The Evolving Enhancing Oncology Model (EOM): Updates and Insights

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Background

In July 2024, the Center for Medicare and Medicaid Innovation announced updates to the Enhancing Oncology Model (EOM) that include **adding a second cohort of participants**, **extending the model**, and **updating payment policies**.[1]

Key EOM Design Updates[1]

Base MEOS Payment Increase

$70 PMPM → $110 PMPM
for individuals who are not dually eligible for Medicare and Medicaid

$100 PMPM → $140 PMPM
for individuals who are dually eligible for Medicare and Medicaid

Patient Care Cost Threshold Increase

98% → 100%
point at which participants are required to pay back Centers for Medicare and Medicaid Services (CMS) for episodes of care costs exceeding benchmark amount

Timing Extension

July 1, 2023
Start date: Cohort 1

July 1, 2025
Start date: Cohort 2

June 2028
Previous end date

June 2030
New expected end date

MEOS=Monthly Enhanced Oncology Services; PMPM=per member per month.

For more information about CMS and the EOM, please visit
https://www.cms.gov/priorities/innovation/innovation-models/enhancing-oncology-model

Evan Slater, PharmD

Director, Pharmacy and Admixture Services
Rocky Mountain Cancer Centers – Central Business Office

Dr Slater provides his perspective as Director of Pharmacy and Admixture Services at an organization that participated in the Oncology Care Model (OCM) and transitioned to the EOM.

Can you describe your organization's transition from OCM to EOM?

"It was relatively seamless for us. We didn't make any changes at the end of OCM that would have put us in a position for failure for EOM. In the OCM, we performed pretty well against our peers and in the model for the indications that are the key focus for EOM. A lot of the drug initiatives and operational initiatives that we developed for OCM transitioned smoothly into the EOM, which laid the groundwork for us to perform well in the EOM."

How has your organization's experience been with EOM so far?

"From our projections prior to enrollment that helped us drive our decision, I feel like we pretty much performed as expected and saw very similar savings to what we projected based on pre-EOM data that we received. We did earn a shared savings."

What aspects of patient care have you seen impacted by EOM?

"Patients feel quality, patients experience quality. Even though the "dollars and cents" aren't there in quality, it certainly is there as a multiplier or potentially punitively. You can be doing wonderfully in your drug initiatives and your drug spend, but if you're not hitting quality measures, you're not going to see a benefit out of the EOM. A major focus on quality is really the best thing we see from the EOM."

What benefits has your organization realized due to EOM?

"Engagement of physicians to truly support pharmacy initiatives and to show trust in pharmacists to make clinical decisions and recommendations brings more of a multidisciplinary approach to community oncology, giving pharmacy a seat at the table."

What challenges has your organization experienced due to EOM?

"The biggest challenge is the data lag and the fear of the unknown. Oftentimes we're alerted to make a change when it's too late. We can't really impact the last two performance periods because we don't have the data to know how we performed. That's the biggest challenge with these programs is a lack of timely data and timely resulting."

Victoria Nachar, PharmD, BCOP
Hematology Clinical Pharmacist Specialist
University of Michigan Rogel Cancer Center

Dr Nachar provides her perspective as Hematology Clinical Pharmacist Specialist at an organization that participated in the OCM but did not choose to transition to the EOM.

What impacted your organization's decision not to transition from OCM to EOM?

"Once it became the 2-way risk model, it wasn't financially incentivizing for us because we would probably not reach some of those benchmarks of the OCM. We spend a lot of money on monthly care management versus excess drug costs or treatment costs, we have a lot of stewardship when it comes to medications, but we probably wouldn't reach the benchmarks for overall monthly cost of patient care."

Have the EOM updates to benchmark threshold had any impact on your organization's decision not to enroll?

"I think some of the same barriers and challenges still apply. They upped some of the reimbursement payments, which kind of leveled the playing field, but it is still below where it was with OCM. For centers that participated in OCM and were in the initial phase of EOM, the changes probably were helpful from a financial perspective, but for new institutions that enrolled when they had the re-enrollment period, I think the same challenges and barriers are there."

"We're such a large institution and a lot of it is care coordination. For example, for the social determinants of health screening we rely on social workers. If they're doing that screening for all the patients, then they can't respond to other social work requests they're getting. Just having them screen for social determinants of health outside of EOM has put them at like an 8- to 10-week turnaround for other requests. It would be risky. And there's not good modeling or financial risk calculators to review an organization's patients or cases and see on average if you would hit it."

Potential Ways to Incentivize EOM

Our panelists agree, the updates may make a positive impact to those participating; however, they shared additional ways the program could be made more attractive for practices.

- Predictive Modeling
- Minimization of Two-Way Risk
- Introductory Period of Optional Risk
- Real-Time Tracking of Performance
- Additional Incentive for High-Risk Patients
- Leveraging Artificial Intelligence to Expedite Data Feeds

Impact of Pharmacist-Driven Interventions on Costs in the EOM

A recent US Oncology Network study evaluating the impact of pharmacists in reducing total cost of care (TCOC) in the EOM model from July 1, 2023 to December 31, 2024, has found that pharmacist medication initiatives within The Network's EOM participation resulted in a $9 million reduction in TCOC across 5 practices.[2]

Medication Initiative and Average TCOC Reduction per Intervention[2]

EOM Initiative	n (%)	TCOC Reduction, $	Average TCOC Reduction per intervention, $
Monoclonal antibody dose rounding	443 (35)	1,537,273	3,470
Pembrolizumab dose banding	106 (8)	1,962,105	18,510
Therapeutic interchange	356 (28)	1,510,945	4,244
Preferred PD-1 agent for NSCLC	26 (2)	153,117	5,889
Decrease in upfront use of long-acting growth factor in metastatic cancer	37 (3)	109,822	2,968
Preferred use of zoledronic acid	181 (14)	2,157,895	11,992

NSCLC=non-small cell lung cancer.

Dr Slater shares his experience with the role of pharmacist-driven interventions in the EOM.

"We estimated that drug spend would contribute about 70% to 75% of overall EOM performance. We developed and really focused on a handful of drug initiatives that we thought were the most impactful and the least disruptive to our operations as a pharmacy team – dose rounding, biologics, savings in bone modifying agents, potential weight-based dosing for checkpoint inhibitors, and really leveraging biosimilars."

"We created internal models and dashboards based on opportunities that we identified as a pharmacy team and based on physician adherence to recommendations. If we make a recommendation for an intervention and messaging is sent to a physician, we track whether the intervention was accepted or not, and that gives us a pretty good indication as to how we are performing."

"A lot of our EOM initiatives are truly driven through pharmacy. The ability to make therapeutic interchanges and recommendations based on a narrow focus of pharmacy initiatives is really where it starts. When it comes to biosimilar preferencing and true dose banding opportunities, it starts with having a strong pharmacy team and engaged and trusting physicians."

References: 1. Centers for Medicare & Medicaid Services (CMS). EOM Second Cohort Fact Sheet. Accessed May 19, 2025. https://www.cms.gov/priorities/innovation/innovation-models/enhancing-oncology-model/second-cohort-fact-sheet **2.** Kendzierski D, Basillo A, Cantley M, et al. Remote clinical pharmacist impact on reducing total cost of care in Enhancing Oncology Model-enrolled oncology practices. 2025 ASCO Annual Meeting. *J Clin Oncol.* 2025;43(16 Suppl).

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