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The Enhancing Oncology Model

First Annual Evaluation Report

Prepared for: **Centers for Medicare & Medicaid Services**

Submitted by: **The Lewin Group, Inc., with our partner Westat**

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The Enhancing Oncology Model: First Annual Evaluation Report

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Authors:

Rachel Henke, Juan Castro, Anissa Chan, Eli Cutler, Nina Ding, Colin Doyle, Kassandra Fate, Projesh Ghosh, Cody Hopewell, Erin Huffstetler, Niklaus Julius, Alexander Kappes, Soumita Lahiri, Annalise Maillet, Jessica Nelson, Lorissa Pagán, Ashe Peters, Jia Pu, David Ross, Mary Beth Schaefer, Carol Simon, Sararat Tosakoon, Shannon Reefer, Andreea Balan-Cohen, Michael Bentz, Eva Brady, Willow Burns, Mikayla Davis, Susan Denton, Stephanie Fry, Margaret Glos, Courtney Hall, Brandon Hesgrove, Grace Huang, Nina Kreiger, Lisa Lentz, Chantel Lewis, Lauren Mercincavage, Sandra Paredes, Jessica Richards, Tina Shah, Natalie Teixeira Bailey, Meti Tesfaye, Sophia Tsakraklides, Sandra Zelaya

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Lewin's address:

3237 Airport Rd, La Crosse, WI 54603

Federal Project Officer:

Caroline Ly
Research and Rapid Cycle Evaluation Group (RREG),
Center for Medicare and Medicaid Innovation (CMMI),
Centers for Medicare & Medicaid Services (CMS)

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1. Introduction

Key Points

EOM Goals	Key Model Components	Financial Incentives
• Improve quality of care and reduce Medicare spending for patients with seven high-risk cancer types • Better support patients, enhance patient care experiences, and make cancer care more accessible	• Voluntary participation of oncology practices • Accountability for cost and quality of treatment in 6-month episodes of care • Required participant redesign activities, such as 24-7 access to care and use of evidence-based care plans	• Monthly Enhanced Oncology Services (MEOS) payment per patient, with an additional payment for patients who are dually eligible for Medicare and Medicaid • Two-sided risk arrangement with opportunities for performance-based payments

First Evaluation Report Goals

- Identify impacts in the first performance period (episodes starting July–December 2023)
- Describe responses to the model through participant site visits, payer interviews, and patient interviews

Advancements in life-enhancing and life-extending treatments have improved cancer care in the United States. However, the complexity of the cancer journey requires patients to effectively navigate care across a multidisciplinary team of providers, while rising costs complicate treatment decisions and pose a threat to access. Recognizing these opportunities to transform cancer care delivery, the Center for Medicare and Medicaid Innovation (Innovation Center) in the Centers for Medicare & Medicaid Services (CMS) has developed and implemented value-based oncology models. The first was the Oncology Care Model (OCM), which was active from 2016 to 2022. Building on OCM, CMS launched the Enhancing Oncology Model (EOM) in July 2023. EOM is a voluntary, episode-based model that incentivizes oncology practices to provide high-quality, patient-centered care to patients receiving treatment for one of seven high-risk cancer types while reducing Medicare fee-for-service (FFS) spending. EOM also encourages multipayer participation, where other payers align with EOM.

The Lewin Group, in partnership with Westat and a team of clinical experts, is conducting an independent evaluation of EOM under contract with CMS. In this first evaluation report, we provide important context for early and future evaluation findings by detailing how EOM can add value to the current cancer care landscape and highlighting what characteristics and trends are unique to the oncology practices that chose to participate in EOM.

Report Summaries

Please refer to the following resources for an overview of findings:

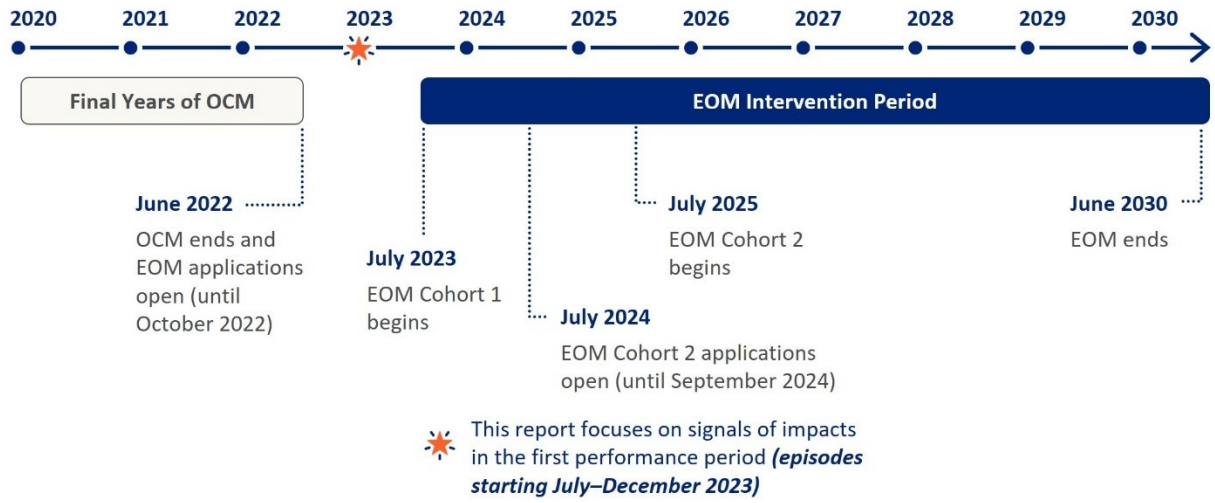
- **Findings at a Glance | 2 pages**
  Concise visual summary of key findings
- **Executive Summary | 5 pages**
  High-level snapshot of the model, evaluation methods, and results

We present impact findings on key payment outcomes for episodes initiated during the first 6 months of the model. We also present findings from interviews with practices that shed light on their early responses to the model.

1.1 Overview of the Enhancing Oncology Model

EOM is scheduled to operate for 7 years, from July 1, 2023, to June 30, 2030 (**Exhibit 1**). The first cohort of EOM participants joined the model on July 1, 2023, and the second cohort joined on July 1, 2025. At the start of the model, EOM participants included 44 oncology practices encompassing 561 sites of care. Three commercial payers participated at the beginning of the model and remained in the model through the first performance period.

Exhibit 1. EOM Timeline



Note: OCM = Oncology Care Model.

CMS refined the EOM design based on lessons learned from OCM. This included engaging with OCM participants, patient advocacy organizations, professional associations in oncology, and other key stakeholders for input. Findings from OCM highlighted the opportunity to reduce cancer care costs among higher-risk cancer types, as well as the potential importance of requiring practices to hold financial risk. Below we describe key elements of EOM that reflect lessons learned from OCM:

- ***EOM patients and episodes.*** EOM focuses on Medicare FFS patients with any of the seven high-risk types of cancer

Seven High-Risk Cancers

EOM includes 6-month episodes of care, starting with an initiating systemic cancer therapy treatment, for patients with any of the following types of cancer:

- High-risk breast cancer
- Chronic leukemia
- Small intestine/colorectal cancer
- Lung cancer
- Lymphoma
- Multiple myeloma
- High-intensity prostate cancer

that showed savings under OCM. Episodes of care begin with patients receiving systemic cancer therapy treatment[1] and last 6 months.

- ***EOM incentive payments.*** Based on lessons from OCM, for EOM's Monthly Enhanced Oncology Services (MEOS) payments, CMS refined the base payment amount to balance incentives with Medicare savings. Rather than receiving a single base payment of $160 per patient per month, EOM practices are eligible to receive a payment of $70 per patient per month, with an additional $30 for patients who are dually eligible for Medicare and Medicaid. Starting January 1, 2025, the base MEOS payment increased to $110 per patient per month. The main purpose of MEOS payments is to incentivize care transformation and support the provision of required Enhanced Services (see **Exhibit 2**) to eligible EOM patients.
- ***EOM risk and performance.*** Unlike OCM, EOM requires two-sided risk from the beginning of the model to strengthen the overall incentive for an accountable care relationship from the model's start and to achieve the goal of reducing Medicare payments. CMS evaluates financial performance based on the total cost of care for a 6-month episode, relative to benchmark costs. CMS adjusts performance incentive amounts distributed to participants based on the attainment of targets for quality metrics covering the following domains: patient experience, avoidable acute care utilization, management of symptoms and toxicity, management of psychosocial health, and management of end-of-life care.
- ***EOM participant redesign activities.*** EOM, like OCM, is designed to drive care transformation through required participant redesign activities. EOM includes the six participant redesign activities from OCM as well as screening for health-related social needs (HRSNs) and collection and monitoring of electronic Patient-Reported Outcomes (ePROs).

EOM has fewer participating oncology practices than OCM—44 versus 190. Of the 44 oncology practices participating in EOM in the first cohort, 31 also participated in OCM, including some of the largest practices. In **Exhibit 2**, we highlight key differences between the two models.

Exhibit 2. Comparison of EOM and OCM

Component	EOM	OCM
Participants	• 44 oncology practices in the first cohort • 3 commercial payers through PP1	• 190 oncology practices at the start of OCM, as of January 2017 • 5 commercial payers through 2020
Cancer Types	• Seven high-risk cancer types	• Most cancer types, including low-risk breast cancer and low-intensity prostate cancer[2]

[1] Systemic cancer therapy is defined as cancer treatments that affect a patient's whole body rather than a specific area. Under EOM, these can include cytotoxic chemotherapies, certain hormonal therapies, biologic therapies, immunotherapies, and combinations of these therapies. We identify systemic therapies using the lists available on the EOM web page. See https://www.cms.gov/priorities/innovation/innovation-models/enhancing-oncology-model.

[2] Low-risk breast cancer and low-intensity prostate cancer were included in OCM. EOM only includes high-risk breast cancer and high-intensity prostate cancer.

Component	EOM	OCM
Financial Incentives	• MEOS payment of $70 per patient per month ($110 starting in 2025); additional $30 per patient per month for dually eligible patients • Potential for performance-based payment or performance-based recoupment, adjusted based on quality performance	• MEOS payment of $160 per patient per month • Potential for performance-based payment (adjusted based on quality performance) or performance-based recoupment
Risk Options	• Option 1: two-sided risk with stop-gain of 4% of benchmark and stop-loss of 2% of benchmark • Option 2: two-sided risk with stop-gain of 12% of benchmark and stop-loss of 6% of benchmark	• Option 1: one-sided risk with practices not responsible for Medicare expenditures that exceeded target price • Option 2: two-sided risk with practices responsible for Medicare expenditures that exceeded target price[a]
Timing	• 7-year voluntary model (July 2023–June 2030)[b]	• 6-year voluntary model (July 2016–June 2022)
Required Redesign Activities	• 24-7 access to care* • Patient navigation* • Use of National Academy of Medicine[c] care plan* • Use of evidence-based clinical guidelines* • Use of data for continuous quality improvement • Use of certified EHR technology • Screening for HRSNs* • Collection and monitoring of ePROs*	• 24-7 access to care* • Patient navigation* • Use of National Academy of Medicine care plan* • Use of evidence-based clinical guidelines* • Use of data for continuous quality improvement • Use of certified EHR technology

Note: EHR = electronic health record; ePRO = electronic Patient-Reported Outcome; HRSN = health-related social need; MEOS = Monthly Enhanced Oncology Services; OCM = Oncology Care Model; PP = performance period.

[a] OCM had the option for one- or two-sided risk beginning in the PP2. OCM practices that earned a performance-based payment by the time of initial reconciliation of PP4 had the option to stay in one-sided risk. Other OCM practices were required to accept two-sided risk or be terminated from the model. Two options for the two-sided risk arrangement included (1) original: 20% of benchmark for stop-gain/stop-loss and 2.75% Medicare discount and (2) alternative: 16%/8% of practice revenue (including additional chemotherapy if applicable), minimum threshold for recoupment of 2.5%, and 2.5% Medicare discount. During the public health emergency (starting June 2020), OCM practices could opt out of financial reconciliation and performance measurement.

[b] CMS extended the model by 2 years, moving the end date from 2028 to 2030.

[c] The National Academy of Medicine was under the name Institute of Medicine until 2015.

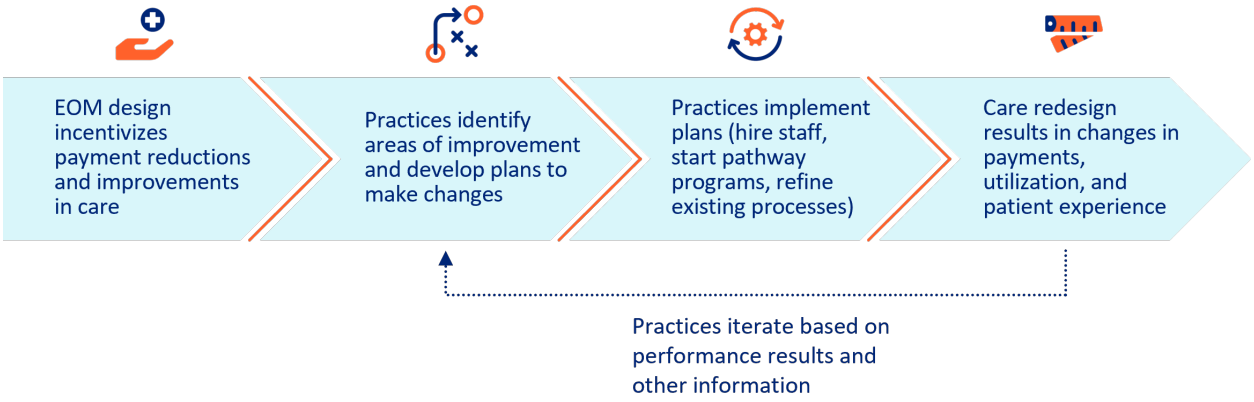
* Indicates participant redesign activities that are Enhanced Services under EOM or OCM.

1.2 How Is EOM Intended to Improve Oncology Care?

EOM was designed to encourage value-based, high-quality oncology care through financial and performance incentives, such as by providing MEOS payments to support Enhanced Services. In **Exhibit 3**, we illustrate how practices might respond to EOM's incentives.

First, practices may identify areas of improvement where they can meaningfully reduce use of lower-value services or improve patient care or experiences (for example, by focusing on value-based pharmacy care or avoiding unnecessary acute care). After identifying areas of improvement, practices develop plans and take steps toward implementing those plans by making investments such as hiring staff (for example, pharmacists or patient navigators), rolling out ways to ensure greater alignment with clinical guidelines (for example, pathway programs), or making other improvements to processes and health information technology. As some areas of focus may require collaboration with the patient's broader care team, practices may need to establish or leverage new and existing relationships and infrastructure.

Exhibit 3. How EOM Is Intended to Improve Oncology Care



Care redesign activities initiated by EOM practices, including implementation of the required participant redesign activities and other strategies, could lead to changes in treatment and other use of services for patients. For example, the adoption of value-based prescribing may increase, which could reduce drug payments. Practices may connect patients with mental health professionals for support, which could lead to increased use of behavioral health services and reduced use of expensive and unnecessary acute care. Changes in services, payments, and patient experience may be reflected in the feedback reports and performance data shared by CMS, allowing practices to identify new or continued areas for improvement. In **Chapter 2**, we discuss potential focus areas for practices, including value-based pharmacy care, aligning treatment with patient preferences and needs, and reducing preventable and unnecessary care. Strategies that may be within the practice's control, such as value-based prescribing and alternative dosing, are likely to yield more immediate impacts and potentially lead to reduced total episode spending and drug spending. Other changes, such as improving end-of-life care and reducing use of unnecessary and avoidable care, may require care coordination across providers and changes to systems, culture, and provider and patient behavior, which can take more time to implement.

EOM provides financial incentives and support for practices to continue their existing care redesign strategies as well as develop new approaches to value-based oncology care. For example, the Average Sales Price–based payment approach for Part B drugs under the Medicare FFS program provides little incentive for practices to prescribe lower-cost drugs. However, under the two-sided risk arrangement of EOM, practices might be incentivized to leverage the biosimilar substitution strategy that many practices adopted under OCM and use new strategies to provide value-based pharmacy care, such as alternative dosing of systemic cancer therapy. In addition, the MEOS payments provide financial support for practices' investment in infrastructure and staff necessary to implement some of these changes.

Care transformation driven by the model is likely to extend beyond just EOM patients as practices adopt new processes and experience changes in culture, relationships, and infrastructure. Physicians and payers participating in EOM may also share their insights through peer networks or within health systems, benefiting patients with cancer types not included in EOM. As a result, changes related to EOM may spill over throughout markets with high EOM concentration.

1.3 Evaluation Goals and Research Questions

Using a hypothesis-based framework, we employ quantitative and qualitative methods to investigate whether EOM is achieving its goals of improving oncology care and reducing Medicare spending, while also assessing drivers of any observed changes. The evaluation findings will provide critical information about the generalizability of results and inform CMS decisions about whether and how EOM might be expanded.

This first evaluation report focuses on findings from claims-based impact analyses for the first performance period, July to December 2023, and practices' experiences at the start of the model, from July 2023 to March 2025. It is organized by the following research questions:

- **Chapter 2:** How Can EOM Add Value to the Current State of Cancer Care?
- **Chapter 3:** Who Is Participating in EOM?
- **Chapter 4:** What Are the Model's Impacts on Spending?
- **Chapter 5:** What Are the Experiences of Practices and Patients in EOM?

Finally, in **Chapter 6**, we summarize findings related to model participation, care redesign activities implemented by practices, and impacts observed in the first model performance period. This chapter also provides a preview of our future evaluation activities.[3]

[3] The appendices include a glossary of terms and a list of all acronyms used in this report (**Appendix A**), details on episode definition and the patient journey (**Appendix B**), qualitative methods (**Appendix C**), quantitative methods (**Appendix D**), baseline descriptive results (**Appendix E**), impact estimates (**Appendix F**), and information on participating payers (**Appendix G**).

2. How Can EOM Add Value to the Current State of Cancer Care?

Key Points

Current Cancer Care	Opportunity for Improvement	Challenges Informed by OCM
Limitations to current cancer care under Medicare FFS: • Medicare FFS payment structure that may incentivize prescribing higher-cost drugs • Treatment not aligned with patients' preferences and needs • Use of avoidable acute care and unnecessary high-cost treatments	Areas with opportunity for higher-value care: • Use of biosimilars and dosing strategies in pharmacy • Care planning and earlier use of palliative and hospice care to reflect patient preferences and support patient needs • Prevention of avoidable or more costly care through increased patient interactions and prompt cancer-specific urgent care	Considerations that may affect a practice's ability to create change: • Limited control over drug prices and formularies • Cultural barriers to accepting hospice care or discontinuing intensive treatment at end of life • Tendency of some patients to use acute care for management of symptoms and side effects of chemotherapy

EOM aims to reshape cancer care by aligning financial incentives with high-quality, patient-centered care. In this chapter, we describe several factors that drive costs and hinder the delivery of high-quality care for patients with cancer. As shown in **Exhibit 4**, EOM practices have opportunities to reduce lower-value care through redesign activities incentivized by EOM, potentially leading to reductions in Medicare spending and improvements in quality of care. Some of these care transformation changes, such as pharmacy interventions, led to savings for CMS under OCM; others, such as end-of-life care and avoidable acute care interventions, had little effect on outcomes despite being a focus of OCM practices.[4] Thus, it may be challenging for EOM practices to improve in some areas despite financial incentives.

Exhibit 4. Examples of Higher-Value Care Activities Aligned With EOM Incentives

Domain	Lower-Value Care	Potential Higher-Value Alternatives
Value-Based Pharmacy Care	• Use of brand-name drugs where lower-cost generics or biosimilars would have similar clinical efficacy • Use of costly supportive therapies without evidence from guidelines	• Appropriate substitutions of biosimilar and generic medications • Alternative dosing strategies that balance clinical effectiveness and efficient drug use • Value-oriented use of costly supportive therapies

[4] Abt Global. (2024). *Evaluation of the Oncology Care Model*. Prepared for the Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/data-and-reports/2024/ocm-final-eval-report-2024

Domain	Lower-Value Care	Potential Higher-Value Alternatives
Aligning Treatment With Patient Preferences and Needs	• Making treatment decisions and planning without effective patient engagement • Underutilization or late introduction of palliative care for symptom management • Intensive treatment at the end of life and underutilization of hospice care	• Use of care plans to support care coordination and tailor treatment to reflect the patient's individual needs and preferences • Earlier conversations between clinicians and patients around palliative and end-of-life care • Earlier referral to palliative care to address unmet medical needs, patient priorities, and end-of-life care preferences • Appropriate and timely use of hospice care
Reducing Preventable and Unnecessary Care	• Avoidable inpatient stays or ED visits, such as those related to chemotoxicity, which may increase total cost of care and may disrupt continuity of care for the patient • Use of high-cost imaging when not indicated	• Use of ePROs and 24-7 access to the care team, allowing patient needs to be identified and addressed in a timely manner and potentially avoiding ED visits and inpatient stays • Use of lower-cost settings to address patient needs such as oncology- and practice-specific urgent care to promptly address patient needs in place of unnecessary ED visits • Avoiding services that are not indicated via alignment with guidelines

Note: ED = emergency department; ePRO = electronic Patient-Reported Outcome.

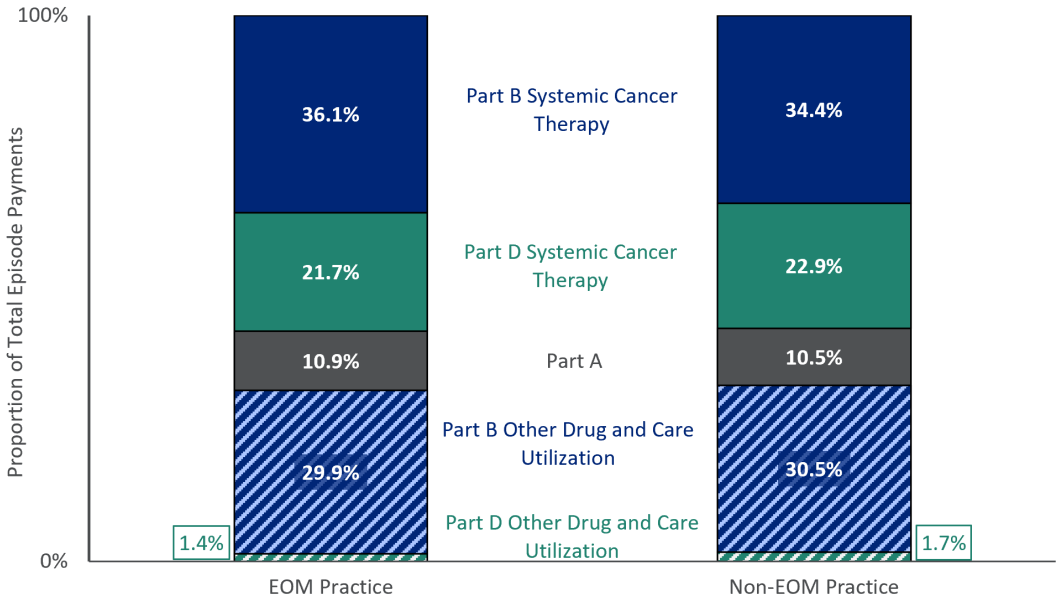
Below, we further discuss these three areas for improvement as examples of potential opportunities under EOM. We describe gaps in the current state of cancer care, supporting evidence or challenges observed under OCM, and how EOM might provide additional incentives and support to improve cancer care in these areas. EOM may also have an impact beyond these three areas. For example, EOM encourages practices to identify avenues for cost savings beyond systemic therapy and supportive care drugs, which may require engaging with other providers, including other cancer care providers, such as radiation oncologists. We will continue to explore additional areas that participants may identify for improvement in future years of the evaluation.

2.1 Value-Based Pharmacy Care

One specific area of expected impact under EOM is pharmacy costs. As shown in **Exhibit 5**, together Part B and Part D systemic cancer therapy spending represents nearly 58% of the total cost of care per 6-month episode for both EOM and non-EOM practices, highlighting the importance of value-based pharmacy interventions.

Movement toward value-based prescribing often requires change at the organizational level, such as formulary modifications by the practice or the health system's pharmacy and therapeutics committee. Under Medicare FFS, practices benefit from prescribing higher-cost drugs because Medicare reimburses for Part B drugs at their Average Sales Price plus 6%. Thus, practices are not incentivized to spend time and resources identifying lower-cost options that are equally effective and may instead continue to prescribe higher-cost drugs. In addition, practices may be able to acquire certain drugs at a lower price, such as through drug price negotiation and rebates via a group purchasing organization, which could motivate practices to deviate from value-based prescribing.

Exhibit 5. Systemic Cancer Therapy Payments as a Proportion of Total Episode Payments



Value-based care initiatives such as OCM and EOM provide incentives to move toward higher-value prescribing. During OCM, participants reduced relative episode expenditures, mainly through decreases in supportive care drug spending among the higher-risk cancer types due to better adherence to clinical guidelines.[5]

Building on OCM's success, EOM's two-sided risk may motivate practices to further reduce drug spending. EOM practices may find opportunities to improve value-based prescribing of systemic cancer therapy, including chemotherapy, in addition to supportive care drugs. To facilitate changes to value-based prescribing, EOM practices may expand the role of pharmacists (for example, integrating pharmacists into workflows to review prescribed regimens). Practices may have a greater ability to make an impact in the pharmacy domain compared with other areas of opportunity because decisions related to the use of biosimilars or alternative dosing can occur through the practice's existing pharmacy and therapeutics committee. Once decisions are made, the practice's pharmacist can review prescribed regimens for compliance, recommending modifications as appropriate. Below are some examples of strategies that practices might adopt for value-based pharmacy interventions.

Biosimilars of anticancer drugs. OCM changed prescribing patterns for supportive care drugs by increasing higher-value prescribing, including the use of biosimilars. Right before OCM (2015) and during OCM (July 2016–June 2022), biosimilars of white blood cell growth factors became available. White blood cell growth factors are a type of supportive care drug used to prevent infection, fever, and neutropenia in patients undergoing chemotherapy. The OCM evaluation found

[5] For example, OCM practices reduced spending on denosumab, prophylactic white blood cell growth factor, prophylactic use of neurokinin-1 antagonists, and long-acting serotonin antagonists. See Brooks, G. A., Landrum, M. B., Kapadia, N. S., Liu, P. H., Wolf, R., Riedel, L. E., Hsu, V. D., Jhatakia Parekh, S., Simon, C., Hassol, A., & Keating, N. L. (2022). Impact of the Oncology Care Model on use of supportive care medications during cancer treatment. *Journal of Clinical Oncology*, *40*(16), 1763–1771.

the adoption of these biosimilar drugs was faster among OCM practices than non-OCM practices.[6] Additional biosimilar drugs have been approved for use since OCM. For example, in 2024—a record year for biosimilar approvals—the Food and Drug Administration approved another biosimilar of trastuzumab, a monoclonal antibody drug to treat human epidermal growth factor receptor 2 (HER2)-positive breast and stomach cancers.[7] In addition, cancer care providers have become more familiar with biosimilars and gained experience in the use of biosimilars over time. Leveraging model incentives and building on experience with prior value-based care, such as OCM, EOM practices may adopt new biosimilar drugs at a faster rate than non-EOM practices.

Alternative dosing of anticancer drugs. While OCM found limited evidence for increased use of higher-value systemic cancer therapy among OCM practices, EOM practices might adopt alternative dosing strategies, such as dose banding, dose rounding, and vial sharing, which have demonstrated potential for reducing drug waste and generating cost savings without lowering effectiveness.[8,9] Despite their benefit, alternative dosing policies require an investment of time, resources, and infrastructure to develop and implement. Practices might need to develop internal guidance, make system and infrastructure changes, and hire additional pharmacy staff to review and manage dosing and regimen changes. Value-based care initiatives such as EOM provide financial incentives and support for practices to make infrastructure and staffing changes necessary for strategies like alternative dosing.

Guideline-concordant use of supportive care drugs. The OCM evaluation found that lower health care spending during episodes was driven by higher-value use of supportive care drugs[10] due to better adherence to clinical guidelines around their prescribing. Clinicians who adhered more strictly to clinical guidelines were less likely to prescribe supportive care drugs such as antiemetics or bone-modifying agents when they were not indicated. Use of evidence-based clinical guidelines is a required participant redesign activity under EOM and may lead to similar impacts on use of supportive care drugs and other high-cost drugs that are prescribed despite a lack of clinical need.

2.2 Aligning Treatment With Patient Preferences and Needs

Another area of opportunity for improvement in cancer care is patient engagement and shared decision-making. In OCM, patient interviews highlighted the importance of communication and active engagement in treatment planning in oncology care.[11] As shown in **Exhibit 6**, the design of

[6] Abt Global. (2024). *Evaluation of the Oncology Care Model*. Prepared for the Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/data-and-reports/2024/ocm-final-eval-report-2024

[7] Jeremias, S. (2025). *A banner year for biosimilars: The 19 FDA approvals from 2024*. https://www.centerforbiosimilars.com/view/a-banner-year-for-biosimilars-the-18-fda-approvals-from-2024

[8] Hall, E., Zhang, J., Kim, E. J., Hwang, G., Chu, G., Bhatia, S., & Reddy, S. (2020). Economics of alternative dosing strategies for pembrolizumab and nivolumab at a single academic cancer center. *Cancer Medicine*, *9*(6), 2106–2112.

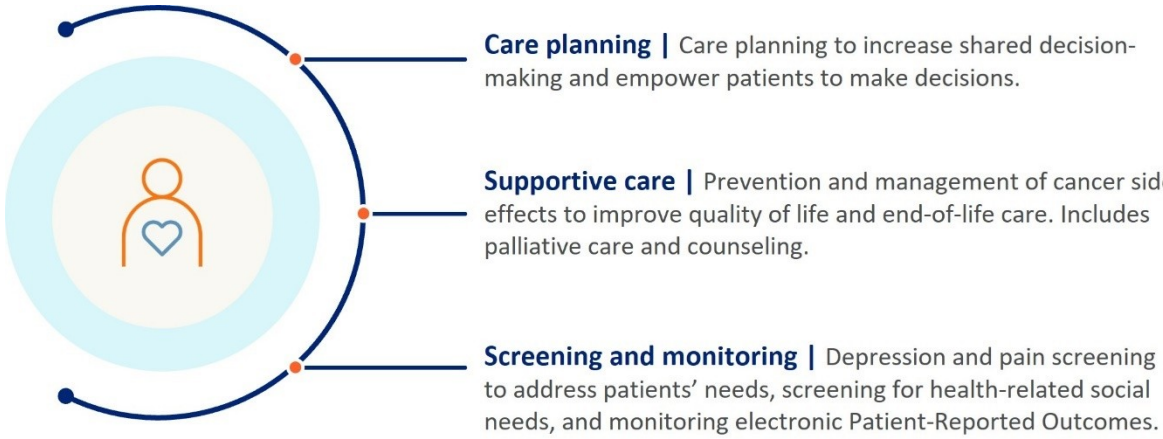
[9] Hematology/Oncology Pharmacy Association. (2017). *Dose rounding of biologic and cytotoxic anticancer agents: A position statement of the Hematology/Oncology Pharmacy Association*. https://www.nccn.org/docs/default-source/clinical/order-templates/hopa.pdf?sfvrsn=3af91118_6

[10] Op. Cit. Abt Global. (2024).

[11] Abt Global. (2024). *Evaluation of the Oncology Care Model*. Prepared for the Centers for Medicare & Medicaid Services. *Cancer Care Experiences Among People Covered by Medicare.* *https://www.cms.gov/priorities/innovation/data-and-reports/2024/ocm-final-eval-report-2024-patient-persp*

EOM encourages practices to concentrate on areas that might promote the alignment of treatment with patient preferences and needs.

Exhibit 6. Treatment and Services to Address Patient Preferences and Needs



Among these services, supportive care, including palliative and end-of-life care, is a focus of EOM and incentivized by EOM's quality strategy.[12] Ideally, palliative care should begin early in the treatment process and last through the end of a patient's life. Similarly, conversations about hospice care are best held well before it becomes an imminent necessity. Early referral to palliative care is associated with improved quality of life, improved mood, and a higher likelihood of discussing end-of-life preferences.[13] Timely transition to hospice care is associated with less intensive treatment and improved quality of life at the end of life, benefitting the patient and family or caregivers.[14] In addition to potential quality-of-life improvements, palliative care after a cancer

Palliative Care

Palliative care is a form of supportive care that prevents or relieves suffering and pain for those with serious or life-threatening conditions. Palliative care also includes end-of-life services such as hospice care, which refers to palliative care for patients with a prognosis of 6 months or less who have stopped curative treatment. *Patient-centered palliative care* integrates the patient's preferences, goals, and values within the context of their prognosis and treatment plan.

[12] CMS (2024). *EOM quality, health equity, and clinical data strategy*. https://www.cms.gov/files/document/eom-qual-health-equity-clin-data-strat.pdf

[13] Sanders, J. J., Temin, S., Ghoshal, A., Alesi, E. R., Ali, Z. V., Chauhan, C., Cleary, J. F., Epstein, A. S., Firn, J. I., Jones, J. A., Litzow, M. R., Lundquist, D., Mardones, M. A., Nipp, R. D., Rabow, M. W., Rosa, W. E., Zimmermann, C., & Ferrell, B. R. (2024). Palliative care for patients with cancer: ASCO guideline update. *Journal of Clinical Oncology*, *42*(19), 2336–2357.

[14] Sharafi, S., Ziaee, A., & Dahmardeh, H. (2022). What are the outcomes of hospice care for cancer patients? A systematic review. *Supportive Care in Cancer*, *31*(1), 64.

diagnosis has been associated with lower costs of care.[15,16] Despite these benefits, palliative care and hospice care remain underutilized.[17]

Both OCM and EOM included elements designed to encourage improvements in the provision of palliative care. During OCM, practices hired clinicians with palliative care training. However, the OCM evaluation did not identify an increase in hospice use during the final days of life or a decrease in the use of high-intensity care, such as chemotherapy or hospital admissions, at the end of life.[18] This finding highlights the cultural and infrastructure barriers to improving end-of-life care. For example, challenges might include misconceptions about palliative and hospice care services by the patient or family, the patient or family's expectations around aggressive treatment near death, provider discomfort with end-of-life discussions or time-constrained clinical settings, and a limited supply of specialized palliative care teams or hospice services.[19,20] Providers may delay important discussions related to palliative care and hospice care out of concern that patients will interpret them as a sign of abandonment or loss of hope. Additionally, use of hospice care may not align with the patient's culture or wishes.

Building on OCM, new model features under EOM may provide an opportunity to address these challenges and support timely and patient-centered palliative and end-of-life care. For example, the required implementation of ePROs and 24-7 access to care will allow providers to be more agile in responding to patient symptoms and side effects. Palliative and end-of-life care might be especially important for patients with high-risk cancers included in EOM, given their intensive care needs and higher likelihood of disease progression.

2.3 Reducing Preventable and Unnecessary Care

EOM practices may also identify opportunities to reduce the use of high-cost treatment settings when lower-cost alternatives may be more appropriate (**Exhibit 7**). For example, patients receiving cancer treatment may go to the emergency department (ED) seeking symptom management or treatment side effect relief. However, in many cases, the clinicians best equipped to assist with these issues are the patient's oncology care team, who know the patient and their specific clinical situation. Patients undergoing cancer treatment presenting in the ED are commonly admitted for an inpatient stay because ED physicians are less familiar with oncology care. Such avoidable ED visits and subsequent hospitalizations would be considered lower-value care compared with the higher-value alternative of being treated at the oncology practice. Other types of lower-value care

[15] Parajuli, J., Tark, A., Jao, Y. L., & Hupcey, J. (2020). Barriers to palliative and hospice care utilization in older adults with cancer: A systematic review. *Journal of Geriatric Oncology*, *11*(1), 8–16.

[16] Chang, J., Han, K. T., Medina, M., & Kim, S. J. (2022). Palliative care and healthcare utilization among deceased metastatic lung cancer patients in U.S. hospitals. *BMC Palliative Care*, *21*(1), 136.

[17] Hu, X., Kwon, Y., Jiang, C., Fan, Q., Shi, K. S., Zheng, Z. J., Zhao, J., Warren, J. L., Yabroff, K. R., & Han, X. (2025). Trend and provider- and organizational-level factors associated with early palliative care billing among patients diagnosed with distant-stage cancers in 2010-2019 in the United States. *Journal of Clinical Oncology*, JCO2401935. Advance online publication.

[18] Abt Global. (2024). *Evaluation of the Oncology Care Model*. Prepared for the Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/data-and-reports/2024/ocm-final-eval-report-2024

[19] Parajuli, J., Tark, A., Jao, Y. L., & Hupcey, J. (2020). Barriers to palliative and hospice care utilization in older adults with cancer: A systematic review. *Journal of Geriatric Oncology*, *11*(1), 8–16.

[20] Chang, J., Han, K. T., Medina, M., & Kim, S. J. (2022). Palliative care and healthcare utilization among deceased metastatic lung cancer patients in U.S. hospitals. *BMC Palliative Care*, *21*(1), 136.

may include use of higher-cost imaging—for example, positron emission tomography (PET) scans and other scans during ED visits when recent scans are available.

Exhibit 7. Examples of Preventable and Unnecessary Care That EOM Might Improve

Type of Care	Potential Improvement Under EOM
Avoidable Acute Care	Some acute care such as ED visits and inpatient stays may be avoidable if practices provide improved coordination and timely communication with patients and if patients receive care in less intensive settings.
High-Cost Imaging	Practice initiatives to promote responsible use of high-cost imaging. For example, adding steps to prevent repeating scans administered by other providers.
Post-Acute Care	Practices can promote appropriate and efficient use of post-acute care by collaborating with hospitals to discharge patients to the least intensive care setting appropriate and partnering with post-acute care providers to minimize length of stay.

Note: ED = emergency department; PET = positron emission tomography.

A variety of challenges may hinder practice efforts to address the use of preventable and unnecessary care. Some ED visits and inpatient stays may be necessary, especially with the high-risk patient population included in EOM. Patients with cancer and their caregivers might be likely to seek acute care out of habit, driven by uncertainty and emotional distress associated with managing the patient's complex needs. OCM practices focused on reducing acute care for chemotherapy-related toxicity, but the OCM evaluation found little or no impact on chemotherapy-related acute care use over the life of the model.[21] Additionally, increased access to clinicians and triage lines could result in increased utilization for some patients.

Several of EOM's design elements may spur a reduction in utilization of avoidable acute care services, particularly when the elements of care redesign work in tandem. For example, the required collection of ePROs could give the patient an opportunity to report worsening side effects, such as dehydration, and enable the care team to proactively respond by scheduling a hydration appointment, helping prevent further decline and avoid an ED visit or hospital stay. Similarly, patient navigators might be able to schedule oncology-specific urgent care in the EOM practice to manage the patient's side effects from chemotherapy and avoid an ED visit or hospital stay. While these care transformation efforts may not be able to fully address challenges in preventing avoidable acute care, together they can play a critical role in delivering timely care and improving the patient experience.

[21] Abt Global. (2024). *Evaluation of the Oncology Care Model*. Prepared for the Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/data-and-reports/2024/ocm-final-eval-report-2024

3. Who Is Participating in EOM?

Key Points

Practice Characteristics	Patient Characteristics	Claims-Based Outcomes
EOM practices were more likely than non-EOM practices to be: • Community based (65% vs. 34%) • Prior OCM participants (72% vs. 10%) EOM practices also had a higher episode volume per practice (411 vs. 107) and nearly 3 times the number of oncology practitioners.	Patients of EOM practices were less likely than patients of non-EOM practices to be: • Dually eligible for Medicare and Medicaid (8% vs. 12%) • Residents of rural areas (16% vs. 19%)	• EOM practices had lower total payments per episode at baseline than non-EOM practices ($56,571 vs. $59,672). • Baseline utilization and quality outcomes are in general comparable between EOM and non-EOM practices.

Because EOM is a voluntary model that requires downside risk, oncology practices that chose to participate in the model likely differ from those that chose not to participate. During the first application period in 2022,[22] 240 practices applied to participate in EOM. Of the 240 that applied, 4 practices were deemed ineligible and 192 withdrew their application, citing reasons such as resource limitations, lack of risk tolerance, insufficient patient volume, and lack of time to evaluate projected performance. A total of 44 practices were participating when the model started on July 1, 2023. By the end of the first performance period on December 31, 2023, 3 practices had withdrawn from the model, leaving 41 participating practices.

In this chapter, we describe how EOM practices differ from the broader set of oncology practices that would likely be eligible for EOM but did not participate (referred to as *non-EOM practices*) in terms of their practice characteristics, the characteristics of patients served by practices, and claims-based outcomes.

3.1 Practice Characteristics

To be considered eligible for EOM, an oncology practice must have at least one practitioner with a specialty of hematology/oncology or medical oncology who has billed at least one cancer-related evaluation and management service under the practice, such as a follow-up office visit with an oncologist. Under this definition, a broad range of entities may qualify as oncology practices, including specialty practices that focus on oncology care as well as hospitals and health systems.[23]

Participating Payers

EOM focuses on Medicare FFS but allows other payers to participate, including commercial insurers, Medicare Advantage plans, state Medicaid agencies, and Medicaid managed care organizations.

A detailed summary of participating payer characteristics is in **Appendix G**.

[22] A second application period began in 2024 for a second cohort of practices to join EOM starting July 1, 2025.

[23] EOM requires each practice to participate under a unique Taxpayer Identification Number to improve clarity in attribution, accountability, and financial reconciliation. Two or more EOM participants may form pools to combine their information for reconciliation calculations. Pools can be voluntary or due to overlap in physicians billing across practices.

To explore how EOM practices compared with those that did not participate, we identified a national set of non-EOM practices that regularly provided cancer care and employed at least one medical oncologist or hematologist oncologist.[24] **Appendix D** presents how we identified the sample and methods used for this comparison.

We compared EOM oncology practices (n=43)[25] with non-EOM practices (n=1,317) in the final year (July 1, 2021–June 30, 2022) of the baseline period (July 1, 2018–June 30, 2022). The episode exclusions applied were aligned with model criteria, with additional restrictions for episode volume to ensure the comparison practices were regularly providing oncology care services to patients.

Practice type and practitioner composition. Oncology practices can be categorized as practices affiliated with academic medical centers, hospital-based practices, and community-based practices. Academic medical centers are university-affiliated institutions that provide comprehensive cancer care, conduct research and clinical trials, and offer educational programs. These centers often hold National Cancer Institute designations and contribute to advancements in cancer treatment and access to cutting-edge therapies.[26] Community-based oncology practices deliver localized cancer care, making treatment accessible to patients, particularly in rural areas.[27]

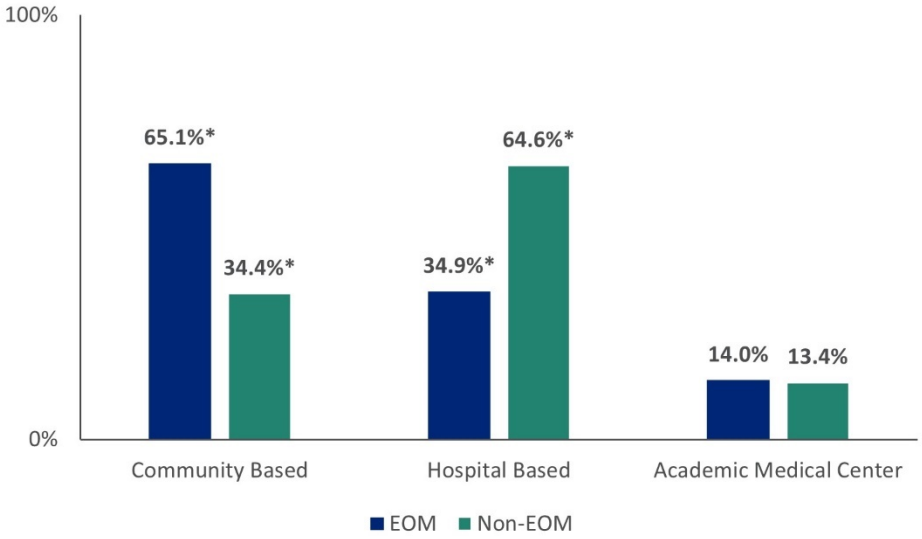
Across EOM oncology practices, most were community-based practices,[28] followed by hospital-based practices[29] and practices affiliated with academic medical centers (**Exhibit 8**).[30] Proportionally, more EOM practices than non-EOM practices were community based (65.1% vs. 34.4%), while fewer EOM practices were hospital based (34.9% vs. 64.6%). A similar proportion of EOM and non-EOM practices were affiliated with an academic medical center (14.0% vs. 13.4%).

EOM and non-EOM practices had a comparable number of practitioners overall but differed in the number of practitioners specializing in oncology. EOM practices had more oncology practitioners (34.4 vs. 11.8) and a slightly greater proportion of nurse practitioners (NPs) and physician assistants (PAs) than did non-EOM practices (25.9% vs. 22.4%) (**Exhibit 9**), which indicates that these practices had a greater focus on and capacity for oncology care. In addition, EOM practices had a larger number of markets on average, as defined by Surveillance, Epidemiology, and End

[24] Employed is defined as billing to the TIN of the practice.
[25] One of the 44 EOM practices did not have any episodes in the baseline period and therefore was not included in the statistics presented in this chapter.
[26] National Cancer Institute. (2025). *NCI-designated cancer centers*. https://www.cancer.gov/research/infrastructure/cancer-centers
[27] Levit, L. A., Byatt, L., Lyss, A. P., Paskett, E. D., Levit, K., Kirkwood, K., Schenkel, C., & Schilsky, R. L. (2020). Closing the rural cancer care gap: Three institutional approaches. *JCO Oncology Practice*, *16*(7), 422–430.
[28] Practices were considered community based if they were not identified as hospital based or affiliated with an academic medical center, based on billing patterns and other characteristics. Given the dynamic way Taxpayer Identification Numbers are used, the "community based" category may include some entities that are not strictly community based.
[29] Hospital-based practices were identified based on practitioner billing patterns and whether the practice was a site of complex procedures. For more details, see **Appendix C**.
[30] Practices were defined as Academic Medical Centers if they were affiliated with an accredited medical school or its teaching hospital. Affiliated practices were identified using 2022 Medicare Data on Provider Practice and Specialty (MD-PPAS) data, the 2024 Association of American Medical Colleges Organizational Characteristics Database, and the Taxpayer Identification Number list and an adapted version of the method used in the following article: Welch, W. P., & Bindman, A. B. (2016). Town and gown differences among the 100 largest medical groups in the United States. *Journal of the Association of American Medical Colleges*, *91*(7), 1007–1014. Hospital-based practices and academic medical centers were not considered mutually exclusive in this definition.

Results Program health service areas, indicating that they are serving patients from more expansive geographic areas than non-EOM practices.

Exhibit 8. Types of EOM and Non-EOM Practices



Note: Based on data in the final year of the baseline period (July 1, 2021–June 30, 2022). A practice may be included in both the hospital based and academic medical center categories. Statistically significant difference at the 10% level in the means is denoted with an asterisk.

Volume of episodes. EOM practices also exhibited significantly higher average episode counts per practice than non-EOM practices. Overall, EOM practices averaged roughly 411 episodes per 6-month period, nearly 4 times higher than the average of 107 episodes for non-EOM practices (**Exhibit 9**). Although some non-EOM practices had a similar number of episodes, most practices had much smaller episode volumes on average than EOM practices.

Regional distribution and market factors. Proportionally, EOM practices were more concentrated in the South than non-EOM practices (44.2% vs. 32.1%) (**Exhibit 9**). Meanwhile, about twice as many non-EOM practices were based in the Midwest (25.0% vs. 14.0%) and the Northeast (20.2% vs. 9.3%). EOM practices also provided care in twice as many markets on average as non-EOM practices (4.5 vs. 2.1). We observed no notable differences between EOM and non-EOM practices in the percentage of Medicare beneficiaries enrolled in Medicare Advantage (MA) in the market.

Exhibit 9. Characteristics of EOM and Non-EOM Practices

Characteristics		EOM[a] (N=43)	Non-EOM[b] (N=1,317)	p-value
Number of Episodes per 6-Month Period	Mean ± SD	410.7 ± 700.0	106.6 ± 189.2	<0.001
	Median (Q1–Q3)	219.5 (86.0–433.0)	52.0 (21.0–122.0)	
Number of Practitioners	Mean ± SD	219.5 ± 406.2	269.5 ± 496.5	0.72
	Median (Q1–Q3)	99.8 (36.5–217.0)	88.0 (12.0–289.3)	
Number of Oncology Practitioners	Mean ± SD	34.4 ± 67.9	11.8 ± 21.8	<0.001
	Median (Q1–Q3)	14.0 (7.0–40.0)	5.0 (2.0–11.1)	
NPs and PAs (%)		25.9%	22.4%	0.03

Characteristics		EOM[a] (N=43)	Non-EOM[b] (N=1,317)	p-value
Regions (%)[c]	South	44.2%	32.1%	0.10
	West	27.9%	20.3%	0.22
	Midwest	14.0%	25.0%	0.10
	Northeast	9.3%	20.2%	0.08
	Multiple Regions	4.7%	2.4%	0.34
Number of Markets	Mean ± SD	4.5 ± 7.0	2.1 ± 1.9	<0.001
	Median (Q1–Q3)	3.0 (1.0–4.0)	1.0 (1.0–2.0)	
Medicare Advantage Penetration (%)		43.8%	41.7%	0.14

Note: NP = nurse practitioner; PA = physician assistant; Q = quartile; SD = standard deviation.

[a] Although 44 practices joined EOM, 1 practice did not have any episodes in the baseline period and is not represented in these statistics.

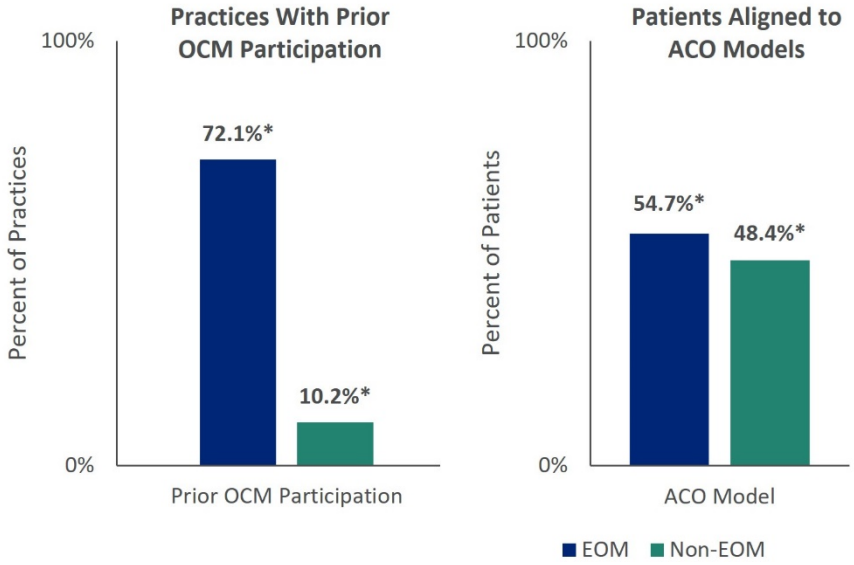
[b] Of the 1,319 non-EOM practices included, there were 1,317 non-EOM practices with episodes in the final year of the baseline period.

[c] Seven non-EOM practices were excluded from the region statistics because they are located in U.S. territories.

Source: The EOM evaluation team's analysis of Medicare claims and enrollment data for 6-month cancer care episodes during the final year of the baseline period (July 1, 2021–June 30, 2022).

Participation in OCM and patient alignment with Medicare Accountable Care Organizations. Most EOM practices (72.1%) previously participated in OCM, whereas only 10.2% of non-EOM practices had prior OCM participation (**Exhibit 10**). Patient alignment to accountable care models was also more common among EOM practices than non-EOM practices. More than half (54.7%) of EOM practices' patients were aligned to a Medicare Accountable Care Organization (ACO), compared with 48.4% of non-EOM practices' patients (**Exhibit 10**). These results suggest that practices participating in EOM are more likely to be invested in advancing value-based care.

Exhibit 10. Practice Participation in OCM and Patient Alignment to ACO Models



Note: ACO = Accountable Care Organization; OCM = Oncology Care Model. Statistically significant difference at the 10% level in the means is denoted with an asterisk. Practices included in prior OCM participation were limited to the 43 practices in EOM with baseline data. ACO types included the Shared Savings Program, ACO REACH, Next Generation ACO, Vermont All-Payer ACO, Comprehensive End-Stage Renal Disease Care ACO, Comprehensive ESRD Care Model, and Kidney Care Choices ACO at any point during the episode.

Source: The EOM evaluation team's analysis of Medicare claims and enrollment data for 6-month cancer care episodes during the final year of the baseline period (July 1, 2021–June 30, 2022).

3.2 Characteristics of Patients Served by Practices

Overall, patients with episodes attributed to EOM practices and non-EOM practices had similar characteristics at baseline (**Exhibit 11**). However, we found differences between EOM and non-EOM practices in several patient demographic factors and in their geographic distribution. For example, a lower proportion of patients at EOM practices reside in rural areas compared with patients at non-EOM practices (15.7% vs. 18.9%). This suggests that EOM practices are more likely to serve urban and suburban regions, where infrastructure for value-based care models is more developed.[31]

Patients at EOM practices also had lower rates of dual eligibility for Medicare and Medicaid than patients at non-EOM practices, with full dual eligibility at 7.7% versus 11.5% and partial dual eligibility at 3.5% versus 3.6%. Similarly, a smaller share of patients at EOM practices received the Part D low-income subsidy (LIS) (13.2% vs. 16.8%). Given that dual eligibility and receipt of the Part D LIS are indicators of financial need, EOM practices may be serving a population with relatively higher socioeconomic status. Such differences highlight the importance of risk adjustment and comparison group selection in evaluating model effects.

Exhibit 11. Patient Characteristics of EOM and Non-EOM Practices

Characteristics		EOM (N=27,111)	Non-EOM (N=213,859)	p-value
Age, Years (%)	<65	6.8%	8.2%	<0.001
	65–74	46.9%	46.5%	0.25
	75–84	36.7%	35.5%	<0.001
	85+	9.7%	9.7%	0.90
Female (%)		54.6%	53.0%	<0.001
Rural Area (%)		15.7%	18.9%	<0.001
Dual Eligibility (%)	Full Dual	7.7%	11.5%	<0.001
	Partial Dual	3.5%	3.6%	0.19
Part D Enrollment (%)		72.8%	72.6%	0.37
Low-Income Subsidy (%)		13.2%	16.8%	<0.001
Types of Cancers, Included in EOM (%)[a]	Breast Cancer	23.7%	21.6%	<0.001
	Lung Cancer	19.8%	21.3%	<0.001
	Multiple Myeloma	15.5%	15.2%	0.12
	Small Intestine/Colorectal Cancer	11.6%	10.6%	<0.001
	Lymphoma	10.7%	10.4%	0.05
	Prostate Cancer	10.1%	12.4%	<0.001
	Chronic Leukemia	8.4%	8.5%	0.71

[31] Lent, A. B., Derksen, D., Jacobs, E. T., Barraza, L., & Calhoun, E. A. (2023). Policy recommendations for improving rural cancer services in the United States. *JCO Oncology Practice*, *19*(5), 288–294.

Characteristics		EOM (N=27,111)	Non-EOM (N=213,859)	p-value
HCC Score	Mean ± SD	3.6 ± 2.0	3.7 ± 2.0	<0.001
	Median (Q1–Q3)	3.5 (2.0–4.8)	3.6 (2.1–4.9)	
Primary Comorbidity (%)	Hypertension	66.3%	66.1%	0.29
	Endocrine Disorder	52.3%	52.4%	0.59
	Heart Disease	45.9%	45.9%	0.91
	COPD	28.0%	27.8%	0.43
	Hematological Disorder	18.7%	20.3%	<0.001
	Autoimmune Disorder	16.2%	15.5%	<0.001
	Obesity	6.6%	6.4%	0.26
	Dementia	5.5%	5.4%	0.35
Number of Comorbidities (%)	0–1	28.2%	28.1%	0.62
	2–3	48.4%	48.4%	0.94
	4–8	23.4%	23.5%	0.67
Clinical Trial Participation (%)		2.5%	2.2%	0.011
Other Cancer-Related Treatments (%)	Radiation Therapy	13.4%	14.0%	0.0029
	Cancer Surgery	3.3%	3.1%	0.012

Note: COPD = chronic obstructive pulmonary disease; HCC = Hierarchical Condition Category; Q = quartile; SD = standard deviation.

[a] Shares may not add up to 100% due to rounding.

Source: The EOM evaluation team's analysis of Medicare claims and enrollment data for 6-month cancer care episodes during the final year of the baseline period (July 1, 2021–June 30, 2022).

3.3 Baseline Episode Characteristics: Payments, Utilization, and Quality

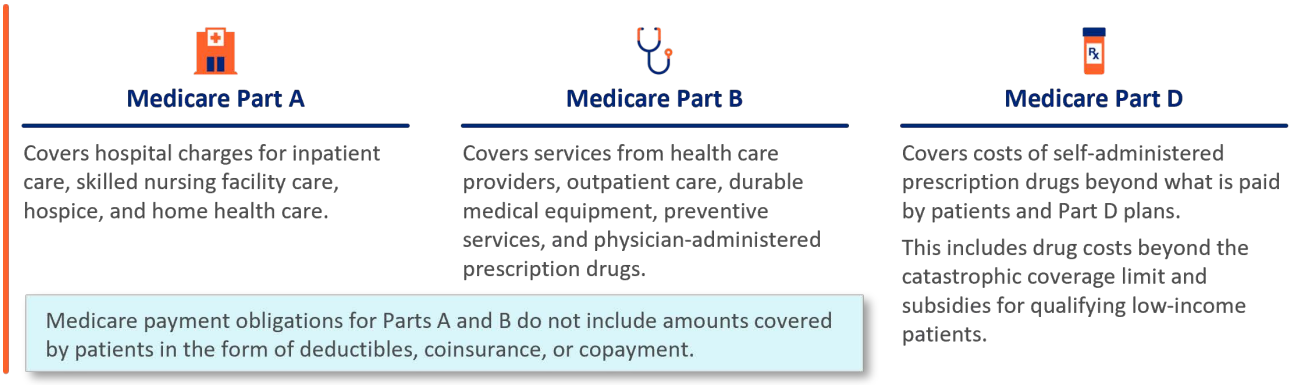
We assessed differences between EOM and non-EOM practices in episode payments, utilization, and quality measures using Medicare FFS claims data.

3.3.1 Episode Payments

Under EOM, participating practices are held accountable for financial and performance outcomes for episodes of care and are incentivized to reduce Medicare spending and improve quality of care. We assessed baseline differences between EOM and non-EOM practices in episode payments, including total payments and payment components to explore whether EOM practices had relatively more opportunity for improvement.

As shown in **Exhibit 12**, medical care costs under Medicare FFS are covered by Medicare Part A and Part B. Medicare Part D also covers certain costs for self-administered prescription drugs, specifically a portion of gross drug costs above the out-of-pocket threshold and low-income cost sharing subsidies for qualifying patients.

Exhibit 12. Medicare Payment Obligations

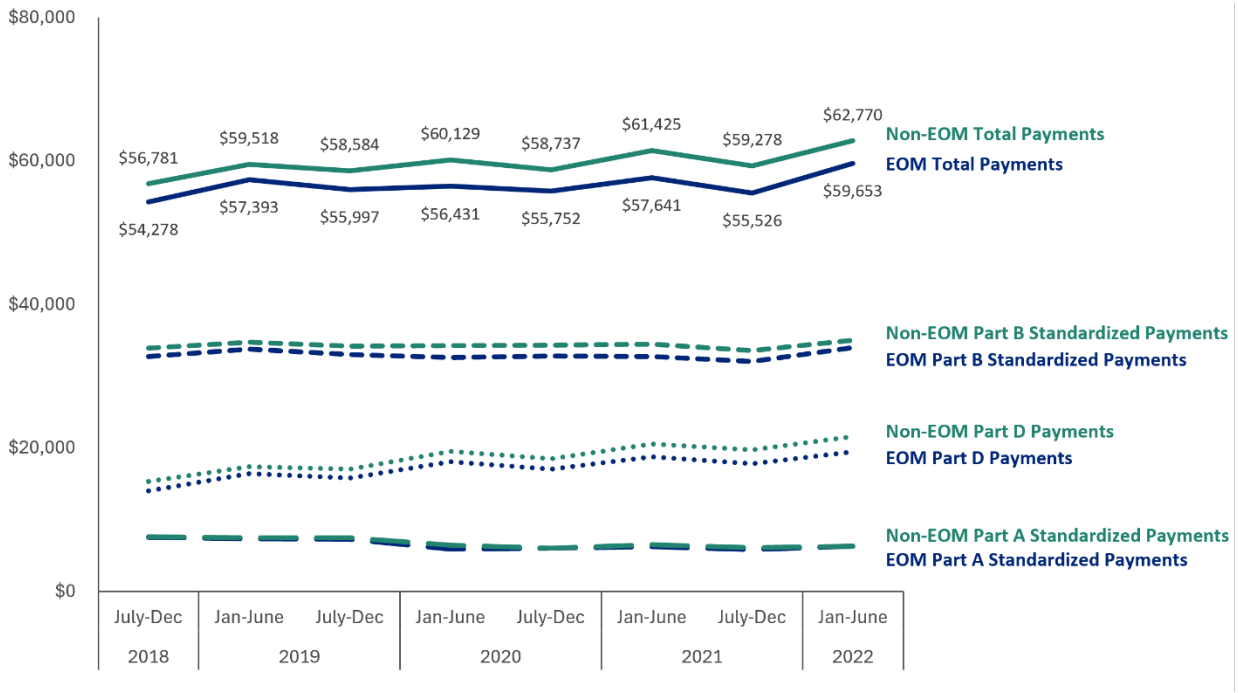


We calculate total episode payments as the sum of standardized[32] Part A, standardized Part B, and Part D payments. Total episode payments in the baseline period varied by cancer type, with EOM practices generally having lower episode payments than non-EOM practices (**Exhibit 13**). Overall, the average episode payment was $56,571 for EOM practices and $59,672 for non-EOM practices. The observed differences between EOM and non-EOM practices may reflect preexisting practice patterns or differences in the patient population. In addition, they might reflect EOM practices' experience in OCM, in which payments for high-risk cancer episodes decreased.

Part B and Part D payments, including systemic cancer therapies, other drugs, and services covered by Part B, comprised nearly 90% of total episode payments in the baseline period (**Exhibit 13**). In contrast, Part A payments made up a relatively small share of total episode payments. The average total episode payments steadily rose throughout the baseline period. For EOM practices, Part A payments decreased slightly, dropping from $7,525 at the start of the baseline period to $6,257 at the end of it. Part B payments per episode gradually increased from $32,735 to $33,972 by the end of the baseline period. The most marked increase was for Part D costs, which rose from $14,018 to $19,423 per episode during the baseline period. A similar trend was observed for non-EOM practices, though EOM practices generally had lower Part B and Part D payments than non-EOM practices. For example, in the final year of the baseline period, Part B payments averaged $34,966 per episode and Part D payments averaged $21,533 per episode for non-EOM practices.

[32] We use standardized Part A and Part B payments to remove geographic and policy-related adjustments to allow consistent comparisons across practices.

Exhibit 13. Average Payment Components Over the Baseline Period



Note: The horizontal axis represents the 6-month period in which the episode was initiated during the baseline period (July 1, 2018–June 30, 2022). Part D payments reflect only the portion of Part D spending that is covered by Medicare.

Source: The EOM evaluation team's analysis of Medicare claims and enrollment data for 6-month cancer care episodes during the baseline period (July 1, 2018–June 30, 2022).

3.3.2 Episode Utilization and Quality

As discussed in **Chapter 2**, EOM provides an incentive for practices to reduce low-value or unnecessary utilization. We explored baseline differences between EOM and non-EOM practices in utilization and quality measures, including acute care utilization measures and quality measures representing those used to implement the performance-based payments (PBPs) and performance-based recoupments (PBRs).

Acute care use. EOM practices and non-EOM practices had similar numbers of ED visits, inpatient admissions, and 30-day hospital readmissions per episode (**Exhibit 14**). At baseline, there were few differences between EOM practices and non-EOM practices in utilization of acute care services, with minimal changes in these trends over the baseline period (**Appendix E**).

Exhibit 14. Acute Care Utilization in the Baseline Period

Practice Status	ED Visits Per Episode		Inpatient Admissions Per Episode		30-Day Hospital Readmissions Per Episode[a]	
	Mean	SD	Mean	SD	Mean	SD
EOM	0.66	1.19	0.39	0.80	0.34	0.75
Non-EOM	0.69	1.21	0.41	0.84	0.37	0.80

Note: ED = emergency department; SD = standard deviation.

[a] Among episodes with 1+ admission.

Source: The EOM evaluation team's analysis of Medicare claims and enrollment data for 6-month cancer care episodes during the baseline period (July 1, 2018–June 30, 2022).

Quality measures. Overall and within cancer types, EOM practices had a slightly smaller share of episodes with systemic cancer treatment–associated ED visits (14.1% vs. 14.6%) and systemic cancer treatment–associated hospitalizations (10.0% vs. 10.5%) in the baseline period (**Exhibit 15**).

Exhibit 15. Mean Episode Share by Quality Measures in the Baseline Period

Practice Status	Systemic Cancer Treatment–Associated ED Visits	Systemic Cancer Treatment–Associated Hospitalizations	Systemic Cancer Treatment in the Last 14 Days of Life	Admitted to Hospice At Least 3 Days Before Death
EOM	14.1%	10.0%	16.8%	51.1%
Non-EOM	14.6%	10.5%	15.6%	49.8%

Note: ED = emergency department. Claims-based EOM quality measures include *Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy (OP-35 Respecified), Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life*, and *Proportion of Patients Who Died Who Were Admitted to Hospice for 3 Days or More*, where "chemotherapy" refers to systemic cancer treatments. See **Appendix D** for details on the definitions used in the evaluation.

Source: The EOM evaluation team's analysis of Medicare claims and enrollment data for 6-month cancer care episodes during the baseline period (July 1, 2018–June 30, 2022).

During the baseline period, EOM practices had a slightly higher share of episodes where patients received systemic cancer treatment in the last 14 days of life compared with non-EOM practices (16.8% vs. 15.6%). This trend was consistent throughout each 6-month period of the baseline (**Appendix E**).

About half of all patients who died during an episode were enrolled in hospice for at least 3 days prior to their death, with a slightly higher share (1.3 percentage points higher) among EOM practices in the baseline period. These results suggest room for improvement on these measures.

4. What Are the Model's Impacts on Spending?

Key Points

Per-Episode Payments	Drivers of Change	Net Savings to Medicare
• EOM likely reduced average Medicare payments per episode in the first performance period (–$646 per episode, 90% confidence interval [CI]: –$1,724, $433). • The inclusion of additional performance periods in future reports will allow for more precise estimates.	• The estimated decrease in average Medicare payments was driven by Part B systemic cancer therapy drug payments (–$645 per episode, 90% CI: –$1,622, $332). • These results align with strategies to reduce costs reported by selected practices during site visits.	• After accounting for model payments made to participants, early estimates suggest a net loss to Medicare of $13.2 million (90% CI: –$35.1 million, $8.5 million) in the first performance period. • However, the estimated range of impacts is wide and includes the possibility of net savings.

A core component of the EOM evaluation is assessing changes in health care costs, utilization, and quality of the 6-month episodes to determine whether the model is achieving its objectives. This chapter presents the estimated impact of EOM in Performance Period 1 (PP1) on key payment measures. To understand the drivers of these changes, we connect quantitative findings to insights from site visits at six selected practices. We include detailed findings from site visits in **Chapter 5**.

We analyzed six payment measures to assess the model's impact on total episode payments as well as payment components. **Exhibit 16** lists outcomes included in our payment impact analyses, along with the desired direction of the change and the impact identified for high-risk episodes in OCM, EOM's predecessor model. The selection of outcome measures was driven by the potential pathways of effects and lessons learned from OCM.

Exhibit 16. Payment Measures and Desired Direction of Change

Episode Payments	Outcome	
	Impact Observed in OCM High-Risk Episodes	Goal of EOM
Total Episode Payments	↓	↓
Total Part A	↓	↓
Total Part B	↓	↓
Part B Systemic Cancer Therapy	—	↓
Part B Other	↓	↓
Total Part D[a]	—	↓

Note: OCM = Oncology Care Model. Arrow indicates direction of change; dash denotes no change. Arrow in the impact observed in OCM high-risk episodes column indicates statistically significant at p≤0.10.

[a] Part D payments include Medicare payments for low-income cost sharing in addition to 80% of gross drug costs above the out-of-pocket threshold.

Estimates for PP1 should be interpreted in the context of three factors that limit our ability to reliably detect impacts, even if the model works as intended. First, with only one performance period of data and 43 practices,[33] the sample size limited our ability to detect statistically significant impacts. Second, it may take time for practices to formulate strategies and implement changes, particularly those that require new staff, changes to systems and workflows, and changes to provider and patient behavior. Many EOM practices have multiple sites, making practice-wide implementation challenging. Thus, one performance period may not be enough time for practice changes to affect outcomes. Third, while we compare episodes at EOM practices with episodes at similar oncology practices in a matched comparison group, unmeasured differences in clinical characteristics among EOM and comparison practices could confound impact estimates. Claims data, our primary data source for the impact analysis, are limited in measuring clinical characteristics, including cancer stage and histology. To strengthen our interpretation of impact findings in light of these limitations, we contextualize PP1 estimates with our qualitative findings.

Methods Overview

To estimate the impact of EOM, we compared changes in the outcome measures for EOM episodes between the baseline period and PP1 relative to the changes in outcome measures for episodes attributed to oncology practices in a matched comparison group of similar oncology practices that did not participate in EOM. More details are included in **Appendix D**.

Baseline Period:
July 1, 2018–June 30, 2022

PP1:
July 1, 2023–December 31, 2023

EOM Group:
Episodes attributed to 43 EOM practices[25] that joined in PP1

Comparison Group:
Episodes attributed to 245 oncology practices with similar characteristics to EOM participants

4.1 What Impact Did EOM Have on Expenditures?

Hypothesis	Potential Pathway	Findings
EOM will drive practices to identify opportunities for cost savings and implement interventions that reduce Medicare payments.	Practices identify drug spending as an opportunity for cost savings and implement strategies such as prioritizing biosimilars to reduce Medicare payments.	EOM likely reduced payments in PP1, driven by declines in Part B systemic cancer therapy payments. This result aligns with reports from practices selected for site visits that they focused on high-value pharmacy care.

EOM is designed to reduce episode expenditures; thus, a key measure of the evaluation is total Medicare episode payments, as well as its payment components—Medicare Part A, Part B, and Part D.[34,35] These payment measures are broad and encompass payments for cancer-specific

[33] One participant without baseline episodes was excluded from the impact analysis.

[34] Our total episode payments measure excludes MEOS payments, which allows for a more direct comparison with costs for the comparison group.

[35] Part D payments include Medicare payments for low-income cost sharing in addition to 80% of gross drug costs above the out-of-pocket threshold.

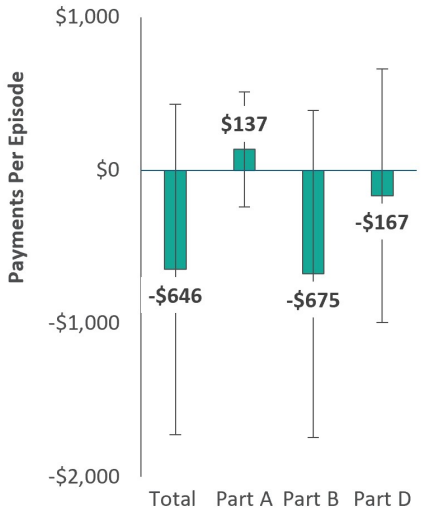
services and other care the patient receives during the episode, including treatment for other conditions.

OCM's Impact on Episode Payments

- OCM reduced episode expenditures throughout the course of the model.
- The reductions in episode expenditures were primarily driven by decreases in Part B payments, although there were also reductions in Part A payments.
- OCM reduced Part D payments, particularly in its last two performance periods.

While our findings were not statistically significant, early impacts suggest that EOM likely reduced total episode payments, driven by reductions in Part B payments (**Exhibit 17**). We estimated that EOM reduced total episode payments in PP1 by $646 per episode, or 1.1% (90% confidence interval [CI]: –$1,724, $433). Throughout the baseline period and into PP1, average total episode payments generally increased for both EOM and comparison episodes. However, EOM episodes had consistently lower average total episode payments than comparison episodes throughout both periods (**Appendix F**). The estimated reduction in episode expenditures in PP1 was consistent with estimated decreases in Part B payments of $675 per episode, or 2.1% (90% CI: –$1,742, $392). Based on the CI range, it is unlikely that the model affected Part A payments per episode ($137, 90% CI: –$237, $510) or Part D payments per episode (–$167, 90% CI: –$994, $661) in PP1.

Exhibit 17. EOM Impact on Total Episode Payments in PP1



Payments	EOM Mean		Comparison Mean	
	Pre (N=155,157)	Post (N=17,165)	Pre (N=646,878)	Post (N=71,464)
Total Payments	$57,673	$60,095	$59,448	$62,516
Part A	$6,445	$6,612	$6,499	$6,530
Part B	$32,415	$35,070	$34,930	$38,260
Part D	$22,775	$22,260	$21,875	$21,526

Note: CI = confidence interval; DiD = difference-in-differences; PP = performance period. The estimates in this exhibit are the results of DiD models. The estimates represent the relative change in dollars. Part A and Part B payment outcomes were standardized to remove the effect of geographic and other payment adjustments. Part D payments include Medicare payments for low-income cost sharing in addition to 80% of gross drug costs above the out-of-pocket threshold. The table presents risk-adjusted means. *Pre* refers to the baseline period, and *Post* refers to PP1. Part D payment regressions are limited to episodes with Part D coverage at the beginning of the episode. Part D sample sizes are as follows: EOM pre-period = 124,070; EOM PP1 = 13,979; comparison pre-period = 534,111; comparison PP1 = 60,345. See **Appendix D** for details of the DiD methodology, outcome definitions, and additional information on methods. Sample sizes for the comparison group reflect weighting for matching with replacement. See **Appendix F** for more detailed results. Significance of the DiD estimate is indicated above the point estimate, where * implies significance at the 10% level, ** at the 5% level, and *** at the 1% level assuming a two-tailed test.

Source: The EOM evaluation team's analysis of Medicare claims and enrollment data for 6-month episodes attributed to EOM practices or matched comparison oncology practices.

OCM's Impact on Part B Systemic Cancer Therapy and Other Payments

- OCM did not reduce systemic cancer therapy payments beyond payments for high-risk breast cancer, leaving further opportunity for value-based savings under EOM.
- Payment reductions due to OCM were greatest for other Part B payments, primarily through supportive care drugs.

To determine whether changes in Part B payments were related to systemic cancer treatment, we analyzed EOM's impact on Part B systemic cancer therapy drug payments separately from other payments. While findings are not statistically significant, impact estimates suggest EOM reduced Part B systemic cancer therapy payments, with an estimated reduction of $645 per episode (90% CI: –$1,622, $332) relative to the comparison group. We did not find evidence that the model affected other Part B payments (**Exhibit 18**).

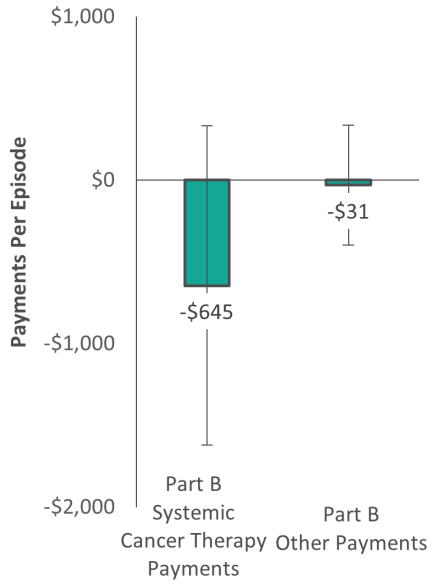
These findings are consistent with what practices reported during site visits, described in detail in **Chapter 5**. We learned that practices built on existing value-based pharmacy care infrastructure by developing new strategies (such as alternative dosing) to target value-based prescribing of systemic cancer therapy:

- ***Practices aimed to reduce costs to Medicare by using value-based pharmacy interventions.*** Most practices engaged in value-based alternative dosing strategies for systemic cancer therapy and other drugs. Several practices also reported implementing dose rounding and weight-based dosing.
- ***Practices used pharmacists to identify opportunities for value-based substitution.*** Multiple practices described hiring or contracting with a pharmacist or consultant to check that the practice was following clinical guidelines and to identify opportunities for substitutions. Two practices expanded the job responsibilities of their pharmacists, and two other practices hired additional staff, such as a pharmaco-economist, or used an implementation support company to identify opportunities to manage pharmacy spending.

If analyses for future reports confirm reductions in Part B systemic cancer therapy payments under EOM, this finding would be new compared with results from the OCM evaluation. Over the course of the model, OCM reduced payments for supportive care drugs but had no impact on systemic cancer therapy payments.[36] One contributing factor may be the evolving availability of biosimilars, which expanded significantly after OCM ended. The reported focus on value-based substitution may help explain emerging reductions in systemic cancer therapy payments. This dynamic may also shape findings in future performance periods as biosimilar uptake continues to increase.

[36] Abt Global. (2024). *Evaluation of the Oncology Care Model*. Prepared for the Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/data-and-reports/2024/ocm-final-eval-report-2024

Exhibit 18. EOM Impact on Part B Systemic Cancer Therapy Payments in PP1



Payments	EOM Mean		Comparison Mean	
	Pre (N=155,157)	Post (N=17,165)	Pre (N=646,878)	Post (N=71,464)
Part B Systemic Cancer Therapy Payments	$20,716	$23,361	$22,168	$25,458
Part B Other Payments	$11,700	$11,708	$12,762	$12,802

Note: CI = confidence interval; DiD = difference-in-differences; PP = performance period. The estimates in this exhibit are the results of DiD models. The estimates represent the relative change in dollars. Part B systemic cancer therapy and Part B other payment outcomes were standardized to remove the effect of geographic and other payment adjustments. The table presents risk-adjusted means. *Pre* refers to the baseline period, and *Post* refers to PP1. See **Appendix D** for details of the DiD methodology, outcome definitions, and additional information on methods. See **Appendix F** for more detailed results. Significance of the DiD estimate is indicated above the point estimate, where * implies significance at the 10% level, ** at the 5% level, and *** at the 1% level assuming a two-tailed test.

Source: The EOM evaluation team's analysis of Medicare claims and enrollment data for 6-month episodes attributed to EOM practices or matched comparison oncology practices.

4.2 Net Savings to Medicare

As part of our impact analysis, we estimated the *net* savings or losses to Medicare caused by the model. To calculate net savings, we consider the *gross savings* (based on the estimated change in episode payments), MEOS payments paid to practices to support Enhanced Services, and performance payments earned and owed by practices. EOM participants can earn PBPs or owe PBRs. PBPs and PBRs are modified by a performance multiplier that incorporates a practice's performance on a set of quality measurements, incentivizing care redesign that lowers episode payments and improves quality.[37] The amount earned or owed by practices is subject to a stop-gain and stop-loss, which is determined by the practice's choice of risk arrangement for the performance period.[38]

Billing for MEOS Payments

Some practices in EOM chose not to bill for MEOS, which could relate to a variety of factors:

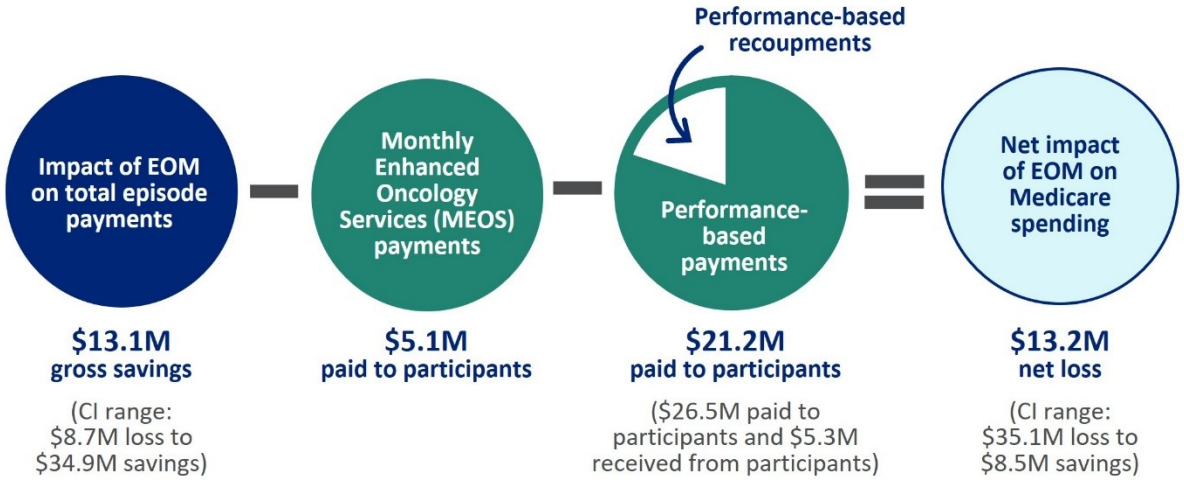
- Practices may have intentionally not billed for MEOS given the two-sided risk of the model.
- Practices reported that predicting patient attribution was challenging, making it difficult for them to know whether a MEOS claim was appropriate.
- Practices may have chosen instead to bill chronic care management codes or to bill for other services that cannot be billed in the same month as MEOS for a patient.

We show the calculation of the net savings estimate in **Exhibit 19**. Starting with the estimated impact on episode payments, we adjusted the estimate to unstandardized dollars, resulting in a per-episode payment reduction of $653. We then multiplied this per-episode payment reduction by the number of reconciled episodes to estimate total gross savings of $13.1 million. Because the gross savings estimate is based on an estimate of the impact on total episode payments, it has a range that includes both gross savings and losses, from a gross loss of $8.7 million to gross savings of $34.9 million. To estimate net savings, we subtract the MEOS payments ($5.1 million for PP1) and the net amount paid to practices for PBPs ($21.2 million). Our estimate of the net impact of EOM to Medicare is a $13.2 million loss with a wide range, from a $35.1 million loss to savings of $8.5 million.

[37] In OCM, CMS only applied quality scores to calculate PBPs, but in EOM, CMS uses quality scores to adjust the size of both PBPs and PBRs.

[38] A total of 12 participants reached the stop-gain and 7 participants reached the stop-loss allowed under their chosen risk arrangement.

Exhibit 19. Calculation of EOM's Impact on Medicare Spending in PP1



Note: CI = confidence interval; PP = performance period.

In EOM, practices can participate as pools, which are groups of two or more practices whose financial performance and quality scores are aggregated for reconciliation as a single entity in the model. For PP1, there was one pool consisting of 2 practices, so financial calculations were conducted for 42 individual practices and one pool of 2 practices. Of these 43 participants,[39] 24 (55.8%) had the highest quality scores that translated to the maximum performance multiplier[40] in PP1. Almost all the remaining practices were in the second highest quality category. The average practice PBP and PBR multipliers were 87% and 93%, respectively.

[39] For the purposes of this calculation, we treated pools of practices as a single practice, as they are treated in reconciliation.

[40] A practice receives a PBP multiplier if it earned a payment from CMS and a PBR multiplier if it owed a recoupment to CMS. Achieving high quality scores on the model's set of quality measures could result in practices maintaining their PBPs earned or reducing PBRs owed. The PBP multiplier ranges from 0% to 100%, and the PBR multiplier ranges from 100% to 90%. Thus, practices in the highest quality category receive 100% of their calculated PBP or owe 90% of their calculated PBR.

5. What Are the Experiences of Practices and Patients in EOM?

Key Points

Motivation for Participation	Responses to EOM	Challenges
Practices chose to participate in EOM because it offers the opportunity to advance value-based care goals and provide high-quality care to patients.	Two-sided risk motivated practices to develop and implement plans to reduce costs in a number of ways, including by decreasing pharmacy spending and reducing avoidable acute care.	Although practices aim to reduce low-value care at end of life, changes at end of life are difficult to accomplish because they require a shift in the provider–patient relationship and take time to implement.

Patient Care Experiences

- Patients reported having ready access to their cancer team and receiving care coordination services, including screening for individual needs and patient navigation.

To assess whether EOM works as intended, understanding how practices are implementing the model, as well as barriers and facilitators of success, is critical. In this chapter, we describe the existing infrastructure and care redesign activities that EOM practices had already adopted before the model began. We also summarize findings related to practice and patient experiences with EOM based on site visits with six practices and interviews with their patients. We connect findings to impact estimates to assess whether strategies implemented by practices led to detectable changes in utilization and discuss drivers of potential EOM impacts on cost, utilization, and quality.

Methods Overview

We reviewed model documents (see **Appendix C4**), conducted virtual and in-person site visits with six EOM practices (one to five sites per practice), and conducted phone interviews with a sample of patients who received care at the six practices.

Practice Site Visits (Nov. 2024–Feb. 2025):

Interviewees – 93 key informants, including executive leadership; physicians; advanced practice providers; nursing, pharmacy, and other clinical staff; nonclinical staff; and consultants

Purpose – Understand motivation for participation, experience with value-based care, responses to the model, implementation activities, and successes and challenges

Patient Interviews (Dec. 2024–Apr. 2025):

Interviewees – 40 EOM patients with a mix of cancer types and sociodemographic backgrounds

Purpose – Assess experiences with accessing cancer care, care coordination and supportive care, and communication and care planning

5.1 Readiness for EOM

Respondents in site visits reported joining the model because EOM aligns with their goal of providing high-value oncology care and offers an opportunity to build on prior investments in value-based care. All six practices selected for site visits had prior experience with value-based care models, and four participated in OCM, which helped practices establish the infrastructure needed for EOM and prepared them to take on two-sided risk. Most practices conducted financial analyses to inform their selection of a risk arrangement.

> *"With our experience in value-based care programs, we felt that we could leverage the infrastructure for EOM … to do better for patients, but to also understand the spend and understand how we could decrease the cost for the patients and potentially for payers and get rewarded for doing that."*
>
> *– Chief of Health Alliance and Population Health*

Many practices engaged in care transformation activities prior to EOM through participation in OCM and other value-based care programs, as well as quality initiatives such as the American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative. We reviewed EOM applications and findings from the Participant Transformation Plan Survey, administered by CMS to participating practices,[41] which indicated that practices joining EOM had many transformation activities in place or planned at the model's start:

- All participating practices used **certified electronic health record (EHR) technology**,[42] and most practices (66%) incorporated treatment guidelines into the EHR to support guideline-based care.
- Nearly all practices implemented **24-7 access** to a clinician on call outside of practice hours, allowing patients to reach out for medical assistance at any time
- Most participating practices had established **patient navigation workflows**. For example, practices integrated a patient navigator or social worker into care coordination (96%) and facilitated linkages to follow-up services and community resources (91%).
- Practices planned to refine existing **HRSN screening** workflows and add resources to address HRSN. Most practices (80%) were using the National Comprehensive Cancer Network Distress Thermometer and Problem List,[43] and others (16%) were using a patient-reported outcomes tool that included HRSN domains.
- Many practices (84%) had **established care plans** that included the 13 components recommended by the National Academy of Medicine (NAM)[44] to empower patients to participate in their care.[45] However, about a third of practices' care plans did not include estimated out-of-pocket costs, survivorship plans, or plans for addressing psychosocial health.
- Practices also sought to improve **patient engagement.** Existing methods for patient engagement included translation services (89%) and documentation of the patient's prognosis and treatment goals (73%). However, fewer practices used decision aids (50%), identified a need for extended visits to discuss changes in the care plan (39%), or trained staff on shared decision-making (30%).

[41] This baseline survey was administered to EOM practices in July 2023 to better understand practice performance and identify potential areas requiring additional support throughout the model.

[42] Centers for Medicare & Medicaid Services. (2024). *Certified EHR technology*. https://www.cms.gov/medicare/regulations-guidance/promoting-interoperability-programs/certified-ehr-technology

[43] National Comprehensive Cancer Network. (2024). *Distress during cancer care*. https://www.nccn.org/patients/guidelines/content/PDF/distress-patient.pdf

[44] The National Academy of Medicine (NAM) was under the name of the Institute of Medicine (IOM) until 2015.

[45] Centers for Medicare & Medicaid Services. (2024). *The Enhancing Oncology Model (EOM) request for applications.* https://www.cms.gov/priorities/innovation/media/document/eom-rfa-2024

While practices had many of the EOM care redesign elements in place at model start, more than half of practices (59%) did not collect ePRO data, and of those that did, only 36% collected ePROs routinely. Many practices reported plans to build on existing workflows to begin collecting ePROs. Practices aimed to use ePRO tools, such as integrated EHR systems and patient portals, to monitor patients' symptoms in real time, allowing providers to address any changes in health status and reduce the likelihood of hospital admissions and ED use. Practices reported investing in staff to support or expand these activities.

5.2 Responses to Elements of Model Design

During site visits, we explored how specific program elements affected practices' responses to EOM. Practices highlighted three EOM program elements that had the biggest impact on their approach: two-sided risk, patient eligibility criteria, and the required participant redesign activities (**Exhibit 20**).

Exhibit 20. EOM Practice Response to Selected Program Elements

EOM Program Element	Practice Response to Program Element and Challenges Faced
Two-Sided Risk Arrangements	• Two-sided risk arrangements motivated EOM practices to prioritize resources and focus on high-cost services (such as pharmacy) and care processes to improve quality measures that factored into performance. • Practices invested in analytics and monitoring to obtain interim feedback on their EOM performance, which helped manage risk. • Practices experienced challenges managing the cost of care for patients with cancer and other health conditions who received care outside the practice.
Patient Eligibility Criteria	• Practices do not receive a list of EOM patients until episodes end. Therefore, they reported creating a process to flag patients who were eligible for EOM in real time. This process allowed them to identify who would receive Enhanced Services, monitor performance, and bill for MEOS payments. • Most practices implemented automated strategies to identify patients triggering an EOM episode using their EHR. Some practices ultimately did not invest in systems to identify EOM episodes because they were too resource intensive. • It was challenging for practices to proactively identify EOM patients because changes in insurance and diagnoses can occur during the episode. Practices also found it difficult to accurately attribute patients who received oral medications, particularly if the prescription was not filled by the practice. • Four of the six site visit practices billed for MEOS payments, which required new workflows. The two practices that did not bill for MEOS reported that identifying episodes and integrating the billing mechanism into their EHR were large hurdles.
Required Participant Redesign Activities	• Except for ePROs and screening for HRSN, all six practices had implemented the required redesign activities prior to the model. • Practices are refining activities, particularly to address patients' HRSNs through patient navigation, and modifying the EHR to capture care plan elements in discrete fields, which facilitates tracking of care plan documentation. • At the time of the site visits, about 6 to 8 months before data collection began in June 2025, most practices had selected an ePRO tool and had started integrating it into their EHR. The resources required for implementation can constrain practices' choice and modification of ePRO tools. • Practices are strategizing how to effectively provide timely responses to patients. This effort involves defining staff roles and responsibilities and hiring more team members, such as nursing and navigation staff, to support these processes. • Practices are also working to reduce patient barriers to ePRO adoption, such as limited internet access and difficulties faced by patients who may lack the technological skills to use these tools.

Note: EHR = electronic health record; ePRO = electronic Patient-Reported Outcome; HRSN = health-related social need; MEOS = Monthly Enhanced Oncology Services.

5.3 How Did Practices Transform Care Under EOM?

EOM practices used episode data provided by CMS, supplemented with their own data sources, to identify areas where there were opportunities to generate savings under the model. The three domains identified by practices with opportunities to reduce costs included pharmacy, end-of-life care, and acute care utilization. We describe practices' approaches to transforming care and reducing costs in these areas below.

5.3.1 Pharmacy

Drug spending is the major driver of oncology care costs. Under the Medicare FFS system, practices have little incentive to be conscious of the cost of Part B drugs. However, under an episode-based payment system, such as EOM, optimizing Part B revenue allows oncology practices to provide comprehensive services and hire nonclinical staff to support patient care. Under EOM, practices are financially accountable for the total cost of patient care, including the costs of Part B and Part D services, and must use strategies to manage these costs. In return, practices can earn incentive payments that they can use for enhanced patient care and nonclinical staff.

> *"Drugs have a giant bull's-eye on them … It's a huge cost driver here. We optimize everything we can, but we're not going to sacrifice patient care—so whether that's dose rounding, weight-based dosing, making sure we're staying on pathway and care plans—I think all those are critical to minimize any waste but ensure the best patient outcomes and access to the best therapy."*
>
> *– Chief Medical Officer*

At baseline, the average systemic cancer therapy spending under Part B and Part D represented nearly 58% of the total costs of care per 6-month episode (**Exhibit 5**). Under OCM, practices increased higher-value use of supportive care drugs by leveraging biosimilars and value-based prescribing based on guidelines.[46] Under EOM, practices reported a focus on value-based prescribing of systemic cancer therapy and used a variety of pharmacy interventions to reduce costs and improve patient care.

Value-based pharmacy interventions aimed to reduce drug costs while maintaining clinical effectiveness.

EOM practices used various strategies to reduce drug costs and potentially earn a PBP (**Exhibit 21**). All site visit practices implemented therapeutic substitutions for systemic cancer therapy and other medications.

Potential savings from the implementation of therapeutic substitutions varied based on the practices' management of their formulary. For some practices, the EOM patient population was not large enough to sway formulary decisions. Shortages of cancer drugs also made it hard for practices to include the lowest-cost drugs on their formulary. One practice pointed to shortages of Zirabev™, a biosimilar for bevacizumab that it uses for almost all its EOM patients. However, when the practice could not get the drug, it had to switch to another biosimilar that cost more.

[46] Abt Global. (2024). *Evaluation of the Oncology Care Model*. Prepared for the Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/data-and-reports/2024/ocm-final-eval-report-2024

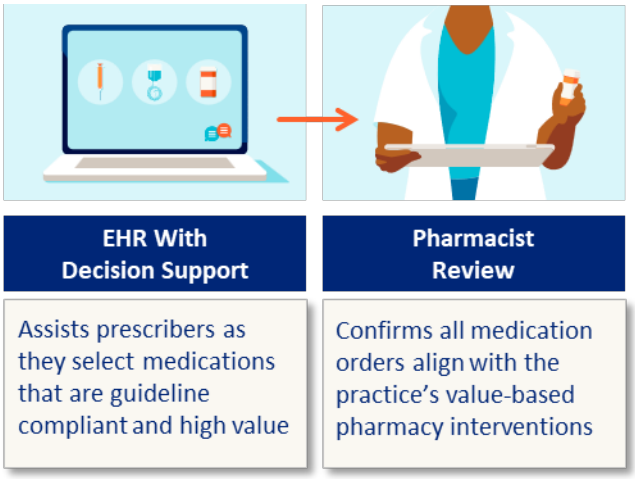
Exhibit 21. Value-Based Pharmacy Interventions Used by Site Visit Participants

Intervention	Description
Therapeutic Substitution	• A lower-cost drug (for example, a biosimilar or generic) is substituted for a higher-cost drug of the same clinical effectiveness. • This intervention is applicable to any systemic cancer therapy or other drug with a lower-cost alternative. • **Benefit:** Increases patient access to lower-cost prescription medications.
Dose Rounding	• For intravenous systemic cancer therapy, a dose may be rounded to the nearest vial size, if within a certain range (for example, ± 10%). • For some oral systemic cancer therapies for which the dose is calculated by body surface area or weight, a dose may be rounded to the nearest capsule or tablet size. • **Benefit:** Minimizes waste, decreases drug costs, and improves efficiency and accuracy of administration.
Weight-Based Dosing of an Immune Checkpoint Inhibitor	• Instead of a standard (flat) dose, dosage may be reduced by 25% to 50% depending on patient weight. • This intervention is applicable to a high-cost immunotherapy agent that does not have a lower-cost substitute available. • **Benefit:** Reduces dosage and costs for patients in certain weight ranges.
Avoiding White Blood Cell Growth Factors for Metastatic Tumors	• Drug is not prescribed for regimens with <20% risk of febrile neutropenia. • **Benefit:** Avoids costs and side effects in instances when a drug has limited clinical benefit.

New analytic staff and consultants enhanced practices' capacity to identify, implement, and monitor value-based pharmacy interventions.

CMS provides participants with claims data as well as a data dashboard that compares their practice with benchmarks designed to make feedback more accessible. Some practices reported investing in resources to support data analysis. Two practices hired additional staff, such as a pharmaco-economist, or contracted with an implementation support company to use data to identify opportunities to manage pharmacy spending, particularly around high-cost immunotherapies. The implementation support company also assisted with patient navigation and monitoring of value-based pharmacy interventions to ensure effectiveness. Half of the practices had access to analytic support, either through a business analytics consultant or the US Oncology Network, and were routinely monitoring pharmacy spending and identifying potential interventions prior to EOM. One community-based, independent practice did not devote resources to analyzing claims data because it had limited resources and chose to leverage data reports from other oncology care initiatives rather than invest in EOM-specific analytics.

Practices promoted prescriber compliance with value-based pharmacy interventions using their EHR and pharmacist reviews.



All six practices used certified EHR technology—supported workflows, order sets, alerts, and other clinical decision support—to guide treatment decisions, often referred to as *clinical pathways*. To support EOM, one practice automated its therapeutic substitution process, and another added alerts for substitutions. Although EHRs helped steer prescribers toward the highest-value regimens and promoted compliance with the formulary, challenges remained. Prescribers deviated from the preferred regimen because the software allowed multiple guideline-compliant options, a prescriber was unaware of a formulary change, or a prescriber overrode the software's recommendation. Also, some practices lacked resources (information technology staff, funding) to update their EHR to align with ongoing formulary changes.

Nearly all practices assigned a pharmacist to review medication orders, with two practices hiring additional pharmacists to support EOM goals. Pharmacists reviewed patient medical records and insurance information and coordinated with prescribers to optimize each order. Practices felt that reviewing all pharmacy orders had a strong return on investment.

Some practices invested in resources to help patients understand and adhere to increasingly complex oral pharmacy regimens.

Pharmacists have specialized knowledge of cancer drugs and their side effects. One practice promoted a pharmacist into a new role focused on patient coordination, and another reorganized its pharmacists by cancer type, in part so that patients would receive increasingly specialized pharmacy care. The same practices instruct their pharmacists to conduct outreach to patients to monitor adherence and side effects.

Practices also support medication adherence by systematically screening for financial distress and providing financial counseling to advise patients on their insurance benefits and out-of-pocket costs. Prior to EOM, screening for financial distress was not implemented systematically at some practices. For patients experiencing financial stress or burden due to drug costs, staff help patients obtain rebates for medications and connect patients to patient assistance programs. These programs can be sponsored by drug manufacturers, the government, and charitable or other organizations.

Patients received information about their cancer drugs and financial help if needed

Of the 40 patients interviewed, most reported discussing their medications with the cancer team, but less than half discussed costs of care.

- Patients reported the cancer team reviewed how and when to take medications. This information was typically shared when there were changes to the medication regimen.
- Of the patients who discussed costs with the practice, many reported receiving help from the practice, including:
  - Direct financial assistance
  - Payment plans
  - Support with grant applications
  - Information about other financial resources

"We did talk about the Verzenio®, and we did talk about the impact of that because it was going to be expensive, but there are ways to get that for free."

– EOM patient

Patient Survey

89%

reported their cancer team "definitely" explained the purpose of their medicines

47%

received help from their cancer team to deal with the financial impact of cancer

Note: Percentages are from the 2023 Patient Experience of Cancer Care Survey administered by CMS to EOM patients.

5.3.2 Palliative and End-of-Life Care

EOM elements are designed to improve end-of-life care through care plans, evidence-based clinical guidelines, and quality measures related to end-of-life care, such as increased hospice use and decreased use of chemotherapy in the last 14 days of life. Further, ePRO monitoring has the potential to increase EOM practices' focus on addressing patient symptoms. This stronger focus on addressing patient symptoms may improve the timing of palliative care and reduce the likelihood of treatments that cause acute side effects at the end of life.

EOM did not affect hospice use for end-of-life care in PP1.

We estimated the impact of EOM on the proportion of patients admitted to hospice 3 or more days before death relative to the comparison group. See **Appendix F** for more information.

There was no evidence that EOM affected the proportion of episodes admitted to hospice 3 or more days before death.

Care planning under EOM is supporting shared decision-making, including planning for end-of-life care.

Across practices, the responsibility for documenting and reviewing care plans with patients is increasingly collaborative under EOM, with multiple care team members contributing to the effort. Practices engage a variety of staff to complete and review care plans, including providers, financial counselors, pharmacists, and administrative personnel. As part of this process, they engage patients

in advance care planning discussions that include goals of care, treatment preferences, and end-of-life wishes.

Shared decision-making is a key component of this collaborative approach to implementing care plans. It includes initiating discussions with patients about symptom and pain management, emotional and psychosocial support, and care coordination. One practice had hired additional staff—a PA who provides counseling in shared decision-making discussions—in part due to EOM, and some practices noted that they were updating their documentation of shared decision-making to meet model requirements.

What Is Shared Decision-Making?

Shared decision-making in oncology care is a collaborative process between the patient and their care team to determine the best treatment plan. With shared decision-making, patients are empowered to make informed choices about their care, and providers consider their values, goals, and concerns when discussing testing and treatment options, as well as end-of-life wishes.

Patients were engaged in planning their care

In interviews, patients reported engaging in care planning discussions with their oncologist.

- Most patients reported receiving detailed information about treatment options, symptoms, and side effects.
- Many patients reported positive communication practices by their cancer team, including:
  - Listening to the patient
  - Clear and thorough explanations
  - Providing interpretation services
- Most patients were satisfied with their involvement in care planning, though some preferred their oncologist to make decisions.

"[The oncologist and I] discuss everything together. Pros and cons, possibilities, what does work, what doesn't work, the results, the effects, everything. We have an excellent relationship."

– EOM patient

Patient Survey

76%

reported being involved as much as they wanted in decisions

80%

reported their cancer team always listened carefully to them

Note: Percentages are from the 2023 Patient Experience of Cancer Care Survey administered by CMS to EOM patients.

Most practices did not have a formal process for determining when patients should be referred to palliative care.

During care planning, providers may introduce palliative care based on a patient's specific needs, often triggered by the severity of their symptoms or by a request from the patient or their family. Although palliative care involves relieving symptoms for patients with serious or life-threatening conditions, it can begin early in the course of disease and is not limited to end-of-life care. Routine monitoring via ePROs may expedite the timing of discussions and support palliative care.

> *"We certainly believe that mental health services [are] going to be a continuously growing need for our patients and especially as we get into really creating a more holistic profile of what's happening in the patient journey."*
>
> *– Chief Innovation and Strategy Officer*

Although practices recognized delayed introduction of palliative care as a concern and opportunity under EOM, most site visit practices said that they relied on clinician judgment about patients' symptoms (such as severity of pain) or frequency of appointments rather than using a formal process to decide when to refer patients to palliative care. One practice conducted a palliative care pilot using data to identify palliative care risk based on screening for HRSNs and symptoms and then referred patients to a palliative care specialist. Another practice with ties to local health systems offers inpatient palliative care, and about half of its patients who are admitted receive these services. Practices continue to face challenges in providing palliative care, including the persistent stigma around palliative care, shortages of palliative care specialists, low reimbursement rates, and hospice eligibility rules.

Some practices are discussing end-of-life care with patients earlier in the treatment journey.

Oncologists or advanced practice providers (APPs)[47] are typically leading end-of-life and hospice care discussions when treatment options are exhausted, but some practices are educating staff to improve documentation and increase awareness that hospice use and chemotherapy at end of life affect EOM performance. This awareness is leading some clinicians to consider end-of-life care discussions earlier in the treatment process; however, they remain cautious because of a concern that patients and families may misinterpret these conversations as a sign that the care team is giving up on them. Additionally, patients are living longer due to medical advancements, which may be shifting the timing of some end-of-life conversations.

Shared decision-making plays a critical role in how systemic cancer therapy and end-of-life care are delivered. Most practices emphasized that the decision to transition to hospice is ultimately the patient's, with the role of the provider centered around educating about prognosis and symptoms and supporting the patient's choice. However, practices noted challenges in getting providers to consistently document shared decision-making conversations. One interviewee mentioned that their practice has implemented EHR documentation and provided templates to guide shared decision-making conversations but said the conversations are still difficult for some providers to have and document regularly.

[47] APPs include nurse practitioners, PAs, and clinical nurse specialists.

> *"I can think of a patient right away, that from the beginning she said, 'I want one round of chemo. If it makes me where I can't go see my grandson play baseball, I'm not doing it anymore.'… And I had to have conversations with her provider about … this is really what she wants. And she went on more chemo, felt worse, and then was like, 'No, I'm really done.'*
>
> *And I really think we were able to honor her goals and her wishes by letting her guide that conversation, even though it was really hard for us, because we knew that we could keep her alive longer, but that wasn't what was important to her. It was really about the quality of her life."*
>
> *– Lead Value-Based Care Manager*

5.3.3 Acute Care Utilization

Acute care services such as hospitalizations are costly and can be disruptive to systemic cancer therapy regimens. Acute care services are often used to address severe symptoms and side effects due to chemotherapy, but such conditions may be better cared for by cancer specialists in the EOM practice. Most practices began initiatives to reduce avoidable acute care prior to EOM; however, findings from OCM suggest that practices' efforts did not move the needle on these outcomes.[48] Even so, practices perceived reducing acute care as an achievable cost savings opportunity under EOM. As such, they reported continuing efforts in this area and trying new approaches. For example, one practice is implementing a new oncology urgent care service to improve care for patients and lower total episode spending. Practices expected that ePRO implementation may improve their ability to mitigate ED use.

There was evidence of mixed impacts on acute care utilization in PP1 of EOM.

We estimated the impact of EOM on three claims-based measures of acute care utilization relative to the comparison group. See **Appendix F** for more information.

EOM may have increased the probability of a hospitalization by 2.3% (0.62 percentage points [pp]; 90% CI: –0.15 pp, 1.38 pp).

EOM may have reduced the probability of a 30-day readmission by 3.7% (–0.91 pp; 90% CI: –2.41 pp, 0.58 pp).

There was no evidence that EOM affected the probability of an ED visit during the episode.

The increased probability of hospitalization for EOM practices is unexpected but could reflect increases in planned admissions or differences in unmeasured patient clinical factors.

[48] Abt Global. (2024). *Evaluation of the Oncology Care Model*. Prepared for the Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/data-and-reports/2024/ocm-final-eval-report-2024

Practices continue to pursue faster, more convenient access to care and patient education to mitigate ED use.

A persistent challenge for some practices is that their patient population depends on the ED for urgent care, including when patients experience acute side effects from cancer treatment. However, patients undergoing active cancer treatment are at risk of being admitted to the hospital since ED clinicians may not feel comfortable addressing cancer-related symptoms and side effects, particularly with newer therapies.

> *"After the patient has treatments, if they encounter any side effects, they will call me and let me know, and I will triage in terms of … do they need to see a provider today, the next day, or if they could wait or if it's something urgent, then I would advise them to go to the [emergency room]. But our main goal is not to send them to the [emergency room] [and] to see if they could come in to see our provider the same day."*
>
> *– Triage Nurse*

To reduce ED visits, all practices reported providing their patients with access to a provider at any time through on-call physicians or APPs, including after hours and on weekends. While this 24-7 access to a provider was also a required redesign activity under OCM, EOM practices reported hiring additional staff, such as APPs, to provide clinical care, support care coordination, and accommodate same-day appointments. Some practices have triage nurses that field patients' questions via the patient portal and phone calls to determine whether the patient needs to be seen by their clinical staff. Some also use telehealth, particularly for patients who live far from care or for follow-up visits. Other practices had existing workflows without telehealth, and one noted that telehealth has brought to light technology barriers for patients. Practices expressed concerns about their ability to continue telehealth after COVID-19-related payment provisions end. EOM offers practices a telehealth benefit enhancement that will allow EOM participants to provide telehealth services after Medicare telehealth coverage expires.[49]

However, one practice familiar with this enhancement was concerned it may have the payment recouped if the patient receiving the telehealth service ends up not being attributed to EOM.

Most practices are investing in patient navigation services to help reduce ED use, and some are focusing on oncology-specific urgent care. For example, two practices established oncology-specific urgent care, one that is sustained from OCM and another that is new under EOM. These urgent care clinics increase practices' capacity for same-day appointments and have access to patients' electronic medical records. The first practice partnered with a local hospital to provide oncology-based urgent care, while the second practice, affiliated with an academic medical center, embedded a rapid-access clinic within its infusion clinic. Another practice has urgent care because it is hospital based, and the other community practices refer patients to local, nonspecialized urgent care clinics.

[49] Centers for Medicare & Medicaid Services. (2025). *Enhancing Oncology Model (EOM) benefit enhancements.* https://www.cms.gov/priorities/innovation/media/document/eom-benefit-enhance-fs

Patients had convenient access to care through their practice, and most had information about 24-7 available help

In interviews, most patients reported easy access to the cancer team through appointments scheduled at preferred times and simple ways to reach the team outside of scheduled appointments.

- Some patients reported having at least one telehealth appointment with their care team, typically to review test results. However, many patients preferred in-person visits for the human connection with their providers and to avoid challenges from lack of stable internet connection or limited technological skills.
- Patients felt well informed about what to do if they had cancer-related questions and needed to speak to someone in between appointments or after hours. Most patients recalled guidance from the practice on what they should do if they needed care right away, including calling the practice or 24-7 hotline or going to the ED in specific circumstances.

"[Care team member] has always said we can just call her [to ask questions], and we have the [patient portal]."

– EOM patient

Patient Survey

72%

reported that visits were always scheduled at convenient times

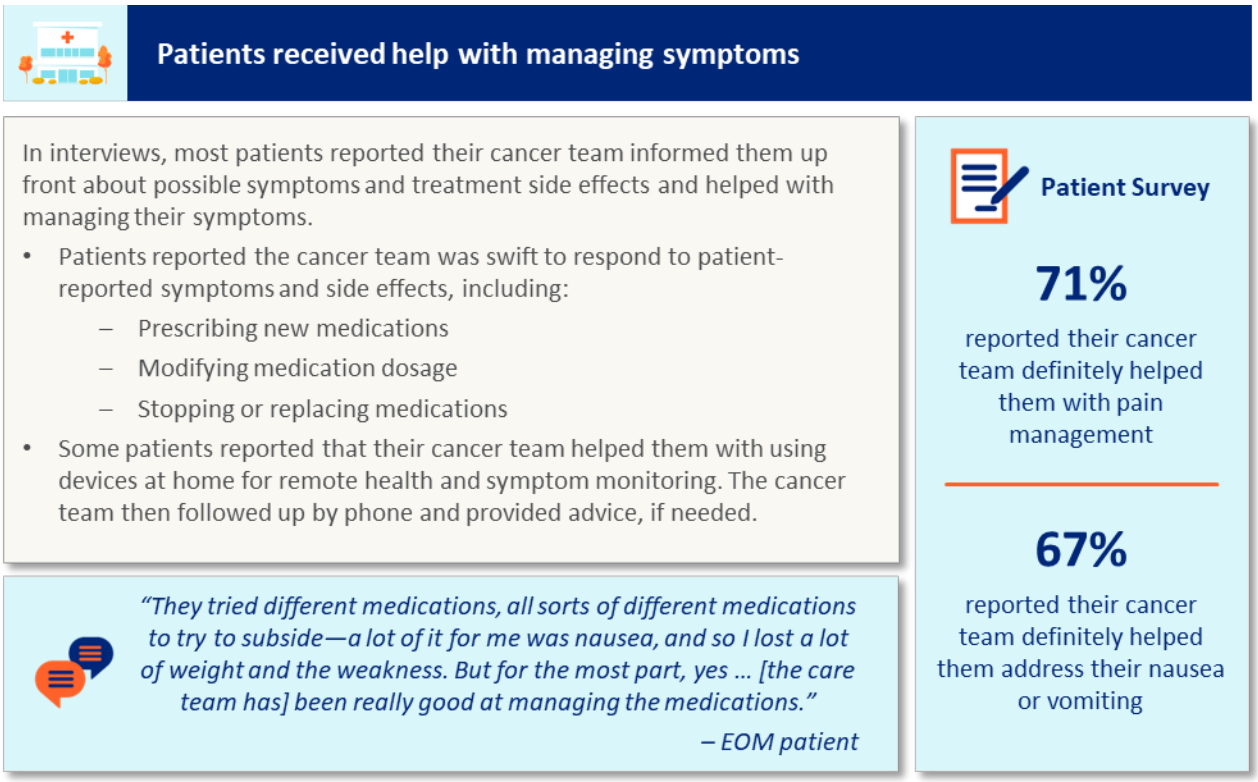
62%

reported always getting answers to their questions as soon as needed when they contacted their team after hours

Note: Percentages are from the 2023 Patient Experience of Cancer Care Survey administered by CMS to EOM patients.

Although practices are implementing a proactive approach to reducing avoidable ED use, it is difficult for practices to manage the total cost of care when patients elect to seek care at a local hospital that does not have a relationship with the practice. Communication and information sharing between the practice and outside providers may be limited, and those outside providers may have less incentive to prioritize high-value treatment decisions if they are not participating in a value-based care program. The practices encouraging patients to use oncology-specific urgent care have established processes and infrastructure that promote awareness of care transitions and support comprehensive care, such as requiring a phone call from the practice for admission to urgent care, sharing staff, and using the same EHR.

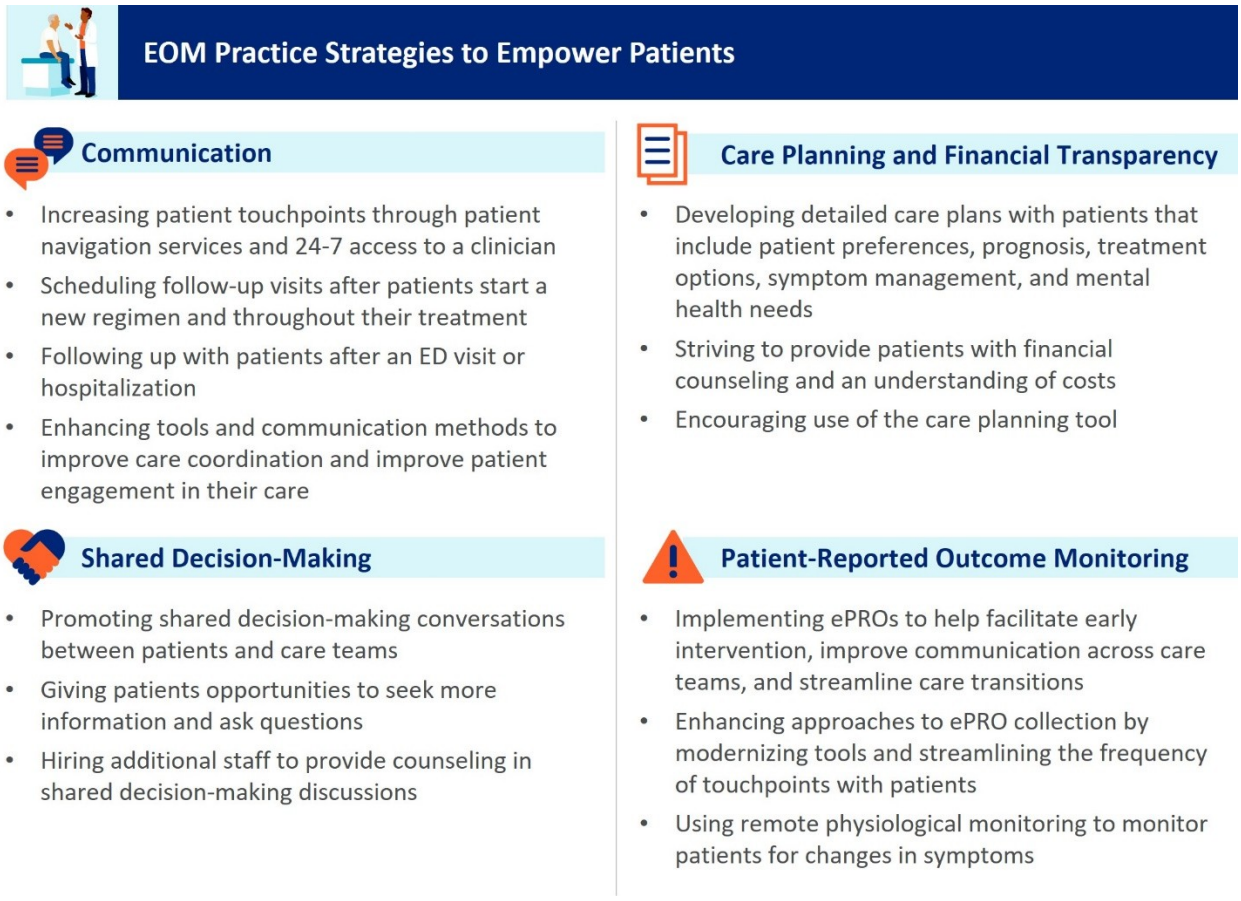
To mitigate ED use, some practices instruct patients to "call us first" before going to the ED and provide extensive education about expected treatment side effects. For example, some newer immunotherapy drugs have distinct side-effect profiles that require close monitoring, as symptoms that initially appear mild or insignificant can quickly escalate to life-threatening conditions. Some practices proactively reach out to patients after infusions to discuss symptom management by phone or encourage patients to seek care within the practice. Further, implementing ePROs can support early detection of symptom changes through enhanced continuous monitoring, enhanced patient engagement between visits, and facilitation of timely care coordination and follow-up, potentially reducing avoidable ED visits.



Note: Percentages are from the 2023 Patient Experience of Cancer Care Survey administered by CMS to EOM patients.

Practices use proactive approaches to monitor symptoms and follow up with patients.

EOM practices are enhancing approaches to proactively monitor symptoms by increasing communication; collecting data via ePROs, including remotely monitoring physiological status; and prioritizing high-risk patients as they transition across care settings. These efforts can help practices identify and address issues as they arise and, in turn, potentially reduce avoidable ED use and hospitalizations. These strategies also empower patients to take an active role in their care.



Although impact results for PP1 show no statistically significant changes on the two measures of acute care utilization we examined, the changes that practices implemented may take time to change patient behavior related to when they seek care at the ED. In contrast, practices have more direct levers to reduce pharmacy payments, such as dose rounding and biosimilar adoption. Similarly, changing approaches to end-of-life care requires provider buy-in and a change to the provider–patient relationship. Thus, these approaches will likely take more time to implement and for the evaluation to observe meaningful change.

6. Conclusion

Since it began in July of 2023, EOM has supported oncology practices to improve care, reduce costs, and build on prior investments in value-based care. EOM is one of the few Innovation Center models that directly engages specialists in adopting value-based care and addresses one of the highest-cost conditions for Medicare. EOM builds on lessons learned from OCM by focusing on seven higher-risk cancer types that showed savings, requiring downside risk from the start, and expanding participant redesign activities to include ePROs. EOM incentivizes practices to leverage their existing strategies as well as continuously look for new opportunities to provide value-based oncology care. While the Medicare FFS system rewards volume and use of high-cost provider-administered drugs, the EOM episode-based payment methodology provides financial incentives for practices to deliver high-value care in line with the Innovation Center objective to produce cost savings as responsible stewards of federal taxpayer dollars.

6.1 Summary of Findings

At the start of the model, 44 oncology practices voluntarily joined EOM. Most EOM practices had previously participated in OCM. EOM practices reported that they decided to participate in the model because it aligns with their commitment to value-based care. EOM practices differed from non-EOM practices. They had higher episode volume in EOM cancers and lower episode costs at baseline than non-EOM practices. These distinguishing factors may have positioned practices to participate in EOM and to adopt new strategies to achieve the model's goals.

Consistent with EOM's objectives, we found a reduction in total spending in the first 6 months of the model, translating to total gross savings of $13.1 million across all episodes. The range of these estimates includes both gross savings and losses but leaned toward savings. This reduction in total episode spending was largely driven by a decrease in spending on Part B systemic cancer therapy. This finding suggests that EOM practices may have different opportunities under EOM than under OCM, which did not lead to reductions in this area. What we learned in site visits supports these quantitative findings, as practices reported that they had already begun attempting to reduce costs to Medicare through value-based pharmacy interventions. For example, they implemented therapeutic substitutions, including the use of biosimilars, dose rounding, weight-based dosing, and dose banding, and hired pharmacists, or expanded pharmacists' role, to review treatment plans for value-based prescribing. This early estimate of gross savings in PP1 likely does not capture all the potential benefits from value-based pharmacy interventions.

To calculate the model's net impact on Medicare savings, we subtracted outgoing payments (PBPs and MEOS) from the gross savings and added incoming payments (PBRs). Our results suggest EOM led to a net loss of $13.2 million in PP1. However, the estimate has a wide CI range that includes the possibility of both net savings and net losses (from a $35.1 million loss to savings of $8.5 million). It is too early to draw a conclusion about EOM's potential for savings as the model matures.

Although the EOM practices that participated in site visits reported value-based pharmacy interventions as the primary strategy for success, they also identified avoidable acute care as one area for improvement and are enhancing approaches to reducing inpatient stays and ED visits. For example, practices have continued the existing strategy of encouraging patients to "call us first"

before going to the ED. In addition, EOM practices are investing in expanded patient navigation services and oncology-specific urgent care to provide care for patients with cancer-related symptoms and side effects. Despite this effort, we did not find reductions in ED visits and inpatient stays in the first 6 months of the model. Similarly, OCM had no impact on most measures of hospital-based care, despite being a focus of OCM practices.[50]

EOM may also encourage practices to focus on improving scores on quality measures that factor into performance, such as measures related to end-of-life care and patient experience. Practices reported working on promoting shared decision-making, including discussing and planning for end-of-life care with patients earlier in their treatment journey. However, in our impact analysis, we did not find evidence that EOM affected hospice use for end-of-life care in the model's first 6 months.

6.2 Key Limitations

We analyzed multiple data sources to holistically evaluate the early implementation and impacts of EOM. Each of these data sources has limitations that should be considered when interpreting results. First, site visits and patient interviews are from a sample of practices and patients and may not be representative of the EOM experience. In addition, the limited number of EOM episodes in PP1 limited our ability to detect statistically significant impacts. Further, it may take time for EOM practices to identify areas for improvement and then develop and implement refinements; one performance period may not be long enough for practice changes to affect outcomes. Finally, while our methods to detect impacts compare episodes at EOM practices with episodes at similar oncology practices in a matched comparison group, claims data are limited in capturing unmeasured differences such as disease severity.

6.3 Looking Forward

In this initial evaluation report, we describe how EOM practices aim to reduce spending through value-based pharmacy interventions and indicate that some of these strategies may be showing early beneficial results. Like OCM, full implementation of EOM will take time. We will continue to assess impacts on payments, utilization, and quality throughout the 7-year model. As the model progresses, we will also consider how EOM may have impacts beyond Medicare FFS patients with the seven cancer types and how the model may interact with other policies and initiatives.

CMS recently implemented changes in the model's design, including a more generous payment methodology to attract more practices in a second cohort, which joined on July 1, 2025. The addition of new practices and patients will add variation in practice characteristics and support the evaluation of EOM's progress in advancing patient-centered oncology care.

[50] Abt Global. (2024). *Evaluation of the Oncology Care Model*. Prepared for the Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/data-and-reports/2024/ocm-final-eval-report-2024