses traditional MIPS) MIPS cost score	TCOC model		(if MIPS) 30% of MIPS score
Provider Considerations	<ul style="list-style-type: none"> While performance scores have skewed high, the threshold is set closer to the mean each year and will become harder to achieve Budget neutrality limits potential payment 	<ul style="list-style-type: none"> Greatest reporting requirement burden MIPS upside is very small with large downside potential 	<ul style="list-style-type: none"> Greatest potential reward and risk under EOM If participant doesn't meet QP or Partial QP thresholds, they would have to participate in MIPS AAPM bonus ends performance year 2023; will not impact EOM 		

 MIPS and EOM
  EOM Only
  MIPS only

QP and partial QP status based on patient volume and payment that passes through an AAPM; MIPS Performance Year 2022 equates to MIPS Payment Year 2024
 MIPS: Merit-based Incentive Payment System; MVP: MIPS Value Pathway EOM: Enhancing Oncology Model; RA: Risk Arrangement; QP: Qualified Professional;
 APM: Alternative Payment Model; AAPM: Advanced Alternative Payment Model; TCOC: Total Cost of Care; RY: Reporting Year



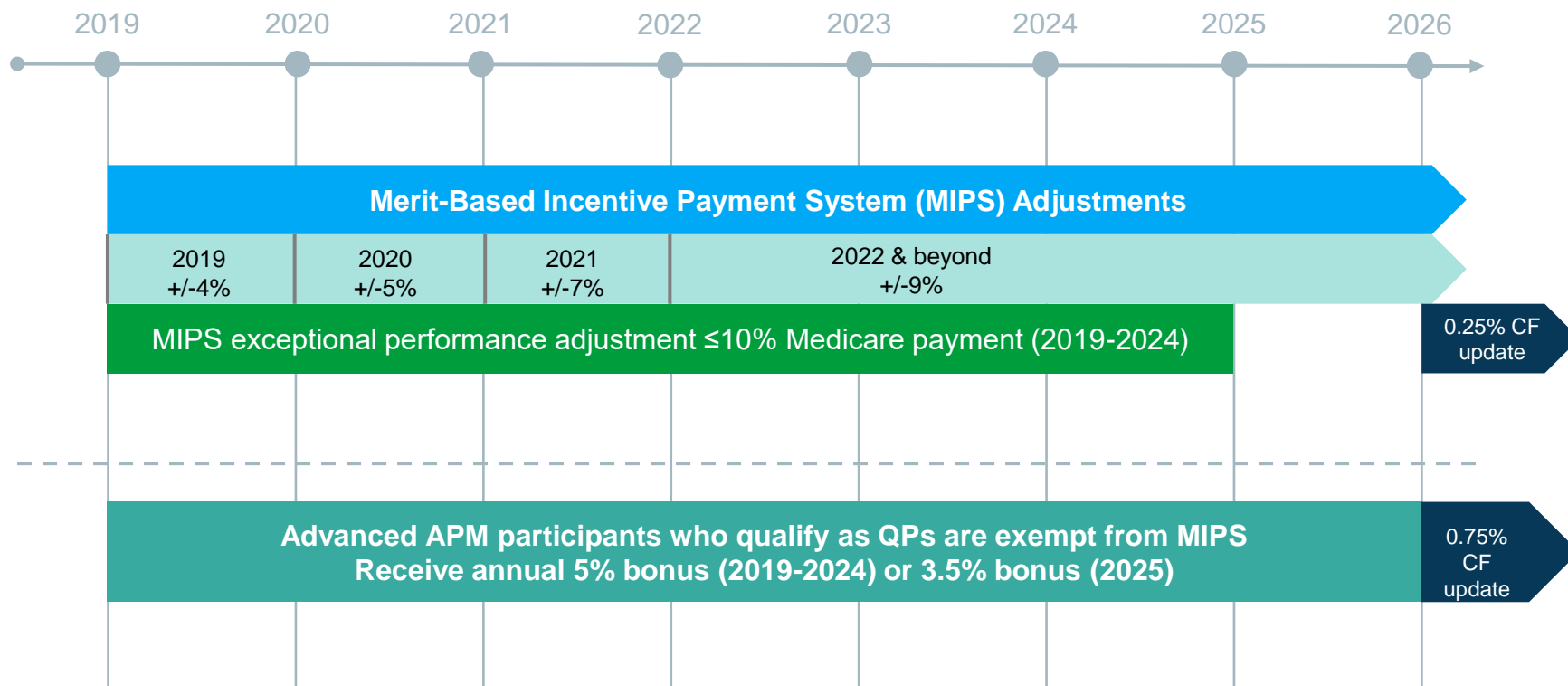
Avalere | 28

©2023. Avalere Health LLC. All Rights Reserved.

MIPS Exceptional Performance Adjustment and the AAPM Bonus Sunset with 2024-2025 Payment Years

Payment Years lag 2 years behind Performance Years - i.e., Performance Year 2023 / Calendar Year 2023 participation will impact 2025 payments

MIPS/QPP Timeline by Payment Year



APM: Alternative Payment Model; AAPM: Advanced Alternative Payment Model; CF: Conversion Factor; MIPS: Merit-Based Incentive Payment System; QP: Qualified Professional



EOM Participation Will Impact Providers' Participation Status Under MACRA (1/2)

Providers billing Medicare Part B Professional Services that meet eligibility requirements are subject to payment adjustments per the MPFS based on their MACRA track and associated performance. Participation in EOM will impact which MACRA track a provider is in, though there is not a direct relationship between EOM tracks and MACRA tracks.

MIPS

- Default track for providers not participating in eligible APMs
- Participants are scored in 4 categories: Quality, Promoting Interoperability, Improvement Activities, and cost
- Participants may select own measures (Traditional MIPS) or pre-determined set (MIPS MVPs)
- Providers receive a payment adjustment on Part B service claims based on total performance score
- Payment adjustments range from -9% to +9%; minimum thresholds are set in advance

MIPS APM

- Includes non-Advanced APM providers or Advanced APM providers who do not meet Partial QP or QP thresholds
- Have the option to report either Traditional MIPS, MIPS MVPs or report via the APM Performance Pathway (APP)
- Providers receive a total score and corresponding payment adjustment
- Historically, MIPS APM participants have scored higher than Traditional MIPS participants

EOM: Enhancing Oncology Model; MACRA: Medicaid and CHIP Reauthorization Act; MIPS: Merit-Based Incentive Payment System;
APM: Alternative Payment Model; QP: Qualified Professional; MVP: MIPS Value Pathway;
AAP: APM Performance Pathway



EOM Participation Will Impact Providers' Participation Status Under MACRA (2/2)

Partial QP

- Providers participating in 1 or more Advanced APMs (such as EOM RA 2) and whose total percentage of patients and/or payments flowing through the AAPM(s) fall between the Partial QP minimum threshold and the QP minimum threshold
- Partial QP threshold for PY 2024 and beyond is either 35% of patients or 50% of Part B Professional Services payments
- Partial QPs are exempt from MIPS, though they may opt-in

QP

- Providers participating in one or more Advanced APMs (such as EOM RA 2) and whose total percentage of patients and/or payments flowing through the AAPM(s) is at or above the QP minimum threshold
- QP threshold for performance year 2024 and beyond is either 50% of patients or 75% of Part B Professional Services payments
- QPs are exempt from MIPS and receive a higher annual conversion factor adjustment (0.75% vs. 0.25% for non-QPs)

As EOM does not begin until the mid-point of the performance year, participants in EOM RA2 are unlikely to hit Partial QP or QP thresholds in 2023 based on EOM participation alone.

Both EOM and MIPS Participants Must Meet Certain Requirements to Remain Eligible for Bonus Payments

As part of practice participation requirements, both EOM and MIPS have their own set of activities to continue to remain eligible for payments. These activities often require infrastructure investments that will be highlighted in the EOM decision tool. Practices that choose to participate in EOM may also be required to participate in MIPS, overlap is dependent on QP/Partial QP status.

EOM Redesign Activities

- 1 Provide 24/7 patient access to appropriate clinician with real-time access to practice's medical records
- 2 Use ONC certified-EHRs technology aligned with Stage 2 meaningful use*
- 3 Document care plan for each beneficiary using the 13 components of the Institute of Medicine (IOM) Care Management Plan
- 4 Provide core functions of patient navigation
- 5 Utilize practice and Medicare claims data to improve performance and achieve EOM goals and report EOM quality measures
- 6 Follow nationally recognized clinical guidelines (e.g., NCCN or ASCO)
- 7 Implement ePROs gradually in years 1 and 2 of EOM with full implementation by year 3
- 8 Screen for at least 3 EOM social needs domains (e.g., transportation, food insecurity, housing instability)
- 9 Develop health equity plan to identify health disparities in patient care plan and collect data to identify and address potential disparities

MIPS Reporting Requirements

Practices must submit 'Quality' and 'Promoting Interoperability' measures as well as improvement activities to calculate a MIPS score (which determines final payment). Cost performance is calculated by CMS using claims data. The 4 performance categories scored to determine bonus payment include:

- 1 **Quality:** Assesses the quality of care a provider delivers
Practices may select the measures that fit best
- 2 **Promoting Interoperability:** Promotes patient engagement and electronic exchange of health information using certified electronic health record technology
- 3 **Improvement Activities:** Assesses how you improve your care processes, enhance patient engagement in care, and increase access to care
- 4 **Cost:** Assesses the cost of the patient care provided

MIPS: Merit-based Incentive Payment System; EOM: Enhancing Oncology Model EHR: Electronic Health Record; ONC: Office of the National Coordinator; IOM: Institute of Medicine; NCCN: National Comprehensive Cancer Network; ASCO: American Society of Clinical Oncology; ePRO: Electronic Patient Reported Outcomes

*Stage 2 Meaningful use focuses on capturing health information in structured format and increasing exchange of information during care transitions



Connect With Us



Maddi Davidson

Associate Principal

MDavidson@avalere.com



Melissa Morley

Principal

MMorley@avalere.com



Shelby Harrington

Principal

SHarrington@avalere.com



Blair Burnett

Consultant II

BBurnett@avalere.com

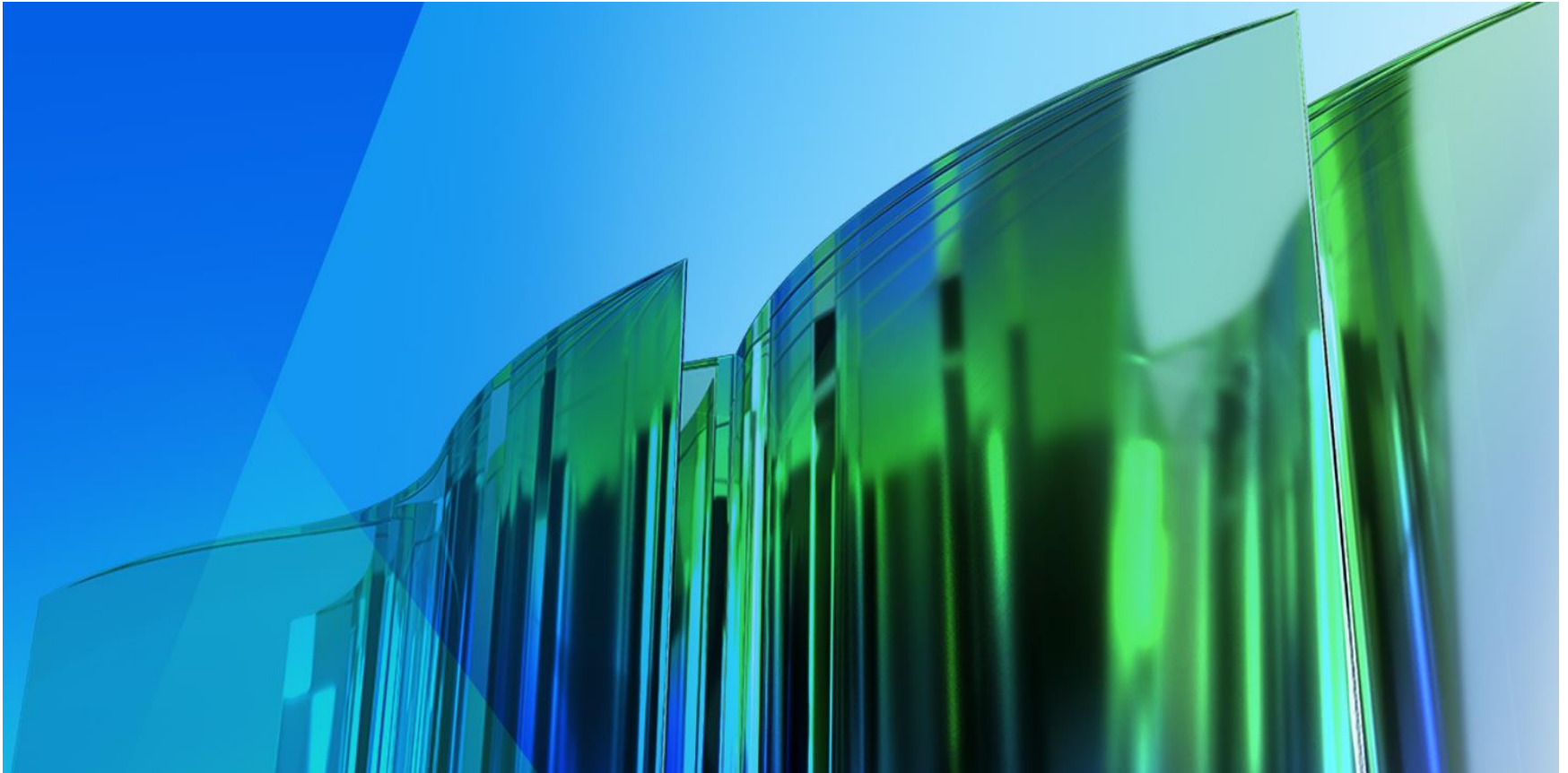
EOM Variable Input Tool Webinar #2

Wednesday, February 22, 2023
4:00-5:30pm EST

Meet Us Live at COA Annual Conference

March 22-23, 2023
Contact Christina Gramling,
cgramling@avalere.com, for scheduling





EOM Tool Inputs

Step 1: Select Practice Characteristics from Drop Down Lists and Enter Episode Count by EOM Cancer Type

Practice Characteristics - select from drop down menus

Practice Type	Community
Census Division	Northeast
Urban or Rural	Urban

EOM Patient Mix Considerations

EOM Episodes per Performance Period	305
-------------------------------------	-----

EOM Case Mix

EOM Cancer Type	Number of Episodes	Percent of Episodes
Breast	70	23%
Lung	70	23%
Multiple Myeloma	45	15%
Lymphoma	40	13%
Small Intestine / Colorectal	30	10%
Prostate	25	8%
Chronic Leukemia	25	8%
Total	305	100%

Patient Demographics - Values populated from average characteristics of practices meeting the practice characteristics and size inputs above

Race	Number of Episodes	Percent of Episodes
White	269	88%
Black	21	7%
Hispanic	4	1%
Asian	5	2%
American Indian & Alaskan Native	0	0%
Other	5	2%
Total	305	100%

Note, race categories are based on available Medicare definitions

Select the characteristic that best describes your practice

Enter episode count per cancer type

For additional detail on EOM episode definitions, cancer type mapping, and initiating therapy, visit the [EOM Payment Methodology](#) (Section 1.2.1) and the [EOM Technical Payment Resources](#)



Former OCM participants may use a previous reconciliation report to help populate this input. Ensure you are only counting cancers with systemic therapies in these counts. Recall that the EOM does not include episodes with hormonal only therapy,

1. Exclude PGPs with less than 50 episodes from 2016 through 2020
EOM: Enhancing Oncology Model; OCM: Oncology Care Model



Step 2: Review and Adjust Race and Dual Eligibility Inputs

Patient Demographics - Values populated from average characteristics of practices meeting the practice characteristics and size inputs above

Race	Number of Episodes	Percent of Episodes
White	269	88%
Black	21	7%
Hispanic	4	1%
Asian	5	2%
American Indian & Alaskan Native	0	0%
Other	5	2%
Total	305	100%

Note, race categories are based on available Medicare definitions

Dual Eligible Patients - Values are populated from average characteristics of practices meeting the practice characteristics and size inputs above

Dual Eligible Patients	Number of Episodes	Percent of Episodes
Dual eligible for Medicare and Medicaid	38	12%
Not dual eligible	267	88%
Total	305	100%

- Percent of episodes by race determined by average across other practices meeting above input criteria
- User may adjust percentages to reflect their practice

- Percent of dual eligible episodes determined by average across other practices meeting above input criteria
- User may adjust percentages to reflect their practice



Knowledge Check: Dual-eligible patients are those qualifying for both Medicare and Medicaid benefits. The number of dual-eligible patients may shift due with the beginning of the Medicaid redetermination period once the COVID-19 PHE ends.

Step 3: Modify Novel Therapy Adjustment and Experience Adjustor Based on Practice Patterns

EOM Methodology Assumptions	
Novel Therapy Adjustment (NTA)	
EOM Cancer Type	Anticipated Novel Therapy Spend Above Non Participant Average
Breast	1.00%
Lung	1.50%
Multiple Myeloma	1.50%
Lymphoma	0.50%
Small Intestine / Colorectal	0.00%
Prostate	0.00%
Chronic Leukemia	0.00%
Note, user may enter value between 0 and 3%	
Experience Adjustor (EA)	
EA Value	1.00
Note, user may enter value between 0.9 and 1.2	

- Enter a value between 0% and 3% to indicate anticipated novel therapy spend ABOVE the non-participant average



Knowledge Check: The NTA increases the benchmark price for episodes in a cancer bundle at a practice with higher novel therapy spend (as a percent of total spend) than the non-participant average. The NTA can only increase the benchmark price and cannot decrease it. NTA will depend on available drugs and inclusion on the CMS novel therapy list

- Enter a value between 0.9 and 1.2
 - A **value less than 1.0** indicates that a practice's expenditures are generally less than predicted after blending the ration of average actual expenditures separately by cancer type at 3 levels of aggregation (national, regional, and EOM participant-specific)
 - A **value greater than 1.0** indicates that a practice's expenditures are generally greater than predicted after blending the ration of average actual expenditures separately by cancer type at 3 levels of aggregation (national, regional, and EOM participant-specific)
 - A **value equal to 1.0** indicates no difference



Knowledge Check: The experience adjustor is practice-specific and reflects a blending of the ratio of average actual expenditures to average predicted expenditures for each included cancer type calculated at three levels of aggregation (national, regional, and EOM participant-specific). Range of utilization will likely change based upon future drug approvals. A single experience adjustor for each practice is calculated based on the practice-specific distribution of episodes in each included cancer type.

This tool includes national and regional values of the experience adjustor based on analysis of publicly available baseline data, have assumed equal weighting across these levels, and have assumed an equal distribution of episodes across included cancer types. Note that during EOM, a practice-specific value will be incorporated into the experience adjustor to reflect practice specific experience, weighting based on total number of attributed episodes, and mix of included cancer types which may result in slightly higher or lower values for the experience adjustor.

EOM: Enhancing Oncology Model; NTA: Novel Therapy Adjustment; EA: Experience Adjustor, OCM: Oncology Care Model

Step 4: Input Part B Beneficiary Count to Determine QP, Partial QP, or MIPS Status Under MACRA Participation

Determination of QP Status, Partial QP Status, or MIPS Status under MACRA for Measure Year 2024 (Payment Year 2026)	
<i>A practice may be eligible for the Partial QP or QP tracks of MACRA if they participate in an Advanced APM (e.g. EOM RA2) and meet minimum thresholds of patients or payments flowing through that Advanced APM</i>	
Patient Count Threshold Score	
	Number of Medicare FFS Beneficiaries Receiving Part B Professional Services
Attributed to EOM	610
All Medicare FFS Patients	1,342
% Patients attributed to EOM	45%
Payment Amount Threshold Score	
	Total Payments for Part B Professional Services
Attributed to EOM	\$14,000,000
All Medicare FFS Payments	\$30,800,000
% Part B payments attributed to EOM	45%

Users inputs the number of FFS Medicare beneficiaries receiving Part B professional services attributed to APMs and all patients to determine the patient count threshold score. To determine the payment amount threshold score, users enter total payments for Part B professional services attributed to APMs and all patients.



Knowledge Check: MACRA outputs are based on performance impact from 2024 and beyond (2023 is not included in this calculation).

Practices will be subject to payment adjustments under 1-4 potential pathways under the QPP, including the Qualified Professional Pathway via participation in EOM, the partial QPP via participation in EOM, MIPS pathway under the Alternative Payment Model, Advanced Alternative Payment Model Performance Pathway via participation in EOM, or MIPS participation by not participating in EOM or other APMs.

EOM: Enhancing Oncology Model; QP: Qualified APM Participant; MIPS: Merit-Based Incentive Payment System; MACRA: Medicare and CHIP Reauthorization Action; FFS: Fee-for-Service; APM: Alternative Payment Model; FFS: Fee-for-Service; QPP: Quality Payment Program



Step 5: Review and Adjust Average Benchmark and Spend for Each EOM Cancer Type

Benchmark and Actual Spend				
Average Benchmark Price and Total Spend by Cancer Type			Price and Spend Adjustment	
EOM Cancer Type	Average Benchmark Price	Average Spend	Benchmark Price Adjustment	Spend Adjustment
Breast	\$47,496	\$47,848	0.00%	0.00%
Lung	\$64,183	\$64,935	0.00%	0.00%
Multiple Myeloma	\$87,467	\$87,745	0.00%	0.00%
Lymphoma	\$55,432	\$56,040	0.00%	0.00%
Small Intestine / Colorectal	\$38,165	\$38,698	0.00%	0.00%
Prostate	\$47,433	\$48,789	0.00%	0.00%
Chronic Leukemia	\$57,480	\$57,835	0.00%	0.00%

Note, user may enter value between -3.00% and 3.00%

- Average benchmark and spend per cancer type are auto populated from beneficiary-level input and EOM baseline file data

- Review the average benchmark and spend amount in the table to the left
- If the values do not align with your practice patterns, increase or decrease each cell up to 3%.
- Enter the percent change you wish to apply with a (-) mark to indicate a decrease
- For conservative estimates, we encourage users to model a variety of scenarios and determine what level of risk they are willing to take on under each scenario



Knowledge Check: The benchmark price is established for each episode based on the prediction model and adjusted for NTA, trend, experience adjustor, and clinical factors. Factors that may lead to higher benchmark prices include, but are not limited to, comorbidities and costly HCCs, dual eligibility, surgery during episode, and metastatic status.



Knowledge Check: The EOM is a total cost of care model and includes all Part A and B and some Part D costs during the 6-month episode of care. Factors that may lead to higher benchmark prices may also lead to higher episode spending.

Step 6: Incorporate Staff and Technology Costs Associated with Model Implementation

EOM Implementation Considerations

New Staff

	Role	Number of FTEs	Annual Salary per FTE
New Employee Role #1	Nurse navigator	2	\$80,000
New Employee Role #2	Social worker	1	\$65,000
New Employee Role #3	Nutrition services	1	\$60,000
New Employee Role #4	Coding expert	0.5	\$75,000
New Employee Role #5			
New Employee Role #6			

Technology Costs

	Description	Up Front / One time Fee	Annual Fees
Technology #1			\$0
Technology #2			
Technology #3			
Technology #4			

Consultant or Other Third Party Support

	Description	Up Front / One time Fee	Annual Fees
Support #1			
Support #2			
Support #3			
Support #4			

New Staff

- May include additional clinical roles, nutrition counselor, social work, billing and coding, data analysts, etc.
- Only count staff that will be hired specifically to support the EOM. Do not count staff hired for OCM who have stayed on in the gap between OCM and EOM.
- The number of new staff hired will depend on practice volume, current staffing, and EOM care redesign priorities.
- Enter the type of role for documentation and the expected number of staff you plan to hire (you may enter fractions) and expected salary.

Consultant of Other Third-Party Support

- May include consultants, ePRO support, data management services, etc.
- Recall that ePRO is not mandatory until EOM year 3.

Technology Costs

- May include electronic health record updates, technology interfaces, phone system update to accommodate nurse hotline, etc.

EOM: Enhancing Oncology Model; FTE: Full Time Equivalent; ePRO: Electronic Patient Reported Outcome; OCM: Oncology Care Model



Step 7: Input Reinsurance Policy Assumptions

Reinsurance Per 6-month Performance Period		
Reinsurance Plan	No	
Plan Details	RA1	RA2
Premium	\$25,000	\$50,000
Deductible	\$50,000	\$30,000
Reinsurance payment cap	\$1,000,000	\$2,000,000

- Select if practice plans to enroll in a reinsurance plan

- Enter policy data by risk arrangement



Knowledge Check: Reinsurance mitigates financial risk for practices enrolled in downside risk arrangements

Premium

- Premium applies to a single 6-month EOM performance period
- Premium will vary based on the number of episodes, deductible, practice's benchmark prices, demonstrated success in OCM or other APMs, etc.

Deductible

- If practice owes recoupment, they will pay the recoupment up to the deductible threshold, then the reinsurance policy will cover amount above deductible
- Some policies offer coinsurance while others may cover 100% of cost after deductible

Payment Cap

- Reinsurance plans may implement a payment cap to protect from losses. If a practice meets the payment cap, then the practice responsibility will include the deductible plus remaining recoupment past the reinsurance cap

Step 8: Input MIPS-Related Staff and Technology Costs to Provide Insight into Overall Oncology VBC Participation

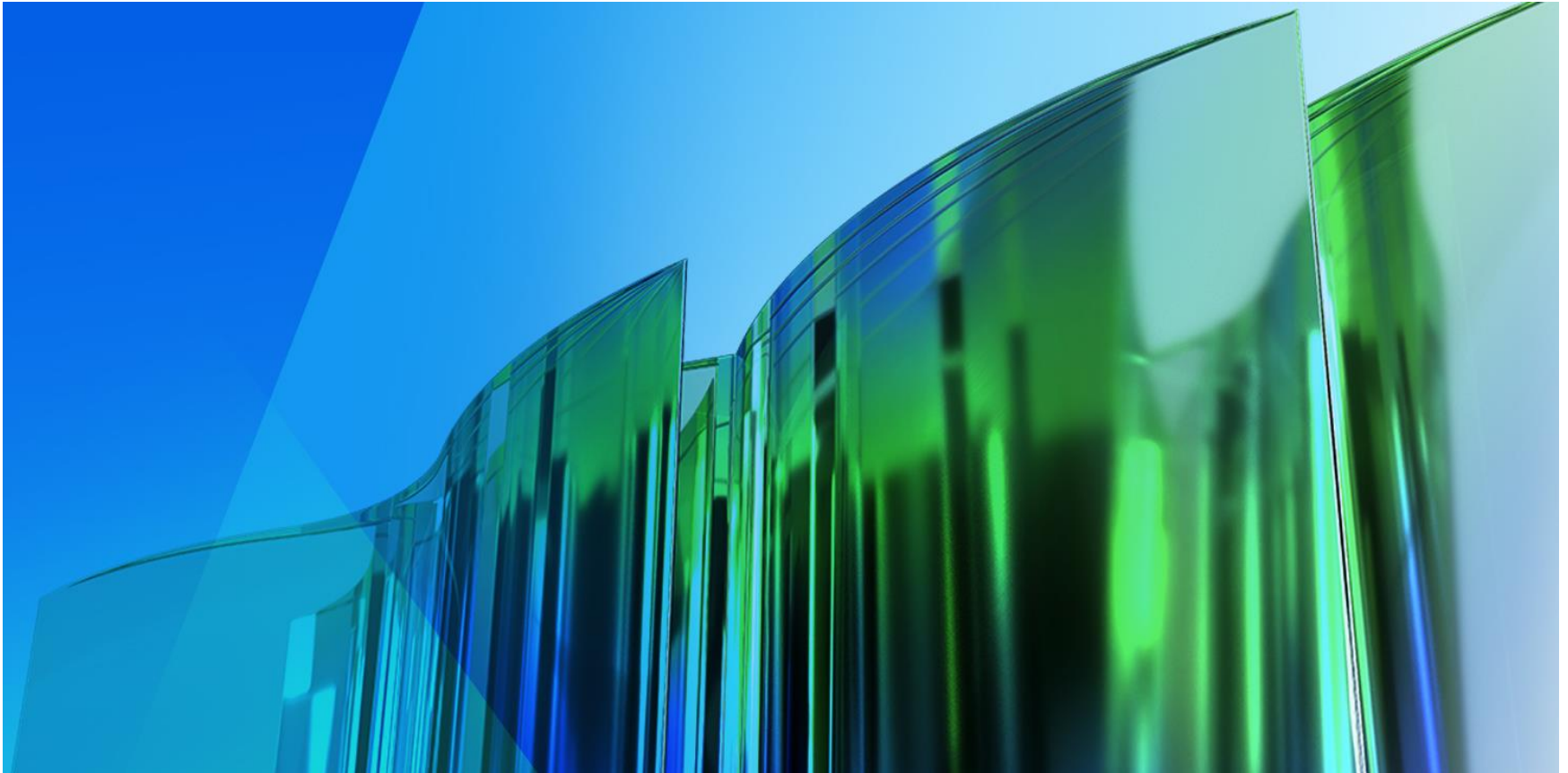
MIPS Implementation Considerations			
New Staff			
	Role	Number of FTEs	Annual Salary per FTE
New Employee Role #1	MIPS Coordinator	0.5	\$65,000
New Employee Role #2			
New Employee Role #3			
Technology Costs			
	Description	Up Front / One time Fee	Annual Fees
Technology #1	MIPS Software Vendor Fees	\$20,000	\$7,500
Technology #2			

This input should capture funds spent improving clinical documentation, improving HIT infrastructure, optimizing EHRs for data collection, and vendors associated with other EHR enhancements.



Knowledge Check

- Practices may participate in traditional MIPS, the Alternative Payment Model Performance Pathway (using a predetermined measure set and promoting interoperability measure), or in MIPS Value Pathways (using fewer measures which are tailored to a specific specialty).
- Under traditional MIPS, practices report several performance categories (i.e., quality, promoting interoperability, improvement activities, and cost).
- Performance categories are scored and added to make up the final score, which determines the payment adjustment which applies to Part B claims.



EOM Tool Outputs

Output of EOM Summary by Participation Track Provides Net Financial Impact of EOM Participation Across 3 Tracks

EOM Summary by Participation Track

Estimates reflect a single 6-month performance period

	EOM RA 1	EOM RA 2	No EOM Participation
EOM Episode Count	135	135	135
Total FFS Payment (among EOM episodes)	\$7,440,000	\$7,440,000	\$7,440,000
EOM Performance Summary			
Total expenditures relative to benchmark amount	1.11%	1.11%	N/A

EOM performance summary quantifies total expenditures and provides a percent distance from benchmark for users

The tool provides overall details on reconciliation.

- The benchmark amount, target amount, recoupment thresholds, and winsorized spend determine a practice's **distance from benchmark**
- A practice's distance from benchmark is calculated by dividing a practice's actual expenditures by their benchmark amount.

The distance from benchmark and the risk arrangement selected will determine how much or little a practice will earn in payments or owe in recoupment



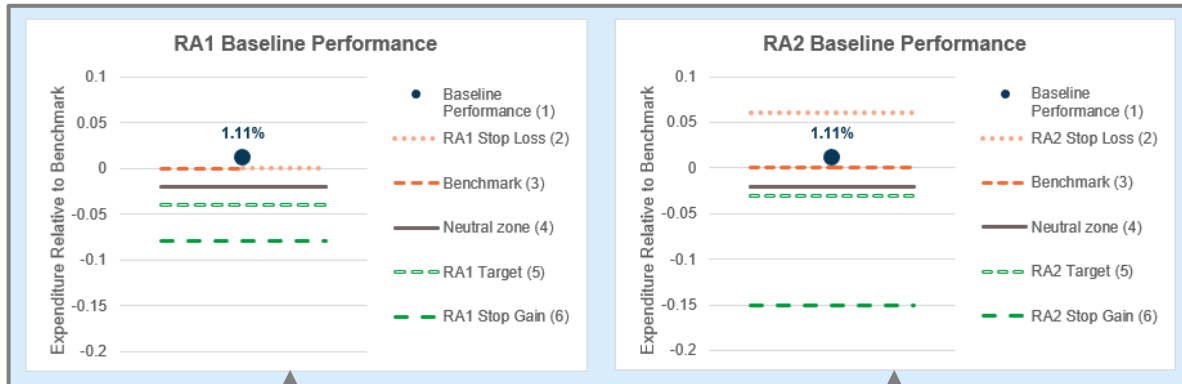
Knowledge Check

- Based on the tool user's inputs, outputs will include key EOM specific payments and recoupments/costs to provide the net financial impact should a practice select either Risk Arrangement 1 or 2
- For non-participants, EOM specific elements will not be included (i.e. episode count, MEOS payments, performance based payment or recoupment, and EOM implementation costs); however, total FFS payment will be provided
- This detail provides insight into the costs and gains associated with EOM participation and non-EOM participation and what the net impact would be for a practice

Tool Output Visually Shows Users Expected Performance in EOM by Risk Arrangement

Risk Arrangement 1 (RA1)

Does not qualify as AAPM
Requires Participation in MIPS



Baseline Performance Estimates

This figure is directional and visualizes baseline performance relative to RA1 and RA2 payment thresholds.

- In RA1 and RA2, baseline performance (1), benchmark (3), and neutral zone (4) are all equal.
- In RA1, the stop loss (2) is equal to the benchmark (3) and the target amount (5) is 4% below the benchmark. The stop gain (6) is 6% below the benchmark (capping RA1 PBP at 4% of the benchmark).
- In RA2, the stop loss (2) is 6% above the benchmark (3) and the target amount (5) is 3% below the benchmark. The stop gain (6) is 15% below the benchmark (capping RA2 PBP at 12% of the benchmark).



Knowledge Check

- Practices must reduce actual expenditure by at least 2% of the benchmark amount to avoid owing a recoupment in both RA 1 and RA2.
- Discount rate in RA2 results in slightly higher target amount in RA2 than RA1
- In both RA1 and RA2, the potential upside (i.e., PBP) is twice the downside (i.e., PBR)

*Illustrative graphs not to scale. Actual values for benchmark, target, stop loss, and stop gain dependent on practice specific variables. More information on EOM risk arrangements can be found on slide 29.
EOM: Enhancing Oncology Model; RA: Risk Arrangement; AAPM: Advanced Alternative Payment Model; MIPS: Merit-based Incentive Payment System; PBP: Performance-based Payment; PBR: Performance-based Recoupment

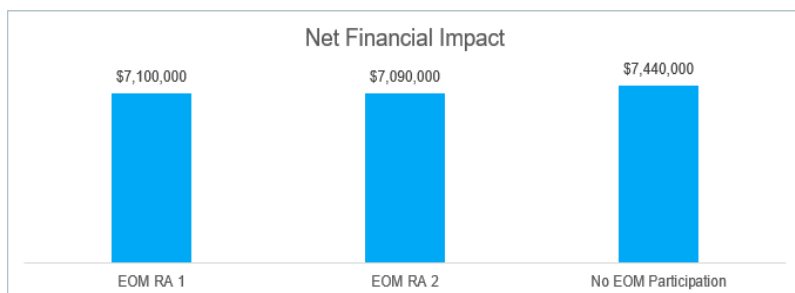
Tool Provides Details on Net Financial Impact of EOM Participation Across Each Model Risk Track

	EOM RA 1	EOM RA 2	No EOM Participation
EOM Specific Payments - <i>Additional Detail Below</i>			
MEOS Payments	\$60,000	\$60,000	N/A
Reconciliation Outcome	Recoupment with Stop Loss	Recoupment	N/A
Performance Based Payment (+) or Recoupment (-)	-\$50,000	-\$30,000	N/A
Recoupment Paid by Reinsurance Carrier (if applicable)	\$102,000	\$207,000	N/A
EOM Implementation Costs			
Infrastructure costs	-\$322,500	-\$322,500	N/A
Reinsurance premium	-\$25,000	-\$50,000	N/A
Net Financial Impact	\$7,100,000	\$7,090,000	\$7,440,000

Reconciliation outcome is a key output that guides overview of net financial impact of EOM participation across risk tracks as well as not participating in the model.

Reconciliation outcome states whether a practice:

- Receives a PBP with or without stop gain
- Is in the safe zone
- Owes a PBR with or without stop loss



Net Financial Impact

- Net Financial Impact is based on a single 6-month EOM performance period
 - (FFS Payments + MEOS Payments) +/- PBP or PBR + EOM Implementation Cost
- If a PBR is owed and reinsurance is in place, the value for recoupment reflect the deductible plus any PBR owed after the reinsurance cap.
- The recoupment paid by reinsurance carrier is not included in net financial impact.

EOM: Enhancing Oncology Model; MEOS: Monthly Enhanced Oncology Services; RA: Risk Arrangement; FFS: Fee-for-Service; PBP: Performance-based Payment; PBR: Performance-based Recoupment



Impact of Participation Decision on MACRA Track Reported in Tool Output

Impact of EOM Participation Decision on MACRA Track

These tracks assume practice is not participating in other APMs. Practice status under MACRA may change depending on participation in other APMs in addition to or instead of EOM.

If the practice elects to participate in EOM RA2, which is considered an Advanced APM, they will fall into the QP, Partial QP, or MIPS APM track of MACRA depending on their patient or payment threshold score. Score below reflect EOM participation only. If the practice participates in other Advanced APMs, their total score will differ.

	EOM RA1 or RA2 Practice Below Partial QP Threshold	EOM RA2 Practice Meets Partial QP Thresholds, but not QP Thresholds	EOM RA2 Practice Meets QP Thresholds	No EOM Participation
MIPS Participation	MIPS APM	Partial QP Status	QP Status	Standard MIPS
Conversion Factor Update*	0.25%	0.25%	0.75%	0.25%
If MIPS:		Neutral adjustment for partial QP		
Average MIPS adjustment	1.60%			0.78%
Max Positive MIPS adjustment	9%			9%
Max Negative MIPS adjustment	-9%			-9%
MIPS Implementation Costs				
MIPS Technology Costs	\$0			\$0
MIPS Personnel Costs	\$65,000			\$65,000

This section of the decision tool demonstrates how potential EOM participation will influence participation under MACRA.

- EOM RAs do not map 1-to-1 to MACRA status; as such, the tool outlines the potential impact of different EOM RAs on MACRA status (e.g., MIPS APM, Partial QP status, QP status, standard MIPS)
- As MACRA incentives and penalties associated with performance year 2023 are different from incentives and penalties in subsequent years, the payment implications displayed in the tool reflect the program design for performance year 2024 and beyond.
 - Also note that for EOM RA2 participants, since the EOM does not begin until July 1, 2023, EOM patient and payment volume is unlikely to be high enough to impact QP or Partial QP status for performance year 2023
- MIPS payment adjustments are applied to Medicare Part B Professional Services claims on a per-claim basis in the payment year corresponding to the performance year
- Estimated total payment in dollars is based on the practice's Part B Professional Services payments entered on the Input tab
- Conversion factor adjustments are applied to the conversion factor annually as determined by statute



Knowledge Check

- MACRA payment impacts occur two years after the corresponding performance year, e.g., participation status and performance in 2024 impacts payment in 2026.

MACRA: Medicare Access and CHIP Reauthorization Act of 2015; MIPS: Merit-based Incentive Payment System; QP: Qualifying APM Participant; RA: Risk Arrangement; EOM: Enhancing Oncology Model; AAMP: Advanced Alternative Payment Model; VBC: Value-based Care; APM: Alternative Payment Model



Tool Calculates EOM-Participating Practice's Threshold Score Based on Patient Count and Payment Amount

Determination of QP Status, Partial QP Status, or MIPS Status under MACRA

Patient Count Threshold Score

	Number of Medicare FFS Beneficiaries Receiving Part B Professional Services
Attributed to EOM	270
All patients	600
Score	45%
Likely Status	Partial QP

Payment Amount Threshold Score

	Total Payments for Part B Professional Services
Attributed to EOM	\$7,290,000
All patients	\$16,000,000
Score	46%
Likely Status	MIPS

Scores are calculated by dividing the number of patients attributed to the APM by the count for all patients.

These scores correspond with whether the practice qualifies for QP status, Partial QP status or MIPS (details in table below). This information is provided in the **Likely Status** rows.

To achieve QP status or Partial QP status, providers must participate in an **Advanced APM (EOM RA2)** and meet the threshold for **ONE** of either the patient count or payment amount.



Knowledge Check

Likely Status	Patient Count Threshold Score	Payment Amount Threshold Score
Qualifying APM Participant (QP)	Must see at least 35% of Medicare patients through an Advanced APM entity during the QP performance period	Must receive at least 50% of Medicare Part B payments through an Advanced APM entity during the QP performance period
Partial Qualifying APM Participant (Partial QP)	Must see at least 25% of Medicare patients through an Advanced APM entity during the QP performance period	Must receive at least 40% of Medicare Part B Payments through an Advanced APM entity during the QP performance period
MIPS (may elect MIPS APM, traditional MIPS, or MIPS MVPs)	Practice is below the patient count threshold for Partial QP status	Practice is below the payment amount threshold for Partial QP status

Source: CMS. "Advanced Alternative Payment Models (APMs)." Available [here](#).

MACRA: Medicare Access and CHIP Reauthorization Act of 2015; MIPS: Merit-based Incentive Payment System; QP: Qualifying APM Participant; EOM: Enhancing Oncology Model; APM: Alternative Payment Model; RA: Risk Arrangement; MVP: MIPS Value Pathway



Tool Provides Detailed Data By Cancer Type to Introduce Insights into Cost and Performance Variation

Illustrative Example of Cancer Specific Detail for 1 of the 7 EOM Cancer Types

EOM Detail by Participation Track

Estimates reflect a single 6-month performance period

Overall Reconciliation Detail

	EOM RA 1	EOM RA 2
Episode Count	135	135
Benchmark Amount	\$7,615,012	\$7,615,012
Target Amount	\$7,310,411	\$7,386,562
Threshold for Recoupment	\$7,462,712	\$7,462,712
Stop Gain	\$304,600	\$913,801
Stop Loss	\$152,300	\$456,901
Total Unwinsorized Spend	\$7,436,973	\$7,436,973
Total Winsorized Spend	\$7,699,775	\$7,699,775
Reconciliation Outcome	Recoupment with Stop Loss	Recoupment
Final PBP or Recoupment Amount	-\$152,300	-\$237,063

Cancer Specific Detail

	Value	% of Total (Across all EOM Cancers)
Breast Cancer		
Episode Count	14	10%
Total Benchmark Price	\$663,339	9%
Total Unwinsorized Spend	\$636,343	9%
Total Winsorized Spend	\$668,736	9%
Lung Cancer		
Episode Count	16	12%
Total Benchmark Price	\$1,025,969	13%
Total Unwinsorized Spend	\$948,829	13%
Total Winsorized Spend	\$1,036,275	13%
Multiple Myeloma		
Episode Count	19	14%
Total Benchmark Price	\$1,658,511	22%
Total Unwinsorized Spend	\$1,487,422	20%
Total Winsorized Spend	\$1,664,215	22%
Lymphoma		
Episode Count	20	15%
Total Benchmark Price	\$1,106,303	15%
Total Unwinsorized Spend	\$1,117,856	15%
Total Winsorized Spend	\$1,118,754	15%
Small Intestine / Colorectal		
Episode Count	21	16%
Total Benchmark Price	\$800,413	11%
Total Unwinsorized Spend	\$845,680	11%
Total Winsorized Spend	\$811,833	11%
Prostate Cancer		
Episode Count	22	16%
Total Benchmark Price	\$1,040,905	14%
Total Unwinsorized Spend	\$1,151,566	15%
Total Winsorized Spend	\$1,070,601	14%
Chronic Leukemia		
Episode Count	23	17%
Total Benchmark Price	\$1,319,572	17%
Total Unwinsorized Spend	\$1,249,277	17%
Total Winsorized Spend	\$1,329,361	17%

For each EOM cancer type, the tool provides the following:

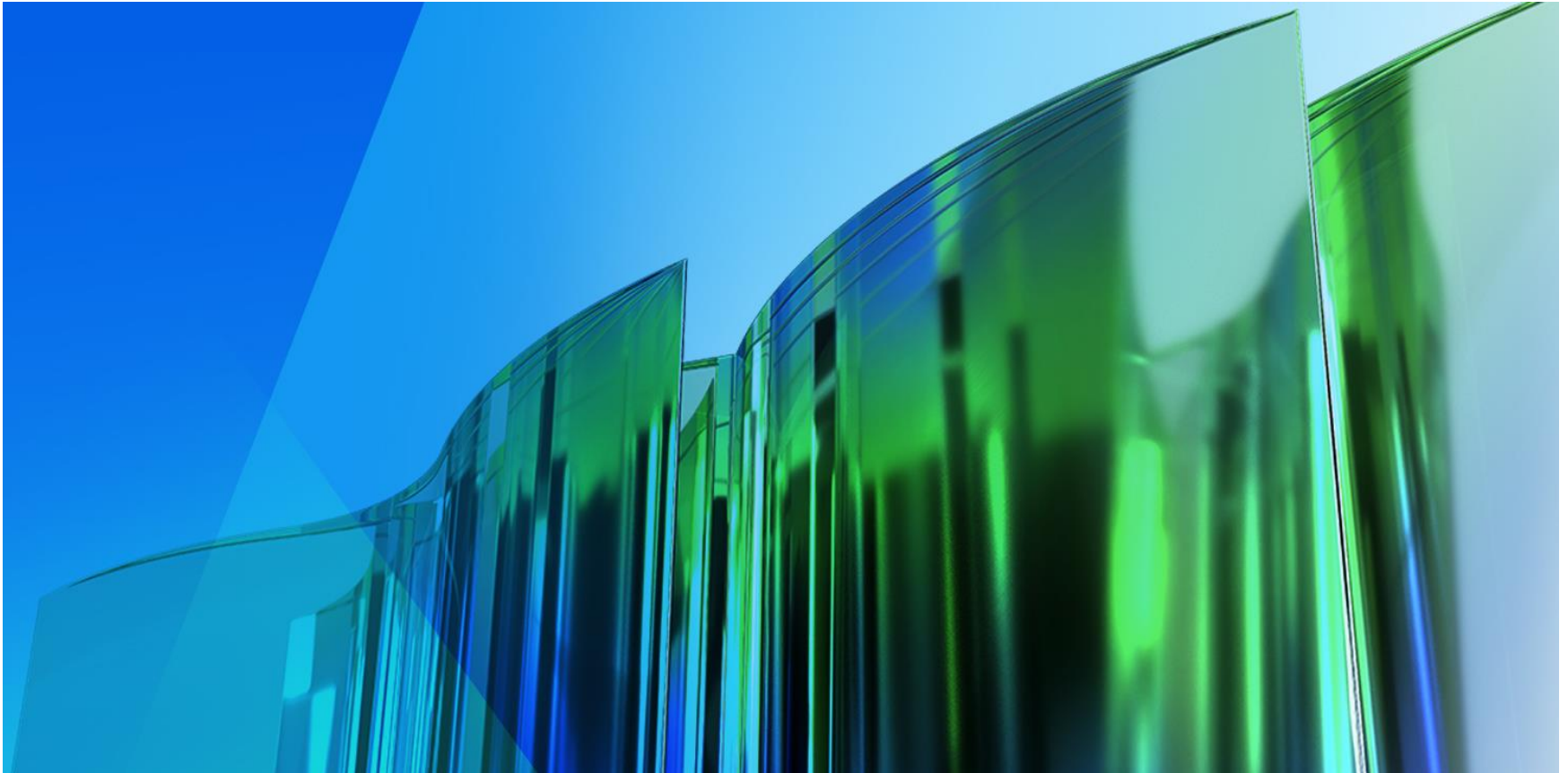
- Episode count: This is the cancer-specific episode count based on inputs from the user
- Total Benchmark Price: This is the cancer-specific benchmark price
- Total Unwinsorized Spend: Includes the cancer-specific total spend
- Total Winsorized Spend: Adjusts the unwinsorized spend so that cancer-specific episode expenditures below the 5th percentile are set to the 5th percentile and expenditures above the 95th percentile are set at the 95th percentile.

This detail gives insight into how well a practice may be doing in a specific cancer type relative to the model at large



Knowledge Check

- Cancer specific details will help practices assess cancer-type specific impact of performance. Performance and volume of episodes for each cancer type may be key when determining participation success.



Glossary & Appendix

Glossary of Key Terms

- **Advanced APM:** Advanced APMs must require participants to (1) use certified EHR technology, (2) provide payment for covered professional services based on quality measures comparable to those used in the MIPS Quality performance category, and (3) either be a Medical Home Model expanded under CMS Innovation Center authority or require participants to bear a significant financial risk.
- **Benchmark Amount:** This is the sum of the benchmark prices for all episodes attributed to an EOM practice. This represents the projected Medicare expenditures for a performance period in the absence of EOM.
- **Enhancing Oncology Model (EOM):** EOM is a voluntary CMMI model that builds on the learnings and structure of the Oncology Care Model (OCM). This model, like OCM, is a total cost of care model and it will begin in July 2023.
- **Experience Adjuster:** Accounts for regional and participant-specific variation in the cost of oncology care that is not otherwise incorporated in the price prediction models. Each experience adjuster is unique to the EOM participant.
- **MACRA:** The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a law that reformed the Medicare payment system, repealing the SGR formula. This was used to update MPFS for determination of physician reimbursement. SGR was replaced with a “value-based” payment system that incorporates quality measurement into payments with the goal of creating an equitable payment system for physicians.
- **MIPS APM:** APMs that are defined as (1) APM entities that participate via an agreement with CMS; and (2) the APM bases payment incentives on performance regarding cost/utilization and quality measures. Participants in MIPS APMs are those APM participants that do not meet QP or Partial QP status, and may elect to meet MIPS requirements via a streamlined set of requirements, called the APM Performance Pathway.
- **Monthly Enhanced Oncology Services (MEOS):** CMS will provide EOM practices with \$70 per beneficiary per month during the episode (counts towards total cost of care) and an additional \$30 per month for dual eligible beneficiaries (does not count toward total costs of care) to provide enhanced services (e.g., 24/7 clinician access, etc.)

APM: Alternative Payment Model; EHR: Electronic Health Record; MIPS: Merit-based Incentive Payment System; CMS: Centers for Medicare and Medicaid Services; EOM: Enhancing Oncology Model; CMMI: Center for Medicare and Medicaid Innovation; OCM: Oncology Care Model; SGR: Sustainable Growth Rate; QP: Qualified APM Participant; MPFS: Medicare Physician Fee Schedule



Glossary of Key Terms

- **Novel Therapy Adjustment (NTA):** This is an adjustment that increases the benchmark prices for all episodes of a specific cancer type attributed to an EOM participant if they use newly FDA-approved oncology drugs for a higher share of total expenditures compared to the average non-EOM participant.
- **Performance Based Payment (PBP):** EOM practices will receive a performance-based payment if their total episode spending is below their target amount and quality metrics are met. This amount is determined by the risk arrangement that a practice selects.
- **Performance Based Recoupment (PBR):** EOM practices may owe a recoupment if their total expenditures exceed their recoupment threshold. This amount is determined by the risk arrangement that a practice selects.
- **Performance Period/Episode:** The model is divided into 9 performance periods, each of which includes a cohort of episodes. EOM episodes are defined as 6-month periods. The first performance period starts on July 1, 2023, and there will be 9 performance periods in EOM total.
- **QP Status:** Advanced APMs allow eligible clinicians to become QPs. To become a QP, clinicians must receive at least 50 percent of Medicare Part B payments or see at least 35 percent of Medicare patients through an Advanced APM Entity during the QP performance period
- **Reinsurance:** To protect a practice against EOM's downside risk potential, practices may choose to purchase reinsurance policies (paying via monthly premiums) so that they are protected against high recoupments/costs associated with EOM episodes.
- **Risk Arrangement (RA):** Practices must select 1 of 2 risk arrangements (RA1 or RA2) at the start of the model (these may later be changed). This determines what your target amount, recoupment threshold, stop gain, and stop loss will be.
- **Stop Gain:** Specific to the risk arrangement selected by a practice—it defines the maximum amount that CMS may pay a practice for exceeding their target.

Glossary of Key Terms

- **Stop Loss:** Specific to the risk arrangement selected by a practice—it defines the maximum amount that a practice may owe for being below their recoupment threshold.
- **Target Amount:** The final target amount for each EOM participant a certain percentage off of that participant's benchmark amount (e.g., if a practice selects RA1, their target amount would be 96% of their benchmark amount).
- **Traditional MIPS:** Traditional MIPS, established in the first year of the Quality Payment Program, is the original reporting option available to MIPS eligible clinicians for collecting and reporting data to MIPS. Clinician performance is measured across 4 areas – quality, improvement activities, Promoting Interoperability, and cost.
- **Trend Factor:** Adjusts for inflation and other changes in expenditure patterns for specific cancer types between the model baseline period and a given performance period
- **Unwinsorized:** This is the actual spend of a practice without adjustments for outliers in spending.
- **Winsorization:** Limits the impact of outliers on average expenditures in EOM. Adjusts the baseline period expenditures to adjust expenditures below the 5th percentile to be at the 5th percentile and adjust those above the 95th percentile to be at the 95th percentile for each EOM cancer type.

Experience Adjustor Accounts for Regional and Participant-Specific Variation in Cost Not Captured in Prediction Model

Experience Adjustor (EA)

- Participant level adjustment applied to predicted baseline prices to reflect the relative costliness of each participant in the baseline period*
- Calculated as a blended and weighted average across the 7 EOM cancer types and 3 levels of aggregation: national, regional, and participant

EA Calculation

For each cancer type (7) & level of aggregation (3), calculate:

$$\frac{\text{Average Actual Baseline Expenditure}}{\text{Average Predicted Price}}$$

Up to 21 Participant-Specific Cancer and Regional “Adjustors”

For each cancer type (7), blend the adjustors by a weighted average of national, regional, and participant EAs

Up to 7 Participant-Specific Blended Cancer “Adjustors”

Calculate a weighted average of the 7 blended cancer adjustors, weighted by cancer type episode count

1 Participant-Level EA

Note, the calculations described above are based on EOM methodology, see tool “EOM Variable Input Tool Introduction” for detail on data sources, assumptions, and limitations of the variable input tool.
EOM: Enhancing Oncology Model; EA: Experience Adjustor; HCC: Hierarchical Condition Category
Source: CMS, Enhancing Oncology Model (EOM) Payment Methodology. July 2022. Available [here](#).



EOM Includes **Clinical Adjusters** For Certain Cancer Types That Are Reported to The Clinical Registry

Baseline Price

Benchmark Price

Benchmark Amount

Target Amount

Ever-Metastatic Status

(Breast, Lung, Small Intestine/Colorectal Cancers)

- CMS analysis shows distinct value in adjusting the baseline price for metastatic disease to capture more accurate benchmark price
- As a PHE flexibility, beneficiary level reporting of clinical and staging data was optional in OCM PP7-PP11. If practices reported data, adjustments were made

HER2 Status

(Breast Cancer)

- Analyses of OCM registry data has shown that HER2 positive status is statistically significantly associated with higher-than-average performance period expenditures versus predicted expenditures within the price prediction model for breast cancer
- EOM will include a HER2 status adjustment to account for this difference

CMMI will apply clinical adjusters for presence of ever-metastatic and HER2 status for all EOM applicable cancer types. Details regarding these adjustments have not been published and will be released prior to start of the first performance period

Note, the calculations described above are based on EOM methodology, see tool "EOM Variable Input Tool Introduction" for detail on data sources, assumptions, and limitations of the variable input tool.

OCM: Oncology Care Model; EOM: Enhancing Oncology Model; PHE: Public Health Emergency; HER2: Human Epidermal Growth Factor Receptor 2; CMS: Centers for Medicare and Medicaid Services; PP: Performance Period

Source: CMS, The Enhancing Oncology Model (EOM) Request for Applications. June 2022. Available [here](#).



The Trend Factor Reflects Underlying Differences In Episode Expenditures Between The Baseline And Performance Periods

Baseline Price

Benchmark Price

Benchmark Amount

Target Amount

The trend factor aims to account for changes that may occur between the baseline period and a given performance period

- ✓ Variation in national expenditures
- ✓ Inflation
- ✓ Changes in episode expenditures due to evolving patterns of care

The trend factor is calculated for each cancer type and performance period

$$\text{Trend Factor} = \frac{\text{Average Episode Expenditures from non-EOM providers for given cancer type}}{\text{Average Baseline Period Expenditures from non-EOM providers for given cancer type}}$$

The cancer-specific trend factor is applied to the cancer-specific baseline price, along the cancer-specific NTA, and will likely improve benchmark price accuracy

Note, the calculations described above are based on EOM methodology, see tool “EOM Variable Input Tool Introduction” for detail on data sources, assumptions, and limitations of the variable input tool.

TF: Trend Factor; OCM: Oncology Care Model; EOM: Enhancing Oncology Model;

Source: CMS, Enhancing Oncology Model (EOM) Payment Methodology. July 2022. Available [here](#).



Winsorization Is a 2-Sided Truncation That Limits the Impact of Outliers on Average Expenditures

For each cancer type, episode expenditures below the 5th percentile will be set to the 5th percentile and expenditures above the 95th percentile will be set to the 95th percentile

Winsorization thresholds are established at baseline using all episodes defined and attributed nationally, for both EOM and non-EOM practices

Winsorization thresholds are applied in the calculation of baseline expenditures

Performance Period winsorization thresholds are trended forward

Note, the calculations described above are based on EOM methodology, see tool “EOM Variable Input Tool Introduction” for detail on data sources, assumptions, and limitations of the variable input tool.

Source: CMS. “Enhancing Oncology Model (EOM) Payment Methodology.” Available [here](#).

