Executive Summary

First Evaluation Report

In July 2023, the Center for Medicare and Medicaid Innovation, within the Centers for Medicare & Medicaid Services (CMS), launched the Enhancing Oncology Model (EOM). EOM is a voluntary model that incentivizes oncology practices to provide high-quality, patient-centered care to patients with one of seven higher-risk cancer types while reducing Medicare fee-for-service (FFS) spending.

To develop EOM, CMS incorporated lessons learned from the Oncology Care Model (OCM), which ended in June 2022. CMS engaged with OCM participants, patient advocacy organizations, professional associations in oncology, and other key stakeholders for input on EOM's design.

The Lewin Group, in partnership with Westat and a team of clinical experts, is conducting an independent evaluation of EOM under contract with CMS. We use quantitative and qualitative methods to assess the model's impacts on payments, utilization, and quality of care for patients under the model, with the aim of understanding whether EOM is achieving its core goals.

Drawing on findings from site visits, patient interviews, and claims-based impact analyses, the first evaluation report provides early insights into how the model is transforming cancer care. It covers how EOM is designed to drive change and who opted to participate in the model. The report also summarizes early changes in spending and service use based on Medicare claims data for the first EOM performance period (July–December 2023) and how EOM oncology practices responded to the model in its initial years (July 2023–March 2025).

Evaluation Approach

We used a mixed-methods approach to assess EOM's early impacts:

- **Claims-based impact analysis:** Compared episode spending and service use between EOM participants and matched nonparticipants
- **Site visits:** Visited six EOM oncology practices to understand early responses to the model
- **Patient interviews:** Interviewed 40 patients receiving care at EOM practices on their experiences
- **EOM document review:** Reviewed model applications and existing survey data from practices and patients

Model Background

- **Timeline:** July 2023–June 2030
- **Goal:** Reshape cancer care by encouraging oncology practices to provide high-quality, patient-centered care while reducing Medicare spending
- **Participants:** 44 oncology practices that volunteered to join the model
- **Patients:** Medicare FFS patients receiving systemic cancer therapies for breast cancer, chronic leukemia, small intestine/colorectal cancer, lung cancer, lymphoma, multiple myeloma, and prostate cancer
- **Model design:** Model holds participants financially accountable for the total cost of a 6-month episode of care against a target amount after adjusting for quality performance

Evaluation Findings

- **Total episode payment reduction:** EOM likely reduced episode payments in the first 6 months of the model, driven by decreases in Part B systemic cancer therapy spending. Although early impact estimates have limited precision, they are consistent with reports from EOM practices, which were focused on implementing value-based pharmacy interventions.
- **Net benefit to Medicare:** EOM likely resulted in a net loss to Medicare in its first 6 months because incentive payments to participants exceeded estimated savings from payment reductions. However, the range of estimated net impacts includes the possibility of net savings.

Oncology practices that chose to participate in EOM have a higher volume of episodes and are more likely to have been in OCM than nonparticipating oncology practices.

EOM attracted practices with more oncology practitioners and a greater focus on cancer care, as reflected by their higher volume of episodes at baseline compared with eligible nonparticipating practices. Among the 44 practices participating at the start of EOM, 31 participated in OCM through the end of the model. EOM practices are also more likely than nonparticipating practices to be community based and located in the South.

EOM practices were motivated to participate in the model because it aligns with their goal of providing high-value oncology care and offers the opportunity to build on prior investments in value-based care.

Participant Motivations

"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, Clinically Integrated Network

Early estimates suggest the model led to reductions in Medicare payments, primarily driven by decreases in Part B systemic cancer therapy spending.

A key goal of EOM is to reduce Medicare expenditures. Building on lessons learned from OCM, the model (1) focuses on seven higher-risk cancers that showed savings, (2) includes lower supplemental model payments to participants for enhanced oncology services (the Monthly Enhanced Oncology Services [MEOS] payments) to balance incentives with Medicare savings, and (3) uses a two-sided risk arrangement to strengthen the overall incentive to reduce Medicare payments. Under EOM's two-sided risk arrangement, participants may earn money or owe money based on their financial and quality performance.

Value-Based Pharmacy Care

"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

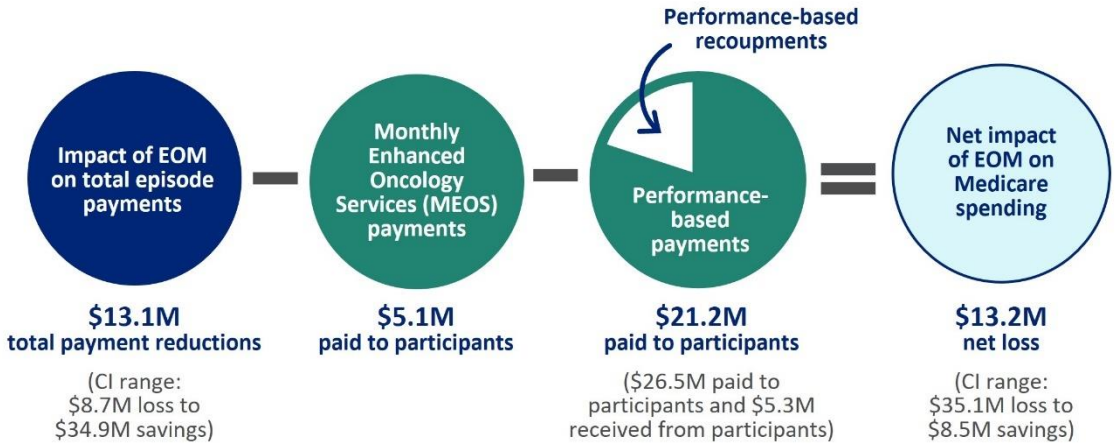
Findings from the evaluation suggest the model likely reduced total episode payments in the first 6 months of EOM. The payment reductions appear to be driven by declines in Part B systemic cancer therapy spending. This finding is consistent with what we learned in site visits, where practices reported identifying and prioritizing areas where they could reduce unnecessary spending and improve quality of care. A key area of focus was strategies to reduce drug expenditures while maintaining clinical effectiveness:

- Therapeutic substitution to increase patient access to lower-cost medications
- Dose rounding and weight-based dosing to minimize waste and improve efficiency and accuracy of administration
- Avoiding drugs with limited clinical benefit, such as white blood cell growth factors for metastatic tumors

OCM also led to payment reductions, but these reductions were primarily driven by the use of high-value supportive care drugs. Under EOM, practices further developed strategies such as dose rounding, weight-based dosing, and dose banding for value-based systemic cancer therapies.

After accounting for incentive payments, estimates indicated net losses to Medicare in the first 6 months of EOM; however, the range includes the possibility of net savings.

Results suggest a net loss of $13.2 million to Medicare in the first 6 months of the model. Incentive payments to participants, including net performance-based payments and recoupments as well as MEOS payments, exceeded savings from payment reductions. However, these results represent only the first performance period of the model and a modest number of episodes. Consequently, the net savings estimate has a wide confidence interval (CI) range and should be treated as an important early indicator rather than definitive. The CI range includes the possibility of both net savings and net losses (90% CI: –$35.1M, $8.5M).



EOM practices have identified three initial domains to reduce spending and improve quality of care: pharmacy, avoidable acute care, and supportive care.

EOM practices used episode data provided by CMS, supplemented with their own data sources, to identify opportunities to generate savings under the model. The domains they highlighted as key areas to reduce spending and improve quality under EOM included pharmacy, as described above; avoidable acute care; and supportive care, such as palliative and end-of-life care.

Practices reported various strategies to reduce the use of unnecessary acute care. Several of the required Enhanced Services under EOM, including 24-7 access to clinicians and the National Academy of Medicine (formerly the Institute of Medicine) 13-point care plans, are aligned with this goal as well as the EOM quality measures. EOM practices are continuing to use approaches implemented under OCM, such as encouraging patients to “call us first”

before going to the emergency department, and some are developing new strategies to reduce avoidable acute care by providing more timely oncology-specific care and increasing patient interactions. For example, they are investing in patient navigation services and establishing oncology-specific urgent care to provide care for patients with cancer-related symptoms and side effects. Practices are also preparing to collect electronic Patient-Reported Outcomes (ePROs), which are real-time, patient-generated data on symptoms. Monitoring ePROs can help facilitate early interventions to reduce avoidable emergency department visits and inpatient stays.

In our analyses of Medicare claims for the first performance period, we did not find any immediate changes in acute care payments or service use that are statistically significant. Some new approaches to care that might affect acute care use, such as setting up care navigation processes and integrating drug use guidance documents into the electronic health record, are complex and take time to implement. Certain efforts might require practices to foster changes in culture and provider or patient behavior to be effective. Consistent with our findings for EOM, OCM had no impact on most measures of hospital-based care despite being a focus of OCM practices, highlighting challenges to reducing avoidable acute care.

EOM may incentivize more timely palliative care and lower-intensity services at the end of life, as demonstrated through the quality measures included in the performance adjustment, as well as more indirectly through care planning, which can include planning for end-of-life care. Some practices have started to discuss end-of-life care with patients earlier in their treatment journey. Others are still developing strategies to address cultural barriers and infrastructure challenges required to improve end-of-life care, including a lack of understanding of palliative or hospice care services by the patient or family, provider discomfort with end-of-life discussions or time-constrained clinical settings, and a limited supply of specialized palliative care teams or hospice services. Similar to results from OCM, our claims-based impact analyses for EOM's first performance period did not find any model impacts on hospice care.

Findings from this first annual evaluation report will inform outcomes examined in future evaluation reports.

In this first evaluation report, we captured EOM practices' early strategies and care transformation activities and connected them to initial evidence of reductions in Medicare payments. We found a likely reduction in total episode payments in the first 6 months of the model; however, our estimates indicated there were net losses to Medicare because incentive payments to participants exceeded savings from payment reductions. In the next evaluation report, we will continue to assess the model's impact on payments, utilization, and quality of care, as well as net savings to Medicare.

CMS recently made several policy changes, including (1) adding a second cohort of EOM practices that joined on July 1, 2025; (2) increasing the base MEOS payment by $40; (3) relaxing the threshold at which practices must make repayments to CMS (practices will not repay CMS until costs exceed 100% of the benchmark amount, as opposed to 98% of the benchmark); and (4) extending EOM by 2 years from the original end date of June 30, 2028, to June 30, 2030. We will include findings that reflect these model design changes in future evaluation reports.

About This Document

The Lewin Group, in partnership with Westat, analyzed claims, survey, interview, and site visit data for this independent evaluation to determine whether the model achieved its primary goals.

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Interested in Learning More?

The following resources are available to obtain a snapshot of key findings or to dive deep into the evaluation of EOM's initial performance period:

- **Findings at a Glance | 2 pages**
  Concise visual summary of key findings
- **In-Depth Report | 45 pages**
  Comprehensive evaluation findings and methodology