Where Should a Value-Based Oncology Program Launch Next?

A state-level market-attractiveness analysis using public CMS and cancer-registry data

Mohammad Ferdaws Homayoon | Independent analysis using public data | October 2026

Interactive dashboard: https://mfhportfolio.com/projects/market-strategy

Executive summary

This paper asks a where-to-play question that any organization building a value-based oncology program faces: a specialty-care management, oncology-pathway, or risk-sharing program sold to health plans, especially Medicare Advantage (MA) plans. Which U.S. states should it enter first? I scored all 50 states and DC on six public measures: cancer volume, Medicare growth, MA share, cost intensity, cancer burden, and oncology clinician supply. I then tested how stable the ranking is under different weights.

- **Recommendation:** Florida, Texas, and New York rank 1–3 under balanced weights.
- **Robustness:** Florida and Texas land in the top 3 in at least 99.98% of 5,000 random weight scenarios (each weight varied ±50%). New York is top 3 in 60% and top 5 in 98%.
- **Why:** The three states hold 22% of U.S. annual cancer cases (404,244 of 1,872,274 a year, 2019–2023) and 21% of Medicare beneficiaries. All three are above the national MA share (50.9% in 2025).
- **Phasing:** Launch in Florida (Phase 1), expand to Texas (Phase 2), then New York (Phase 3). Minnesota is a smaller "proof market" alternative if early risk tolerance is low.
- **Caveat:** Per-state MA share and cost are only a screen. Before committing, validate them with payer-level enrollment, contract-by-contract demand, and local competitor mapping (see Limitations).

1. Question and framing

Value-based specialty programs make money by managing high-cost episodes, like chemotherapy and immunotherapy regimens, site of care, and end-of-life care, on behalf of payers. A launch market needs enough patients, a payer mix that buys these programs, a cost baseline high enough to create savings, and a clinician network to work with. I turned those needs into six measurable factors. Each is scored 0–100 across states (min-max). Cancer case counts are log-scaled so the largest states don't swamp the rest.

Factor	Measure (source, year)	Why it matters	Base weight
Market size	Avg. annual cancer cases (State Cancer Profiles, 2019–2023)	Patient volume to manage	25%
MA share	MA & other plan enrollees ÷ all Medicare (CMS Monthly Enrollment, 2025)	MA plans are the main buyers of delegated specialty programs (judgment)	25%
Growth	Medicare enrollment CAGR 2020→2025 (CMS Monthly Enrollment)	Future demand	15%
Cost intensity	Standardized FFS spend per capita (CMS Geographic Variation, 2024)	Higher baseline means more savings headroom (judgment, proxy)	15%
Cancer burden	Age-adjusted incidence per 100k (State Cancer Profiles, 2019–2023)	Clinical need	10%

Network feasibility	Oncology clinicians billing Medicare per 100k beneficiaries (CMS Physician & Other Practitioners, 2024)	Partners for pathways and site-of-care moves (judgment)	10%

Assumption label: The weights are my judgment. That's why Section 4 tests four alternative weight sets and 5,000 randomized ones. The dashboard lets readers set their own weights.

2. Data and method

All inputs are free, public, state-level files downloaded in October 2026 (references at the end). Medicare enrollment uses the annual rows of the CMS Medicare Monthly Enrollment file. "MA share" counts Medicare Advantage and other health plans (for example cost plans and PACE), as CMS reports them. Cost intensity uses CMS's price-standardized total Medicare payment per fee-for-service beneficiary, which strips out geographic wage differences. Oncology clinicians are unique NPIs billing Medicare in six specialties: hematology-oncology, medical oncology, radiation oncology, hematology, gynecologic oncology, and surgical oncology. Composite score = weighted average of the six 0–100 factor scores. Analysis in Python/pandas.

3. Findings

MA is now the majority channel. MA covered 50.9% of Medicare beneficiaries in 2025, up from 39.7% in 2020 (34,659,411 of 68,094,870). The buyer base for payer-sold specialty programs has grown fast. Mississippi gained the most (+20.3 points), followed by West Virginia, Maine, Arkansas, and North Carolina (each +16 to +17 points).

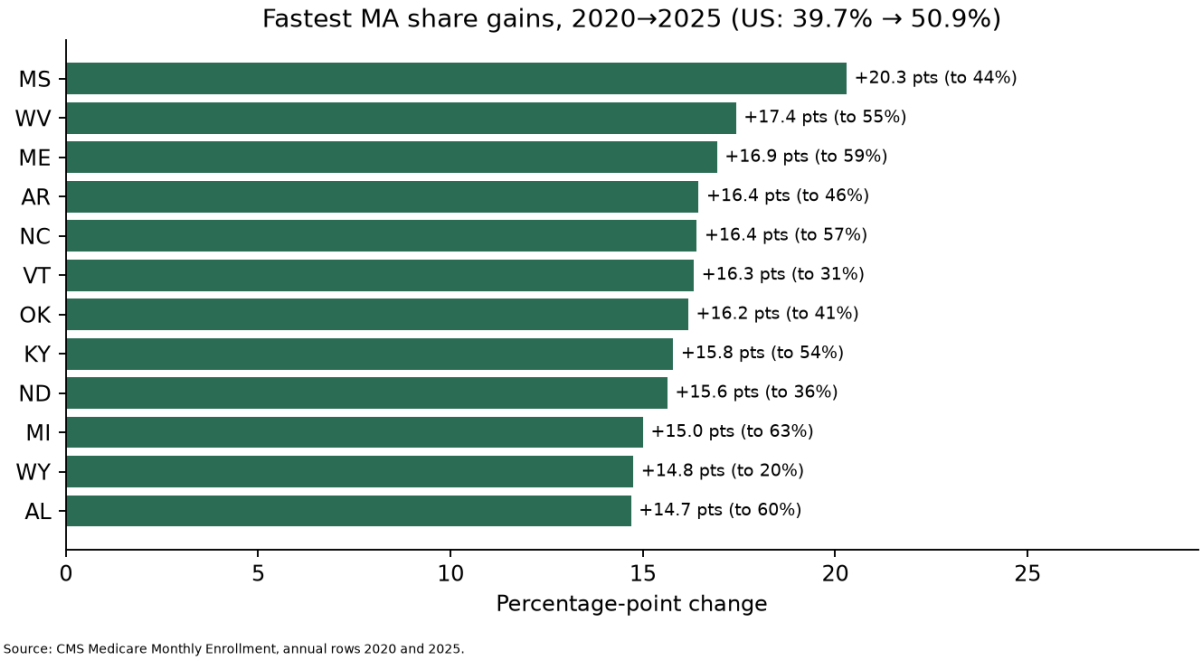


Figure 1. States with the largest MA share gains, 2020→2025.

Cost intensity varies by about 70% across states. Standardized FFS spend per capita ranges from $8,622 to $14,680 (median $12,145). Florida is the highest at $14,680, with Louisiana ($14,247) and Texas ($14,056) close behind. High cost combined with high MA share marks the best payer opportunity.

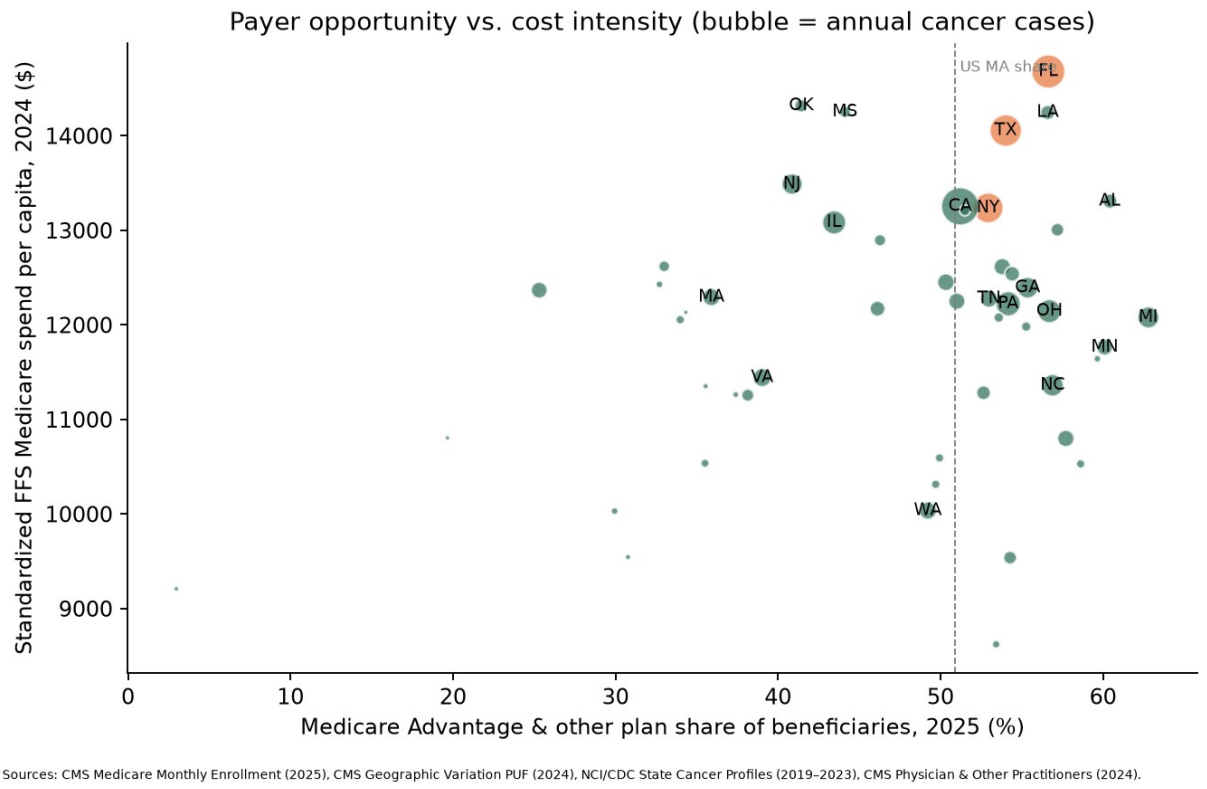


Figure 2. MA share vs. standardized FFS cost; bubble size = annual cancer cases. Orange = recommended markets.

Ranking. Under balanced weights, Florida scores 78.7, Texas 76.0, and New York 70.6. California (69.1) has the most cancer cases (187,921 a year) but ranks 4th because of lower MA share (51.2%), lower cost, and the lowest incidence rate among large states (413 per 100k). Minnesota ranks 5th on the highest MA share of any top-10 state (60.1%).

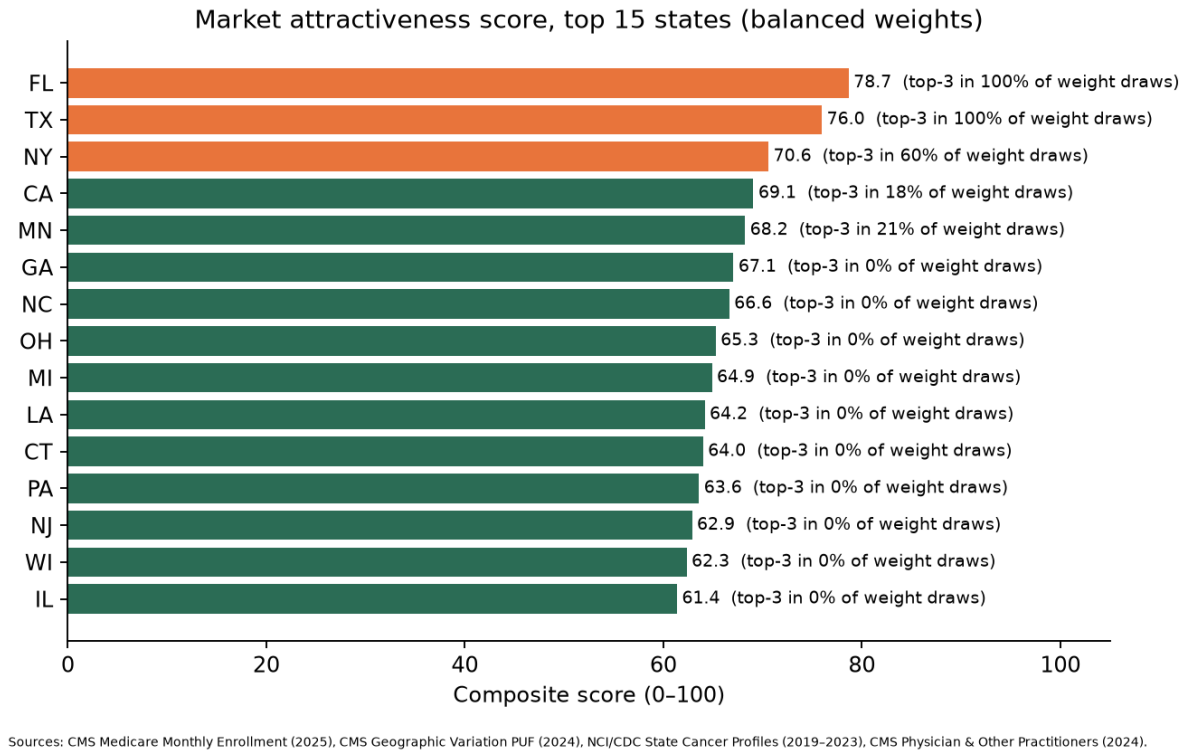


Figure 3. Composite score, top 15 states (balanced weights); labels show share of 5,000 random weight draws in which the state ranks top 3.

4. Sensitivity: how much do the weights matter?

I re-ranked states under four preset strategies: Balanced; Payer-partner (MA weight 45%); Cost-savings (cost weight 40%); and Growth (growth weight 40%). I also ran 5,000 draws that varied each base weight independently by ±50%.

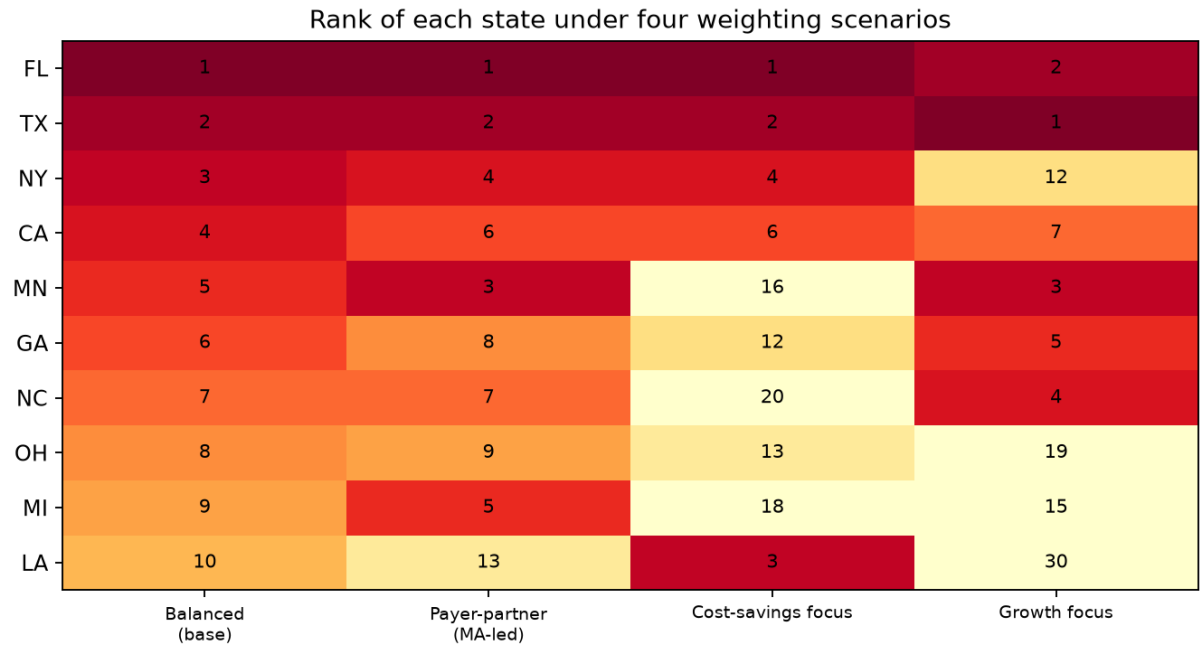


Figure 4. Rank of the base top 10 under each preset (1 = best).

- **Robust:** Florida and Texas stay in the top 2 in every preset.
- **Weight-sensitive:** New York ranks 4th under MA-led weights and 12th under Growth, so it's the least certain pick. Minnesota rises to 3rd (MA-led) and 3rd (Growth). Louisiana rises to 3rd under Cost-savings.

5. Options and recommendation

State	Cases/yr	MA share 2025	FFS $/capita 2024	Onc. clinicians /100k benes
FL	149,440	56.6%	$14,680	29.7
TX	134,736	54.0%	$14,056	32.5
NY	120,068	52.9%	$13,237	44.5
CA	187,921	51.2%	$13,254	28.9
MN	34,827	60.1%	$11,764	43.6

- **Florida (launch first):** 149,440 cases a year, 56.6% MA share, and the highest cost baseline in the U.S. The strongest mix of volume, buyer base, and savings headroom.
- **Texas (second):** 134,736 cases a year, the fastest Medicare growth among large states (2.8% a year), and the 3rd-highest cost. A big market that keeps growing.
- **New York (third):** 120,068 cases a year and the densest oncology network of the top 3 (44.5 per 100k). Its MA share (52.9%) and growth are lower, so treat it as a conditional third market.
- **California / Minnesota:** Not recommended first. California is very large but has lower cost intensity and MA share. Minnesota is attractive but small (34,827 cases a year). It could work as a low-risk pilot.

6. Phased roadmap (illustrative)

- **Phase 0 (months 0–3): validate.** Confirm top-3 with plan-level MA enrollment, competitor mapping, and payer interviews. Set go/no-go criteria.

- **Phase 1 (months 3–12): Florida.** Sign 1–2 MA plan partners. Build a network with high-volume oncology groups. Launch pathway and prior-authorization program.
- **Phase 2 (months 12–24): Texas.** Repeat the Florida playbook in the largest metros first. Add site-of-care and biosimilar programs.
- **Phase 3 (months 24–36): New York.** Enter if Phase 1–2 KPIs are met. Prioritize plans with the largest MA books.

7. KPIs

- Covered lives under contract and number of payer partners per state
- Pathway adherence rate and share of eligible cases reviewed
- Episode cost trend vs. a matched baseline (PMPM or per episode)
- Biosimilar and lower-cost site-of-care adoption
- Provider network participation and satisfaction; review turnaround time
- Member outcomes: ED visits and admissions during treatment, hospice use at end of life

8. Risks and mitigations

- **Payer concentration.** A few MA plans may dominate a state. Mitigate by mapping plan-level share before entry.
- **Provider pushback.** Pathway programs can strain relationships. Co-design pathways with local oncologists and keep reviews fast.
- **Policy change.** MA payment rules and prior-authorization rules are changing. Build the model around outcomes, not denials.
- **Competition.** Established specialty-benefit and oncology-network players are already in big states. Differentiate on data and provider experience.
- **Model risk.** The ranking depends on weights and proxies. See Section 4 and the interactive dashboard.

9. Limitations

State-level data hides metro and county differences. "MA share" includes other plan types and says nothing about which plans buy delegated specialty programs. FFS cost per capita covers all services, not just oncology, so it's only a proxy for cancer-care cost. Cancer incidence is all-ages, while MA covers mostly people 65+. The clinician counts include only those billing Medicare FFS. There is no direct competitor or policy data, and those factors are qualitative. All weights are judgment calls. This is an independent portfolio analysis, not advice for any specific organization.

References

1. CMS, Medicare Monthly Enrollment (July 2026 release; annual rows 2020 and 2025). https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment
2. CMS, Medicare Geographic Variation by National, State & County (2014–2024 PUF; 2024 used). https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-geographic-comparisons/medicare-geographic-variation-by-national-state-county

3. National Cancer Institute & CDC, State Cancer Profiles: Incidence Rates by State, all sites, 2019–2023. https://statecancerprofiles.cancer.gov/incidencerates/
4. CMS, Medicare Physician & Other Practitioners by Provider (2024 release). https://data.cms.gov/provider-summary-by-type-of-service/medicare-physician-other-practitioners/medicare-physician-other-practitioners-by-provider
5. Analysis code and scored data are available on request; interactive dashboard: https://mfhportfolio.com/projects/market-strategy